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UNGA81 Rapid Brief
- AI for Health in Global Health

Pacing Is Not Enough: Making AI Ethics the Shared Language for AI for Health Innovation



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<Key messages>

- The frontier is asking for a steady pace. In September 2026, leaders of frontier AI developers publicly called for slowing capability gains because safeguards, evaluation and regulation are not keeping up. Pacing buys time; it does not tell us how to use that time.
- Discussions at UNGA81 shifted the question from "Can AI be controlled?" to "What is AI already doing to people?"—to human capability, whose knowledge counts, who is accountable and who decides.
- In health, especially in LMICs, these questions become concrete risks across the AI value chain: extractive data practices, epidemiological mismatch, unvalidated deployment, automation bias and a liability vacuum.
- We recommend a lifecycle-aligned risk-check framework shared that developers, regulators/procurers and intermediaries can use as a common language, so that ethics accelerates trusted adoption rather than acting as a brake on innovation.

AI is moving faster than society's capacity to govern it

On 12 September 2026, Anthropic's CEO published an essay calling on the industry to "pace the frontier", arguing that safety guardrails and regulation are not keeping pace with capability gains and committing to give independent evaluators employee-level access to verify safety practices; the heads of OpenAI, Google DeepMind and xAI publicly endorsed the direction, while critics questioned whether it will change industry behaviour [1]. Two weeks later, calls for safe and responsible AI filled the UN General Assembly's general debate [2], and on 23 September the Deputy Secretary-General convened "AI and Human Development", bringing to New York a series of regional convenings held in Cairo, Mexico City, Xi'an and Rome [3, 4]. At that event, the analogy of aviation was used to ask whether safety should ever be traded for competitive speed [3].

We interpreted these developments as symptoms of the same structural problem: the ethical, legal and social questions raised by AI are evolving faster than the

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institutions expected to answer them. For global health, the decisive question is therefore not only whether AI should slow down, but whether the time gained is used to build a practical, shared ethics that allows beneficial innovation to reach the people who need it most.

Five signals from UNGA81 that matter for global health

We obtained five significant insights from UNGA81 with respect to AI ethical considerations in the global health context:

i. **Human capability, not safety alone.** The Deputy Secretary-General stressed that smarter machines must not make for less capable people, warning of skills that weaken through disuse [3]. In health systems, this translates into deskilling and automation bias among over-stretched health workers [5].

ii. **Whose knowledge.** The Deputy Secretary-General showed the view that AI is not culturally neutral. Sierra Leone's Chief Minister noted that online content is concentrated in a handful of languages while Africa is home to 1,500–2,000 languages, and framed today's data flows as the latest chapter of extraction from the continent [3]—echoing concerns about "data colonialism" and health data poverty [6, 7].

iii. **Accountability stays human.** "A machine cannot be held to account. People can and must" [3]. In clinical settings, unclear allocation of responsibility leaves frontline workers carrying the risk.

iv. **Sovereignty with mobility.** Rwanda's ICT & Innovation Minister reframed data sovereignty as whether data can "move with my rules" [3]—directly relevant to cross-border storage of clinical and validation data.

v. **Verifiable conduct and inclusive design.** Panellists described draft principles for human-centered AI with red lines (e.g., no decision on someone's livelihood or freedom without a person to appeal to) and proposed that the burden of proof rest with companies and countries to publish evidence third parties can check. Sierra Leone's "Country as AI Lab" sandbox showed how designing for the most marginalised produces better solutions for all [3].

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Why AI for Health in LMICs needs operational—not only declaratory—ethics

Normative consensus already exists: WHO's six principles for AI in health [8], its guidance on large multi-modal models [9], the OECD AI Principles [10] and the EU AI Act [11]. Yet a persistent principles-to-practice gap remains: developers and health organisations struggle to turn high-level values into concrete decisions, and organisations risk "ethics washing" [12, 13]. In LMICs the gap is amplified. Models trained largely on high-income-country data degrade when deployed against a different epidemiological profile and under-represented populations [6, 14]; digital determinants of health (DDoH)—connectivity, interoperable records, digital literacy—shape who benefits [15]; and local capacity for context-specific validation and post-market monitoring of drift is often limited [16]. These failures are rarely the result of "bad intent"; they are systemic outcomes of misaligned incentives and capacity gaps among actors [17, 18].

