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A Roadmap to the World Health Organization

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A Roadmap to the World Health Organization*

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Abstract

This chapter explains why the World Health Organisation (WHO) remains indispensable to global health governance while repeatedly facing constrains in fulfilling its mandate. It argues that WHO's achievements and persistent governance difficulties arise from a durable institutional bargain wherein member states endorse ambitious global health objectives with incomplete delegation of authority, finance and implementation. Drawing on the evolution, institutional design, performance, and reform of the WHO from its historical origins to 2026, the chapter shows how the incomplete delegation shapes both organisational capacity and political legitimacy. The analysis integrates perspectives from global public goods and collective action, principal-agent and common-agency theory, historical institutionalism, legitimacy theory, and the literature on orchestration in international organizations. Particular attention is given to three enduring features of WHO governance: the decentralized regional structure, the growing dependence on voluntary and often earmarked financial contributions, and its use of legal and normative instruments with limited enforcement mechanisms. It shows that many apparent institutional weaknesses also reflect underlying governance trade-offs: decentralization can improve regional responsiveness while complicating coordination; voluntary finance expands resources while constraining agenda autonomy; and sovereignty-preserving legal instruments facilitate broad participation while limiting compliance. The paper evaluates these dynamics across WHO's normative standard-setting and health intelligence, emergency response, country-level technical cooperation, and coordination within an increasingly fragmented global health system. The chapter further assesses major reform episodes, including post-Ebola emergency reforms, sustainable-financing initiatives, the 2024 amendments to the International Health Regulations, the adoption of 2025 Pandemic Agreement, and the renewed U.S. withdrawal process. It concludes that WHO's central challenge is not to eliminate the tension between national sovereignty and collective health governance, but to manage it more effectively through stronger financial resilience, more coherent institutional authority, and legitimacy preserving accountability.

Key words: World Health Organization; Global public goods; Incomplete delegation; Institutional design; Fiscal federalism; Earmarked contributions

JEL: F55; F53; D02; H41; I18

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Introduction

The World Health Organization (WHO) is the specialized agency of the United Nations responsible for directing and coordinating international health work. Its Constitution, effective since April 7, 1948, defines the Organization's objective as "the attainment by all peoples of the highest possible level of health" (World Health Organization 1946). WHO currently lists 194 Member States. The latest change has been the status of the United States of America: while the United Nations Secretary-General circulated the U.S. notification of an intended withdrawal with a stated effective date of January 22, 2026, but WHO continues to list the United States among its members and states that the notification remains pending consideration by its governing bodies (World Health Organization 2026a, 2026d). WHO therefore remains a near-universal intergovernmental organization with unusually broad constitutional responsibilities in health.

The WHO's institutional importance goes beyond the size of its budget as its comparative advantages lies in functions for which international coordination and credible common standards are difficult to supply through decentralized national action alone. These include epidemiological surveillance, disease classification, technical standards, emergency information, treaty and regulation making, and the convening of governments and specialist communities. Many of these activities have global-public-good characteristics because their benefits cross borders and because individual states can have incentives to underinvest in surveillance, preparedness, information sharing, and research while benefiting from the efforts of others (Kaul and Faust 2001). WHO can therefore be understood as an institutional response to collective-action problems in health.

Despite its strategic importance, WHO operates under unusually demanding political constraints. While member States delegate authority because they value coordination, they remain reluctant to surrender control over domestic health policy, financing, and implementation. The Organization's regional structure gives substantial political and administrative influence to six Regional Offices. Its financial model evolved from reliance on assessed contributions toward dependence on voluntary funding, much of it earmarked. Its legal instruments range from binding treaties and regulations to nonbinding recommendations and technical guidance. These arrangements do not simply constitute defects, in fact, each reflects a trade-off between central authority and political acceptability; between additional resources and agenda autonomy; or between legal obligation and state sovereignty (Abbott and Snidal 2000; Burci and Vignes 2004; Hanrieder 2015b).

The central question analysed in this chapter is therefore not why WHO "fails" to achieve an aspirational constitutional objective, but, under what institutional conditions can WHO transform formal authority, expertise, and Member State delegation into effective collective action, and why does its effectiveness vary across functions and crises? The answer developed here is conditional rather than deterministic. Three persistent institutional tensions are especially important. Regional autonomy can improve adaptation to local conditions but raise coordination costs. Voluntary financing can expand the resource envelope but allow individual donors to exercise influence outside collective governing bodies. Sovereignty-preserving legal arrangements can make agreement possible but limit compliance and enforcement. These tensions have become path dependent, but their consequences also depend on leadership, geopolitical conditions, the nature of particular health threats, and national implementation capacity (Table 1 provides an overview of these and other institutional trade-offs.) (Chorev 2012; Hanrieder 2015a; Brunner, Gatti, and Hall 2026).

The chapter follows the organizing idea of "Respice, Adspice, Prospice": look to the past, the present, and the future. It first develops an analytical framework drawing on the economics of global public goods, delegation and organizational autonomy, historical institutionalism, legitimacy, and the changing focal role of international organizations. It then traces the emergence of WHO and the institutional settlement reached in 1946-1948. The next sections examine governance, financing, normative authority, and performance. A separate discussion identifies persistent governance challenges and evaluates reform since the late 1990s. The final section considers alternative institutional trajectories rather than attempting to forecast a single future for WHO.

Analytical framework

Global public goods, delegation, and organizational autonomy

The economic rationale for international health cooperation begins with cross-border externalities and the under provision of global public goods. An infectious-disease surveillance system produces information that benefits many countries, including countries that contribute little to its production. Common disease classifications, laboratory standards, and quality benchmarks reduce transaction costs and permit interoperability across national systems. Preparedness also involves strategic complementarities: one country's weak detection capacity can impose risks on others. These features create familiar incentives for free riding and help explain why states create international institutions even while resisting extensive transfers of authority (Kaul and Faust 2001).

Principal-agent theory provides a second layer of analysis. States delegate tasks to international organizations in order to obtain expertise, continuity, credible commitments, and coordinated action, but delegation creates monitoring and control problems (Nielson and Tierney 2003; Hawkins et al. 2006). WHO is a particularly complex case because there is no single principal. Its membership expanded from 55 states in 1948 to 127 by late 1960s and the newly independent developing countries that joined demanded technical assistance – by the late 1960s more than half of WHO's budget went to operational activities in less developed countries, compared with 8% at the international labor organization (ILO) (Jacobson, 1969). Member States thus hold formally equal votes in the World Health Assembly but heterogeneous preferences and highly unequal financial contributions, a configuration that has resulted in the Organisation balancing wealthy financing states against poorer states with numerical voting strength while trying to protect institutional goals of its own (Chorev 2012). Donors can exercise influence through earmarked finance even when they lack special voting rights, while the Secretariat can use expertise, agenda setting, and information advantages to shape outcomes. Regional Directors and Regional Offices introduce an additional layer of delegation. WHO is therefore better understood as a multiple-principal or common-agency setting than as a simple bilateral principal-agent relationship (Cortell and Peterson 2006; Chorev 2012; Jankauskas, Knill, and Bayerlein 2024).

