The Pandemic Agreement Impasse is an Opportunity, Not a Failure

Context

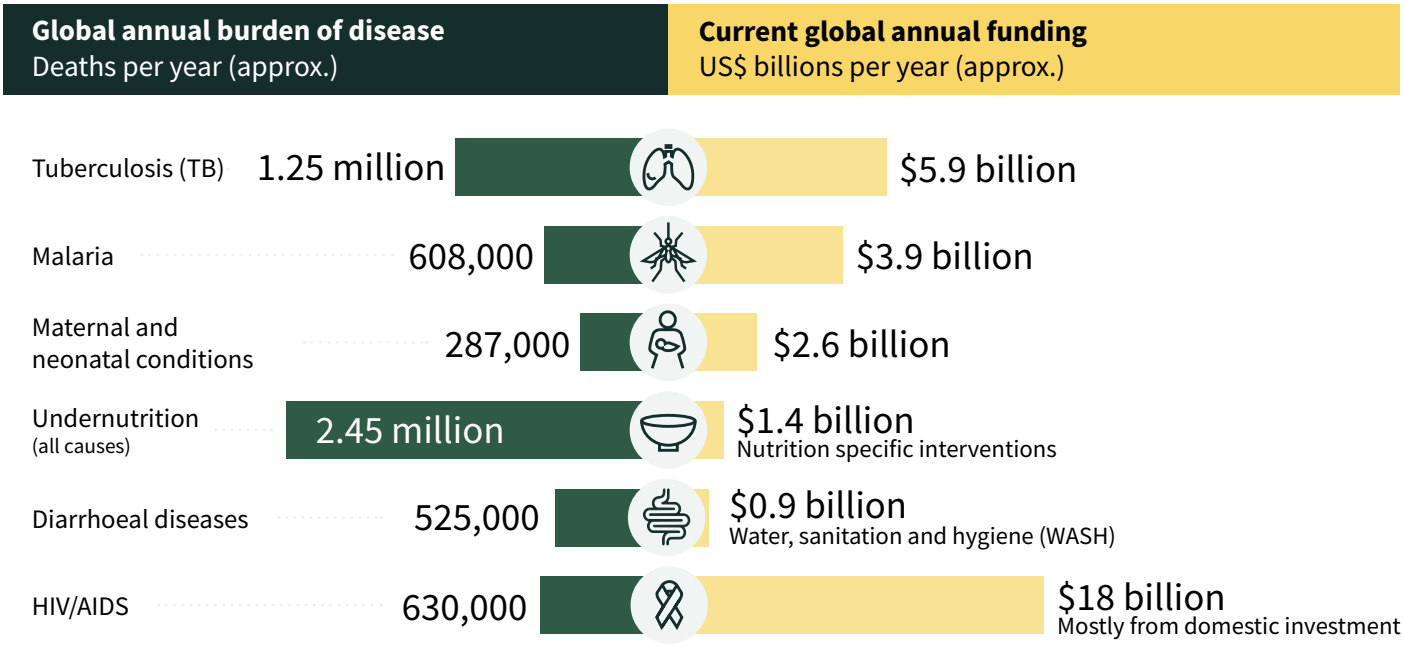
Repeated failure to conclude negotiations on the World Health Organization's Pandemic Agreement and its provisions for Pathogen Access and Benefit Sharing (**PABS**) reflects more than a temporary diplomatic impasse. It exposes deeper structural tensions concerning sovereignty, reciprocity, proportionality and the future direction of global health governance.

While many commentators portray the current stalemate as a failure of multilateralism, it should, more appropriately, be seen as multilateralism working. States being asked to commit to far-reaching obligations involving pathogen sharing, surveillance expansion, financing and emergency response mechanisms are emphasising unresolved questions regarding fairness, evidence, implementation and expected public health benefits.

Key Facts

- The Pandemic Agreement will institutionalise binding obligations for pathogen sharing and surveillance while leaving the most valuable benefits dependent upon political discretion, manufacturing concentration and market power.
- Pandemics amount to roughly eight million deaths in the last 100 years, yet the proposed pandemic preparedness spending exceeds $31 billion annually. This could potentially divert resources from more pressing health priorities and burdens (Figure 1).

Figure 1: Comparisons for annual mortality and investment



Pandemic preparedness funding ($31 billion annually) is ~**15x larger** than funding for the deadliest endemic diseases.

- Evidence for claims of escalating pandemic frequency is considerably weaker than preparedness narratives suggest once changes in surveillance intensity and definitional expansion are accounted for.
- The COVID-19 experience demonstrated that equal access to pharmaceutical commodities does not equate to equal public health outcomes across populations (health equity).
- Africa's median age of 19 years versus Europe's 44 years, with highly different endemic disease priorities, means identical pandemic policies will impose very different risks and costs, yet the preparedness architecture assumes broadly uniform responses.
- The preparedness agenda prioritises surveillance, emergency declaration and pharmaceutical deployment over broader determinants of health and resilience measures such as nutrition, sanitation, primary healthcare and health systems strengthening (Figure 2).
- Resisting the Pandemic Agreement is, therefore, not a rejection of cooperation but a demand for greater proportionality, clearer reciprocity, stronger evidence and public health policy better tailored to national priorities and population need.

Figure 2: The opportunity cost of financing pandemic preparedness

Redirecting even a fraction of current preparedness spending toward high-burden endemic conditions could save millions of lives each year.

TUBERCULOSIS

1.25 million deaths

year on year, but only

$5.9 billion funded

MALARIA

608,000 deaths

year on year, but only

$3.9 billion funded

UNDERNUTRITION

2.45 million deaths

year on year, but only

$1.4 billion funded

Call to Action

The current impasse provides an opportunity to strengthen global health governance by ensuring that future agreements rest on a firmer foundation of evidence, reciprocity, legitimacy and national ownership.

Political groupings such as the Friends of Equity and the Africa Group are, therefore, justified in resisting pressure to conclude negotiations prematurely. They are demanding stronger evidence for the unprecedented resource commitments proposed under the preparedness agenda, clearer guarantees regarding benefit sharing, and a balanced assessment of national and regional health priorities.

Conclusion: The aim should be good public health policy

A slower and more deliberative process may ultimately produce a stronger agreement or demonstrate that alternative approaches to international cooperation would better serve global health. Moreover, the Pandemic Agreement itself offers little positive value over existing collaborative structures, such as the International Health Regulations (IHRs).

Agreements reached primarily to secure closure, despite unresolved structural disagreements and uncertain evidence, risk weakening institutional legitimacy, undermining trust and disrupting good resource allocation.

This policy brief is based on the report '**The Pandemic Agreement at an Impasse: Proportionality, Political Incentives, and the Future of Global Health Governance' by members of the International Health Reform Panel (IHRP)**.

For more information, please email **info@internationalhealthreformpanel.org** or visit **internationalhealthreformpanel.org/reports**.

Sources: IHME Global Burden of Disease 2025; WHO Global Health Observatory; WHO Global TB Report 2025; WHO World Malaria Report 2025; Gavi 2023; UNICEF 2022; WHO-World Bank G20 Pandemic Gap Analysis 2022; UNAIDS 2025; WHO Covid Dashboard 2025.

Designed by Research Retold. Published July 2026.