

Leadership Series

STRATEGIC POLICY BRIEF

Global Health System Redesign Lab

From Proliferation to Purposeful Progress of AI

On the Sidelines of the 79th
World Health Assembly

19 May 2026



John Knox International
Centre, Geneva



CO-CHAIR'S MESSAGE



Dear Esteemed Colleagues,

The Global Commission for 21st Century Healthcare began with a simple but uncomfortable question: if a health system is broken, can digital health fix it? The answer we arrived at was clear: *keep investing in a broken health system, and you only build a bigger broken one*. Add digital health on top, and you build a bigger broken digital health system. The fix isn't more investment in the same direction. It's going back to the drawing board. That conviction is what led to this Commission.

What the Research Has Shown Us:

Healthcare today is a trillion-dollar global industry, yet more than half the world's population still lacks access to quality care, and 10 million people become statistics every year — deaths we don't even fully count. Looking across thousands of years of healthcare's evolution, three dominant models have emerged globally: public, private, and mixed systems. But across all of them, we found the same structural flaw: every system is built for acute, episodic emergencies, then applied to four very different kinds of care — acute, chronic, assistive, and emergency. Applying an emergency-built system to all four isn't a malfunction. It's the design working exactly as built. That is the problem.

The numbers reinforce this. The WHO projects an 11 million health worker shortfall by 2030. Africa carries 25% of the global disease burden with just 3% of the world's health workforce. Physician burnout sits at 40% globally. And of all healthcare spending, 97% goes to treatment and just 3% to prevention.

Despite remarkable scientific and technological progress, global life expectancy is rising while health-adjusted life expectancy is falling. People are living longer, but sicker. Our financing models tell an equally difficult story: insurance depends on low-risk individuals subsidizing high-risk ones, but as the world ages, with more senior citizens than working-age people within the next 30 years, that model will not hold, in any country. We cannot keep raising premiums indefinitely.

We also examined an underexamined area: social and emotional medicine. Loneliness and disconnection, especially in an increasingly hyperconnected world, carry real health costs that today's systems barely register.

The clearest conclusion from this research is that the problem isn't just systemic, it's a design problem, present at every touchpoint of care. That means the path forward isn't a technology decision, or even a management decision. It is a policy decision. A thinking decision. We have to reimagine the system, not patch it.

Several priorities now sit ahead of us:

- New medical specializations: Examining whether medical education and specialty structures built decades ago are equipped for what's coming, and what new specialties the next era of healthcare actually requires.
- Precision, predictive, and personalized medicine: Understanding how genetics and precision medicine will fundamentally change diagnosis and treatment.
- Responsible AI integration: Not a question of whether AI enters healthcare, since that shift is already underway, but of how we ensure it improves access, engagement, and outcomes rather than becoming a business model without guardrails.
- Workforce and training transformation: Capacity-building for a workforce operating in a technology-driven, lower-barrier environment.
- Re-examining the three-tiered care structure itself, in light of all of the above.

None of us stands outside the consequences of the health system we build, or fail to build. We will each, eventually, be either its beneficiaries or its victims. That is why this work matters, and why it cannot wait.



Dr. Rajendra Pratap Gupta

Co-chair

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ABOUT

Global Commission for 21st Century Healthcare (GC21CH)

GC21CH is convened by Health Parliament and is a once-in-a-century movement to rebuild healthcare for the 21st Century. It is co-chaired by Dr. Rajendra Pratap Gupta, Founder and Chairman of Health Parliament, and Prof. (Dr.) Thomas Zeltner, Chairman of the WHO Foundation.

The Commission brings together 12 global leaders spanning medicine, nursing, pharmacy, digital health, economics, informatics, and public health. Together, this group is working to design what the Commission calls a **New Global Healthcare Architecture**, one that is equitable, proactive, digitally enabled, and human-centered, built for a moment when health systems worldwide are straining under rising costs, fragmentation, and declining public trust.

Milestones So Far:

- **12 November 2025, Global Health System Redesign Lab, Pfarrkirchen, Germany:** An early working session bringing youth and students together to interrogate the current model.
- **15 December 2025, Inaugural Global Meeting held virtually as a side event of the WSIS+20 UN General Assembly High-Level Meeting:** This was GC21CH's formal launch framed around the idea that the current system is, in effect, still an 18th-century model running on 21st-century problems, undermined by mis-measurement and misaligned incentives.
- **19 May 2026, Global Health System Redesign Lab: From Proliferation to Purposeful Progress of AI:** Hosted at the John Knox International Centre in Geneva during 79th World Health Assembly. This session zeroed in on how AI's rapid, scattered growth in healthcare can be redirected toward purposeful, system-wide progress.

