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Commentary

Rupture as Catalyst: The Case for Deep WHO Governance Reform

Comment on "The United States Withdrawal From the World Health Organization: Implications and Challenges"

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Abstract

US withdrawal from World Health Organization (WHO) in 2026 is widely framed as a crisis to be managed toward eventual membership restoration. We argue the opposite: geopolitical rupture has created the first genuine political opening for deep governance reform of an institution whose architecture has, for decades, enabled dominant funders to shape priorities. The burden-sharing critique of Global South non-engagement is reframed as a legitimacy deficit: countries have contributed pathogen samples, data, and biological materials to global systems while watching the resulting benefits captured by high-income states and their manufacturers, as illustrated by H5N1, COVID-19 vaccine inequity, and the unresolved Pathogen Access and Benefit Sharing (PABS) annex of the Pandemic Agreement. Seven interdependent reforms are identified spanning earmarking caps, assessed contributions, a single non-renewable Director-General term, a global common framing, civil society oversight, Executive Board (EB) reform, and regional director appointments. Our argument is that the rupture has disturbed the conditions that made structural change unlikely, and that durable legitimacy is more achievable now than at any prior moment.

Keywords: Global Health Governance, Health Geopolitics, WHO Reform

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A Rupture

Global health is treating the US withdrawal from WHO as an interruption. It is better understood as a rupture: one expression of the unravelling of the post-war multilateral order and the emergence of a multipolar world in which no single power can anchor global governance. The US withdrawal from World Health Organization (WHO) is one expression of a broader shift: the unravelling of the post-war multilateral order and the emergence of a multipolar world in which no single power can anchor global governance.

The dominant reflex in global health – stabilise, bridge the funding gap, welcome the US back – is understandable but insufficient. Yazdi-Feyzabadi and colleagues document the operational damage astutely in this journal,[1] but framing it as a crisis to be managed toward restoring US membership misses what the rupture has made possible.[2] Reforms long regarded as politically infeasible have become newly thinkable, and countries whose engagement is most needed may now find in a reformed architecture the co-ownership required for global health solidarity.

An Architecture Built for a Different Era

WHO's governance architecture reflects the power distribution of 1948 and the donor dominance of the post-Cold War era. Three structural features illustrate the problem. First, voluntary earmarked contributions came to constitute the bulk of WHO's budget, making the organisation dependent on a small cluster of Western governments and philanthropic foundations whose preferences shaped its agenda. For the 2024–2025 biennium, the US was assessed $264 million yet projected to contribute $442 million in voluntary, almost entirely earmarked funds[3] – granting it agenda-setting power exceeding its formal vote.

Second, assessed contributions were set so low, and so decoupled from economic weight, that large and increasingly prosperous economies benefit from WHO's surveillance, standard-setting, and technical functions at negligible cost. The anomaly extends to programme flows: WHO resources continue to reach upper-middle-income and high-income countries, blurring the distinction between contributor and beneficiary and weakening incentives for fiscally capable states to assume greater ownership.[4]

Third, regional director appointments have often functioned as political patronage rather than merit-based selection, eroding technical credibility and the Director-General's authority over regional and country offices. The

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Independent Panel for Pandemic Preparedness and Response found that regional autonomy structurally undermined that authority during COVID-19,[5] and recommended a single non-renewable term for the Director-General.

Why the Global South Has Not Stepped Up

Appeals for middle-income and Gulf economies to fill the financing gap typically rest on a burden-sharing logic: these countries benefit from WHO's functions and should pay a commensurate share. That logic is partially correct but incomplete, for three reasons.

The first concerns political identity. India and Brazil occupy an ambiguous space between recipient and donor roles, reflecting historical self-perceptions and domestic fiscal constraints. Brazil hosted the culminating G20 event for the WHO Investment Round in November 2024 and pledged nothing of its own[6]; India's health diplomacy operates largely through bilateral and South-South channels rather than multilateral core contributions.

The second is bilateralism as control. The major Gulf donors – Saudi Arabia, United Arab Emirates, Qatar, and Kuwait – give substantial official development assistance but almost exclusively through bilateral channels: Saudi Arabia's 2023 official development assistance was 94% bilateral, with just 6% reaching multilateral organisations as unearmarked contributions.[7] Bilateral aid offers visibility and control unconstrained by multilateral norms. Saudi Arabia co-chaired the WHO Investment Round and made no pledge.