Principal-agent models also need to be complemented by theories of bureaucratic autonomy. International organizations are not merely passive instruments: professional expertise, organizational routines, legal authority, and control over technical information give secretariats room for independent action. Such autonomy can be productive when it enables technical leadership, but it can also generate bureaucratic rigidities or priorities that diverge from those of Member States (Barnett and Finnemore 2004). WHO's autonomy is, however, bounded by design. The Organization was not established as an authority that can exercise its power unilaterally; but

as a cooperative body through which Member States to share power in pursuit of "the attainment by all peoples of highest possible level of health." Its Secretariat therefore combines considerable technical authority with limited power to compel state compliance, a gap that constrained its effectiveness during health crisis (Benvenisti, 2020).

Where formal authority is limited, control over resources becomes a principal channel through which states shape what the Organization does. Financing can thus operate as a substitute for formal voting control mechanism: assessed contributions pool resources under collective governance, whereas earmarked voluntary contributions allow individual donors to direct resources to particular purposes. Empirical research on the WHO and other international organizations finds that earmarking can reduce administrative autonomy, increase transaction costs, and distort priorities, but that these effects are conditional rather than uniformly negative: where donor priorities and organizational objectives are aligned, earmarked finance may improve performance (Ege and Bauer 2017; Iwunna, Kennedy, and Harmer 2023; Brunner, Gatti, and Hall 2026). The relevant analytical question is therefore not whether voluntary contributions are inherently undesirable, but when donor control changes the Organization's ability to set priorities and allocate resources across functions.

Path dependence, regionalization, and institutional trade-offs

Historical institutionalism explains why arrangements adopted at an organization's founding can persist even when their costs become visible, and also how institutions can change gradually without formal redesign. Critical-juncture decisions create organizations, careers, constituencies, and expectations that make later reversal politically expensive, turning initial compromises into durable institutional paths (Pierson 2000). Change, when it occurs, often proceeds incrementally, as new arrangements are layered onto existing ones rather than replacing them (Streeck and Thelen 2005; Mahoney and Thelen, 2010). WHO's regional system is a strong example of persistence. The Constitution created six regional organizations with substantial political standing, and the formal appointment of Regional Directors depends on agreement between the Executive Board and the respective Regional Committee (World Health Organization 1946). Over time, regional constituencies, administrative capacity, and electoral processes reinforced this decentralized architecture (Hanrieder 2015b).

Whether this persistence is costly depends on how the benefits of decentralization weigh against its costs. By analogy with the fiscal-federalism literature, a regional structure can improve information, local fit, political ownership, and responsiveness (Oates 1972). Decentralized authority can, however, complicate organization-wide priority setting, personnel management, emergency command, and accountability. The relevant issue is therefore a trade-off between adaptation and coordination, not a simple choice between efficient centralization and inefficient regionalization.

Financing, by contrast, illustrates gradual change rather than persistence. The Constitution did not create an organization dominated by voluntary contributions: assessed contributions were initially the principal source of finance; and voluntary contributions, introduced later alongside them, gradually became predominant (Walt, 1993). The contemporary funding model is thus better viewed as an endogenous institutional evolution than as a single founding decision. This distinction shifts the analytical focus from constitutional design alone to the cumulative effects of Member State preferences, budget politics, and donor practices (Graham 2017; Brunner, Gatti, and Hall 2026).

Legitimacy, orchestration, and focality

Legitimacy matters because WHO has limited coercive power. Its Constitution designates it the directing and coordinating authority on international health work within the United Nations systems. Its effectiveness depends heavily on whether governments, experts, civil society, and other organizations accept its authority, use its standards, provide information, and mobilize resources. Scharpf's classic distinction separates input legitimacy, which concerns participation and representation, from output legitimacy, which concerns effective problem solving (Scharpf 1999). Schmidt adds throughput legitimacy, which concerns the accountability, transparency, inclusiveness, and quality of governance processes between input and output (Schmidt 2013). As legitimacy is relational, shaped by audiences perception of institutional procedures, performance, and public justification (Tallberg and Zürn 2019), these dimensions are best analysed together rather than in isolation.

WHO faces tensions along all three dimensions. The World Health Assembly provides formal sovereign equality, but unequal financial influence complicates input legitimacy. Closed or technically complex decision processes can raise throughput concerns. Emergency failures can undermine output legitimacy. The dimensions also interact: low perceived fairness can reduce compliance, while weak performance can encourage unilateral national action. They should therefore be treated as mechanisms affecting organizational capacity, not merely as normative labels.

Legitimacy matters all the more because WHO operates in a crowded institutional environment. Since the late twentieth century, the World Bank, UNAIDS, Gavi, the Global Fund, philanthropic foundations, regional bodies, and specialized partnerships have acquired substantial financial and operational roles in health. Gatti describes this development as contestation of WHO's focality, especially in its relationship with the World Bank (Gatti 2025). In response, WHO increasingly relies on orchestration, standard setting, and convening rather than hierarchical direction (Hanrieder 2015c). Institutional pluralism can fragment authority, but it can also permit functional specialization. The performance question is therefore whether WHO can use its normative legitimacy and convening power to coordinate actors it does not control.

Artificial intelligence offers a current test of this question. In AI for health, WHO shares normative leadership with other multilateral bodies, national and regional AI strategies, and private technology firms with far greater computational and financial resources. The WHO has issued ethics-and-governance guidance for AI in health (World Health Organisation, 2021), extended to large multi-modal models (World Health Organisation, 2025c), and pursue its Global Initiative on AI for Health. Whether it can convert its convening authority and technical credibility into effective coordination in this field, or is instead sidelined by better-resourced actors, is an open empirical question.

Table 1 lists five institutional features of WHO governance: regional autonomy, voluntary earmarked finance, sovereignty-preserving legal design, a broad mandate, and a plural global health system. Each feature has a potential benefit and a principal cost or risk. The table also relates these trade-offs to the analytical mechanisms used in this chapter, such as fiscal federalism, common agency, delegation, multiple objectives, and orchestration. Taken together, these perspectives suggest a conditional thesis. WHO's recurrent difficulties are shaped by durable institutional arrangements, but they are not mechanically determined by them. The same arrangements that produce coordination costs may also generate political support, local knowledge,

additional resources, or wider participation. The task is to identify when those trade-offs become binding constraints on performance.

Table 1. Institutional features and governance trade-offs

Institutional feature	Potential benefit	Principal cost or risk	Analytical mechanism
Regional autonomy	Local adaptation, information, and political ownership	Coordination and command costs	Fiscal federalism; path dependence
Voluntary earmarked finance	Additional resources and donor commitment	Agenda distortion and reduced flexibility	Common agency; resource dependence
Sovereignty-preserving legal design	Wider participation and lower sovereignty costs	Weak enforcement and uneven compliance	Delegation; hard/soft-law choice
Broad mandate	Adaptability and continuing relevance	Overload and difficult prioritization	Multiple objectives
Plural global health system	Specialization and additional resources	Duplication and contested focality	Orchestration; regime complexity

Source: Authors analysis.

Historical origins and institutional evolution

From sanitary diplomacy to a permanent international health organization

International health cooperation long predates WHO. The first International Sanitary Conference met in Paris in 1851 in response to cross-border epidemics and the economic costs of uncoordinated quarantine. Repeated conferences during the nineteenth century struggled to reconcile competing scientific theories, commercial interests, and national sovereignty, but they established a durable idea: epidemic control required international information and common rules (Howard-Jones 1974; Fidler 2001).

