NCDs and the Future of Global Health Architecture

MAY 2026

Key Messages

- The current global health architecture is built for priorities from the early 2000s. It must now evolve to respond to the health challenges or today and tomorrow, and this means integrating NCDs.
- Global health architecture (GHA) reform is no longer optional - health system transformation is now the only way to avoid a global health crisis.
- Achievement of Universal Health Coverage and the principles of the Lusaka Agenda must be central to all GHA reform. This includes a shift to integrated, people-centred health systems, national sovereignty, and sustainable domestic resourcing.
- Vertical health programming alone is no longer fit to purpose. The current epidemiological burden requires integration of global health priorities for comprehensive service provision to be a shared responsibility across all global health actors.
- Formalised engagement of civil society and people with lived experience must be embedded in GHA reform processes to ensure health systems are equity-driven, responding to the true needs and challenges of countries and communities and delivering Health for All.

Purpose of this paper

Drastic cuts to global health financing, combined with shifting geopolitics around multilateralism, are driving a "reimagining" of global health and reforms to global health architecture (GHA) not seen since the early 2000s. At its core, GHA encompasses the systems, structures, institutions, rules, and processes that guide, coordinate, finance, and implement efforts to improve global health. The noncommunicable disease (NCD) community must be at the table and engaged in reform processes to help ensure that NCDs – which include diseases such as cancer, diabetes, chronic respiratory diseases, cardiovascular diseases, and mental health and neurological conditions – are reflected in alignment with the burden they represent, as the leading cause of death, disease, and disability worldwide.

This paper sets out NCDA's policy position on the future of GHA, outlining why NCDs must be included, the risks of their omission, and where they fit into current reform dialogues and processes. We anticipate updates to our recommendations as these dialogues progress.

The overall aim of this paper is to promote GHA reforms that give appropriate weight to NCD prevention, control, and financing within integrated, people-centred health systems. We also aim to see specific consideration on NCDs developed within the WHO proposed joint planning process for GHA reform to be developed during 2026[I].

I Dependent on a World Health Assembly decision in May 2026.

Global health architecture transformation: why now?

2025 marks a pivotal moment for global health. At the beginning of the second Trump Administration, the US made massive cuts to Official Development Assistance (ODA) and retreated from multilateral engagement, withdrawing from the World Health Organization (WHO) and other development-related processes. Significant financing cuts by other countries have exposed the fragility of our current GHA, heavily dependent on donor financing and shared political objectives.

This weakening of multilateral solidarity will have seismic consequences – not only for global health governance, but for the millions of people who have relied on Development Assistance for Health (DAH)-supported interventions and programming for access to care and medicines, and for the health workers who will lose their jobs. Modelling from *The Lancet* suggests that, if not reversed, these ODA cuts could cause up to 22 million avoidable deaths by 2030.[1]

Bold decision-making and collaboration are urgently needed to seize the opportunity within the crisis, and move beyond a global health system that is increasingly criticised for being too fragmented and inefficient. This moment calls for strong advocacy towards integration and cooperation, towards people-centred health systems that are fit for today and tomorrow's health challenges.

This transformation of health systems and GHA is now both urgent and unavoidable, no longer just a compelling topic for panel debates at conferences. In response, a number of different initiatives emerged in 2025 to respond to shocks and rethink GHA. These include the Accra Health Sovereignty Summit (August) and the Accra Reset launch at UNGA (September), the Wellcome Trust Rethinking the Future of Global Health consultations, the European Union and Like-Minded Donors' Reflection Process on Global Health Reform, and the HEAR-CSO civil society consortium. These dialogues have continued in 2026, with a decision at EB158 for WHO to develop a joint process on GHA reform that will be presented at the World Health Assembly (WHA79) in May *(See Annex for more on these initiatives).*

Meaningful reform must include NCDs

NCDs are the leading cause of death and disability worldwide, accounting for 75% of all deaths. 82% of premature NCD deaths (before the age of 70) occur in low- and lower-middle-income countries, where health systems are least able to respond. The number of people living with NCDs is staggering – 1.3 billion live with hypertension, 537 million with diabetes, and 970 million with a mental health condition. These numbers are growing at an alarming rate – particularly in low- and middle-income countries (LMICs) - and will continue to rise until governments take decisive policy action for NCD prevention and control, backed up with sufficient sustainable funding.[2]

