Tough Times, Tough Choices

Surviving the Aid Collapse

A Lean World Health Organization for the Global Good

CENTER FOR GLOBAL DEVELOPMENT

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The World Health Organization (WHO) is facing an immediate fiscal crisis, resulting from the US withdrawal and subsequent cuts to the organisation, and lower-than-anticipated future contributions from other funders. It faces a 35 percent budget gap of $1.5 billion—even after cutting its planned 2026–2027 biennial budget to $4.27 billion—a 14 percent decrease from its 2024–2025 budget.

The ongoing crisis has prompted WHO's leadership to undertake an urgent cost-cutting and reorganisation process. At the highest level, this is the correct response—yet we are deeply concerned that the process so far appears focused on a stakeholder-mollifying cost-cutting exercise across the board, rather than serious prioritisation of functions.

KEY RECOMMENDATIONS

The World Health Organization should:

1. Articulate a clear vision for a lean WHO for the global good, with a laser-focus on its global comparative advantage:
   - Global leadership and convening
   - Global health security
   - Global public goods
2. Substantially rebalance staffing and resources away from country offices and technical assistance and towards the three priorities at HQ
3. Reorient scaled-down country offices to support WHO's global focus:
   - Serve as liaison between global public good production and country needs
   - Retain modest direct TA and service provision role in outbreak preparedness and response
   - Directly report to headquarters
4. Prioritise and focus its global public goods production through a member state committee, the consolidation of global technical centers, time-bound WHA resolutions, and coordination with other partners
5. Develop a transitional budget that protects the poorest countries and guides the organisation rapidly towards the vision

In this brief—the first in the *Tough Times, Tough Choices* series that will target the major global health and development institutions and their funders—we propose a different approach: radically streamlining the WHO to fulfil its unique global functions. Instead of muddling through with budget cuts across the board, the WHO leadership must chart a path of retrenchment to global leadership, global health security, and global public goods—the irreplaceable core of its mission and mandate.

We preface this analysis with a warning: we expect these ideas will be provocative, perhaps quite unpopular, and not necessarily aligned with WHO's current views of its own mission. Yet we maintain that a lean WHO desperately needs clarity of mission and mandate to focus scarce resources and fulfil its essential global role—and consider this note a first salvo in defining how that mandate should be understood.

The WHO's current cost-cutting strategy lacks a clear vision

The WHO's planned cuts have so far focused on broad-based cost-cutting and operational efficiency. While understandable given the urgency of the moment, this exercise has stopped short of articulating a clear and focused vision for the institution. For example, there has been consolidation of ten departments into four without any clear prioritisation or loss of function—suggesting the primary goal is to reduce the salary costs of senior leadership and directors. Operational efficiency improvements are always welcome—at least on the margins—but will not realistically make up a 35 percent shortfall without severely compromising functions.

More broadly, the restructuring and cuts appear to be motivated primarily by regional balance, with equal cuts of 14–15 percent applied across all regions. Only headquarters has a planned greater cut at 23 percent, with key functions set to move out of Geneva to the WHO's regional offices. Equal cuts to each region are clear evidence of stakeholder management, rather than strategic prioritisation.

Why is the WHO focusing on technical efficiencies and stakeholder management rather than protecting and advancing core essential functions? In part, it may be because the cuts have been driven by a consultative, member-state driven process, which will naturally lead all member states to protect their individual interests, including access to direct technical support and services, versus global functions. Indeed, direct support to country implementation or operations support is mentioned in eight out of the ten programme budget outputs prioritised by member states, suggesting that countries are trying to sustain their WHO technical assistance services. The evenness of the cuts is also likely a result of the WHO's unique three-tiered governance structure, with substantial power invested in the regional offices. This consensus-based, rather than vision-based, approach to prioritisation is understandable, but leads to the tragedy of the commons, with no one standing up for the WHO's core global functions.

From first principles: The WHO must prioritise the global good

Tough times require tough choices—but also offer an opportunity to tear down long-standing barriers to change. We argue that the WHO must therefore retrench back to its comparative advantage and deliver on its core global mandate—in turn pulling back from country-level technical assistance and humanitarian services.