A more permanent institutional architecture emerged in the early twentieth century. The Office International d'Hygiène Publique (OIHP), created in 1907, collected epidemiological information and addressed quarantine matters. The League of Nations Health Organization (LNHO), established after World War I, developed broader work on surveillance, nutrition, rural health, and social medicine. The coexistence of OIHP and LNHO, together with regional organizations such as the Pan American Sanitary Bureau, demonstrated both the value of international cooperation and the coordination problems created by overlapping institutions (Cueto, Brown, and Fee 2019).

World War II added another institutional layer. The United Nations Relief and Rehabilitation Administration undertook large-scale health operations and created networks of personnel with international experience. By 1945, there was therefore both a political opening and an accumulated administrative legacy on which a universal health organization could be built (Charles 1968; Cueto, Brown, and Fee 2019).

The constitutional settlement of 1946-1948

At the San Francisco Conference in 1945, China and Brazil promoted the creation of an international health organization. A Technical Preparatory Committee met in Paris in 1946, and an International Health Conference in New York subsequently negotiated the WHO Constitution. The

Constitution was signed on July 22, 1946, and entered into force on April 7, 1948, after the required number of ratifications. The first World Health Assembly met in Geneva later that year and elected Brock Chisholm as the first Director-General (World Health Organization 1948; Cueto, Brown, and Fee 2019).

The constitutional settlement combined a broad substantive mandate with limited supranational authority. The Preamble famously defines health in expansive terms, and Article 1 establishes the objective of attaining the highest possible level of health for all peoples. Yet the Organization remained controlled by sovereign states. The World Health Assembly would be the supreme governing body; the Executive Board would connect technical and political functions; and the Secretariat would provide professional administration. Articles 44-54 established regional organizations, partly reflecting the need to accommodate pre-existing institutions in the Americas and regional political preferences (Burci and Vignes 2004; Hanrieder 2015b).

Two elements of this settlement would prove particularly consequential. First, the regional structure dispersed authority in ways that later complicated centralized coordination. Second, WHO received unusually significant lawmaking powers for a UN specialized agency. Article 19 authorizes conventions and agreements, Article 21 authorizes regulations in specified fields, and Article 23 authorizes recommendations. These powers were substantial, but their use remained embedded in sovereign consent and implementation (Burci and Vignes 2004; Gostin et al. 2024).

From technical agency to global health coordinator, 1948-2000

The WHO's early decades combined technical standard setting with large disease-control programs. Initial priorities included malaria, tuberculosis, maternal and child health, venereal disease, nutrition, and environmental sanitation. The WHO launched the Global Malaria Eradication Program (GMEP) in 1955, after the success of using dichloro-diphenyl-trichloroethane (DDT) against malaria. While malaria was eradicated from many regions, eradication was not achieved in several other areas due to financial constraints, as the United States stopped contributing to the WHO Malaria Special Account in 1963, resurgences of epidemic proportions in Sri Lanka, and global crises in the 1970s; the GMEP campaign was discontinued fourteen years later (Nájera et al, 2011). This illustrates the limits of a highly vertical strategy when ecological, political, and health-system conditions varied across countries (Charles 1968; Lee 2009).

Smallpox became the contrasting success. Learning from the failure of GMEP, the Smallpox Eradication Program was designed with the principle of integrating the pattern of operation of each national program with the health and social cultural settings of the country (Nájera et al, 2011). The intensified eradication program launched in 1967 combined surveillance, vaccination, national implementation, and international coordination. The last naturally occurring case was identified in Somalia in 1977, and the World Health Assembly declared smallpox eradicated in 1980. It remains the only human infectious disease eradicated globally through deliberate intervention (Lee 2009; Cueto, Brown, and Fee 2019).

The political environment also changed. Decolonization expanded the membership and altered the balance of the World Health Assembly. Under Director-General Halfdan Mahler, WHO increasingly emphasized health equity and primary health care, culminating in the 1978 Declaration of Alma-Ata. The resulting debate between horizontal health-system development and vertical disease programs became a recurrent theme in global health policy (Cueto, Brown, and Fee 2019).

By the late 1980s and early 1990s, the WHO faced stronger competition and financial constraints. Extrabudgetary funding rose to more than half of total resources, with the possibility of shifting policy influence toward donors (Walt 1993). The HIV/AIDS crisis produced both innovation and institutional fragmentation. The WHO's Global Programme on AIDS under Jonathan Mann integrated human rights and biomedical responses, but responsibility later shifted to the newly created UNAIDS. At the same time, the World Bank expanded its role in health finance, challenging WHO's position as the focal international health institution (Lee 2009; Gatti 2025).

Global health pluralization and crisis, 2000-2026

The Brundtland period at WHO (1998-2003), under former Norwegian Prime Minister Gro Harlem Brundtland as Director-General, marked an effort to restore strategic focus and political influence. WHO successfully negotiated the Framework Convention on Tobacco Control (FCTC), adopted in 2003, the first treaty concluded under Article 19. The 2002-2003 SARS outbreak exposed limitations in the older International Health Regulations (IHR) and accelerated the revision process that produced the IHR (2005), adopted in 2005 and entering into force in 2007 (Gostin and Katz 2016; Gostin et al. 2024).

The 2009 H1N1 pandemic provided the first major stress test of the revised IHR and was the first event designated a Public Health Emergency of International Concern under the Regulations. The 2011 Review Committee concluded that WHO had performed well in important respects but identified shortcomings in Emergency Committee procedures and transparency, the pandemic phase framework, and communication, and recommended changes in each area (World Health Organization 2011). The 2015 Ebola Interim Assessment Panel later identified the criticism WHO had received for declaring H1N1 a PHEIC as one of several factors contributing to the delay in declaring a PHEIC during the West African Ebola outbreak, alongside concerns about affected governments, economic and trade consequences, information problems, and WHO’s organizational culture (World Health Organization 2015). This sequence illustrates that IHR performance depends not only on legal design but also on institutional practice.

Alongside these legal and operational developments, global health governance became increasingly pluralized. Gavi, the Global Fund, bilateral programs such as PEPFAR, and the Bill & Melinda Gates Foundation mobilized resources on a scale that changed incentives across the sector. While these actors often increased global health capacity, they also reduced WHO's ability to define priorities through its intergovernmental processes alone (Clinton and Sridhar 2017; Gatti 2025).

The West African Ebola epidemic of 2014-2016 exposed serious weaknesses in WHO's emergency system. The Ebola Interim Assessment Panel identified delayed escalation, weak information flows, inadequate emergency capacity, and failures across country, regional, headquarters, Member State, and wider international levels (World Health Organization 2015). The key lesson is not that one Regional Office caused the failure, but that WHO's multi-level structure and risk-averse administrative processes were poorly suited to a rapidly escalating emergency.