Despite this, NCDs have received an average of just 2% of ODA financing over the past three decades.[3] There is a clear and fundamental mismatch between the healthcare needs and rights of people living with NCDs and the resources allocated to respond. Although recent ODA cuts have not directly impacted NCD programmes and services, the broader impact on health systems will widen the existing NCD financing gap and contribute to a deepening health crisis. Reduced resources will disproportionately impact people living with NCDs, and this vulnerability is intensified in polycrisis settings such as pandemics, humanitarian crises, and climate-related emergencies.

For GHA to be credible and responsive to needs, it must be grounded in evidence and the epidemiological reality. Current and projected morbidity and mortality data make the inclusion of NCDs not optional, but essential.

The economic case for NCD action

There is also an economic imperative to addressing NCDs, which cost the global economy more than US$ 2 trillion annually in healthcare costs and lost productivity, greatly outweighing that of other global health priorities[4]. At the household level, an estimated 1.4 billion people are facing impoverishing or catastrophic healthcare costs, with a large proportion driven by NCD-related care. In a context of shrinking fiscal space, investment in NCD prevention and care returns dividends in both the short- and long-term, relieving financial strain on households while supporting healthier, more productive economies. For instance, WHO calculated that full implementation

of the NCD "Best Buys" would yield a return on investment of 4:1 by 2030, increasing to 7:1 by 2035, indicating significant savings to the health system while saving 12 million lives.[5]

NCDs, equity and sustainable development

Although NCDs are embedded within the Sustainable Development Goals (SDGs), progress has fallen short of expectations over the past decade since their adoption. As a result, we are far off-track to meet SDG target 3.4 to reduce premature NCD mortality by one-third and promote mental health and well-being by 2030, as well as related health goals such as SDG 3.8 to achieve Universal Health Coverage (UHC), and other global priorities, like equity, poverty elimination, and healthy economies.

Due to their high prevalence and chronic nature requiring long-term or lifelong care, NCDs are a major driver of poverty and inequality. It is widely evidenced that NCDs follow a distinct social gradient: the lower a person's socio-economic status, the higher their risk of morbidity and premature death from NCDs. Achieving 'health for all' requires action beyond clinic walls, to address the commercial, social and environmental determinants of health, ensuring policy discussions – including those on GHA – are safeguarded against conflicts of interest.

The path forward: integrated, people-centred care delivered through UHC

Ongoing GHA discussions and the WHO reform process present a rare opportunity where a transformation of global health decision-making and health systems is the desired outcome.

Following the first UN High-Level Meeting (HLM) on UHC in 2019 and the COVID-19 pandemic, there was broad recognition of the need for UHC, integrated health systems, and whole-of-system resilience. Policy discussions emphasised UHC delivered through a strong PHC foundation, a position reinforced at the HLM on UHC in 2023. However, "build back better" reform efforts ultimately came up short[6].

More recent initiatives, notably the Lusaka Agenda *(see Annex Box 1)* and efforts linked to the World Bank's UHC target *(see Annex Box 2)*, have picked up where post-pandemic efforts faltered. As a result, tangible progress has followed. The Lusaka Agenda has been adopted by the WHO African Region as a framework for health system transformation, with implementation underway in 10 champion countries. In parallel, the World Bank announced in March 2026 that it had reached 575 million people with quality, affordable health services, 38% of its target of 1.5 billion people by 2030.[7]

One of the most effective opportunities to improve lives globally is the inclusion of NCDs within UHC benefit packages, with services delivered from a strong PHC foundation equipped with strong referral systems. A large proportion of NCDs can be prevented or diagnosed early and effectively managed at PHC level, yet this requires systemic transformation. **This paradigm shift - toward integrated person-centered health systems that address needs throughout the life course under UHC efforts - should be the overall aim and the foundation of a reformed GHA.**

The Lusaka Agenda and the World Bank's UHC efforts are two initiatives which are successfully delivering the health system solutions so urgently needed, and can provide important guidance and lessons to GHA reform processes. However, GHA reform must also address persistent structural weaknesses, including those outlined below.