How to Get Involved:

If your organization would like to engage and participate in the Commission's work, write to us at:
contact@parliament.health



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INTRODUCTION



During 79th World Health Assembly, Global Health System Redesign Lab: "From Proliferation to Purposeful Progress of AI" was convened against a backdrop of compounding systemic pressures: a projected shortfall of 11 million health workers by 2030, a global health expenditure exceeding \$12 trillion with outcomes that still leave more than half the world's population without adequate care, and an artificial intelligence landscape advancing at a pace that outstrips governance by at least a decade. Into this context, the Global Commission for 21st Century Healthcare convened a diverse assembly of global leaders not to debate the merits of technology, but to confront a more fundamental question: is the system itself fit to be improved?

What made this convening distinctive was its diagnostic honesty. Rather than celebrating digital innovation, participants converged on an uncomfortable recognition: trillions invested in health systems over recent decades have produced declining healthy life span alongside

rising life expectancy, persistent workforce burnout rates approaching 40%, and an architecture designed for episodic emergency care that is now being asked to manage a predominantly chronic, aging, and complex global burden. This is not a resource problem. It is, as multiple voices underscored, a design problem.



The introduction of AI presents both an extraordinary opportunity and a structural risk of historic proportion. The opportunity lies in extending the reach of diagnostics, clinical decision support, preventive surveillance, and workforce efficiency to populations that have never had equitable access to specialist care. The risk lies in the possibility, already materializing in dozens of countries, that AI will be layered atop fragmented, under-governed, sovereignty-compromised health data infrastructure, amplifying existing inequities rather than dismantling them. This convening mattered precisely because it refused to treat these as separate conversations.

THE CENTRAL QUESTION

Will 21st century health system redesign be built upon foundations of equity, sovereignty, and contextual intelligence or will it replicate, in digital form, the same dependencies and disparities that have failed the 20th century system?

Embedded within this are three subsidiary questions that shaped the entire discussion: How do we distinguish purposeful AI deployment from proliferation without intent? What governance architecture must precede AI adoption, not follow it? And which new roles, specializations, and educational paradigms does the workforce of tomorrow actually require?

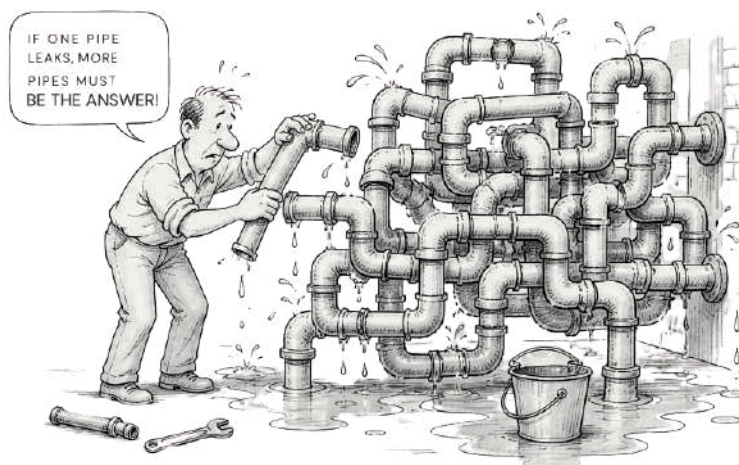


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KEY SIGNALS EMERGING FROM THE DISCUSSION

Signal 1

The Design Failure Precedes the Technology Failure

Observation

Leaders from across geographies and disciplines converged on the view that the foundational architecture of most health systems built for acute, episodic, hospital-centric care is structurally misaligned with the disease burden it is now asked to address. Chronic disease, aging populations, mental health, and social determinants require a system designed around prevention, continuity, and community and not one designed around emergency response.

Why It Matters

No technology investment, AI or otherwise, can overcome an architectural mismatch of this magnitude. Introducing advanced diagnostic AI into a system that allocates 97% of resources to treatment and 3% to prevention does not rebalance the system; it accelerates its existing trajectory.

Decade Implications

Nations that prioritize systemic redesign before technology adoption will generate compounding returns. Those that invest in AI first will face escalating costs, provider burnout, and outcomes that plateau. The design question is therefore a fiscal question as much as a clinical one.