COVID-19 produced an even larger stress test. WHO declared a Public Health Emergency of International Concern on January 30, 2020, when fewer than 100 cases had been reported outside China and no deaths outside China had been reported to WHO. Subsequent reviews nevertheless identified weaknesses in the broader international alert and response system, uneven state compliance, and major failures of solidarity in access to vaccines and other medical

countermeasures (Independent Panel for Pandemic Preparedness and Response 2021; Jones and Hameiri 2022). COVID-19 reinforced both sides of the WHO debate: no alternative institution possessed comparable universal convening and normative authority, but WHO could not compel governments to comply with its recommendations or legal obligations.

At the same time, the COVID-19 experience demonstrated WHO's coordinating and informational value. The Independent Panel for Pandemic Preparedness and Response noted the exceptionally high reliance on WHO during the pandemic and found that the Health Emergencies Programme and the newly established Science Division enabled stronger operational support and more systematic scientific advice than had been available during earlier emergencies (Independent Panel for Pandemic Preparedness and Response 2021). WHO's surveillance systems, expert networks, risk communication and information-sharing platforms also became important components of the international response. The resulting policy implication is better framed as strengthening WHO's capacity and authority than as replacing the Organization. This orientation has continued in the post-pandemic reform process: in 2026 the World Health Assembly established a Member State-led, WHO-hosted process to reform the global health architecture, with Member States emphasizing WHO's central convening and normative role (World Health Organization 2026h).

The post-pandemic period has therefore combined legal reform with geopolitical stress. In 2024 Member States adopted substantial amendments to the IHR. In 2025 they adopted a WHO Pandemic Agreement under Article 19, although the Agreement is not yet open for signature because its Pathogen Access and Benefit Sharing (PABS) annex remains under negotiation. In 2025 the United States again notified the United Nations of an intention to withdraw from WHO. As of September 2026, WHO continues to list 194 Member States and states that the U.S. notification remains pending consideration by its governing bodies (World Health Organization 2024, 2025j, 2026a, 2026d). These developments frame the contemporary governance questions examined below.

Governance, financing, and normative authority

Governance bodies and the three-level operational structure

At the global level, WHO governance operates through the World Health Assembly and the Executive Board, while six Regional Committees exercise governance at the regional level. The World Health Assembly, composed of all Member States, determines the Organization's policies, approves the program budget, appoints the Director-General, and exercises the treaty-making and regulatory powers assigned by the Constitution. The Regional Committees formulate and oversee regional policies and participate in the appointment of Regional Directors under Article 52. The Executive Board is a constitutional governing body that gives effect to the decisions and policies of the Health Assembly, advises it, and facilitates its work; it is not a third operational level. The Secretariat, headed by the Director-General, constitutes WHO's technical and administrative apparatus (World Health Organization 1946; Burci and Vignes 2004).

Operationally, the Secretariat works through headquarters (HQ) in Geneva, six Regional Offices (ROs) and Country Offices (COs). HQ provides organization-wide normative, strategic and emergency coordination; ROs implement global decisions and regional policies and adapt activities to regional circumstances; and Country Offices provide policy, technical, and operational support to Member States. This three-level structure gives WHO extensive local and regional reach, but can also create coordination costs and ambiguity in authority and escalation across organizational

levels, risks that became particularly visible during the West African Ebola response (Hanrieder 2015a, 2015b; World Health Organization 2015).

This formal design combines sovereign equality with professional administration. In practice, the boundary between technical and political authority is necessarily porous. Member States use governing bodies to advance national and regional preferences, while the Secretariat shapes agendas through expertise, drafting, data production, and program implementation. International secretariats rarely operate as either neutral machines or autonomous political actors; WHO's behavior reflects both principal control and bureaucratic agency (Barnett and Finnemore 2004; Chorev 2012).

The regional level is the distinctive element of this structure. Under Article 52 of the Constitution, a Regional Director is appointed by the Executive Board in agreement with the relevant Regional Committee. Regional nomination processes therefore give Member States in each region substantial influence, while Article 51 places Regional Offices under the general authority of the Director-General (World Health Organization 1946). The resulting arrangement is neither full hierarchy nor complete regional independence.

Country Offices are the third operational level. WHO's 2025 country-presence report identified 153 Country Offices and a physical presence in 166 Member States (World Health Organization 2025f). They provide technical advice and support national authorities during emergencies, complementing the normative and coordinating functions exercised at HQ and RO levels.

The advantages and costs of regionalization vary by function. Routine technical cooperation can benefit from regional knowledge and long-term relationships. Acute emergencies may require faster organization-wide command, standardized procedures, and rapid movement of staff and resources. The appropriate degree of centralization is therefore task dependent. Treating regional autonomy as either inherently dysfunctional or intrinsically valuable obscures this variation.

Financing and agenda autonomy

WHO's financing is central to its political economy. Assessed contributions are compulsory membership dues approved by the Health Assembly and are flexible once incorporated into the program budget. Voluntary contributions come from governments, intergovernmental organizations, philanthropic foundations, and other eligible contributors. Many voluntary contributions are earmarked for specific programs, locations, or activities. The historical shift toward voluntary finance was gradual rather than constitutional. Voluntary contributions were introduced in the 1950s and expanded substantially from the late twentieth century onward (Walt 1993; Brunner, Gatti, and Hall 2026).

This shift solved one problem while creating another. Voluntary contributions enabled WHO to expand activities without securing politically difficult increases in mandatory dues. They also allowed donors to support programs with visible objectives and measurable outputs. Yet heavy earmarking reduces the Secretariat's capacity to move resources toward underfunded functions, creates reporting and transaction costs, and can produce a divergence between collectively approved priorities and financed activities (Vaughan et al. 1996; Ege and Bauer 2017; Iwunna, Kennedy, and Harmer 2023).

Private philanthropy illustrates the issue. Kennedy and Thakrar identify 640 grants from the Bill & Melinda Gates Foundation to WHO between 2000 and 2024, with a total value of about US$5.5 billion. More than 80 percent of the funding was directed to infectious diseases and nearly 60

percent to polio, while noncommunicable diseases and health-system strengthening each received less than 1 percent (Kennedy and Thakrar 2025). These figures demonstrate strong concentration, but they do not by themselves establish organizational "capture." Donor influence should be understood as conditional on the size, earmarking, and substitutability of funds, as well as on whether donor priorities coincide with WHO's agreed program.

Member States have adopted a sustainable-financing reform intended to rebalance these incentives. Its specific targets, budget implications, and political consequences are discussed in the sustainable-financing section below.

WHO's Framework of Engagement with Non-State Actors (FENSA), adopted in 2016, addresses a related governance problem. FENSA establishes rules for due diligence, risk assessment, transparency, and management of conflicts of interest in WHO's engagement with nongovernmental organizations, private-sector entities, philanthropic foundations, and academic institutions (World Health Organization 2016). FENSA cannot remove the political economy of resource dependence, but it provides procedural safeguards for relationships that have become structurally important to global health governance.

Emerging technologies illustrate the same financing dynamics. WHO's work on artificial intelligence in health is funded largely through voluntary and philanthropic contributions rather than assessed dues, and a 2024-2025 survey of the WHO European Region found that only a small share of responding Member States had adopted a health-specific AI strategy, pointing to uneven governance capacity even where WHO guidance exists (Adib et al. 2026).