From vertical programming to integrated systems

The current GHA remains caught between its legacy structures and more recent political commitments for health. To move forward, GHA reforms must extend the roles of global health initiatives (GHIs), such as GAVI, the Global Fund, and the Global Financing Facility, toward shared responsibility in the delivery of person-centered care, UHC and health systems strengthening, moving beyond narrow, vertical interventions toward resilient and integrated systems.

These GHIs were established to support progress toward the Millennium Development Goals, focused on infectious diseases and maternal, newborn, and child health. This resulted in highly effective vertical programming, bolstered by an era of strong international cooperation and development assistance. However, upon the adoption of the

SDGs, these vertical systems remained in place, rather than evolving to respond to new global health priorities or aligning with the integrated approach of the SDGs.

Philanthropies also continue to shape GHA, often reinforcing vertical programming. With the withdrawal of the United States, the Gates Foundation has become the largest contributor to WHO.[8] Recent research has shown that its funding significantly shapes multilateral work and WHO priorities and funding flows, as well as the behaviour of other development and philanthropic donors in country.

To date, discussions on GHA reform have focused on achieving efficiencies within and across existing structures, UN institutions, GHIs, and the current architecture delivering their priorities. This focus, and the "institutional incentives that favour preservation over transformation,"[9] may limit the paradigm shift needed to respond to population needs, now and in the future.[10] NCDs have never had a dedicated global health initiative, putting them at a disadvantage in GHA discussions, given the current prioritisation of those initiatives. This increases the risk that NCDs will remain deprioritised in GHA planning.

GHA discussions should be focused both on how to best align existing structures and available resources with population needs, and on how existing systems can be extended to support delivery of comprehensive and person-centred disease prevention and care. NCDs must be central to this shift. While GHIs are unlikely to fundamentally change their mandates, working 'diagonally' within existing frameworks by combining disease-specific or vertical funding with broader system-strengthening efforts may offer a realistic pathway towards better integration of NCDs into current global health priorities.

Various GHIs have recently recognised the need to broaden their funding to address multi-morbidities, including NCDs, and deliver wider health system strengthening to achieve their mandates. For example, the Global Fund's integration of mental health and NCD services for people living with HIV as part of its focus on Resilient and Sustainable Systems for Health, and GAVI expanding to include HPV vaccinations. However, the data show that actual investment remains a fraction of what is needed, stopping short of the comprehensive system reform required: UNAIDS and United for Global Mental Health found that NCD mentions in funding requests have increased by 600% in Global Fund applications, but that only $61.7 million was disbursed in Grant Cycle 7 for priority comorbidities[11].

Within the transition to person-centred care and UHC, there is a more explicit focus on health systems strengthening, moving beyond narrow, vertical interventions toward resilient and integrated systems. In a constricting fiscal environment, integration of global health agendas has never been more important, for both economic efficiency and improved patient outcomes.[12] These systems are also more resilient to shocks such as pandemics, climate-related emergencies, and conflict.

The GHA process must clearly define institutional roles, including a shared responsibility to support integrated care, to respond to population needs now and in the future, and to health system strengthening and resilience. NCDs must be treated as an integral component of health system strengthening, rather than a peripheral add-on.

From donor dependence to country leadership and long-term sustainability

The reformed GHA must transition from donor-driven vertical funding streams towards systems that prioritise nationally-defined priorities, strengthen country ownership, and support LMICs to move from aid dependence to health sovereignty. These shifts are already gaining political momentum through the Lusaka Agenda and related initiatives like the Accra Reset *(See Annex Box 3)*. Although some influential donors remain focused on a narrow set of priorities, it is crucial that GHA aligns with country needs and supports the changes needed to deliver on the principles of the Lusaka Agenda.

The role of WHO Regional offices and regional intergovernmental organisations should also be recognised and clarified, determining locally appropriate means of implementing the GHA framework, addressing similar challenges, and strengthening cooperation for shared solutions.

Impactful reform of GHA will require flexible financing and tailored technical support, supporting countries to address their own priorities and their specific challenges to delivering UHC. NCDs must be fully integrated as this transformation advances in order to reflect current disease burdens, and thus are inextricably linked to country ownership and leadership.

