International Health Council

AN ALTERNATIVE TO THE WORLD HEALTH ORGANIZATION



Action on World Health Foundation

International Health Council

Global Health Assessment and Recommendations Report

A Proposal for a New Model of International Health Cooperation

Carl Heneghan and Tom Jefferson

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List of Abbreviations and Definitions

The following terms are used throughout this report. The definitions reflect the institutional concepts and terminology set out in the IHC draft and are intended to support consistent usage as the report develops.

Abbreviations

Abbreviation	Meaning / Usage
GRADE	Grading of Recommendations Assessment, Development and Evaluation — referenced in the draft as a methodology for the proposed evidence repository.
IHC	International Health Council
NGO	Non-governmental organisation
WHO	World Health Organization

Definitions

Term	Working definition
Advisory	A scientific or technical function without legal force, financial leverage, conditional aid, naming and shaming, compliance monitoring, inspections or sanctions. The draft associates advisory activity with scientific recommendations, standards, data, expert deployment, early warning and non-commercial incentives.
Capacity building	Technical assistance provided to Member States on request, framed as a service rather than as a mechanism for directing domestic policy.
Treaty-based restraint	The principle that the IHC may exercise only functions expressly conferred by its founding treaty, with explicit exclusions and a test for whether proposed activities fall within its remit.
Treaty Remit and Subsidiarity Test	The three-part test determining whether IHC activity is justified. An activity must: (1) fall within a purpose expressly authorised by the Treaty Articles; (2) provide demonstrable international added value, which may arise from cross-border necessity, shared scientific capability or Member-State scientific and technical service; and (3) satisfy subsidiarity, so that IHC involvement extends no further than necessary to realise that international added value. Reserved governmental competences of Member States and protections for individual autonomy remain standing Treaty limitations.
Cross-border externalities / cross-border health issue	A health issue for which there is a genuine international coordination problem and where action by individual states acting independently is insufficient.
Early-warning intelligence	The collection, verification and communication of information intended to identify emerging cross-border health threats at an early stage.

Evidence repository	A proposed IHC function for transparent evidence synthesis and dissemination, including living systematic reviews, rapid evidence reviews, public peer review, version history, minority reports, AI search tools and data transparency.
Member-State Service	The principle that the IHC exists for governments, acts at their request and under their control, and frames operational functions as services to Member States.
Mission creep	Expansion of an institution beyond the functions or purposes originally entrusted to it. The proposed IHC safeguards are intended to prevent such expansion.
Non-state actor	For the proposed funding restriction, an actor other than a state, including commercial entities, charitable foundations, non-governmental organisations and professional associations or organisations.
Scientific coordination	The proposed focus of the IHC remit: international scientific and technical cooperation rather than the direction of national public health policy.
Scientific governance	The rules and processes governing evidence review, expert appointment and removal, systematic reviews, conflicts of interest, scientific disagreement, minority opinion and transparency.
Subsidiarity	The principle that activity should be undertaken at the lowest level capable of achieving the objective effectively. IHC involvement is justified where international action provides demonstrable added value, but its role should extend no further than necessary to realise that value. Functions that can be performed as effectively and efficiently at national, local or clinical level should remain at that level.
Sovereignty of Member States	The principle that Member States retain authority over domestic health policy and legislation and are not subject to direct or indirect obligations created by IHC scientific or technical cooperation.
Technical standards	International technical standards developed as part of scientific or technical cooperation, without creating binding obligations on Member States.

Source note: The abbreviations and working definitions above reflect the terminology and concepts used throughout this report. Detailed legal definitions would be developed subsequently through the drafting of the Treaty Articles.

Foreword

Professor Karol Sikora, Chairman of the Board of Fellows, the Action on World Health Foundation

Living long and well in good health is a ubiquitous human goal. Modern medicine has delivered unprecedented health gains to rich and poor alike. Most once lethal infectious diseases can now be cured and prevented. Remarkable scientific advances have dramatically improved survival from cancer and heart attacks. But the costs of optimal care have soared.

