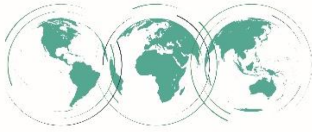

Global Health Multilateralism Without the United States: Next Steps

Thomas J. Bollyky, Council on Foreign Relations

In September, President Donald Trump addressed the UN General Assembly (UNGA), as world leaders gathered in New York City to discuss how multilateral cooperation can help slow the rising number of premature deaths from cancer, cardiovascular diseases, and diabetes, and how to manage the health-related risks and opportunities posed by artificial intelligence. A U.S. State Department communiqué announced that the U.S. messages to its multilateral partners would be, first, that the United States has shouldered the burden for health and humanitarian assistance for decades and that it is "imperative for other donors to step up," and, second, that UN agencies need to improve efficiencies, eliminate redundancies, and reduce staff costs. The recently released "America First Global Health Strategy" calls for the U.S. government to negotiate bilateral agreements on global health, circumventing multinational institutions and nongovernmental organizations. As if to reinforce the point, the Trump administration launched those bilateral negotiations last week, while at UNGA.

That messaging builds on a broader U.S. retreat on multilateralism in global health under Trump. In May 2025, the World Health Assembly (WHA) convened for the first time without the United States, following the Trump administration's renewed withdrawal from World Health Organization (WHO). Previously, the United States was responsible for roughly 20 percent of the WHO's budget and provided more than 12 percent of experts to WHO committees and programs. The withdrawal created a $600 million shortfall to this year's WHO annual budget, which will grow to $1.5 billion next year. Consequent restructuring to the WHO projects a 28 percent staff cut from nine hundred thousand to seven hundred thousand staff, reducing the number of program divisions from ten to four, and shrinking the leadership team from eleven to six.

The discontinuance of U.S. support for global health multilateralism goes beyond the WHO. The Trump administration's recent rescission package removed funding to the Pan American

Health Organization, the oldest international health agency, the UN Children's Fund (UNICEF), and the Joint UN Program on HIV/AIDS (UNAIDS). Earlier this year, the United States stopped funding Gavi, a global health initiative that manages a multilateral partnership on vaccination, and U.S. leaders announced that the country would not adopt the new amendments to the International Health Regulations nor sign the Pandemic Treaty, international legal instruments designed to promote a more equitable response when countries confront the next global outbreak.

Aspects of the U.S. retreat from global health multilateralism have spread internationally. Following the Trump administration's decision to exit the WHO, Argentina announced a similar withdrawal from the organization in February, while Hungary, Israel, and Russia declared their intentions to explore an exit. After the U.S. cuts in its official development assistance, France, Germany, and the Netherlands have since announced cuts in their foreign assistance budgets, citing competing demands for increased defense spending amid ongoing Russian aggression in Ukraine. In May, China sent the largest assembly to the WHA to date, but the country nevertheless pushed back on increased membership dues and changes in health programs.

At the height of the COVID-19 pandemic, with nations scrambling against the economic, social, and health harms of a dangerous disease that knew no national boundaries, many observers would have been surprised to learn that, just a few years later, the response by the United States and others would be to scale back multilateral cooperation on global health. Yet that broader pullback reflects a deepening dissatisfaction, shared by traditional donor nations and longtime aid recipients alike, with how global health governance performed during that crisis and with the long-standing dependencies and vulnerabilities the global system has failed to resolve. A striking outcome in the wake of the dissolution of the U.S. Agency for International Development (USAID) has been the muted response from the agency's biggest recipients: African leaders. The lack of political outcry in part underscores enduring ambivalence about the operation of foreign assistance. Global health leaders sought to address that dissatisfaction in pandemic treaty negotiations that concluded this past spring with a hard-won agreement, but much of the deal remains unfinalized.

The story of multilateral cooperation, however, is not over. Even without U.S. support this year, Gavi has secured more than $9 billion out of its $11.9 billion pledging goal, drawing commitments from a record number of donors for the next five years. The United States has not withdrawn its support for the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and a November replenishment round will determine the depth of support from the United States and

other nations. Even the "America First Global Health Strategy" acknowledges that the Trump administration will need to continue multilateral relationships for "specific, targeted, and limited" purposes.