Signal 2

AI Governance Is a Prerequisite, not a Sequel

Observation

A consistent pattern emerged across high-income and lower-income country experiences: AI systems are being adopted ahead of the regulatory, evaluative, and data governance infrastructure needed to assess their real-world performance, contextual fit, or equity impact. The systems most eagerly marketed to under-resourced health ministries are frequently those whose training data least reflects the populations they will serve.

Why It Matters

Algorithms that achieve expert-level accuracy in aggregate can still systematically under-diagnose disease in marginalized communities whose data was not adequately represented during training.

When countries adopt externally developed AI systems without domestic capacity to evaluate them, they are not adopting AI, they are inheriting assumptions. The generalizability gap between development context and deployment context has become the defining equity risk of the digital health era.

Decade Implications

The next global health divide will not be between nations that have AI and those that do not. It will be between nations that can govern AI – evaluating, procuring, monitoring, and adapting it and those that cannot.

Signal 3

Data Infrastructure Is Non-Negotiable and Chronically Under-Funded

Observation

The collapse of digital health systems in more than 40 countries when donor funding ended in 2025 was cited as a defining cautionary signal. Systems failed not because the technology was inadequate, but because foundational infrastructure including unique identifiers, facility registries, interoperability standards, and sustainable domestic financing was never built. Meanwhile, globally, two out of ten births and four out of ten deaths remain unregistered, undermining the very baseline data that AI systems require to function with equity.

Why It Matters

Digital public infrastructure for health is as foundational as roads or power grids and as chronically neglected in development financing. The current pattern of funding applications and pilots without funding infrastructure systematically produces fragmentation, vendor dependency, and eventual collapse. AI readiness is entirely downstream of data system maturity.

Decade Implications

The most consequential investments in health AI over the next decade will not look like AI investments. They will look like civil registration modernization, interoperable data architecture, primary care digitization, and long-term domestic health financing reform.

Framing these as foundational rather than preparatory is a critical reorientation for both governments and multilateral funders.

Signal 4

The Health Workforce Crisis Has Structural, Not Merely Numerical Dimensions

Observation

With a projected global shortfall of 11 million health workers by 2030, a 40% physician burnout rate, and the concentrated departure of trained nurses from lower-income to higher-income countries, the workforce crisis is well-documented numerically. What emerged in this convening was a more structural diagnosis: the workforce is being trained for a system that no longer reflects the disease burden, deployed into roles that do not match their competencies, and governed through regulatory frameworks that were designed for a different era of medicine.

Why It Matters

A 30-million-strong global nursing workforce whose scope of practice is constrained by outdated regulations represents both a policy failure and an unrealized asset. Similarly, a pharmacist workforce among the most accessible health professionals globally, that is limited to dispensing functions in most health systems represents a missed prevention infrastructure. The question is not only how many workers, but whether the architecture of roles enables their full contribution.

Decade Implications

Scope-of-practice reform, curriculum modernization, global credential recognition, and AI-augmented task shifting could together constitute a workforce transformation comparable in impact to any technology investment. Countries that reform professional roles ahead of workforce shortages will be better positioned to absorb both the aging burden and the coming AI augmentation.

Signal 5

Sovereignty Must Be Engineered, Not Declared

Observation

Data sovereignty emerged as a word used with increasing frequency but decreasing precision.

Concrete examples underscored the operational stakes: African countries being asked to supply fifteen years of patient records in exchange for technology services; European nations reinterpreting privacy law to exit US-owned cloud services; AI language models making clinical recommendations entirely disconnected from the population and regulatory context in which they are deployed.

Why It Matters

Sovereignty over health data is not a rhetorical commitment; it requires institutional architecture, governance bodies, regulatory capacity, domestic cloud infrastructure, and procurement standards that can withstand commercial pressure. Without this architecture, the path of least resistance, deploying externally developed systems because domestic capacity does not exist, becomes the default. And that default transfers control of the most sensitive national data to entities with no accountability to the populations affected.

Decade Implications

As AI systems become embedded in clinical workflows, the cost of reversing vendor dependency will escalate. The window for building the institutional infrastructure needed for genuine sovereignty is now, before systems become too entrenched to govern. This is a political economy problem as much as a technical one.