The biggest health gains within our reach come from the judicious application of what we already know in an economically sustainable manner. This alone provides a clear need for a widely recognised, overarching health advisory body skilled at the analysis of the economics of health gain and the evidence behind it. Most agree the WHO is no longer fit for this purpose. But what should replace it?

In 2026, the Board of Fellows at the Action on World Health Foundation commissioned Professor Carl Heneghan and Dr Tom Jefferson from the Centre for Evidence-Based Medicine at the University of Oxford to produce a report on how best to reorganise international health collaboration.

Their report provides an excellent starting point to build a realistic plan for a new international health advisory body appropriate for the challenges facing all health care systems. Cross border externalities, scientific coordination, specialty medicine capacity building are all addressed. Subsidiarity, the principle that decisions should be taken at the lowest effective level is stressed throughout. Mission creep into politically charged areas outside health need to cease.

As a practising oncologist and former Chief of the WHO Cancer Programme, the report resonates with my experience. The Organisation simply has too little medical knowledge and instead plays politics through an unmanageable structure. Carl Heneghan was instrumental in using evidence to persuade our Health Department to modify the advice received from the WHO during the Covid 19 pandemic. This undoubtedly saved the lives of many of those requiring urgent treatment for other illnesses during this period. In a highly interconnected world, leading expertise is naturally diffuse. We need to harness it directly from the front, wherever that may be. Concentrating it into a massive bureaucracy simply makes no sense.

Here we have an amazing plan for discussion, consultation and implementation. The proposed International Health Council is a futuristic glimpse of what's really needed now to improve world health. For the sake of all our futures we need to move forward quickly on this very credible proposal.

Executive Summary

Diseases do not recognise national borders: Scientific information sometimes needs to be shared quickly, and many countries rely on scientific capabilities that are difficult or inefficient to replicate on their own, making international health cooperation essential for societal health and wellbeing.

Member States differ markedly in population, resources, disease burden, health-system capacity and national priorities. The central institutional requirement is therefore to identify the functions they genuinely need to undertake collectively—while ensuring that decisions which can be made effectively at national level remain the responsibility of sovereign governments.

Therefore, this report focuses on how to effectively organise international health cooperation, rather than questioning whether it should continue.

For over seven decades, the World Health Organization has provided global leadership in health, developing critical capabilities in disease surveillance, technical standards, scientific coordination, and support for Member States. However, the assessment in this report highlights ongoing institutional problems within the WHO that have persisted despite numerous reform initiatives. These include:

- An exceptionally broad and expanding institutional mandate;
- Dependence upon voluntary and frequently earmarked financing;
- Concentration of funding among a relatively small number of major contributors;
- Potential political and geopolitical pressures arising from Member-State governance;
- Risks to actual or perceived scientific independence;
- Weak constitutional boundaries around institutional expansion;
- Overlap between scientific assessment, advocacy and international policymaking;
- Recurring difficulties involving transparency, uncertainty and institutional trust.

The COVID-19 pandemic highlighted underlying tensions in global health management under exceptional circumstances, undermining the effective use of resources and the protection of population health and wellbeing. In response, the WHO implemented successive reforms to address genuine weaknesses in management, financing, emergency preparedness, and governance; these reforms are ongoing and continue to evolve.

However, the central conclusion of this report is that the numerous recurring issues facing the WHO are structural, rather than merely managerial shortcomings.

Several reforms could address elements of these problems. A funding model based on collective Member-State financing could better align financial responsibility with governance and reduce dependence on voluntary and earmarked contributions.

The limitations that persist despite several attempts at WHO reform necessitate proposing an alternative institutional model: the International Health Council (IHC), a focused international scientific institution dedicated to assisting sovereign Member States.