UNGA is an opportunity for governments to critically shape what comes next for global health multilateralism and to find whatever common ground still exists. COVID-19 revealed the weaknesses of the current international system. The strategic drivers that once underpinned many global health programs two decades ago—such as stabilizing fragile states, countering terrorism, and embracing globalization in the post–Cold War era—have, too, largely receded from foreign policy and domestic agendas, replaced with concerns about stagnant economies, polarization at home, and intensifying geopolitical conflicts abroad. What the future holds depends on how global health policymakers, from Europe to the Global South, choose to react to that new landscape.

Health, Rights, and Returns in Latin America and the Caribbean: Why Investing in People Still Pays Off

Victoria Costoya, Argentine Council for International Relations

Since its founding in 1948, the World Health Organization (WHO) has saved countless lives and, with adequate support, the health agency has the opportunity to save even more through investments in primary health. According to the *Lancet Global Health*, efforts to scale up primary health care (PHC) alone could prevent more than sixty million deaths between 2020 and 2030, particularly in low- and middle-income countries (LMICs). WHO-supported vaccination campaigns have eradicated smallpox, driven polio to the brink of elimination, and prevented millions of child deaths. Economically, strengthening primary health care offers substantial benefits by boosting productivity and reducing long-term health costs—some estimates forecast a return of up to $16 for every $1 invested.

Despite those achievements, the WHO faces a dual crisis: deep financial cuts—its 2026–27 budget reduced by more than $1 billion—and an erosion of political support, exemplified by the withdrawal of U.S. funding and membership. Those setbacks jeopardize not only global coordination during pandemics but also long-term development strategies in regions such as Latin America and the Caribbean (LAC), where national institutions are often fragile and politically volatile.

This memo outlines three interconnected points on the urgent need for global health investment in Latin America:

- the critical role the WHO and its regional office, the Pan American Health Organization (PAHO), play in sustaining public health systems in LAC;
- the importance of primary health care as a driver of equitable human development; and
- why the weakening of global health governance threatens both fundamental human rights and economic efficiency.

Multilateralism as a Public Good: Global Norms and Shared Gains

The WHO serves as more than a technical advisor. It builds consensus around global health norms—such as routine vaccination, disease surveillance, and emergency response—and ensures that they are operationalized across borders. Its role is foundational in generating scientific

agreements and fostering standards that poorer nations can adopt, thanks to shared research and data infrastructure.

In Latin America, PAHO plays that consensus-bridging role. As both the WHO Regional Office and the specialized health agency of the Inter-American System, it supports thirty-five member states. Through mechanisms such as the Revolving Fund for Access to Vaccines and medicine procurement, in 2024, strengthening national immunization programs across the region. That year alone, PAHO further supported Belize, Jamaica, and Saint Vincent and the Grenadines in achieving elimination of mother-to-child transmission of HIV and syphilis, while Brazil was recognized for eliminating lymphatic filariasis.

Those achievements are health victories but also represent governance victories. They reflect decades of sustained regional cooperation across various government administrations in the participating nations. In countries such as Argentina, where governments frequently shift agendas and restructure and replace technical teams after elections, institutions such as PAHO act as custodians of institutional memory and guarantors of policy continuity. That capacity to maintain medium- and long-term development strategies is indispensable, especially in contexts where short-term political pressures often override evidence-based planning.

When Symbolism Becomes Substance: The U.S.-Argentina Alignment

Argentina has historically been a leader in health policy in Latin America, with robust scientific institutions and deep ties to WHO and PAHO frameworks. However, the recent political realignment under President Javier Milei, who publicly supported the U.S. withdrawal from the WHO and subsequently in May withdrew Argentina from the organization, sends a troubling signal.

That symbolic alignment risks undermining Argentina's credibility as a regional health leader, weakening access to vital technical assistance and funding, and eroding long-term capacity for coordinated, equitable health policy. Even if the cost is not immediate, it will nevertheless be profound. As consensus weakens globally, national health agendas risk becoming increasingly politicized and fragmented, especially in countries with limited institutional resilience.