The third is a legitimacy deficit rooted in the recent practice of multilateral health cooperation. Indonesia's refusal in 2007 to share H5N1 influenza virus samples with WHO was not obstruction but a rational response to an architecture that allowed northern pharmaceutical manufacturers to convert shared pathogen data into proprietary vaccines without equitable benefit to the countries of origin.[8] The COVID-19 pandemic confirmed that logic at scale: countries that contributed biological materials and epidemiological data to global surveillance systems watched high-income nations corner vaccine supply while their populations waited. The Pathogen Access and Benefit Sharing (PABS) provisions of the WHO Pandemic Agreement address this in principle – the US was among the most resistant parties to those equity provisions, and the agreement passed 124 votes to zero in US absence.[9] The PABS annex remains unfinished and its resolution will shape whether countries whose biological sovereignty was discounted come to trust the institutions being remade.[10]

None of this eliminates emerging powers' responsibilities to contribute proportionately to global public goods, but it reframes burden-sharing appeals that alone have generated limited traction. The Accra Reset, launched by President Mahama in August 2025, articulates this directly: the global health architecture has treated governments of the Global South as passive takers rather than sovereign actors.[11] These countries are not disengaged; they are demanding to co-own the process on different terms. The politics of reform cannot, however, be reduced to a simple contest between a resistant Global North and a reformist Global South. The status quo serves distinct interests across the membership: northern donors shape agendas through earmarking; many southern member states benefit from patronage over regional appointments and budgets. Reform that addresses only the first would be incomplete.

Seven Reforms the Rupture Enables

Recent high-level analyses have made the substantive case for paradigm-level reform of the global health architecture[12]; we explain why the current political moment makes long agreed reforms newly executable. First, the US is absent from the Director-General election. Second, the assessed contributions reform trajectory agreed at World Health Assembly (WHA) in 2022 – moving toward 50% of WHO's core budget by 2030–2031 – is headed in the right direction.[13] And third, the broader geopolitical realignment is reshaping the field in which reform must be negotiated. China's $500 million pledge (over five years) at the 2025 Assembly signals strategic engagement,[14] but as voluntary restricted funding it perpetuates the governance problem the reform must address. The Lusaka Agenda demonstrated that endorsement without structural pressure yields incrementalism[15]; what is different now is that the coalition holding the donor-driven model in place has fractured.

Seven reforms now sit on a more favourable political-economy footing than at any prior moment. None is new: most have been recommended by successive review panels and several, notably the assessed contributions increase and the Evaluation Policy, are already in slow motion.

The first is capping earmarked voluntary contributions and incentivising core funding. A progressive ceiling on the proportion of WHO's budget that can be tightly earmarked would limit dependence on any single philanthropic or bilateral donor. The Gates Foundation is now WHO's single largest voluntary contributor[16]; the WHO Foundation, established to widen the philanthropic base, has added a further governance layer without resolving the earmarking problem and introduced corporate donors whose interests are not always aligned with WHO's independence.

The second is rebalancing assessed contributions to economic weight. WHO inherits the United Nations scale of assessments, under which even substantial economies contribute modestly: Saudi Arabia is assessed at around 1.2% of the scale – affordable for a state providing $5.2 billion in annual development assistance[17] – while the bulk of genuine financing falls to a narrow donor club. A Director-General elected with broad support from emerging and middle-income countries may be better placed to advance this reform than predecessors shaped by traditional donor priorities – but only alongside reforms that strengthen co-ownership and accountability.

The third is a single non-renewable term for the Director-General. The Independent Panel for Pandemic Preparedness and Response recommended it because a Director-General eligible for re-election has a structural incentive to maintain the support of the funders whose voluntary contributions dominate the budget. The reform is procedurally modest – a WHA resolution – but politically decisive, and with an open

election and donor influence weakened, the WHA majority needed to adopt it is, for the first time, within reach.

The fourth is reframing global health as a global common good rather than an aid relationship. A global commons framing, in which shared surveillance systems, pathogen data networks, normative standards, and pandemic preparedness infrastructure are understood as goods from which all states benefit and for which all bear proportionate responsibility, changes the political economy of who engages seriously and on what terms. The framing has a constitutional foundation: the WHO Constitution envisages all member states as equal participants in a universal health enterprise.