Its mission would be:

To strengthen health through independent scientific cooperation between sovereign states, providing cross-border health protection and producing trusted scientific evidence and resources for the benefit of all Member States.

The IHC would concentrate its work within two principal domains.

Two Principal Domains

Cross-Border Health Protection

The IHC would provide the scientific infrastructure required for:

- International surveillance and early warning;
- Epidemiological information sharing;
- Laboratory cooperation;
- Pathogen genomics;
- Common reference methods and standards; and
- Scientific assessment of emerging international health threats.

National authorities would retain responsibility for domestic preparedness and response.

International Scientific Resources

The IHC would also provide shared scientific resources across both communicable and noncommunicable diseases. These would include:

- Systematic reviews and living evidence;
- Clinical guidelines;
- Comparative effectiveness assessment;
- Health technology assessment and appraisal;
- Evaluation of benefits and harms;
- Methodological standards; and
- Identification of important evidence gaps.

This second pillar is crucial: the IHC should not focus solely on infectious diseases, especially since noncommunicable diseases account for the majority of international morbidity and mortality.

The IHC would aim to conduct costly, technically challenging scientific assessments in collaboration with Member States and make the findings available to all. However, decisions regarding regulation, reimbursement, clinical practices, and policies should remain at the national level, without imposing supranational authority.

The IHC would clearly distinguish between scientific assessment and political authority. It would be responsible for collecting information, assessing evidence, developing scientific guidelines, conducting technology appraisals, and issuing technical recommendations. However, it would not have the power to legislate for Member States, impose domestic health policies, regulate national health systems, or compel the implementation of its recommendations.

The IHC's scientific products would serve as advisory outputs, and subsidiarity would guide its activities: scientific capabilities would be organised internationally where doing so provides demonstrable added value, while decision-making would remain at the lowest effective level.

This approach allows for ambitious international scientific cooperation without necessitating a corresponding centralisation of political authority.

Priorities

Treaty-Based Restraint

The IHC would exercise only those functions expressly conferred upon it by its Treaty Articles. A general connection with health would not, by itself, provide a sufficient basis for IHC activity. Every significant programme, initiative or service would instead be required to satisfy the Treaty Remit and Subsidiarity Test, comprising three requirements:

1. Treaty-Defined Purpose — The activity must fall within an expressly authorised IHC function under the Treaty Articles, within either Cross-Border Health Protection or International Scientific Resources, including authorised scientific and technical services to Member States.

2. International Added Value — There must be a demonstrable benefit from undertaking the activity through the IHC rather than leaving it entirely to individual Member States or existing institutions. This value may arise from cross-border necessity, shared scientific capability, reduced duplication, access to specialist expertise, or scientific and technical support requested by Member States.

3. Subsidiarity — IHC involvement must be no greater than necessary to realise that international added value. Where an objective can be achieved effectively by Member States, national institutions or existing organisations, responsibility should remain at that level.

Satisfaction of the test would not expand the IHC's authority beyond that conferred by the Treaty Articles. Reserved governmental competences would remain with Member States, while individual autonomy, bodily integrity and informed consent would remain protected.

In this way, Treaty-based restraint would provide both a positive basis for necessary international cooperation and a continuing safeguard against unnecessary institutional expansion.

Broad Scientific Inquiry, Narrow Institutional Power

Treaty-based limitations would focus on the institution's powers rather than on the legitimate scope of scientific inquiry. The IHC would be able to assess scientific evidence on behavioural

interventions, environmental exposures, reproductive health, consumer products, or other matters pertinent to authorised scientific questions.

However, assessments would not grant the IHC policy-making authority over these subject areas.

The IHC remit includes evaluating evidence of benefits, harms, and uncertainties. Nevertheless, this would not give it the power to legislate, regulate, advocate for policy changes, or penalise governments for making different decisions. This distinction would allow scientific inquiry to follow the evidence without allowing scientific expertise to serve as a basis for unlimited institutional influence.