Normative and legal instruments

WHO's authority is unusually diverse for a UN specialized agency. Article 19 of the Constitution permits the Health Assembly to adopt conventions or agreements by a two-thirds vote; they become binding on states that accept them through their constitutional processes. Article 21 permits the Assembly to adopt regulations on specified technical matters. Under Article 22, these regulations enter into force for Member States after notice, subject to rejection or reservation where permitted. Article 23 authorizes non-binding recommendations (World Health Organization 1946; Burci and Vignes 2004).

This spectrum matters because legal bindingness and enforcement are distinct. The International Health Regulations are legally binding, yet WHO lacks a general sanctioning mechanism comparable to domestic public law. Recommendations are nonbinding, but technical standards can become highly influential when governments, procurement agencies, clinicians, or other international regimes adopt them. Codex Alimentarius standards, for example, acquire additional significance because the World Trade Organization's sanitary and phytosanitary regime recognizes relevant international standards as benchmarks (Veggeland and Borgen 2005).

The prevalence of soft law should therefore not be interpreted only as weakness. States may deliberately prefer softer instruments when uncertainty is high, preferences diverge, or harder obligations would prevent agreement. Soft law can facilitate experimentation and adaptation while imposing lower sovereignty costs (Abbott and Snidal 2000). The trade-off is that implementation depends more heavily on professional authority, peer pressure, domestic incorporation, and incentives outside WHO.

The FCTC and the IHR illustrate the two strongest legal instruments available to WHO. The FCTC, adopted in 2003 and entering into force in 2005, is the first treaty negotiated under Article 19. Its

impact has been substantial, although implementation varies across Parties and the United States signed but did not ratify the Convention (Chung-Hall et al. 2019). The IHR (2005) use WHO's regulatory authority. They require States Parties to develop core capacities, notify WHO of events that may constitute a public health emergency of international concern, and cooperate in managing risks while avoiding unnecessary interference with international traffic (Gostin and Katz 2016).

The IHR were amended in 2024 after the COVID-19 experience. The amendments entered into force on September 19, 2025, for States Parties that did not reject them. WHO reports 196 IHR States Parties, including all 194 WHO Member States; 11 States Parties rejected the 2024 amendments, so previous versions continue to apply to them unless those rejections are withdrawn (World Health Organization 2025a). The amendments created a pandemic-emergency category for communicable-disease emergencies meeting additional criteria, strengthened provisions on equity and access to health products, established National IHR Authorities, created a Coordinating Financial Mechanism, and established a nonpunitive States Parties Committee to facilitate implementation (World Health Organization 2024; Habibi, Eccleston-Turner, and Burci 2025).

The amended IHR expand institutional machinery but retain the basic sovereignty bargain. The new implementation committee is facilitative rather than punitive, and WHO still cannot compel national governments to adopt particular health measures. This is a deliberate design choice. Stronger formal enforcement might improve compliance in some cases, but it could also reduce willingness to accept common rules or to report sensitive events. The effectiveness of the amended IHR will therefore depend on incentives, financing, domestic capacity, and reputational mechanisms as much as on legal text.

WHO performance: outputs, outcomes, and attribution

An important aspect of this analysis is to distinguish WHO's organizational outputs from broader health outcomes and from causal impact. WHO can be directly assessed for producing standards, risk assessments, technical assistance, and coordination. Whether governments implement those outputs is a second stage. Population health outcomes depend on many additional factors, including national policy, economic conditions, other international organizations, private actors, and the epidemiology of specific diseases. WHO's contribution can be substantial without being separately identifiable from these complementary inputs (Moser and Bump 2022).Table 2 provides the analytical structure for the evaluation of WHO's performance in this chapter. It distinguishes four levels: organizational inputs and capabilities, organizational outputs, implementation and behavioral outcomes, and population-health outcomes. It also indicates the degree of direct WHO control or attribution at each level, from high internal control over inputs to low attribution for population-health outcomes. This four-level distinction is particularly important because WHO's own results framework mixes Secretariat outputs with country and global outcomes.

This four-level distinction is important because WHO's own results framework mixes Secretariat outputs with country and global outcomes. Official reporting is valuable for accountability, but it should not be read as a causal evaluation of WHO. The following assessment therefore focuses on areas in which WHO has a plausible comparative advantage and treats global outcome indicators as contextual evidence rather than as estimates of WHO's marginal effect.

Table 2. A performance framework for evaluating WHO

Level	Examples	Degree of direct WHO control / attribution
Organizational inputs and capabilities	Flexible finance, staff, laboratories, data networks	High control over internal allocation, subject to donor and Member State constraints
Organizational outputs	Standards, surveillance notices, risk assessments, guidance, technical missions	Relatively high; appropriate for direct organizational accountability
Implementation and behavioral outcomes	National adoption, reporting, compliance, policy change	Shared with Member States and partners
Population-health outcomes	Mortality, service coverage, emergency protection, healthier lives	Low direct attribution; many complementary determinants

Normative standards and health intelligence

Normative standard setting through the creation of global guidelines, medical standards, and health data frameworks is one of WHO's clearest comparative advantages. The International Classification of Diseases, the Model List of Essential Medicines, pharmaceutical and vaccine prequalification, laboratory standards, and a large body of clinical and public-health guidance provide common reference points for national systems. The 24th WHO Model List of Essential Medicines was published in 2025, continuing a process that has shaped national essential-medicines policies for decades (Jenei 2025; World Health Organization 2025e).

WHO's prequalification function similarly illustrates indirect influence. By evaluating the quality, safety, and efficacy of selected health products, WHO creates information that can be used by national regulators and international procurement agencies. The mechanism is not hierarchical enforcement but reduction of information asymmetry and coordination around a common benchmark. This is precisely the type of activity for which a technically credible international institution can produce large benefits at relatively modest direct cost.

Health intelligence is another core function. In 2024 WHO screened more than 13,000 information sources, triaged more than 1.2 million raw signals, and reported 494 events with initial risk assessments (World Health Organization 2025g). These figures are organizational outputs, not measures of prevented morbidity or mortality. Their importance lies in the informational infrastructure they provide to governments and emergency networks.

WHO's official Results Reports provide a broader picture. For 2025, WHO estimated that, relative to a 2018 baseline, 567 million additional people were covered by essential health services without catastrophic health spending, 698 million additional people were better protected from health emergencies, and 1.75 billion additional people were living healthier lives. WHO also reported that only about half of Secretariat output indicators met or exceeded their end-of-period targets (World Health Organization 2026b). These indicators summarize global and country progress to which WHO contributes, but they should not be interpreted as the number of people whose outcomes were caused by WHO intervention.

Emergency preparedness and response

WHO's emergency role changed substantially after the West African Ebola epidemic. The WHO Health Emergencies Programme (WHE), established in 2016, was designed to integrate normative expertise with operational capacity, strengthen incident management, and reduce fragmentation

across headquarters, regional, and country levels. The Contingency Fund for Emergencies (CFE) was created to make early financing available without waiting for program-specific donor commitments (World Health Organization 2015; World Health Organization 2025b).

The financing mechanism has produced visible gains in speed. In 2024, the CFE released roughly US$52 million for responses across 28 countries and territories (World Health Organization 2025b). However, faster release of funds does not imply that all elements of emergency response have become faster. WHO's 2024 corporate flexible-funding report shows that the share of critical acute public-health events for which a formal rapid risk assessment was completed and circulated within one week fell from a 39 percent baseline in 2019 to 27 percent in 2024, below a 43 percent target. WHO attributes part of this decline to the growing complexity of multi-country and global assessments, which can require longer technical processes (World Health Organization 2025h).

