

Innovation must remain a core function

We welcome and support the move towards a more country-led, coordinated and effective global health architecture. **Greater country ownership, stronger regional institutions and more efficient use of resources should all be central to future reforms. But as the architecture evolves, care must be taken not to weaken the collective ability to develop the next generation of health tools.**

The debate should therefore focus less on institutional labels and more on the essential functions the future health system must retain. Developing new medicines and health technologies to cure, prevent and eliminate high burden infectious diseases requires sustained investment, specialist expertise and organisations capable of navigating the long and complex path from laboratory to patient.

This capability will become more important, not less, in the years ahead. Climate change is reshaping disease patterns. Antimicrobial resistance is reaching a tipping point. Emerging infectious diseases, including Ebola, continue to pose global risks. Against this backdrop, needs-driven R&D and innovation must be recognised as a global public good and preserved as an essential function of the future health system.

The reform process must therefore:

- Protect essential innovation capabilities across the R&D ecosystem
- Ensure predictable financing across the product development continuum
- Support country and regional leadership in setting R&D priorities and shaping innovation agendas
- Draw on R&D expertise and experience to inform reform decisions
- Establish clear indicators to assess the impact of reforms on health outcomes, innovation and access



Photo credit: UCL - MMV

Continuing the conversation

We acknowledge this is a dynamic and ongoing conversation. We welcome continued discussion on how research, innovation and product development can be strengthened in support of a more sovereign, resilient and equitable future for health.

This paper reflects discussions with funders, partners, thought leaders and PDP colleagues whose perspectives helped shape its content. We thank them for their contributions.

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References

1. Psaki S, et al. The future of global health: themes and thorny questions. Think Global Health. 2026 Sep 1.
2. Apeagyei AE, et al. Tracking development assistance for health, 1990–2030: historical trends, recent cuts, and outlook. Lancet. 2025;406:337–48.
3. Impact Global Health. Funding for global health R&D in 2024. 2026 Feb 5.
4. Christen P, et al. Measuring the impact of global research and development investment in product development partnerships: a case study on return on investment in antimalarial drug development. Lancet Glob Health. 2026;14:e427–34.
5. Ashigbie P, et al. Innovation in medicines for global health: a 20-year landscape analysis. Nat Rev Drug Discov. 2025;24:818–19. doi:10.1038/d41573-025-00164-1.
6. Access to Medicine Foundation. 2024 Access to Medicine Index. 2024.
7. Policy Cures Research. Neglected disease research and development: the higher cost of lower funding. 2024.
8. IFPMA. #AlwaysInnovating: Pharmaceutical Industry Facts & Figures. 2024 Dec.

Research, innovation and product development in the evolving global health ecosystem: an essential global public good

Global health has never been static. Health needs, funding models, and institutional roles and responsibilities have continually evolved over time. In recent years, however, the need for change has accelerated, driven by constrained resources and growing demands from countries to define their own health priorities, influence the investments, partnerships and institutions that support them, and secure equitable access.

There is now strong momentum for a reassessment of how the global health ecosystem should evolve in the years ahead. At least 67 documents have reflected on reform recommendations since 2023,¹ mostly focusing on institutions, financing mechanisms and governance structures. The future of global health will depend on its capacity to deliver essential functions – including the ability to innovate to develop and deliver new medicines and health technologies for diseases and populations that markets do not adequately serve. This innovation for unmet needs is a global public good that is essential for the health of people in low-resource settings and for global health security.

At a time when new health threats are emerging and progress against existing ones is beginning to stall, development assistance for global health was projected to fall by approximately 22% in 2025,² while investment in neglected disease research and product development (R&D) remains well below its 2018 peak.³ National, regional, and international funding will all be needed. Without corrective action, the consequences of these dynamics will be felt most sharply by those already carrying the greatest burden of disease.

The role of R&D and innovation in a reformed global health architecture

The four organisations represented here differ in size, structure, disease focus and operating model. Despite these differences, we share a track record of developing and delivering medicines for health needs that conventional market incentives have failed to address. We therefore bring a practical perspective to the reform debate grounded in decades of experience addressing unmet global health needs.

At the heart of this experience is the Product Development Partnership (PDP) model. PDPs bring together expertise and resources from governments, industry, academia, research institutions, funders

and communities to develop much-needed medical products that are affordable, accessible and suited to real-world settings. Combining a public health mandate with the scientific, clinical, regulatory and partnership expertise needed to manage product development across successive stages, PDPs identify and advance promising candidates, coordinate partners and evidence generation, and build manufacturing and access considerations into development from the outset. No other stakeholder works across the full product development pathway while maintaining an overview of the global pipeline for specific diseases in the way PDPs do.

For diseases that affect populations with limited ability to pay, essential medicines and health technologies may never be developed without a PDP-type model. But the value of this model extends well beyond individual products. Over time, PDPs have strengthened scientific, clinical, regulatory, manufacturing and access capabilities across research institutions, manufacturers and health systems worldwide, especially in endemic countries. These can be mobilised in response to outbreaks and emerging threats as demonstrated during the COVID-19 pandemic.