Ensuring equity: Meaningful engagement of civil society and communities

Equity must be a pillar of GHA reform. As the WHO process launches at WHA79, ensuring participation is inclusive remains a central challenge *(see Annex Box 6)*. To be successful, the GHA reform process must move beyond high-level discussions. Meaningful reform requires translating these dialogues into concrete technical and institutional backing that supports national leadership to address local priorities and challenges. It should also clearly define the roles and responsibilities of all stakeholders, as well as accountability measures for them, particularly those who benefit from the current structure.

To date, civil society engagement in GHA discussions has been limited,[13] with the notable exception of the CSO-led initiative HEAR-CSO *(see Annex box 5)*. This underlines a clear challenge to inclusivity and transparency, but also limits the probability that reforms will respond to people's needs, particularly for the most marginalised and vulnerable populations. This includes people living with NCDs, who often face economic hardship and other challenges due to these diseases and the care they require. The participation of civil society, in addition to people living with health conditions, must be acknowledged and regularised within the WHO GHA reform processes to ensure a safe, open, and enabling environment where they can make meaningful contributions to its design, implementation, and accountability. This representation will also help to ensure that NCDs are not overlooked in GHA reforms.

Beyond WHO processes, countries must uphold their own commitment to social participation and embed civil society engagement within national decision-making.

Market shaping and access to medicines

Global health financing plays a critical role in shaping pharmaceutical markets and access to health technologies. Historically, it has prioritised infectious diseases and emergency responses, through mechanisms such as pooled procurement and advance purchasing to expand access to medicines and other products.

Comparable efforts have not been applied to NCDs, despite the scale of the NCD burden and persistent access barriers associated with it. As a result, markets for essential NCD medicines remain weak and unreliable in many LMICs, resulting in widespread unmet need. For instance, only 36% of people in LMICs who need insulin have access to it[14], and 1 billion people live with uncontrolled hypertension[15].

As GHIs and financing mechanisms evolve, there is increasing emphasis on strengthening country capacity and responsibility for the sustainable financing, procurement, and delivery of health products. This transition will require investments in national procurement systems, market stewardship, and supply chain resilience, and must incorporate NCD medicines and technologies, rather than continuing to prioritise only traditionally funded disease areas.

Access to medicines is recognised as a main barrier to achieving UHC, and GHA reform discussions must close these gaps to meet population needs and achieve health for all.[16]

Recommendations

In what has the potential to become an increasingly complex, multi-faceted discussion, NCD Alliance identifies the following key recommendations that must be reflected in any GHA reform.

Principles of GHA

- Name a rights-based approach and equity as core principles of GHA reform, to ensure that governments remain accountable for delivering health systems that promote Health for All.
- Ensure that the engagement of civil society, people living with health conditions, and impacted communities is meaningful and institutionalised, and that all governments respect the right to health in decision-making.
- Place LMIC perspectives at the centre of global governance reform to ensure their needs are met, as these countries are the most vulnerable to system shocks, including impacts from the climate crisis, on the burden of NCDs.

Health system transformation

- Prioritise the development of integrated health systems which emphasise disease prevention, primary care with strong referral systems, and evidence-based responses to national disease burdens and unmet care needs.
- Ensure that GHA addresses disease risk factors and supports multisectoral action on the commercial, social, and environmental determinants of health as integral to health promotion, disease prevention, and achieving Health for All.

Financing and governance

- Align DAH with national priorities and disease burdens to support the continued pursuit of the principles of the Lusaka Agenda.
- Utlise DAH in ways that complement national and regional plans and catalyse domestic resource mobilisation by bridging funding gaps and addressing structural and systemic bottlenecks.
- Strengthen and protect the core functions of the WHO, including technical expertise, norm and standard setting, emergency response, and convening of governments.
- Align and simplify accountability mechanisms to measure progress beyond basic metrics on disease burdens, including through metrics on health system and economic resilience, population well-being, and planetary health.