This illustrates the need to separate organizational capacity from outcome. An emergency response depends on the affected government's willingness to share information, the speed of local detection, laboratory and logistics capacity, the behavior of neighboring states, financing, and the actions of many humanitarian partners. WHO can improve coordination and still be unable to command a unified response. Its operational model therefore resembles orchestration more than hierarchy (Hanrieder 2015c).

COVID-19 also demonstrates that stronger WHO powers would not automatically resolve the main problems. Governments ignored or exceeded WHO advice in different directions, particularly through extensive travel restrictions and uneven information sharing. At the same time, inequitable access to vaccines and medical products reflected production capacity, intellectual-property rules, procurement power, and national export policies that were largely outside WHO's direct control (Independent Panel for Pandemic Preparedness and Response 2021; Jones and Hameiri 2022). WHO's performance should therefore be judged partly by whether it provided timely information and coordination, while recognizing that the global outcome reflected a broader governance system.

Country-level technical cooperation

WHO's country presence is the main channel through which global standards become national policy advice. Country Offices support ministries of health, help develop Country Cooperation Strategies, provide technical assistance, and connect national authorities to regional and global expertise. As of March 2025, 62 percent of WHO Country Offices had an up-to-date Country Cooperation Strategy, twice the proportion reported in 2023 (World Health Organization 2025f).

Tobacco control provides an example of a norm translated into national implementation. The MPOWER technical package supports implementation of FCTC demand-reduction measures. By 2025, 155 countries had implemented at least one MPOWER measure at best-practice level, covering more than 6.1 billion people, while 40 countries still had no measure at that level (World Health Organization 202ih). These figures show wide diffusion but also major implementation heterogeneity.

Country cooperation is difficult to evaluate causally because WHO typically works alongside governments, other UN agencies, development banks, bilateral donors, and nongovernmental organizations. Country-level evidence is therefore most useful for identifying mechanisms and constraints rather than estimating a single WHO treatment effect. Evaluations often find stronger performance when WHO provides technical guidance, convening, and emergency support than

when long-term implementation requires sustained financing and domestic administrative capacity. That pattern is consistent with WHO's comparative advantage as a normative and coordinating organization rather than a large-scale service-delivery agency (Moser and Bump 2022).

Coordination in a fragmented global health system

WHO's Constitution assigns it the role of directing and coordinating international health work, but the meaning of coordination has changed. In humanitarian emergencies, WHO leads the Global Health Cluster and has an institutionalized role in interagency coordination. In development finance and program delivery, other actors control large budgets and independent implementation channels. WHO therefore coordinates primarily through standards, technical legitimacy, and convening rather than through budgetary or administrative control (Clinton and Sridhar 2017; Hanrieder 2015c).

This division of labor can be efficient. UNICEF's procurement capacity, the Global Fund's financing model, Gavi's vaccine focus, and the World Bank's lending instruments differ from WHO's strengths. The governance problem arises when specialization turns into duplication, inconsistent priorities, or competition for donor resources. WHO's focal role has consequently become contestable rather than exclusive (Gatti 2025).

A realistic performance benchmark is thus not whether WHO commands the global health system. It is whether WHO can supply functions that would otherwise be underprovided, maintain credible standards, coordinate information, and reduce transaction costs among actors with independent authority. This benchmark is less dramatic than the constitutional language of "directing and coordinating authority," but it is analytically more useful for assessing a fragmented governance system.

Persistent governance challenges

Sovereignty and compliance

The most fundamental constraint on WHO is incomplete delegation. Governments create common rules because health threats cross borders, but they retain primary authority over public-health measures within their territories. The IHR are legally binding, yet compliance depends heavily on domestic institutions and political incentives. WHO can request verification, publish information, provide assistance, and issue temporary recommendations, but it does not possess a general enforcement apparatus (Gostin and Katz 2016; Habibi, Eccleston-Turner, and Burci 2025).

This creates a recurring reporting problem. Early notification of an outbreak can generate international benefits while imposing concentrated political and economic costs on the notifying state through travel restrictions, trade effects, or reputational damage. If states expect punishment for transparency, they may have incentives to delay reporting. International rules therefore need not only obligations but also mechanisms that make compliance politically and economically feasible.

The 2024 IHR amendments move in this direction by emphasizing equity, financing, and implementation support rather than punitive enforcement. The new States Parties Committee is explicitly consultative and nonpunitive. Critics may regard that as insufficient, but the design reflects the same sovereignty constraint that has shaped WHO since 1948. A harder enforcement regime would require Member States to delegate powers they have repeatedly been unwilling to confer.

Regional autonomy and organization-wide coordination

WHO's regional system creates a second persistent challenge. Regional institutions can adapt global policy to different epidemiological, administrative, and political environments. They also give Member States a direct role in regional leadership. These are genuine benefits. Yet regional political autonomy can complicate organization-wide staffing, budgeting, and emergency command (Hanrieder 2015b).

The West African Ebola crisis made these costs visible, but it would be misleading to treat regionalization as the sole cause of failure. The independent assessment identified problems across multiple levels, including delayed recognition, weak escalation, risk aversion, national political constraints, and insufficient international mobilization (World Health Organization 2015). The policy issue is therefore how to define circumstances in which emergency authority should become more centralized while preserving the informational and political advantages of regional structures.

WHE's "One WHO" approach is one response. It standardizes emergency procedures and incident management across levels without abolishing the regional system. The remaining frictions show why institutional reform is difficult: changing formal reporting lines would alter established political rights and organizational constituencies. Historical institutionalism predicts precisely this pattern of incremental adaptation rather than constitutional replacement (Hanrieder 2015a).

Financing, donor influence, and mandate overload

WHO's financing problem is partly a collective-action problem among Member States. Many governments favor a well-resourced WHO in principle but prefer to retain control over incremental funds through earmarking. The result is a mismatch between collectively approved mandates and flexible resources. This can produce underfunding of functions that are difficult to attribute to a single donor, such as surveillance infrastructure, norm production, organizational management, and long-term health-system work (Reddy, Mazhar, and Lencucha 2018; Iwunna, Kennedy, and Harmer 2023).

The broad constitutional mandate intensifies the problem. WHO is expected to address infectious diseases, noncommunicable diseases, universal health coverage, emergencies, health systems, climate-related health risks, antimicrobial resistance, mental health, and many other issues. A broad mandate provides adaptability, but it also creates prioritization problems when resources are constrained. Calls for WHO to "focus on its core mandate" are therefore politically difficult because Member States disagree about what the core should include (Hanrieder 2020).

The right response is not necessarily a narrow WHO. Some global health problems are interconnected and cannot be handled by a purely disease-specific institution. But an organization with finite managerial and financial capacity needs clearer comparative-advantage criteria. Normative standards, surveillance, emergency coordination, and high-level technical cooperation are areas where WHO's universal membership and scientific authority are difficult to substitute. Direct service delivery should generally be justified by emergency need or by the absence of more appropriate implementing institutions.