In early September, the United States announced a recission of $45 million from PAHO, citing the hiring of Cuban health workers through a PAHO program as potential human trafficking of those individuals. As of yet, Argentina does not appear to be withdrawing its funding or support for PAHO.

Health as Human Capital: Why Primary Care Is a Smart Investment

Health is more than a service—it is a core enabler of human development. Without access to quality health services, especially at the primary level, individuals cannot pursue education, access labor markets, or live lives they value—a central tenet of the Nobel laureate economist and philosopher Amartya Sen's human development approach.

LAC remains the most unequal and violent region in the world. Despite representing only 8 percent of the global population, the region experienced one of the highest COVID-19 death rates per capita, according to WHO data. The pandemic revealed and amplified preexisting vulnerabilities. In middle-income countries such as Argentina, where informality and inequality are high and public investment often fluctuates, PHC is a vital equalizer. Establishing universal health coverage through PHC has been estimated to prevent 8.6 million excess deaths annually. Yet the symbolic and financial weakening of the WHO undermines national advocacy for PHC investments. Without a strong global standard-setter, domestic policies risk deprioritizing PHC in favor of visible, short-term health interventions.

Health Investment Is a Rights-Based and Economic Imperative

The weakening of the WHO poses a dual human rights and economic threat to society. From a human rights perspective, it impairs equitable access to essential services for the world's most vulnerable. When global health governance falters, the poorest suffer most—from missed vaccinations to unchecked epidemics. From an economic perspective, hobbling the WHO erodes one of the most efficient tools for inclusive development. Few investments rival primary health care in terms of cost-effectiveness and returns for society.

The real cost of U.S. withdrawal and multilateral retreat is not just in dollars—it is in deaths, lost opportunities, and the long-term degradation of human capital in countries that can least afford it. For Latin America and countries such as Argentina, preserving the integrity of the WHO and PAHO is not optional but rather a strategic necessity. If we fail to uphold those institutions, we risk entrenching inequality and sacrificing the very foundations of human development for generations to come.

After the U.S. Retreat: European Responses and Implications for Health Security and Global Health Governance

Emma Ross, Chatham House

The renewed U.S. withdrawal from the World Health Organization (WHO) and its retreat from wider global health international cooperation has thrown key institutions, norms, and financing into turmoil, generating significant consequences for global health security, leadership, equity, and geopolitics.

When President Donald Trump first tried to withdraw the United States from WHO, in 2020, leading European donors and champions of multilateralism stepped in to fill the gap until he lost reelection. Upon assuming office a year later, President Joe Biden rapidly reversed the withdrawal. In January 2025, during the immediate aftermath of Trump's second bid to pull U.S. commitments to the WHO, international aid, and health cooperation more broadly, eyes turned to European countries in the hope they would fill the void again.

The world is in a different place. This time, the U.S. withdrawal is not so temporary. The sheer scale and speed of the United States' retreat—and the realization of how dependent global health coordination had been on U.S. largesse and leadership—has shocked nearly everyone involved in the sector. Meanwhile, the voice of the Global South demanding equity in global health and its governance has grown louder and more effective. Equity has become more of a priority, exemplified by the Pandemic Agreement—which included the proposal by the Africa Group and several LMICs for a pathogen access and benefit-sharing system as an annex, now under negotiation—and by the World Bank's Pandemic Fund, where implementing-country governments have equal representation on its governing board. Additionally, the African Union's permanent Group of Twenty membership since 2023 has given the bloc a seat at the table of the foremost economic forum shaping global health financing.

New players, such as China with its Health Silk Road initiative, COVID vaccine diplomacy, and increased participation in global health, as well as regional blocs presenting shared positions, are thinking through the opportunities. Those developments have combined to create an environment that leaves Europeans with less capacity to fill the gap or even stabilize the situation, and more competition in shaping the future of global health governance.

The UK and other European countries are historically significant supporters of WHO and of global health initiatives more widely. In 2023, the United States was the biggest global health

donor—far outstripping the combined spend of the next four contributors: the United Kingdom, Germany, Japan, and France. The EU was the sixth largest global health donor in 2023.

