U.S.-CHINA TRACK II DIALOGUE ON HEALTHCARE

CONSENSUS AGREEMENT

June 22–24, 2026
Hangzhou, China

The National Committee on U.S.-China Relations, the **National School of Development (NSD) at Peking University**, and the **Peking University Institute for Global Health and Development (PKU GHD)** convened the eleventh round of the U.S.-China Track II Dialogue on Healthcare in Hangzhou, China, on June 22–24, 2026. The Dialogue brought together American and Chinese experts (attendee list below) from academia, think tanks, and industry for off-the-record discussions on healthcare issues pertaining to both countries.

All participants agreed that maintaining in-person dialogues in both the United States and China helps to ensure that channels of communication among academics, researchers, practitioners, business communities, and their governments remain open. At a time of heightened bilateral tension, participants from both countries were eager to meet to examine how the two nations can continue to advance shared health interests even as national security concerns increasingly intersect with governance of biomedical science and public health in both countries and beyond. The key issues for this year included (1) the accelerating pace of biomedical innovation in China; (2) the growing concerns that biomedical research and health data are matters of national security; (3) the role of artificial intelligence and real-world evidence in building health systems; and (4) the prevention and treatment of cardiovascular disease.

KEY POINTS OF CONSENSUS

The Dialogue participants recognized that the policy and rhetorical environment for bilateral health cooperation has continued to deteriorate since the last session, which took place in July 2025, even as the scientific and health services stakes have grown. The relationship between the two governments remains tense, with both still taking actions that are driven by concerns over advanced biomedical technology, increasingly rich and identifiable health data, dual-use biomanufacturing, and generative artificial intelligence, which makes collaboration more difficult. At the same time, the pace of biomedical innovation, particularly in China, has noticeably accelerated. Participants agreed that unless there is careful analysis that distinguishes genuine national security risks and intellectual property concerns from over-securitization that constrains legitimate scientific and commercial exchange, the two countries risk foreclosing opportunities to improve the health of their own citizens and of populations worldwide. Participants noted the following areas of particular concern and consensus:

China's biomedical innovation has reached an inflection point, reshaping the terms of bilateral cooperation. Participants noted that China's biomedical sector has moved decisively from a "fast follower" toward a source of first-in-class innovation. In 2025, China's National Medical Products Administration (NMPA) approved a record number of Class 1 innovative drugs; Chinese sites hosted a large and growing share of the world's innovative-drug clinical trials (by some accounts approaching half of the global total); and out-licensing of China-originated assets accounted for a substantial and rising portion of global deal value. This maturation reflects more than a decade of continuous policy reform, including China's 2017 accession to the International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use (ICH), the expansion and professionalization of the NMPA's Center for Drug Evaluation, and the growth of world-class clinical and manufacturing capacity. Both sides observed that the United States increasingly regards China as a peer and competitor in biomedical innovation, and that this shift changes the calculus of both cooperation and competition. Participants agreed that this progress creates an opportunity to accelerate the delivery of improved medicines to patients in both countries and worldwide. That opportunity will be realized only if the pace of innovation is matched by commensurate rigor, appropriate transparency, and regulatory stability, all of which risks being undermined through avoidable decoupling.

Increased securitization is imposing significant costs on both countries. Participants distinguished between legitimate national security concerns, such as those involving dual-use biotechnology, identifiable health data, and advanced biomanufacturing, and a broader over-securitization that is increasingly constraining beneficial scientific and commercial exchange. The difficulty, they noted, often lies less in the letter of the law, such as the U.S. BIOSECURE Act or the Biosecurity Law of the People's Republic of China, than in its interpretation and application, which can chill collaboration even where no genuine risk exists. The costs are already visible: bilateral academic co-authorship, which peaked at roughly 15,000 joint publications in 2020, has since declined; visa denials prevent Chinese scientists from visiting the United States and a climate of caution has accelerated the departure of scientific talent from the United States to China, to the detriment of laboratories in the United States; the elimination of foreign subawards under U.S. National Institutes of Health policy has removed the principal funding vehicle for jointly conducted academic work; and government-to-government and academic collaboration have eroded even as commercial transactions have continued to grow. Participants agreed that both countries would benefit from a more disciplined, risk-based process for addressing the specific security and intellectual property concerns that genuinely warrant regulatory/managerial intervention. Both nations should strive to delineate mechanisms that allow for mutually beneficial work to proceed.