The WHO's comparative advantage stems from three unique characteristics:

- It is uniquely *global*, serving all countries and all health topics.
- It is uniquely *legitimate*, as a UN agency, and governed by all countries through the World Health Assembly.
- It is uniquely *technical*, with a primary objective to be evidence-based and normative, rather than focusing on service delivery.

These three characteristics lead to three comparative advantages.

1. Global leadership and convening power

The WHO can uniquely utilise the high-profile global position, legitimacy, and technical expertise of the Director-General to convene member states and lead the world on emerging health issues. This leadership can be informal, for example, efforts to raise awareness of antimicrobial resistance, or more formal, such as development of joint treaties, i.e., the 2025 Pandemic Agreement.

2. Global health security at a truly global level

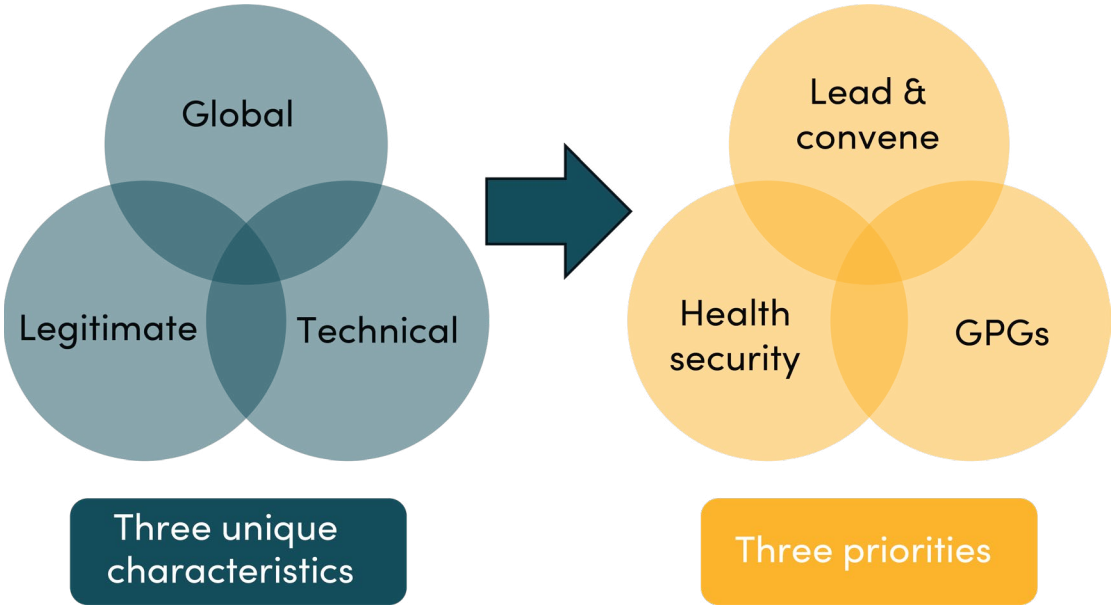
This includes global leadership of pandemic and outbreak preparedness and response, declaring public health emergencies of international concern, and collating data on pathogens and resistance profiles. Beyond these core issues, the WHO risks scope creep when it attempts to expand its purview into other multisectoral, cross-border threats such as climate change, industrial pollution, and international trade in unhealthy products such as tobacco and alcohol. There may be a modest role for the WHO to play here, but it should accept a secondary role to other agencies such as the Intergovernmental Panel on Climate Change and focus only on providing narrowly tailored health security input and oversight.

3. Producing global public goods on health issues

This means establishing international norms and standards (e.g., reference materials for laboratories) and producing centralised resources such as data and reports that all countries can draw upon (e.g., the global health expenditure database). It also means drawing on country-based expertise and experience to produce global guidance that prevents each country from having to reinvent the wheel—for example vaccine guidelines and pre-qualification of drugs and diagnostics.

These three priorities—global leadership and convening; global health security; and global public goods—are WHO's comparative advantage and should form the backbone of a radically simplified WHO (Figure 1). Only once there is clear evidence of achieving this core mandate should the WHO consider expanding its remit.