Scientific Independence

The authority of the IHC would primarily stem from the quality of its scientific work. Scientific assessments would be conducted using transparent methods and, where applicable, prospective protocols, with clear evidence standards and independent procedures to manage conflicts of interest.

Key outputs would clearly differentiate among observed evidence, estimates, modelling assumptions, and expert judgment. Any missing information would be identified, and uncertainties would be reported explicitly. Significant scientific disagreements could be included by publishing minority opinions. Additionally, changes in scientific conclusions would be documented with transparent version histories.

The IHC would not have the authority to suppress lawful scientific disagreements or regulate lawful expressions of opinion. Scientific criticism would be addressed through evidence and methodological review.

Governance and Independent Oversight

Member States would govern the IHC through a Governing Council operating on the principle of sovereign equality. Governance authority and scientific authority would be separated.

Member States would determine the Treaty framework, the budget, appointments, and the authorised work programme. However, they would not negotiate scientific conclusions.

A small permanent Secretariat would coordinate administration and scientific networks while relying substantially upon distributed expertise across national agencies, laboratories, universities and other scientific institutions. Senior leadership would be appointed through open procedures and serve single non-renewable terms where appropriate. Independent oversight would include:

- An Ethics Commissioner;
- Inspector General;
- Independent Auditor; and
- Scientific Ombudsman.

Whistleblowers and good-faith scientific dissent would receive explicit protection.

The governance principle would be that Member States govern the institution; evidence governs its scientific conclusions; and independent oversight holds both to account.

Financial Independence

The IHC's Treaty-defined functions would be funded through collectively determined Member-State funding. Commercial entities, philanthropic foundations, NGOs, professional organisations, and other non-state interests would not finance its Treaty-defined functions.

Member States would not be allowed to designate Member-State funding for specific programmes of their choice. While external organisations may submit evidence, expertise, and scientific information through transparent processes, they cannot influence scientific priorities through financial means.

This establishes a link between governance and financial responsibility within the same Founding Treaty framework: those who collectively govern the institution should also collectively finance it.

Scientific Governance and Establishment

The founding framework should establish scientific principles while allowing flexibility in scientific methods. Therefore, the IHC would be prescriptive through its Treaty Articles regarding scientific principles, while remaining operationally adaptable in its scientific methods.

During its first year, independent methodological groups would develop a detailed Scientific Operating Framework for Cross-Border Health Protection and International Scientific Resources.

The framework would undergo public consultation, external peer review, and pilot testing.

The IHC would progressively become operational. In Year 1, the focus would be on establishing the Treaty, governance, financial, and scientific foundations. Years 2 and 3 would involve introducing controlled operations. Years 4 and 5 would concentrate on consolidating and evaluating these operations. At the end of Year 5, the institution would undergo a comprehensive independent review before any substantial further expansion.

A Different Measure of Success

The IHC would assess its performance through:

- Scientific quality;
- Timeliness;
- Transparency;
- Independence;
- Usefulness to Member States;
- Compliance with the Treaty Articles; and
- Efficiency.

Programmes that no longer provide sufficient international value should be discontinued, and institutional restraint should therefore be regarded as evidence of successful governance rather than

institutional weakness. The long-term objective is an organisation that becomes influential because its scientific services are consistently useful and trustworthy, while remaining sufficiently limited by its Treaty Articles to retain the confidence of sovereign Member States.

The same principle of restraint would extend to individuals. The IHC would respect bodily autonomy, bodily integrity, and informed consent, and would have no authority to compel medical treatment, vaccination, testing, or other medical interventions. Its role would be to assess and communicate evidence; decisions affecting individuals would remain subject to established medical ethics, applicable law and appropriate individual consent.

Recommendations

1. Establish an International Health Council focused on two core scientific domains.

Member States should consider establishing an IHC centred upon Cross-Border Health Protection and International Scientific Resources, providing permanent international scientific capability across both communicable and noncommunicable disease.