Regulatory convergence and transparency remain essential. Both sides reaffirmed that complementary regulations and practices enhance access to essential health products and help save lives. With respect to achieving this goal, the ICH remains a critical platform for continued alignment where U.S. and Chinese engagement can advance regulatory science globally. However, on-site inspections and regulatory-science exchanges which declined precipitously during the COVID-19 pandemic have not fully recovered. In part because of these factors, the participants observed that the two regulatory systems are moving in directions that could be better aligned. They identified several priorities: adequate transparency into research data and methods for regulatory review; standards for parallel clinical trials and analyses that do not require the exchange of sensitive, identifiable personal data; and a clear articulation of the requirements and processes by which each country approves innovative products developed in the other. Participants specifically supported commissioning a joint,

comparative study of the quality and characteristics of products approved by the U.S. Food and Drug Administration (FDA) and the NMPA. At the same time, they also acknowledged a genuine tension: transparency can serve both as a mechanism to build trust between the nations but also a potential vulnerability amidst securitization of biomedical science and politicization of the relationship.

Artificial intelligence and real-world evidence are transforming health systems faster than the science and standards needed to govern them. Participants agreed that artificial intelligence (AI) is now reshaping every stage of the development and delivery of care, from drug discovery and clinical-trial design through documentation, decision support, and population health. Ambient and "agentic" tools are reducing the administrative burden and extending the reach of a constrained clinical workforce, while consumer use of AI is rapidly altering the information asymmetry between patients and clinicians. Both sides saw in these tools a means to narrow the long-standing gap between what research establishes and what routine care delivers. This creates a corresponding need to accelerate implementation science and increase the generation of real-world evidence (RWE). At the same time, participants expressed caution on three fronts. First, adaptive and agentic systems strain existing ethical-review and regulatory frameworks and must be studied in timely and ongoing cycles. Second, these AI models require guardrails against bias and calibration drift. Participants agreed that the overseeing clinician should retain clinical and legal responsibility for AI-assisted care, and that both countries need to improve the validation science and assurance frameworks that safe deployment requires, especially for AI-delivered care. This gap is also an area of opportunity for both countries to develop such frameworks together.

Data is the foundation of biomedical innovation and AI, and reliable and appropriate data sharing is chiefly a policy challenge, not just a technical one. All modern medical research, drug testing, and AI development depends on increasingly rich, standardized data, together with transparency about provenance and the quality of endpoints. Participants noted that alarm over data misuse, in particular the potential for re-identification, has heightened securitization of data sharing in both countries. However, they emphasized that the principal barriers are matters of policy: the United States' Healthcare Cost and Utilization Project (HCUP) and Medical Expenditure Panel Survey (MEPS), for example, demonstrate that broad, even global, access to de-identified data can coexist with privacy and security. Without reliable sharing of data while addressing privacy and security concerns, the development of new medical products and better care models is slower, more costly, and less accurate. Participants supported advancing methods — such as federated learning and parallel analysis — that permit shared insight without the exchange of identifiable individual data.

Cardiovascular disease is a large and growing shared burden that illustrates the value of collaboration on prevention and population health. Cardiovascular disease accounts for a far larger share of deaths in China than the global average. An aging population is driving a rising absolute burden even where age-standardized mortality has improved. The United States, meanwhile, experienced a slowdown in the decades-long decline in cardiovascular mortality during the 2010s, followed by a pandemic-era increase. Although age-adjusted mortality rates have since declined, persistent risk factors and elevated mortality from several cardiovascular conditions underscore continuing challenges. Metabolic risk factors — dyslipidemia and obesity affecting hundreds of millions of people in China — now dominate, hypertension control remains low, and only a small fraction of children and adults meet criteria for ideal cardiovascular health. Against this background, China's Healthy China 2030 plan sets an explicit target for reducing age-standardized cardiovascular mortality. Participants identified a set of high-value, comparatively low-sensitivity levers as promising areas for joint work: hypertension and

lipid control, secondary prevention, salt substitution (low-sodium potassium-enriched salt), GLP-1 receptor agonists (soon to become generic in China), small-interfering-RNA therapeutics, digital and AI-enabled remote monitoring and healthier lifestyle supports, and air-quality and tobacco control measures. They further agreed that prevention, and above all the elimination of combustible tobacco use represents the single highest-return, lowest-sensitivity opportunity for cooperation, and a natural candidate for bilateral collaboration.