FIGURE 1 Three unique characteristics of the WHO, and three proposed priorities



Recommendation 1

Articulate a clear vision for a lean WHO for the global good, with a laser-focus on its global comparative advantage:

- Global leadership and convening
- Global health security
- Global public goods

Retrenchment on the global good would mean big strategic cuts elsewhere

This retrenchment comes with tough trade-offs. It would mean stripping the WHO of almost all technical assistance and country delivery functions, with modest exceptions for outbreak and pandemic response. These functions also provide sources of income for the WHO and so may result in the need for further cuts down the line. But these functions are better delivered by local and/or regional organisations with an operational focus, such as NGOs, universities, and consultants, which also tend to be more efficient and flexible in delivery than a UN agency.

They are also areas with a significant management burden that distract the WHO from its core mission, often requiring large country offices that constantly apply for specific grants and then procure temporary consultants to deliver. The WHO should relieve itself of this burden, instead focusing on global leadership on any given topic, the development of guidelines and tools that all technical assistance providers can harness, and its role as a trusted partner of health ministries, helping to identify and coordinate technical assistance providers in each country.

For example, the WHO recently announced that it has provided support to a range of countries on the health financing emergency caused by aid cuts—however it has not yet released overall guidance and tools to manage these financing cliffs. This is evidence of the trade-offs inherent in trying to be both a direct delivery agency for technical assistance and a global guidance agency.

To be clear, a focus on global public goods does not imply that all global public goods are necessarily high-value and worth producing. The World Health Assembly tasks the WHO to produce new reports every year, but these requests do not adequately consider the WHO's capacity to deliver, nor do they expire, meaning the secretariat is incrementally overwhelmed by pressures from member states. One practical recommendation is for all resolutions to be time-bound pending explicit renewal. A second recommendation is for the WHO to have a standing committee of member states (balanced across regions and income) who—based on advice from the secretariat—set yearly priorities for its GPGs and submit a deprioritised "negative list" of GPGs to WHA for approval annually. This prioritisation process should include criteria such as potential results and impact, WHO comparative advantage, and the number of member state requests. There is no point producing guidance without member state interest in using them.

What does this mean for the perennial challenge of the country-regional-global balance at WHO? It primarily means a substantial relative shift away from the 4,584 staff in 153 country offices towards more resources at global HQ. This may be unpopular with member states, and indeed runs counter to currently proposed changes, but it is where most of the global functions are best carried out.

Country offices would scale down dramatically. In their new form, they would still lead on outbreak response and preparedness, but for other topic areas they would serve primarily as liaison between ministries and WHO global functions, helping encourage submission of data and use of GPGs while supporting countries to access other technical assistance providers, and reporting directly to the global level to ensure this connection is maximised.

The balance between regional and global is more subtle. Truly regional public goods—for example, guidance on control of African trypanosomiasis, should clearly be anchored at the regional level—and, importantly, global public good production does not necessarily need to physically take place in Geneva. Staffing and budgets may be shared amongst the regions, if they are clearly coordinated centrally. This could increase regional support for this reform agenda, as well as generate some cost savings.

Finally, the recent proliferation of global technical centres must be reviewed. Their location appears to be tied to specific donors such as Germany and Japan. Consolidation in Geneva or WHO regional offices is likely to be more effective and efficient.

Recommendation 2

Substantially rebalance staffing and resources away from country offices and technical assistance and towards the three priorities at HQ

Recommendation 3

Reorient scaled-down country offices to support WHO's global focus:

- Serve as liaison between global public good production and country needs
- Retain modest direct TA and service provision role in outbreak preparedness and response
- Directly report to headquarters

Recommendation 4

Prioritise and focus global public goods production through a member state committee, the consolidation of global technical centres, time-bound WHA resolutions, and coordination with other agencies.

How member states can swallow a bitter pill: Key challenges to address

It is clear from the survey of member states during the recent budget cutting exercise that our proposed prioritisation—leadership, global health security, and GPGs—cuts against expressed member state priorities. Nevertheless, we argue that the WHO leadership must do more in this moment than simply mirror current member states priorities: it must lead on setting a radically streamlined vision for the institution that should serve as the basis for prioritisation. The Director-General must have a vision for the WHO, and he and the secretariat must make the case for the most impactful WHO possible.