With increased pressure on national budgets from other priorities such as the war in Ukraine, rising obligations for defense spending, and escalating refugee costs at home, several European countries have also announced cuts to their foreign aid budgets, hitting global health programs particularly hard. Those cuts started before the U.S. retreat, as the cost of COVID-19 bit and priorities shifted from the pandemic to the war in Ukraine, but they have since quickly expanded.

The UK's Constrained Leadership

Lacking the financial heft of the United States, Germany, or the EU, the UK has responded more like a middle power. Curtailing its role as a major donor forced the country to concentrate on areas where its aid can punch above weight and align with national security. In February, the UK announced a plan to bolster defense spending by reducing foreign aid spending from 2025's mark of 0.5 percent of gross national income (GNI) to 0.3 percent in 2027. The decision continues a trend that started with the slashing of aid spending from 0.7 percent to 0.5 percent of GNI in 2021, which at the time was presented as temporary. A defender of multilateralism historically, the UK has already committed funding to initiatives such as the Global Fund and Gavi. Yet little room exists for bilateral UK health partnerships, and in 2025, the country reduced development assistance for health by 39 percent.

The prospects for the UK stepping up are further hampered by the fact that the money simply is not there. The political leadership is not as animated by the global health agenda as during the era of Prime Ministers Tony Blair and Gordon Brown, and in recent years, the UK has spent nearly one-third of its overseas aid budget at home accommodating recent surges in asylum seekers and refugees. At the 2025 World Health Assembly in May, the UK did not increase its funding to the WHO but maintained existing commitments. Going forward, a key trade-off in funding will be between the issues of global health and climate change, and the contributions of the UK to global health have already become more targeted on priorities such as strengthening health systems, improving pandemic preparedness, supporting equitable access to vaccines and essential medicines, bolstering global health security, and combating antimicrobial resistance.

Europe Recasts Its Role

Europe is transitioning from a supportive role in the shadow of U.S. dominance to one of political and normative leadership in global health, framing the issue more as one of security and resilience than its previous characterization as development cooperation.

Germany, now home to a high-profile WHO expert hub for pandemic and epidemic intelligence, positions itself as a global health standard bearer—with an increasing role in global health security, too. The country stepped up its funding to the WHO after the 2020 U.S. withdrawal announcement but is now cutting its official development assistance (ODA) budget below the 0.7 percent of gross domestic product (GDP) target due to austerity measures. Despite that trend, Germany remains a leading WHO donor, pledging an additional €10 million in May 2025 to backfill gaps left by the U.S. exit—even while overall pledges to multilateral health initiatives decline. With its financial, institutional, and diplomatic resources, Germany stands out as a global health anchor among European countries and has benefited significantly from WHO decentralization efforts, as many relocated staff head to the Berlin Hub. Those efforts have enhanced Germany's soft power and influence.

Other nations—Belgium, Finland, France, the Netherlands, Sweden, and Switzerland—have announced similar cuts to ODA. France will reduce its ODA to 0.38 percent of GNI by 2026, the lowest in nearly a decade. France's has further reduced its capacity to support global health multilateral initiatives by abolishing its Solidarity Fund, which automatically allocated money to multilateral health funds. While Sweden and Switzerland committed additional funding to the WHO beyond their mandated contributions despite cutting their ODA budgets, France maintained its existing commitments without increases.

As the fiscal space tightens, European countries are expected to focus on supporting the multilateral institutions and initiatives they have traditionally championed, although at lower levels. In June, the UK pledged $1.25 billion to Gavi—a 40 percent cut compared to its 2020 commitment—while, according to the Center for Global Development, Norway reduced its Gavi commitment by 20 percent. European governments have committed to honoring existing contracts and are allocating more time to wind down their projects relative to the United States.

The EU has narrowed its international health engagement since the renewed U.S. retreat, prioritizing health security and pandemic preparedness while leveraging strengths in multilateral partnerships and research. The EU continues to position itself as a multilateral leader, offering support to the WHO as the cornerstone of the global health system. Internal priorities could take

precedence over leadership in global health, however, given constrained resources and the EU's drive to strengthen its own public health infrastructure, which EU officials have framed as being part of strategic autonomy and resilience.