Signal 6

The Insurance and Financing Model for Health Is Structurally Unsustainable

Observation

Demographic modelling presented at the convening projects that the actuarial logic underpinning health insurance, low-risk populations subsidizing high-risk ones, will break down within 30 to 40 years as the ratio of older to younger populations inverts in most major economies. Simulations conducted for India, Japan, and several European contexts all point toward insurance unsustainability absent fundamental redesign.

Why It Matters

Health financing is rarely examined as a design question in these settings, yet it is inseparable from the system architecture question. A health system financially dependent on an insurance model that cannot survive demographic transition is a system with a structural failure embedded in its foundations. AI-driven efficiency gains cannot compensate for a financing model that will eventually require premiums higher than populations can sustain.

Decade Implications

A back casting approach: designing backward from a sustainable 2050 or 2060 scenario rather than projecting forward from current trajectories is needed for health financing. The global wellness market, currently valued at \$7 trillion and growing, suggests that shifting economic incentives toward prevention is commercially viable, not merely aspirational.

Signal 7

One Health and Pandemic Preparedness Remain Structurally Fragmented

Observation

With 75% of emerging human infections being zoonotic and less than 0.6% of global health spending directed to animal health systems, the structural separation between human and animal health governance was highlighted as a systemic vulnerability.

Why It Matters

The One Health framework remains aspirational in most governance systems. Meanwhile, the conditions that produce zoonotic spillover; deforestation, climate change, intensified animal agriculture are accelerating. AI offers genuine capacity for early warning surveillance, outbreak modelling, and cross-sector data integration. But these capabilities require institutional linkages that do not yet exist at national level in most countries.

Decade Implications

The next pandemic will most likely be zoonotic. Countries that invest in One Health institutional architecture and AI-enabled surveillance before the next spillover will be demonstrably better positioned. The cost of prevention, as the convening noted, is a fraction of the cost of response.



NEW THINKING EMERGING FROM THE CONVENING

From Forecasting to Backcasting in Health System Design

It was proposed that health systems should be designed backward from a desired 2050 or 2060 state rather than forward-projected from current trajectories. This reframing from forecasting (where are we headed?) to backcasting (where must we arrive, and what design choices lead there?) changes both the analytical frame and the policy implications. Insurance unsustainability, workforce shortages, and AI governance gaps all look different from a backcasting perspective: they become design constraints to be engineered around rather than trends to be managed.

AI Governance as Downstream of Data Governance

The proposition that data governance is a prerequisite for AI governance and not merely a parallel concern reorders the standard policy sequence. In this framing, AI regulation without prior data governance architecture is incoherent: you cannot govern what you cannot evaluate, and you cannot evaluate AI without data infrastructure that reflects the populations it will serve. This sequence has significant implications for development finance: investing in AI applications before data infrastructure is not progress, it is premature deployment.

The Three Lenses of AI: Additional, Augmented, and Agentic Information

A framework proposed during the convening distinguished AI as providing additional information (supplementary data points a clinician can weigh), augmented information (high-relevance signals that clinical judgment must engage), and agentic influence (systems that actively guide clinical and system behaviour). This taxonomy is not merely conceptual, it maps directly onto different governance requirements, liability frameworks, and training implications. Conflating these three modes produces both over-regulation of low-risk AI uses and under-regulation of high-risk ones.

Health Workforce as Prevention Infrastructure

The reframing of the 30-million-strong nursing workforce and the globally distributed pharmacist workforce as prevention infrastructure, not merely delivery personnel, constitutes a significant reorientation. Community health nurses in schools, pharmacists conducting chronic disease monitoring and screening, community health officers in wellness centres: these represent a latent prevention architecture that exists within the current system but is constrained by scope-of-practice regulations, curriculum design, and political short-termism. Unlocking this infrastructure does not require new technology; it requires policy reform.



The Trust Infrastructure Problem

Across multiple discussions, trust emerged not merely as a communications challenge but as an infrastructure problem. Trust in AI systems, in health institutions, in data governance frameworks, and in the professionals who work within them is a prerequisite for the behavioral changes, prevention-seeking, adherence, vaccination, that produce health outcomes. The observation that declining institutional trust, rising misinformation, and erosion of patient-professional relationships constitute a health systems problem, as serious as any infrastructural gap, is under-appreciated in current policy frameworks.