2. Establish clear Treaty limits from the outset.

The founding treaty should expressly incorporate the conferred functions, subsidiarity, national sovereignty, explicit exclusions, and the Treaty Remit and Subsidiarity Test. Scientific competence should not confer legislative, regulatory or executive authority.

3. Make scientific independence a structural requirement.

Scientific assessment should be separated from political governance and protected through transparent methods, evidence standards, disclosure and management of conflicts, publication of uncertainty and scientific disagreement, independent oversight and protection for good-faith scientific dissent.

4. Finance the institution collectively through Member States.

Core functions should be financed by collectively determined Member-State funding. Non-state organisations should be permitted to contribute evidence and expertise, provided they meet rigorous disclosure, conflict-of-interest and submission procedures, but should not finance the institution's Treaty-defined functions nor determine scientific priorities.

5. Establish the IHC progressively rather than attempting immediate full operation.

The first year should establish governance, oversight, financing and the Scientific Operating Framework. Core capabilities should then be introduced and tested progressively across both scientific domains.

6. Require continuing Treaty compliance and independent evaluation.

All major activities should remain subject to the Treaty Remit and Subsidiarity Test and periodic review. A comprehensive independent evaluation should take place after five years, assessing scientific performance, usefulness, financial and political independence, compliance with the Treaty Articles, organisational size and evidence of mission creep before substantial further expansion.

These recommendations reflect a single institutional proposition:

International health cooperation should be scientifically strong, limited by its Treaty Articles, financially independent and accountable to the sovereign states it exists to serve.

With the aim to:

Establish an international institution that is indispensable for the quality of the scientific services it provides, while remaining sufficiently limited to ensure that Member States retain confidence in the authority they have chosen not to relinquish.

Part I

1. The Case for Institutional Change

1.1 Current Global Health Architecture

A single institution does not govern the contemporary global healthcare system. It comprises a network of sovereign states, multilateral organisations, global financing mechanisms, regional bodies, national public health agencies, research institutions and non-state actors. These organisations perform overlapping functions, including disease surveillance, emergency coordination, standard-setting, technical assistance, research, procurement, programme implementation, and health financing.

At the centre of this architecture sits the World Health Organization (WHO), established in 1948 as the specialised global health agency of the United Nations system. Its constitutional objective is "the attainment by all peoples of the highest possible level of health". The WHO Constitution gives the organisation a broad mandate encompassing global healthcare coordination, technical assistance, epidemiological and statistical services, global standards, research, disease control and cooperation with governments and other organisations. [1]

WHO is governed principally through the World Health Assembly (WHA), the Executive Board and the Secretariat. The WHA is the organisation's principal decision-making body and consists of delegations from WHO Member States. It determines WHO policies, appoints the Director-General, supervises financial policies and approves the organisation's programme budget. The Executive Board consists of 34 technically qualified members elected for three-year terms and is responsible for implementing and facilitating the Health Assembly's decisions and policies. [2, 3]

This structure combines intergovernmental decision-making with a permanent global secretariat. The Director-General serves as WHO's chief technical and administrative officer, while WHO's six regional structures provide an additional layer of governance and implementation. [2]

International Health Regulations

The International Health Regulations (IHR 2005) constitute a legally binding global framework governing the management of public health risks and events that can spread across national borders.

[1] Constitution of the World Health Organization. WHO.
https://www.who.int/about/governance/constitution
[2] Governance. WHO.
https://www.who.int/about/governance
[3] World Health Assembly and Executive Board. WHO.
https://www.who.int/about/governance/world-health-assembly
https://www.who.int/about/governance/executive-board

The IHR regulations establish responsibilities for both States Parties and the WHO. Countries are required, among other things, to maintain specified surveillance and response capacities and to notify WHO of events with actual or potential international public health implications. WHO, in turn, performs global surveillance and assessment functions, disseminates information, provides technical assistance and maintains a global early-warning function. [4]

The IHR also provides mechanisms through which the WHO can determine whether an event constitutes a Public Health Emergency of International Concern (PHEIC) and issue recommendations concerning appropriate health measures.