Emergency Preparedness

A focal point of EU health emergency preparedness is the Health Emergency Preparedness and Response Authority (HERA), established in 2021 to bolster the union's strategic autonomy in health. In its short lifetime, HERA has sought to expand its international focus and forge global partnerships while reducing U.S. reliance. HERA now faces budgetary competition from increased defense spending, but benefits from health security are increasingly being framed as a component of national and European security. That framing helps justify HERA investments in medical countermeasures, strategic stockpiles, and infectious disease surveillance as security spending. The agency survived a recent proposal to fold it into another EU directorate—and needs to maintain its security agenda to preserve its emerging leadership role.

At the outset of the Pandemic Treaty negotiations, the EU was an agenda-setter, championing multilateral approaches, but the bloc played a less decisive role in drafting the agreement. Treaty negotiations occurred in a changing geopolitical context with diminished urgency as the pandemic faded, becoming polarized between emerging economies and the Global North. Provisions centered on equitable access to pathogens and benefit sharing——the diagnostic tests, therapeutics, and vaccines produced from collecting data on emergent infections—remain sticking points. This year, after the United States pledged once more to exit the WHO, the EU doubled down on defending the health agency's legitimacy and the Pandemic Accord while softening its stance toward the equity provisions demanded by the Global South. Both the UK and continental Europe have significant research-based pharmaceutical industries; given the U.S. withdrawal from a pandemic agreement and aggressive protectionism, they need to balance pharmaceutical interests and countermeasures supply-chain security with promoting global equity through multilateral initiatives.

The Center of Gravity Shifts From Geneva

Another knock-on effect of U.S. WHO withdrawal is intensifying debate over Geneva's future as the global health diplomacy hub. With WHO headquarters restructuring and dramatically contracting staff and programs, regions showing increased public health interest, and calls to shift

from Eurocentric power concentration growing, serious discussion is emerging about how to reshape the WHO's structure and redistribute global health governance institutions. More authority will need to be granted to regions on the front lines of pressing health challenges, either to WHO regional offices or even further decentralized to over eight hundred WHO collaborating centers across more than ninety member states. That trend is starting already and will inevitably result in more distributed decision-making power, leadership, and resources. A federation model could be an appropriate way forward, with Geneva retaining control over matters requiring global consensus, uniformity, or coordination. Even then, centralized decisions can occur outside of Geneva, as demonstrated when this year's technical meeting for seasonal influenza vaccine strains moved from Geneva to London.

The idea of shifting global health coordination away from Geneva is an old one but gains renewed consideration following the U.S. retreat and reduced Global North donor support. During 2010–13 structural reforms after the 2009 flu pandemic, the WHO tried voluntary staff relocation from Geneva to regional or country offices, but implementation failed, as staff were unwilling to leave, especially to move to low-income countries. Power struggles between headquarters and the regional offices complicate matters, as moving staff and resources transfers control from headquarters to regional offices. In recent months, the WHO has instigated another relocation effort, this time moving staff to hubs outside of Geneva while maintaining WHO headquarters control, such as with the epidemic intelligence hub in Berlin as well as sites in Lyon, France; Dubai, United Arab Emirates; and Jamnagar, India.

Geneva's multilateral symbolism becomes increasingly expensive and difficult to defend in the face of calls for greater Global South representation and the recent flight of UN functions and non-UN global health organizations to locations such as Nairobi, Kenya. The turmoil forces a rethink of actual needs. The mismatch between global health governance systems and real need has been recognized for decades, but the current crisis has opened space for diffused global health leadership and could accelerate countries taking greater responsibility and ownership. Some countries, including Ghana and Rwanda, have raised health spending, but a full-scale transition requires major effort, strong leadership, and time.

As the move toward regionalization in global health continues, champions of the multilateral approach ought to build coalitions with those regional groups to minimize the risk of uneven preparedness across the world. As regions build their capacity, the WHO's hands-on approach should decline, transitioning to a complementary role, rather than substituting for local capacity.

Europe faces a strategic crossroads in its global health engagement, and it needs to decide whether it intends to shape opportunities for a new, polycentric, global health governance model as it unfolds.