Our ongoing research suggests only a small fraction of advanced research systematically organises ethical considerations or governance frameworks for AI for Health in global health, and none offers an end-to-end, value-chain-based framework usable as a common operational language across industry, policymakers, academia and civil society.

Proposal: a shared risk-check framework as a common language

We propose mapping WHO's six principles onto the four phases of the AI for Health value chain, reinforced by a DDoH lens and the human-development questions raised at UNGA81. The framework is not a compliance checklist: it is a shared set of questions that each actor can answer with evidence, so that a developer, a Ministry of Health, a regulator, a funder and other stakeholders are discussing the same risks in the same terms.

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Value-chain phase	Illustrative: shared risk-check questions	Who holds the evidence / who acts
Ideation & R&D	– Is the use case driven by local disease burden and unmet need, rather than by where data and capital happen to be? – Who was in the room when the problem was defined?	•Developers •funders •Ministries of Health (which set priorities) •Intermediaries (e.g., PDPs) (which de-risk neglected areas)
Data procurement & model training	– Do training data represent rural, low-income and linguistic-minority populations? – Are consent and benefit-sharing in place? – Do the data "move with local rules"?	•Developers •data-protection authorities •communities •data custodians
Clinical validation & regulatory clearance	– Has performance been validated in the intended setting (out-of-distribution risk, LMM hallucination, cultural appropriateness)? – Is the evidence published so third parties can check it?	•Developers with local clinical/academic partners •national and regional regulators
Deployment & post-market surveillance	– Is there meaningful human oversight and a route to appeal? – Is model drift monitored? – Is liability shared rather than shifted to frontline workers? – Does the tool build, not erode, health-worker capability?	•Providers •Procurers •Developers •funders (which condition finance on monitoring)
Cross-cutting: DDoH & human dignity	– Can intended users access, understand and refuse the tool, given connectivity and digital literacy? – Do the most vulnerable benefit first, not last?	•All stakeholders

A shared language could deliver practical value by reducing regulatory uncertainty and transaction costs for innovators; it gives Ministries of Health a ready basis for procurement and approval criteria; it gives donors and impact investors measurable, policy-linked conditions; and it makes visible where responsibility sits at each phase—turning UNGA81's question "who decides?" into something that can be answered.

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Recommendations

We would like to propose recommendations to key stakeholders as follows:

i. Governments and regulators (especially in LMICs): embed phase-by-phase risk checks in procurement for AI for Health solutions including medical device/SaMD approval; use regulatory sandboxes to learn in real settings; pursue regional reliance to pool scarce evaluation capacity.

ii. AI developers: treat the risk check as a market-entry asset, not a burden; disclose training-data composition and local validation results; extend the independent-evaluation commitments now voiced at the frontier [1] to health deployments in LMICs.

iii. Intermediaries, donors, DFIs and impact investors: condition finance on risk-check evidence, and fund local validation, drift monitoring and data infrastructure as global public goods.

iv. The UN system and WHO: bring a health-specific, LMIC-grounded risk-check lens into the Global Dialogue on AI Governance, the Independent Scientific Panel on AI and the country-level conversations leading to the 2027 SDG Summit, as referenced by the Deputy Secretary-General at UNGA81 [3].

Conclusion

"Pacing the frontier buys time."- Whether that time translates into equitable health outcomes depends on a common language that developers, governments, funders and other stakeholders can all use. Shared risk checks make AI ethics an enabler of trustworthy scalable AI for Health—and keep the most vulnerable at the center of innovation, not at its margins.

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