AGENDA FOR ACTION

FOR GOVERNMENTS

-  Establish independent AI evaluation bodies with the mandate and capacity to assess whether AI systems perform for the specific populations in which they will be deployed, not merely in benchmark settings.
-  Legislate scope-of-practice reforms that enable nurses, pharmacists, and community health workers to function as prevention infrastructure redesigning roles before technology, not after.
-  Commission backcasting models of health financing sustainability through mid-century, with insurance reform and prevention investment as central variables.

FOR INTERNATIONAL ORGANIZATIONS

-  Develop and resource a Resilient Essential Digital Health Infrastructure (REDI-equivalent) framework as a global public good, with dedicated financing mechanisms not dependent on donor-cycle continuity.
-  Establish binding AI procurement standards that require vendors to demonstrate contextual fit, disaggregated equity performance, and post-deployment monitoring for any AI system sold to public health systems.
-  Build One Health institutional linkages at the UN level that operationalise cross-sector data sharing for pandemic surveillance translating the pandemic treaty into daily governance architecture.
-  Treat all major WHO and multilateral health guidelines as living documents with mandatory update cycles responsive to technological and epidemiological change.

FOR HEALTH SYSTEM LEADERS

-  Prioritize data infrastructure modernization including unique patient identifiers, facility registries, and interoperability standards as a precondition for AI investment, not an afterthought.
-  Design AI integration into clinical workflows with direct input from frontline professionals across all disciplines, including nursing, pharmacy, and community health not only physicians and technologists.
-  Measure AI's value not against benchmark accuracy scores but against real-world outcomes for the most marginalized patients in each deployment context.

FOR INDUSTRY & INNOVATORS

-  Develop and publish disaggregated performance data by gender, socioeconomic status, geography, and language for all AI systems intended for deployment in diverse health contexts.
-  Design for asset-light, low-connectivity, and assisted-model deployment from the outset and not as an afterthought for lower-income markets.
-  Engage with federated learning architectures that allow AI models to be trained on local data without requiring its export directly addressing sovereignty concerns.

FOR ACADEMIA AND CIVIL SOCIETY

-  Develop and advocate for globally standardized AI literacy curricula for health professionals at all levels from undergraduate programmes through continuing professional development with regular update cycles.
-  Produce cross-sector One Health research that integrates human, animal, and environmental health data for pandemic preparedness modelling.
-  Ensure that patients and civil society representatives including those from the global south are structurally embedded in governance bodies for health AI, not merely consulted.



VOTE OF THANKS



Distinguished commissioners, excellencies, colleagues, and dear friends,

As we come to the close of today's Global Health System Redesign Lab, I would like to sincerely thank each one of you for your presence, your insights, and your commitment to this important global effort.

Over the next few weeks, our Secretariat at Health Parliament will carefully review all the discussions that took place today. We will reach out to some of you for deeper insights and further engagement on specific themes that emerged during these deliberations.

We may also invite some leaders from across the ecosystem to take responsibility for particular thematic areas or working groups, enabling us to distribute responsibilities meaningfully among commissioners and collaborators and move this work forward in a structured and outcome-oriented manner. We will reconvene in approximately three months to review the progress made. Thereafter, we will continue to meet every few months to share updates with the commissioners and work closely with each of you based on the responsibilities you choose to undertake and the guidance you provide to the Secretariat.

Our next major convening is planned on the sidelines of the United Nations General Assembly in New York. We also plan to meet during the annual Internet Governance Forum in Nairobi, and, if needed, we may convene even before then. By the time we meet again, we hope to have completed substantial work and moved beyond discussions towards practical frameworks, meaningful collaborations, and actionable pathways. None of this would be possible without the extraordinary intellectual capital gathered in this room today. We are deeply grateful to each one of you for contributing your wisdom, experience, and leadership to this journey.

Before I conclude, I would also like to place on record our heartfelt gratitude to all our distinguished speakers, commissioners, partner organizations, collaborators, and participants who made today's convening so meaningful. A special thank you to the entire team at Health Parliament and the organizing Secretariat, whose dedication and hard work behind the scenes made this gathering possible. Most importantly, thank you to every participant, both online and in person, for believing that the healthcare systems of the future must become more purposeful, more collaborative, more equitable, and more human-centered.

We look forward to connecting with each of you over the coming weeks as we build on today's discussions and work together to shape the future of healthcare.

Thank you once again for your time, your trust, your partnership, and your continued support.

Ms. Mevish P. Vaishnav

President

Health Parliament and Academy of Digital Health Sciences



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