Sustained engagement remains valuable, and "safe harbors" offer a pragmatic path forward. Participants reaffirmed that maintaining the channel that track II dialogues provide is itself valuable. In moments of crisis, such as the COVID-19 pandemic, track II dialogues have proven able to surface information more rapidly than official channels alone. They pointed to additional low-sensitivity avenues, including food and agricultural exchanges, and to the potential of China's Hainan Free Trade Port and its Boao Lecheng special medical zone as controlled settings in which to pilot innovative therapies. Participants agreed that the value of such engagement depends on translating consensus into concrete, actionable proposals directed to the agencies in both countries best positioned to act.

RECOMMENDATIONS

As the world's two largest economies, China and the United States bear a shared responsibility to lead improvements in global health. Even while relations between the two governments remain tense, there are many opportunities in biomedical science, healthcare, and public health for both countries to coordinate more effectively. In many cases, there are opportunities that would also improve the health security of both nations. Recommended next steps include the following:

Exchange best practices and strategies for AI in health. Both countries share an interest in developing their domestic AI capabilities in a manner that prevents biased results and safety failures. Sharing best practices for AI development and implementation, particularly in areas such as data validation, documentation of applications and updates, diversity and adequacy of testing, real-world monitoring, and publication of results, which form the foundations of emerging health-AI assurance and regulatory frameworks, would help both countries avoid mistakes and increase safety. This can be done without the need to share sensitive data or the intellectual property underlying AI algorithms or applications. Particular attention should be given to the validation science required for adaptive and agentic systems and for their study in rapid, continuous learning cycles.

Define safe harbors for data sharing and advance parallel-analysis methods that do not require divulging individual data. Identifying specific categories of non-sensitive data for sharing would enable continued insight into trends and the impact of interventions. Examples include standardized, aggregated epidemiological data for public-health threats such as avian influenza, cardiovascular risk, and maternal mortality. Specifying both the types of data the two countries can share and the appropriate uses of that data can create safe harbors in which the benefits of exchange clearly exceed the risks of misuse. Methods such as federated learning, which generate results without transferring underlying data, are of particular importance in this era of heightened data protection, as are common standards for data provenance and endpoint quality.

Deepen regulatory harmonization and transparency. The key healthcare agencies of both governments, in conjunction with global bodies such as ICH and the World Health Organization (WHO), should identify bilateral priorities for modernizing and clarifying healthcare regulation and for educating agencies and providers on proper interpretation and implementation. Specific steps may include advancing a joint,

comparative study of the quality and characteristics of products approved by the FDA and the NMPA; developing standards for parallel trials and analyses that meet the requirements of academic journals and regulatory authorities without exchanging identifiable data; resuming regulatory-science exchanges and, where feasible, on-site inspections; and more clearly defining the requirements and processes by which each country approves innovative products developed in the other, including the basis on which each may recognize the other's standards.

Adopt a shared, risk-based framework to distinguish genuine biosecurity risks from over-securitization. Most manufacturing of drugs and biologics involves well-understood chemistry and techniques, whereas advanced or emerging genetic and cellular methods raise legitimate dual-use concerns. Biomanufacturing and national security experts from both countries should develop a risk-based framework that reliably separates the specific capabilities warranting restriction from the far larger body of beneficial work, so that both nations can ensure access to needed medicines while addressing their evolving biosecurity concerns. Such a framework should incorporate cybersecurity safeguards and should be paired with a disciplined process for defining, and revisiting as necessary, the concerns that genuinely justify restriction. The framework should also address the resilience of pharmaceutical supply chains, including active pharmaceutical ingredients and critical starting materials, which both governments treat as a first-order health-security concern.

