THE WHO'S SHRINKING BUDGET AND EXPANDING CHALLENGES

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Summary generated by AI of the webinar "Defunding Global Health: What A Wakened WHO Means for the World". Recording available here.

Introduction

In May 2025, the 78th World Health Assembly approved a drastically reduced base budget for the World Health Organization (WHO) for the 2026–2027 biennium. At $4.2 billion, the new budget falls over $1 billion short of what the organization had originally requested to fulfill its core mandate. While such decisions may appear technical, they could have far-reaching implications—particularly for the world's most vulnerable populations, including women, LGBTQIA+ communities, migrants, and those historically marginalized. The WHO's role in norm-setting through guidelines and other materials serves as a reference for advancing the promotion of human rights.

This development is not isolated. It reflects deeper tensions in the governance of global health and in the multilateral system more broadly. Scrutinizing WHO's budgetary trajectory and funding architecture reveals persistent structural inequities, a fragmented financing system, and troubling signals about the future of international cooperation in health.

Budget Cut or Return to "Normal"?

Following the pandemic-era surge in funding, WHO's budget is now reverting to pre-COVID levels. From a pandemic peak of around $8 billion, the organization's operating funds have returned to the familiar ~$4.5 billion range, which has remained effectively flat for decades. While this may look like stability, it also reflects an artificial ceiling imposed by a handful of high-income donor states, dating back to the 1980s, when a zero-growth policy on assessed contributions was adopted and maintained, even below inflation rates.

What is now being interpreted as a "crisis" could also be seen as a long-standing policy of constraint —a deliberate strategy to keep WHO small and reliant on conditional funding, even as global health challenges grow.

Inside WHO's Financing: The 20/80 Dilemma

WHO's budget is structured around two major streams:

- Assessed Contributions (ACs): These are mandatory membership fees from states, calculated based on economic metrics. They are predictable, flexible, and of high quality—but make up only about 20% of the overall budget.
- Voluntary Contributions (VCs): These account for 80% of WHO's funding and are highly earmarked, donor-driven, and volatile. They often reflect geopolitical and commercial priorities rather than public health needs.

This imbalance has created structural distortions in WHO's ability to plan and act. Some health areas and regions receive far more funding than they are budgeted for, while others are consistently neglected. For instance, programs aimed at improving access to essential health services are well supported, while those focused on emergency preparedness—despite being consistently ranked as high priorities—remain seriously underfunded. In Africa, such emergency programs are only 38% funded; in the Americas, 32%.

This skewed funding landscape undermines the coherence and effectiveness of WHO's work. A program's importance is no guarantee of its financial sustainability.

The Investment Round and Its Discontents

In response to chronic underfunding and unpredictable income flows, WHO launched what it now calls the "investment round"—a form of replenishment modeled on mechanisms used by vertical health funds like GAVI and the Global Fund. The aim is to secure upfront, multi-year commitments that are less restricted and more predictable.

While this initiative has brought in new donors, including several philanthropic foundations and multilateral banks, it has also raised concerns about accountability and influence. Notably, contributions from foundations with close ties to the pharmaceutical industry—such as the Novo Nordisk Foundation—blur the line between public-interest funding and private agenda-setting. Despite its corporate links, Novo Nordisk's foundation is treated as a philanthropic donor, raising alarm among civil society groups about conflicts of interest.

Disappearing Priorities: The Problem with WHO's Planning Language

Beyond budget lines, WHO's programmatic priorities are shaped through a bureaucratic exercise known as "priority setting." Comparing documents from recent bienniums reveals both shifting language and a concerning trend: vague, convoluted descriptions that make meaningful analysis—and accountability—more difficult.

For example, the 2026–2027 outcome on noncommunicable diseases (NCDs), mental health, and antimicrobial resistance is bundled into a single catch-all phrase: "Equity and access to quality services improved for non-communicable diseases, mental health conditions and communicable diseases while addressing antimicrobial resistance." Such phrasing obscures where funding goes and makes it easier to mask underfunding in one area by aggregating it with another.

This deliberate complexity can serve political ends—allowing the Secretariat and donors to highlight "investment" in broad outcomes without revealing what is actually being deprioritized. Notably, explicit references to the structural, political, and socio-economic determinants of health have been sidelined in the new program budget.

Core Functions or Narrow Mandate? A Battle Over WHO's Role

Beneath the technicalities of budget cuts and jargon-heavy documents lies a deeper political struggle: what should the WHO do?

On one side are member states and advocates who envision a WHO that not only sets norms and standards but also intervenes operationally—on the ground, in emergencies, and in support of health systems. On the other side are those pushing for a minimalist WHO, one that limits itself to technical guidance, data collection, and diplomacy.

Terms like "core functions" are often used to justify this latter view. Yet this concept has no grounding in WHO's constitution and only emerged from internal reinterpretations in the 2000s. Today, "core functions" are invoked to shut down more expansive visions of WHO's role—particularly in areas like emergency response, health system strengthening, and regulation of harmful commercial industries.

The Influence Question: Who Shapes WHO?

Voluntary contributions don't just shape where WHO can act—they also raise questions about who sets its agenda.

The largest funders to WHO include the Gates Foundation, the UK government (notably contributing entirely flexible funds), Gavi, and a growing roster of non-state actors. While it may seem intuitive to equate financial size with political influence, the picture is more complex. Influence also flows through secondments, lobbying, consultancy relationships, and leadership appointments.

For example, the former head of the Wellcome Trust —one of WHO's top private funders—now holds a senior post at WHO. This revolving door dynamic raises questions about policy alignment, especially in areas like NCDs, where the private sector has major commercial stakes.

The Human Cost: Staff Cuts and Institutional Hollowing

The austerity measures following the reduced budget are already being felt internally. WHO plans to cut over 2,000 positions—primarily professional-grade staff—amounting to a 20% reduction in workforce. Departments are being restructured, and long-serving staff face uncertain futures. Consultants and headquarters personnel are expected to bear the brunt of the downsizing.

The consequences are more than human; they are institutional. Hollowing out the Secretariat reduces WHO's ability to serve as a global knowledge base, respond to crises, or maintain continuity in technical programs. It is, quite literally, a weakening of the world's health architecture.

What Next? Funding Justice and Multilateral Integrity

The implications of this crisis—and of calling it a crisis—are profound. WHO's fragility is not a natural condition but the result of political choices. Rebuilding requires not only more funding, but a reimagined narrative: one that treats health as a global public good and WHO as a public institution worth investing in.

Several civil society voices argue that now is the time to push for:

- **Global public investment mechanisms**, with clear obligations and protections from private capture
- **Stronger conflict-of-interest safeguards**, especially in engagements with philanthropic or corporate-linked foundations
- **A renewed defense of WHO's public-interest mandate**, including its capacity to regulate harmful industries and support health systems, not just monitor disease

As one recent statement from WHO leadership pointedly observed, the world spends $2.1 billion on military every eight hours—roughly the same cost as a stealth bomber or a quarter of what the tobacco industry spends on marketing each year. The problem, then, is not scarcity. It is political will.

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