Geopolitics, legitimacy, and organizational capacity

WHO has never been politically insulated. Cold War conflict, decolonization, North-South disputes, and contemporary strategic rivalry have all shaped its governing bodies. Politics is not an external contamination of an otherwise technical institution; it is inherent in an organization whose

rules allocate authority and resources across sovereign states (Brown, Cueto, and Fee 2006; Chorev 2012).

The challenge is to preserve technical credibility within political governance. WHO's legitimacy depends on transparent procedures, credible evidence, fair representation, and demonstrated performance. Formal one-state-one-vote rules support sovereign equality, but financial concentration and informal bargaining create asymmetries. Technical expert processes can increase scientific quality while appearing opaque to outsiders. Faster emergency decision making can improve output legitimacy while reducing opportunities for consultation. These tensions make legitimacy a multi-objective governance problem rather than a single metric (Scharpf 1999; Schmidt 2013; Tallberg and Zürn 2019).

The Director-General election illustrates this tension. Earlier elections were criticized for opacity and political bargaining, especially during the 1990s (Peabody 1995; Lee 2009). Subsequent reforms introduced clearer nomination procedures, candidate forums, and codes of conduct. It would therefore be inaccurate to describe the current process as institutionally identical to the earlier era. Geopolitical bargaining remains plausible, as it does across the UN system, but claims that it dominates technical qualifications require case-specific evidence.

Organizational capacity also depends on workforce stability. The 2025-2026 financing shock forced WHO to reduce its planned 2026-2027 budget and realign staffing and structures. This episode demonstrates a more defensible consequence of financial dependence than speculative claims that particular surveillance functions would collapse by a fixed percentage. Budget uncertainty can reduce long-term planning, increase reliance on short contracts, and make it harder to retain specialized capacity, even when the Organization protects country-level operations (World Health Organization 2025d; Tang and Merson 2026).

Reform and adaptation

Brundtland, partnerships, and institutional repositioning

WHO's modern reform cycle accelerated under Director-General Brundtland, from 1998 to 2003. Her administration sought to reduce internal fragmentation, reorganize programs into broader clusters, strengthen evidence-based priority setting, and reassert WHO's relevance in a global health field increasingly populated by powerful external actors. The FCTC negotiations were an important demonstration that WHO could use its constitutional lawmaking authority, while new partnerships with governments, foundations, and public-private initiatives broadened its access to resources and political networks (Brundtland 2001; Lee 2009).

The Brundtland reforms also clarified a persistent dilemma. Partnerships can extend reach and mobilize expertise, but they may blur accountability and encourage program-specific financing. A more open organization can become more influential while simultaneously becoming more dependent on actors outside its formal governing structure. Later reforms did not resolve this tension; they institutionalized procedures for managing it, most notably through FENSA.

Post-Ebola emergency reform

The Ebola crisis generated a more targeted institutional response. WHO created the CFE and, in 2016, established WHE to combine normative responsibilities with operational emergency capacity. The reform aimed to shorten decision times, establish common incident-management procedures, and clarify organization-wide responsibilities. An Independent Oversight and

Advisory Committee was also created to provide continuing external review of WHE (World Health Organization 2015; Lee 2009).

These reforms addressed identifiable operational weaknesses, but they did not rewrite WHO's regional constitution or give the Secretariat coercive powers over Member States. This is an important distinction between administrative reform and constitutional reform. WHE can improve internal coordination, but it cannot eliminate delays caused by national reporting incentives or compel governments to follow WHO recommendations. The post-Ebola experience therefore supports a broader pattern: crises often produce meaningful institutional adaptation while leaving the political foundations of the organization largely intact.

Sustainable financing

Financing reform moved from recurrent debate to concrete decisions after 2021. A Member State working group examined the widening gap between WHO's mandate and predictable resources. In 2022, the Health Assembly agreed on the target of progressively increasing assessed contributions to 50 percent of the 2022-2023 base budget by 2030-2031 at the latest (World Health Organization 2022). The first two increases have now been approved, covering the 2024-2025 and 2026-2027 bienniums (World Health Organization 2025d).

This is an important institutional change because assessed contributions are flexible and collectively governed. It should nevertheless be evaluated against realistic expectations. Reaching the target will not make WHO independent of voluntary funding, nor will it remove political influence from assessed contributions. Member States still set the scale and approve the program budget. The reform instead changes the margin at which WHO can protect underfunded functions and respond to shocks.

The reform also shows how exogenous shocks can alter institutional coalitions. The renewed U.S. withdrawal initiative and reductions in development assistance increased the perceived cost of dependence on a small donor base. In 2025 WHO reduced its planned 2026-2027 base budget from US$5.3 billion to US$4.2 billion, while Member States simultaneously approved the second assessed-contribution increase (World Health Organization 2025d). The combination of retrenchment and more predictable dues illustrates adaptation under constraint rather than simple organizational expansion.

The amended IHR and the Pandemic Agreement

The post-COVID legal reform agenda has two main pillars. The first is the 2024 package of IHR amendments. These amendments entered into force for most States Parties in September 2025 and introduced new institutions and principles, including the pandemic-emergency category, National IHR Authorities, a coordinating financing mechanism, and the States Parties Committee for implementation (World Health Organization 2024; 2025a). The first meeting of the implementation committee took place in August 2026, marking a shift from negotiation to operationalization (World Health Organization 2026e).

The second pillar is the WHO Pandemic Agreement was adopted by the World Health Assembly on May 20, 2025 under Article 19 of the Constitution. The Agreement addresses prevention, preparedness, equitable access to pandemic-related products, supply chains, financing, research and development, and institutional cooperation. It is not yet in force. The Agreement will open for signature only after the Health Assembly adopts the PABS annex, and it will enter into force after 60 ratifications (World Health Organization 2025j; Villarreal 2025).

PABS is politically central because it links rapid access to pathogens and sequence information with benefit sharing, including access to diagnostics, therapeutics, and vaccines. Negotiations remained unresolved in 2026. The Seventy-ninth World Health Assembly extended the mandate of the Intergovernmental Working Group and requested that the outcome be submitted to the Eightieth World Health Assembly in May 2027 or, if necessary, to an earlier special session. As this chapter is finalized in September 2026, the eighth negotiation round is under way in Geneva (World Health Organization 2026c).

The Pandemic Agreement is therefore best described as adopted but incomplete as an operational treaty regime. It is a significant return to Article 19 lawmaking, but its eventual effect will depend on the PABS annex, ratification, domestic implementation, financing, and the willingness of states and manufacturers to make the new mechanisms work. Recent legal scholarship accordingly treats the Agreement as an institutional advance with unresolved accountability and equity challenges rather than as a completed solution (Villarreal 2025; Bandara et al. 2026).

U.S. withdrawal and the politics of organizational resilience

The United States has historically been one of WHO's most important political and financial supporters, while also periodically challenging the Organization's policies. As early as 1948, when it joined the Organization, the United States, through a joint resolution of Congress, reserved the special right to withdraw unilaterally from the WHO, subject to one year’s notice and the fulfillment of its financial obligations in full (Ruotolo, 2023). In July 2020, the first Trump administration submitted a withdrawal notification during the COVID-19 crisis. The Biden administration reversed this process in January 2021 before it would have taken effect on July 6, 2021. After returning to office, President Trump again announced withdrawal in January 2025 and the United Nations circulated a notification with a stated effective date of January 22, 2026 (Meier et al. 2024; United Nations 2025), and the country formally exited.