For example, MMV's long-term partnership with H3D at the University of Cape Town contributed to the establishment of sub-Saharan Africa's first integrated drug discovery centre, strengthening expertise in biology, medicinal chemistry and translational science and supporting locally led innovation.

Similarly, working with the Ghana Food and Drugs Authority, MDGH supported the world's first endemic-country approval of moxidectin. Beyond enabling access to new treatments, the process helped strengthen local regulatory expertise and established experience that can inform future regulatory reviews across Africa.

Because our funding is awarded not through replenishments but through competitive processes from country and philanthropic donors, PDPs must continually demonstrate value and impact. A recent analysis published in The Lancet Global Health found that every US\$1 invested in MMV between 2000 and 2023 generated US\$13 in health benefits,⁴ illustrating the substantial returns that investments in needs-driven innovation can deliver.

A growing R&D gap

Today, diseases that primarily affect poorer populations impose a heavy burden on health systems, communities and economies.

- Less than 2% of medicines approved by the US FDA between 2005 and 2024 were developed for neglected diseases.⁵
- Among 20 leading pharmaceutical companies, the pipeline of projects addressing unmet health needs in low- and middle-income countries declined by 31% between 2022 and 2024.⁶
- Just under 2% of private-sector health R&D spending is directed towards malaria, tuberculosis, HIV/AIDS and diarrhoeal diseases, and only 0.2% towards neglected tropical diseases.^{7,8}



With commercial investment and development assistance for health both under pressure, the gap between public health need and available R&D investment is likely to widen, making the organisations and partnerships that drive needs-driven innovation more critical than ever.

Adapting for the next era in global health

Our organisations support the move towards a more country-led, coordinated and efficient global health architecture. Many of these principles are already reflected in the way PDPs operate today, as the examples below illustrate, providing a strong foundation for future evolution.

1. Shift the centre of gravity towards country and regional ownership

Scientific, clinical, regulatory and manufacturing capabilities are expanding significantly across low- and middle-income countries. The future of global health innovation should increasingly reflect this reality. PDPs already work closely with national and regional institutions in endemic countries through governance, advisory and research partnerships.

Looking ahead, PDPs will feed into opportunities defined by country partners, to lead development activities with clear responsibilities, resources and recognition. PDPs can also help connect expertise across different countries and coordinate programmes that serve multiple populations.

DNDi was founded by partners from Brazil, India, Kenya, and Malaysia, and has a partnership model built around endemic country institutions as co-leaders. This includes the Dengue Alliance which aims to develop the first therapeutic for this disease. Over the past decade, MMV has tripled representation of malaria-endemic countries on its Board.

2. Reduce duplication without losing specialisation

Reform discussions have highlighted the need for greater efficiency and coordination. Infrastructure, technical platforms and other capabilities can often be shared among PDPs to improve efficiency, maximise impact and extend reach. Collaboration, including mutualisation and rationalisation of resources, will become the default wherever it strengthens impact, reduces duplication or improves cost-effectiveness. This includes our organisations speaking with one voice on issues of common interest.

However, in pursuing these goals, we must not dilute the therapeutic depth and specialist expertise that underpin progress against complex health challenges. Future funding models should therefore encourage the sharing of capabilities and technical platforms while preserving the specialist expertise needed to drive innovation.

In 2010, the TB Alliance granted DNDi access to compounds originally investigated for tuberculosis, for potential use against neglected tropical diseases. DNDi and MMV have created a joint regulatory platform. MDGH is represented in DNDi's scientific advisory committee.



Photo credit: Xavier Vahed - DNDi

3. Focus sharply on people-centred R&D

Developing medicines and health technologies for underserved populations is the core function of PDPs. But innovation only delivers value when it reaches the people who need it. To achieve this, we will continue working with the World Health Organization, governments, manufacturers and other partners to ensure that access, licensing and manufacturing pathways are planned alongside product development from the outset.

Over the past 27 years, the four PDPs contributing to this paper have supported and launched 40 new therapeutics. Examples include:

- **Sleeping sickness**
Acoziborole, a single-dose oral cure for sleeping sickness paving the way for sustainable disease elimination by enabling screen-and-treat approaches outside the hospital, including the hardest-to-reach areas.
- **Malaria**
Coartem® Baby, the first and only malaria treatment for newborns and young infants closing a long-standing treatment gap.
- **River blindness**
Moxidectin, the first new treatment for river blindness (onchocerciasis) in over 30 years.
- **Drug-resistant TB**
Pretomanid, a breakthrough medicine that has transformed treatment for drug-resistant TB, a major global antimicrobial resistance threat.

4. Evolve to increase efficiency and equity

We are each evolving our model through closer collaboration with regional partners and manufacturers, new financing approaches and the use of emerging technologies. Together we collaborate on an AI Working Group and on a Gender Equality, Disability and Social Inclusion (GEDSI) Working Group. We must continue embracing new partnerships and ways of working that enable us to develop and deliver medicines more efficiently while ensuring that neglected diseases and equitable access remain at the heart of our mission.

An AI-powered drug discovery platform developed by MMV and DeepMirror, Drug Design for Global Health (dd4gh), expands access to advanced drug design capabilities, enabling eligible researchers across countries working on malaria, tuberculosis and neglected tropical diseases to participate for free.



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