Define safe harbors and guidelines for non-governmental cooperation. As national security concerns lead both governments to constrain bilateral cooperation, the two nations should define discrete areas in which corporations, organizations, researchers, and agencies may work together. This definition process should also seek to delineate how organizations may cooperate on AI applications, how data may be shared and used in the design and conduct of clinical trials, and how intellectual property is to be protected. Commercial collaboration and food and agricultural exchanges are promising, durable safe harbors. The Hainan Free Trade Port and its Boao Lecheng special medical zone merit particular attention as controlled settings in which to accelerate local validation of innovative therapies, to introduce vaccines and therapies not yet available in China, and to pilot global insurance-backed care, building on the model of existing special medical economic zones.

Pursue targeted areas of mutual interest in public health, with cardiovascular disease and prevention as a priority. Where bilateral tensions make cooperation on broad questions difficult, the two countries should focus on specific areas that carry limited security sensitivity, high health benefits, and manageable data requirements, building trust and concrete results that can be extended to other areas over time. Illustrative areas of collaboration include:

- **Cardiovascular disease and prevention.** Shared standards for real-world studies of cardiometabolic therapies across diverse populations; joint work on hypertension and lipid control, secondary prevention, salt substitution, and digital and AI-enabled remote monitoring.
- **Tobacco control.** A joint commitment to reducing, and ultimately eliminating, combustible tobacco use — the highest-return population-health intervention available — offered as a flagship prevention safe harbor, analogous to concerted elimination campaigns such as that for cervical cancer.

- **Salt substitution**. Switching regular salt to a low-sodium potassium-enriched salt substitute is a low-cost, feasible, and scalable approach for effective lowering of dietary sodium intake, blood pressure, and cardiovascular and renal disease risks. Scaling this approach in both nations and globally represents an area of collaboration that is low-risk and high yield.
- **Obesity and non-communicable disease.** Shared standards for real-world studies of GLP-1 and related therapies to clarify long-term risks, subgroup differences, and combination strategies across the two populations.
- **Combination cancer therapy.** Joint identification of opportunities to advance combination and immune-potentiating therapies, and to improve the transparency of trial conduct that continues to complicate bilateral approvals.
- **AI-augmented frontline workforce.** Collaboration on AI-enabled models that augment less intensively trained health workers to meet the challenges of population aging and frontline care, particularly in underserved areas — work unlikely to raise significant data or IP concerns.
- **Aging, dementia, and persistent global public health threats.** Continued cooperation on healthy aging and dementia care and on persistent infectious and non-communicable disease threats, through jointly supported real-world studies and AI-enabled models of care delivery.

Country-specific priorities. Within cardiovascular disease and prevention, the United States can consider prioritizing the implementation of proven standards of care to achieve further mortality reductions, empowering primary care and aligning incentives across the continuum of care, and broadening appropriate access to GLP-1 therapies. In China, priorities could include scaling opportunistic hypertension screening at first clinical contact with adequate incentives for community physicians, expanding salt substitution and tobacco control measures, and preparing health-financing pathways for the imminent availability of generic GLP-1 therapies, building on the Healthy China 2030 framework.

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After the Healthcare Dialogue concluded, the Dialogue conveners held a public forum on the prevention and treatment of cardiovascular disease. Experts from both nations convened to discuss technological innovation, clinical practice, and service delivery. Events such as these demonstrate the deep U.S.-China connection in the field of healthcare and help develop common goals and aspirations for further exchange and cooperation. Dialogue participants look forward to strengthening pragmatic cooperation on major public health issues, aiming to advance medical technology and to bring tangible benefits to the health and well-being of the people of both nations and around the world.

CONCLUSION

At a time of mounting global health concerns, ranging from aging populations to the persistent threat of pandemics to the rising rates of obesity and cardiovascular disease to the now accelerating but unevenly governed adoption of artificial intelligence, it is more important than ever that China and the United States work together to address the health challenges facing their populations and the world. The evidence is clear that such collaboration helps save lives. Given the tense relations between the two governments, this focus on discrete areas of cooperation can achieve near-term benefit for both countries and build mutual trust in the healthcare field. The Dialogue participants will continue to work together to identify and advance projects that serve this purpose.