The legal and institutional status after that date is more complicated than a simple statement that U.S. membership definitively ended. WHO's current country list still reports 194 Member States and explicitly notes that the U.S. notification remains pending consideration by WHO's governing bodies (World Health Organization 2026a). WHO's January 2026 statement similarly said that the notification raised issues for consideration by the Executive Board and the World Health Assembly (World Health Organization 2026d). The chapter therefore treats the U.S. action as a major withdrawal shock and financing loss while avoiding a categorical legal conclusion that WHO itself has not adopted.

The episode nevertheless demonstrates structural exposure to donor concentration. The most important lesson is not that WHO should insulate itself from any particular country. It is that an organization supplying global public goods requires a financing model resilient to national political cycles. The assessed-contribution reform, donor diversification, and attempts to broaden flexible financing are responses to that general problem.

Prospice: alternative institutional trajectories

The future of WHO should not be reduced to a binary choice between a stronger supranational organization and institutional decline. The preceding analysis suggests at least four plausible trajectories. These are not forecasts. They are institutional scenarios that clarify the choices facing Member States.

The first trajectory is a more strongly core-financed coordinator. Under this model, Member States complete the assessed-contribution pathway, protect flexible resources for surveillance and normative functions, and strengthen organization-wide emergency procedures. Regional structures remain in place, but clearer triggers specify when emergency authority becomes more centralized. This trajectory would increase organizational resilience without requiring a wholesale constitutional redesign.

A second trajectory is a narrower normative hub. WHO would concentrate more explicitly on standards, health intelligence, emergency coordination, treaty support, and high-level technical assistance, while leaving more implementation and financing to specialized partnerships, development banks, humanitarian organizations, and national systems. The advantage would be greater focus. The risk is that a narrower operational footprint could reduce country knowledge and weaken the feedback between global norms and implementation.

A third trajectory is networked orchestration. WHO would accept that global health governance is permanently plural and invest deliberately in its capacity to coordinate institutions it does not control. In this model, focality is earned through technical credibility, data infrastructure, convening, and interoperability rather than through formal hierarchy (Hanrieder 2015c; Gatti 2025). Success would depend on reducing duplication and clarifying comparative advantages across organizations.

A fourth trajectory is deeper geopolitical fragmentation. Major powers could increasingly channel health cooperation through bilateral, regional, or ideologically aligned institutions, leaving WHO with universal formal authority but reduced financial and operational centrality. This outcome would not necessarily eliminate WHO's normative functions, but it could weaken its capacity to coordinate emergencies in which political rivalry is itself a barrier to information sharing and collective action.

A fifth cross-cutting factor could reshape any of these four trajectories: artificial intelligence. The WHO has positioned itself as a normative leader through ethics-and-governance guidance issued in 2021 and extended to large multi-modal models in 2024, and it pursues its Global Initiative on AI for Health jointly with the International Telecommunication Union and the World Intellectual Property Organization rather than alone, illustrating the orchestration dynamic discussed above (World Health Organization 2021, 2025c; World Health Organization, International Telecommunication Union, and World Intellectual Property Organization 2023). A 2026 assessment by WHO's European Region concluded that the central obstacle to responsible AI in health is institutional capacity rather than the technology itself (World Health Organization 2026f). AI therefore reproduces the chapter's central tensions in a new arena: it is financed largely through earmarked philanthropic and donor support rather than assessed contributions; its governance instruments so far take the form of non-binding technical guidance rather than binding regulation; and WHO's claim to coordinate it is contested by other multilateral bodies, regional AI strategies, and private technology firms with far greater computational and financial resources (World Health Organization 2026g). Whether AI becomes a tool that strengthens WHO's normative and surveillance functions, or a further driver of institutional fragmentation, will depend on the same variables identified throughout this chapter: financing predictability, organization-wide authority, and legitimacy.

The most plausible future may combine elements of the first three trajectories, face continuing pressure from the fourth, and be reshaped by cross-cutting factors such as AI. The WHO's

institutional comparative advantage is unlikely to lie in becoming a global health ministry. It lies in providing credible common rules, information, convening, and technical coordination in areas where fragmented national action is costly. The key reform question is therefore how much autonomy, flexible financing, and organization-wide authority are needed for those functions; and how much sovereignty Member States are willing to pool to obtain them.

Summary

WHO is best understood neither as a failing bureaucracy that could be repaired through better management alone nor as a potentially autonomous global health authority held back only by insufficient resources. It is an international organization built around incomplete delegation. States seek the benefits of coordination while retaining control over domestic health policy, regional representation, finance, and implementation. Many of WHO's achievements and limitations arise from that same bargain.

The historical record demonstrates substantial achievements. WHO helped build a global infrastructure of disease classification, surveillance, technical standards, and health guidance. It coordinated the eradication of smallpox, developed internationally influential medicines and product standards, negotiated the FCTC, and created a legal framework for reporting and managing cross-border health emergencies. These functions are difficult to reproduce through purely bilateral or market mechanisms (Lee 2009; Gostin et al. 2024).

The record also reveals persistent constraints. Regional autonomy raises coordination costs even as it provides local legitimacy and knowledge. Earmarked voluntary finance expands resources but can shift effective control toward individual donors. Binding international rules coexist with weak enforcement because Member States retain sovereignty over implementation. Institutional pluralism provides specialized capacity but weakens WHO's ability to act as an uncontested focal organization. These are trade-offs rather than isolated administrative mistakes.

This interpretation changes how reform should be evaluated. The relevant benchmark is not whether a reform eliminates political conflict or makes WHO fully autonomous. It is whether the reform improves the Organization's ability to supply global public goods while preserving enough political consent for states to participate. The CFE and WHE improved emergency capacity without abolishing regional government. The 2022-2025 financing decisions increased predictable core resources without eliminating voluntary finance. The 2024 IHR amendments strengthened implementation support and equity provisions without creating punitive supranational enforcement. The Pandemic Agreement extends the legal architecture but still depends on PABS, ratification, domestic policy, and sustained cooperation.

A further implication concerns performance measurement. WHO should be held accountable for the quality and timeliness of its own outputs, including surveillance, standards, risk assessments, technical assistance, and coordination. It should not be credited with all improvements in global health outcomes, and it should not be blamed for all failures of Member States or the wider global health system. Distinguishing organizational outputs, implementation outcomes, and population health effects is essential for a credible social-science assessment (Moser and Bump 2022).

The theme of "Respice, Adspice, Prospice" therefore leads to a qualified conclusion. Looking backward shows that WHO's institutional compromises were often the price of creating and maintaining a near-universal organization. Looking at the present shows that those compromises create real costs when rapid, coordinated action is required. Looking forward suggests that the

central challenge is not to remove politics from global health, which is impossible, but to design incentives and institutions that allow cooperation to survive political disagreement. WHO's continued relevance will depend on whether its Member States are willing to finance and use the common infrastructure they created, while accepting the degree of pooled authority that effective global health cooperation requires.

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