ANNEX
Key global health architecture initiatives

BOX 1
Lusaka Agenda

Completed in 2023, the Lusaka Agenda is the outcome of the Future of Global Health Initiatives process (FGHI), funded by the Wellcome Trust. The hallmark of this platform is a "one plan, one budget" approach to health systems and encourages development actors to align their support with nationally-led plans and priorities, rather than donor-driven priorities. This approach was adopted by WHO-AFRO members as a health system approach in 2024, with 10 countries piloting health system reform and operationalisation based on its principles. It has also been endorsed by the G7. The Lusaka Agenda is a guiding document for national health system reform.

BOX 2
The World Bank on UHC

At the World Bank Spring Meetings in 2024, World Bank President Ajay Banga, alongside WHO Director-General Tedros Adhanom Ghebreyesus, announced a Bank initiative aiming to support countries in delivering an additional 1.5 billion people with quality and affordable health services under UHC by 2030. Related activities have included the establishment of the "Health Works" by the Government of Japan, World Bank, and WHO, and associated UHC Knowledge Hub, National Health Compacts, the "Health Works Leaders Coalition," and the yearly UHC Forum launched in 2025.

BOX 3
The Accra Reset

Led by Ghanaian President John Mahama, the Accra Reset, announced in August 2025 at the Accra Health Sovereignty Summit, is positioned as an African-led global initiative that is responding to the drastic reduction in development assistance. Similar to the Lusaka Agenda in its principles of aligning DAH with national priorities, it differs in that it promotes health sovereignty and the reduction of aid dependence by centring nationally-owned work and bilateral agreements. It also focuses on mobilising funding within African sovereign wealth funds and the governrments' investment vehicles, rather than depending on the initiatives of GHIs and other stakeholders to carry out the paradigm shift.

BOX 4
Wellcome Trust's Rethinking the Future of Global Health Architecture

Commissioning a set of five regional thought papers and consultations as starting points to reimagine global health in this new era, the Wellcome Trust process invited participation to brainstorm potential forms and functions of a new global health architecture and the pathways to reach it. Their consultation process continued with a global dialogue meeting in Bangkok, where participants focused on and discussed the importance of UHC as a great equalizer that serves as the moral and political imperative for reform that can bring together many key attributes critical to advancing the NCD agenda, such as pivoting to a country-systems agenda and aligning the investment case between ministries of health, finance, and multilateral development banks.

BOX 5

HEAR-CSO

Health Architecture Reimagined Civil Society Organizations, or HEAR-CSO, is a civil society consortium providing a coordinated platform to promote civil society engagement in global health architecture reform and principles for CSO engagement in future FGHA dialogues. Since the fourth quarter of 2025, HEAR CSO has run regional consultations and a global survey on the GHA process to gather perspectives on the current architecture and identify where change is needed.

One of the key survey findings was that civil society's readiness to engage in GHA dialogues was high, but participation was low, with many actors citing the abstract nature of the topic or limited space for meaningful engagement as barriers to their participation. NCD Alliance is a member of the steering committee of the HEAR-CSO consortium and fully supports its statements.

The initiative is supported by the Wellcome Trust, which has also run regional consultations on "Rethinking the Future of Global Health Architecture."

BOX 6

WHO Process

At the 158th meeting of the WHA Executive Board, WHO presented a report from the Director-General examining the growing pressures on GHA arising from 2025's decline in ODA, increasing fragmentation among global actors about the utility and effectiveness of the UN, and multilateralism more broadly. WHO's active engagement across other multilateral reform processes were highlighted, along with potential implications for its role in coordinating health action.

The report underscored the need for a more coherent, equitable, and accountable GHA, with sustainable financing, reduced duplication, stronger country leadership aligned with the Lusaka Agenda, and a reinforced normative, convening, and coordinating role for WHO. It proposed that WHO host a joint, inclusive process in 2026 to help converge GHA and UN80 reform discussions relevant to health into a common framework to guide priorities, investment, financing, and governance. The request was approved by the EB and asked for WHO to present a proposal at the 79th World Healh Assembly.

In April 2026, WHO opened a consultation on two proposals for the GHA process, asking stakeholders for written feedback on the scope, principles, workstreams, timeline, and more. NCDA's WHA79 Advocacy Briefing with a response to the WHO process proposal is available on our website.

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