The fifth is strengthening independent oversight and civil society voice in governance. The revised WHO Evaluation Policy adopted in June 2025 moves in the right direction on accountability,[18] though as a member-state-approved instrument it strengthens evaluation but without securing independence from the interests it is meant to scrutinise. Formalising civil society participation beyond consultative status toward genuine accountability roles would expose institutional inefficiency to external scrutiny. The Joint Process on Global Health Architecture Reform approved at WHA79 explicitly excludes civil society from its formal task force membership, confining it to consultative engagement - illustrating the limit the reform must address.[19]

The sixth is reforming the Executive Board (EB) itself. The EB sets the WHA agenda, nominates the Director-General, and is the body where co-ownership demands would become operational decisions or be quietly deflected. Options include rebalancing regional seat allocation to reflect contemporary disease burden and demographic weight, lengthening member terms to support institutional memory, publishing voting records and conflict-of-interest declarations, and opening EB sessions to civil society observation.

The seventh is reforming regional director appointments. Patronage in regional and country-level governance includes documented vote trading, opaque campaign finance and the nomination of close relatives of heads of government; it extends to professional staffing at country offices and has, in documented cases, shaped the allocation of emergency resources, including COVID-19 funding. Meaningful reform must encompass both headquarters and regional governance: the same ministerial representatives participate in both, yet the structures operate as parallel hierarchies largely insulated from mutual accountability.

The Calculated Bet

These reforms carry three risks. A first is successor capture – that US influence is simply replaced by Chinese or other dominance rather than producing genuinely representative multilateralism: China is not a straightforwardly progressive actor on the normative dimensions WHO must defend, including sexual and reproductive health and rights, gender equality, science independence, and accountability to affected populations. A second is WHO marginalisation; China may prefer bilateral channels, leaving WHO peripheral while influence is exercised through the Health Silk Road. A third is performative rather than enacted reform, compounded by time: the assessed contributions trajectory agreed in 2022 will not be complete until 2030–2031, and constitutional amendments to the EB or regional director selection would take longer still. The political window opened by the rupture may close before the reforms it makes thinkable can be enacted, which argues for sequencing: the procedurally modest measures, above all the single Director-General term and earmarking caps, should be pursued first.

The Accra Reset includes actors whose normative commitments are not reducible to Chinese interests. As Richard Horton reported from WHA79, Edem Adzogenu, Global Emissary for the Accra Reset, noted that Ebola was discovered in DR Congo in 1976 and, 50 years on, the country still lacks adequate national surveillance capacity – the governance failure the Reset targets. Horton, in the same column, characterised much of the current reform conversation as procedural change managed to leave the institutional status quo intact,[20] and the Joint Global Health Reform Process agreed at WHA79—which explicitly excludes mandate revision and organisational consolidation—lends weight to that concern.

That critique of performative reform is well taken, but describes reform processes inside a political economy that no longer exists: a donor coalition with Washington at its centre, aligned European capitals around it, and the major philanthropic funders alongside. The rupture has disturbed that whole configuration, not only its American anchor. Post-war alliances are loosening, Gulf security relationships are recalibrating, and middle powers—Brazil, Indonesia, South Africa, India—are organising on their own terms. What is now possible is a WHO less dominated by any single power: a stronger assessed contribution base, depoliticised regional governance, civil society voice, and a global commons framing of its mandate – the institutional form in which durable legitimacy can be built. It is also an organisation able to recover its constitutional core: normative standard-setting, science and evidence-based policy guidance, and systematic investment in prevention and preparedness capacity, rather than one sustained through emergency response appeals and operational delivery that crowds out upstream functions. Global South governments long positioned as recipients of technical support rather than co-authors of global norms have the most to gain from that reorientation.

None of this presupposes permanent US absence. The governance failures described here—donor capture, inadequate assessed contributions, regional patronage—are the features that made WHO vulnerable to charges of unaccountability and inefficiency. A reformed WHO is the institution a future US administration could re-engage with on terms that do not reproduce the old governance model.

WHO has always been universal in mandate; it has never been universal in ownership. The rupture, painful as it is, provides the opening to close that gap.

Disclosure of artificial intelligence (AI) use

Not applicable.

Ethical issues

Not applicable.

Conflicts of interest

Kent Buse has previously served as staff and advisor to WHO. He is co-CEO of Global Health 50/50, which receives funding from several philanthropies; and a trustee of the World Obesity Federation, which receives industry funding, although not from the food and beverage industry. Shambhu Acharya has served WHO at country, regional, and headquarter levels and was a candidate for the position of WHO Regional Director for South-East Asia (SEARO) in 2024.

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