CHINESE PARTICIPANTS

Ningshan Chen, M.D., Ph.D.	Vice President, Chinese Hospital Association
Xi Chen, Ph.D.	Associate Professor, Health Policy and Economics, Yale University; Editor, *Journal of Population Economics*
George F. Gao, D.Phil.	Professor, Institute of Microbiology, Chinese Academy of Sciences and the Chinese Center for Disease Control and Prevention (China CDC); Former Director-General, China CDC (China Co-chair, U.S. China Track II Dialogue on Healthcare)
Peng Gong, Ph.D.	Chair Professor of Global Sustainability, Vice-President, and Pro-Vice-Chancellor, University of Hong Kong
Dongfeng Gu, M.D.	Academician, Chinese Academy of Sciences; Chair Professor, Southern University of Science and Technology; Professor, Peking Union Medical College
Cheng Huang, Ph.D.	Assistant Dean and Professor, Peking University (PKU) Institute for Global Health and Development (PKU GHD); Director, PKU China Center for Health Economic Research; Jointly Appointed Professor, PKU School of Economics
Xiaoyan Lei, Ph.D.	Professor of Economics, PKU National School of Development; MOE Cheung-Kong Scholar Professor of Economics and Boya Distinguished Professor, PKU
Zili Li, M.D., M.P.H.	Special Advisor, Department of Health, Hong Kong SAR; Drug Information Association Board Member; Former Global Vice President and Head of Asia Pacific R&D, Johnson & Johnson
Gordon G. Liu, Ph.D.	BOYA Distinguished Professor of Economics, PKU; Fellow, Chinese Academy of Medicine; Dean, PKU GHD (Co-organizer, U.S.-China Track II Dialogue on Healthcare)
Bernhard Schwartländer, Ph.D.	Co-chair, Governing Board and Distinguished Chair Professor of Planetary Health, PKU GHD
Jian'an Wang, M.D., Ph.D.	Academician, Chinese Academy of Sciences; Professor of Cardiology and President, Second Affiliated Hospital of the Zhejiang University School of Medicine; Editor-in-Chief, *JACC: Asia*
Rui-Ping Xiao, Ph.D.	Chair Professor and founding Dean, College of Future Technology, PKU; Associate Editor, *New England Journal of Medicine*

Anlong Xu, Ph.D.	Dean, Sun Yat-sen University Institute of Advanced Studies Hong Kong; Former President, Beijing University of Chinese Medicine
Lijing Yan, Ph.D., M.P.H.	Tenured Professor of Global Health; Head of Noncommunicable Disease (NCD) Research; Director of the Implementation Research on Noncommunicable Disease Management Laboratory (IRoNman Lab), Duke Kunshan University, China
Lee Ligang Zhang, M.S.	Founder and CEO, iKang Healthcare Group

AMERICAN PARTICIPANTS

Amy Abernethy, M.D., Ph.D.	Cofounder, Highlander Health; Former Principal Deputy Commissioner, U.S. Food and Drug Administration (FDA)
Carlos del Rio, M.D.	Distinguished Professor and Chair, Department of Medicine, Emory University School of Medicine; International Secretary, U.S. National Academy of Medicine
Karen Eggleston, Ph.D.	Senior Fellow, Freeman Spogli Institute for International Studies, Stanford University
Katherine Evans, DNP	President, Novocardia Division, Cardiovascular Associates of America
Clifford Hudis, M.D.	Chief Executive Officer, American Society of Clinical Oncology
Harlan Krumholz, M.D., M.S., S.M.	Harold H. Hines Jr. Professor, Section of Cardiovascular Medicine, Yale School of Medicine
Roberta Lipson	Founder, United Family Healthcare; Vice Chair, New Frontier Health
Carolyn Magill, MBA	Chief Executive Officer, SanLuca Behavioral Health; Venture Partner, Define Ventures
Mark B. McClellan, M.D., Ph.D.	Director and Robert J. Margolis, M.D., Professor of Business, Medicine, and Health Policy, Duke-Margolis Institute for Health Policy, Duke University (U.S. Co-chair, U.S.-China Track II Dialogue on Healthcare)
Stephen A. Orlins	President, National Committee on U.S.-China Relations (Co-organizer, U.S.-China Track II Dialogue on Healthcare)