Yet retrenchment to a global WHO does not necessarily mean neglecting all preferences and priorities of member states. Member states have a clear role to play in steering the WHO's internal prioritisation of GPGs, thus ensuring its focus areas are relevant and responsive to country needs. Donors could also consider alternative routes to support in-country demand for technical assistance (TA), for example, via a World Bank trust fund that could co-finance International Development Association operations, allowing countries to procure and deploy TA at their own discretion in consultation with the WHO country office. Where the World Bank is restricted by shareholders—for instance on sexual and reproductive health and rights—specific donors should provide technical assistance through separate mechanisms. This approach would have the added advantage of focusing donor money for TA on those countries that can least afford it, rather than the current ad hoc approach to WHO TA projects.

We recognise that a significant transition of this kind would best be carried out via a multi-year, phased process. The WHO, however, must make cuts now. Based on current budget projections, a prioritisation process that fully protects the secretariat (27 precent of budget) and global technical

centres (3 percent of budget) from further cuts would imply average immediate cuts of 50 percent at the regional and country levels—on top of the roughly 15 percent budget decrease that they have already absorbed. To ease the transition, the WHO could urge supportive funders to front-load their contributions to the budget and make greater use of reserves; it could also make deeper cuts to relatively wealthy countries and regions, in turn partially shielding the poorest countries from extreme short-term disruption (see Table 1 and Figure 2 for plausible scenarios).

Recommendation 5

Develop a transitional budget that protects the poorest countries and guides the organisation rapidly towards the vision

It is not just low- and middle-income countries that may resist significant change. Other actors, notably the Gates Foundation and US government, have established extensive GPG infrastructure (e.g., the Institute for Health Metrics and Evaluation databases and the now defunct Demographic & Health Surveys) that competes with the WHO mandate in this regard. The US government itself has now fully withdrawn from the WHO—further eroding the WHO's ability to assert itself as the uniquely legitimate global body. Remaining donors to the WHO at times implicitly or explicitly demand influence quid pro quos, including input into technical guidance and appointment of their nationals to leadership positions. In addition, funding bureaucracies such as PEPFAR and the Global Fund may not agree with or follow WHO guidance, undermining WHO's ability to lead.

Partial solutions for these challenges might include:

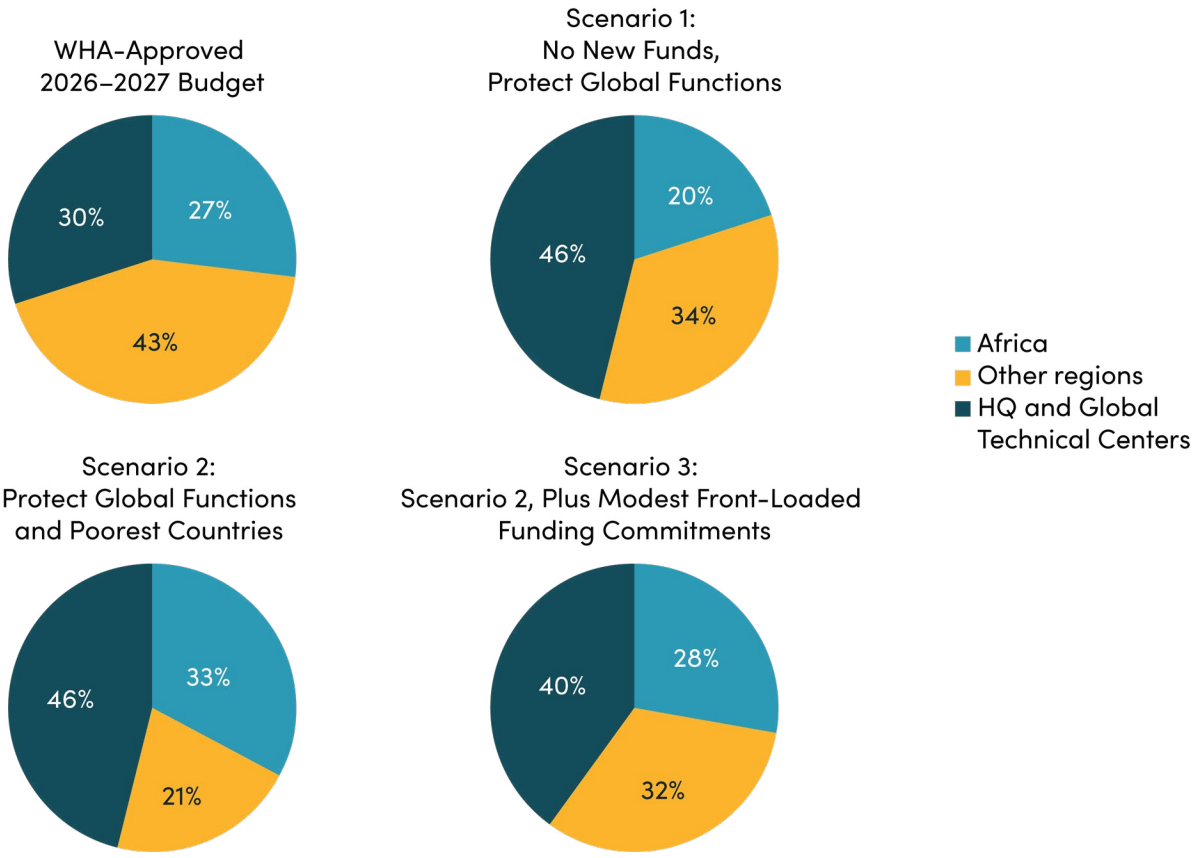
- a GPG coordination committee with other partners, reaching yearly agreement as to each agency's comparative advantage and contribution to key GPG functions
- concentration of WHO staff on a narrow set of top priority GPGs to develop increased credibility
- better mechanisms to ensure the independence of teams producing technical and clinical guidance, e.g., to avoid conflicts of interest with funders
- increased use of eminent advisory committees to ensure quality and credibility of each piece of guidance, that can carry out outreach to other agencies
- establishment of a genuinely merit-based appointment system for senior leadership

TABLE 1 Possible budget scenarios

REGION	WHA APPROVED 2026-2027 BUDGET (MILLIONS)	Scenario 1: No New Funds, Protect Global Functions		Scenario 2: Protect Global Functions and Poorest Countries from Immediate National Cuts*		Scenario 3: Scenario 2, Plus Modest Front Loaded Funding Commitments	
		NEW BUDGET (MILLIONS)	PERCENT CUT	NEW BUDGET (MILLIONS)	PERCENT CUT	NEW BUDGET (MILLIONS)	PERCENT CUT
Africa	$1,139.60	$569.80	50	$911.68	20	$911.68	20
The Americas	$254.80	$127.40	50	$80.26	69	$140.14	45
South-East Asia	$417.20	$208.60	50	$131.42	69	$229.46	45
Europe	$308.90	$154.45	50	$97.30	69	$169.90	45
Eastern Mediterranean	$533.70	$266.85	50	$168.12	69	$293.54	45
Western Pacific	$347.20	$173.60	50	$109.37	69	$190.96	45
Headquarters	$1,125.80	$1,125.80	0	$1,125.80	0	$1,125.80	0
Global technical centres	$140.00	$140.00	0	$140.00	0	$140.00	0
Total	$4,267.20	$2,766.50	35	$2,763.95	35	$3,201.47	25

*In scenario 2 we use the Africa region as a rough proxy for poorest countries, as all but four low-income countries are located in Africa, though in practice this should be done based on actual country need.

FIGURE 2 Three budget scenarios for protecting global functions and blunting the cuts for the poorest countries



In conclusion, because the WHO is uniquely global, legitimate, and technical, it is the only agency that can truly serve as the world's public health organisation. It must focus on a lean and highly prioritised set of three functions: global leadership, global health security, and the production of global public goods. In short, a WHO facing budget cuts must prioritise the global good.

We invite interested individuals to propose a 300-word response article with clear counter proposals, which we plan to publish as a collection later in the year, as we all seek to identify a healthier future for the WHO and for us all.

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This brief is part of the *Tough Times, Tough Choices* series, which offers guidance to major global health and development institutions and their funders on how to allocate resources strategically and effectively in an era of aid austerity.

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