The framework has evolved since 2005, having entered into force in 2007. Amendments adopted by the WHA in 2024 entered into force for many States Parties on 19 September 2025, further demonstrating that the legal architecture governing global health cooperation continues to develop.

A Plural Institutional System

WHO does not operate in isolation. It sits at the centre of a much broader and increasingly complex global health ecosystem. This includes United Nations agencies and programmes; multilateral development institutions; global health financing mechanisms; regional organisations; national governments and public health agencies; universities and research institutions; philanthropic foundations; non-governmental organisations; professional organisations; and private-sector entities.

Consequently, responsibility for global health is dispersed rather than concentrated within a single institutional structure. The resulting architecture combines several different forms of global activity:

- Governance and coordination, principally through states and intergovernmental organisations;
- Surveillance and emergency response;
- Scientific and technical advice;
- Standard setting and normative guidance;
- Health financing and development assistance;
- Procurement and programme implementation;
- Research and evidence generation; and
- National and regional public health capacity building.

These functions frequently intersect, as similar health problems may simultaneously involve global standard-setting, national implementation, donor financing, technical advice, research organisations, and private suppliers.

Financing and Institutional Influence

The financing of global health institutions is therefore a principal part of the architecture and a mechanism for delivering programmes. WHO itself is financed through a combination of assessed contributions and voluntary contributions. Assessed contributions are membership payments made by Member States in accordance with an agreed assessment scale. WHO states that these

[4] International Health Regulations. WHO.
https://www.who.int/health-topics/international-health-regulations/

contributions currently account for less than 20% of its total financing, with the remainder principally provided through voluntary contributions. [5]

Voluntary contributions can come from Member States and other sources, including the United Nations and intergovernmental organisations, philanthropic foundations, and the private sector.

The distinction matters institutionally because assessed funding is comparatively predictable and can be allocated through the organisation's agreed programme budget. In contrast, voluntary financing may be associated with specific programmes or priorities.

What Do Member States Need from International Health Cooperation?

WHO serves an exceptionally diverse membership, encompassing countries with markedly different populations, disease burdens, health systems, resources and political priorities. It is therefore unlikely that a single global institution can—or should—determine a common domestic health policy for all Member States.

The strongest common requirements arise where cooperation provides capabilities that states cannot efficiently achieve on their own. These include early warning of cross-border threats, rapid exchange of epidemiological and genomic information, laboratory and reference standards, independent assessment of emerging risks, and shared scientific resources that avoid unnecessary duplication.

Beyond these common requirements, national needs increasingly diverge. Health-service organisation, expenditure, prevention priorities, regulation, and implementation depend substantially on local epidemiology, resources, institutions, and public preferences.

The institutional question is therefore what do Member States genuinely need to do collectively, and what should remain their responsibility individually?

An Architecture Under Review

The existing global health architecture has expanded considerably in scope, institutional complexity and financing since WHO was established. WHO itself now recognises that the global health architecture faces problems including fragmentation, duplication, misaligned priorities, competition, financing gaps and persistent power imbalances. It has consequently participated in processes examining how the architecture might become more country-led, coherent and responsive to national and collective needs. [6]

Problem statement

"A joint process aims to address the overarching problem that the GHA has not kept pace with

[5] How WHO is funded and Assessed contributions. WHO.
https://www.who.int/about/funding/
https://www.who.int/about/funding/assessed-contributions
[6] Global Health Architecture. WHO.
https://www.who.int/about/governance/global-health-architecture

evolving national health sovereignty and regional capacities, changing disease burdens, advances in science and technology and a changing financing landscape, and is constrained by power imbalances, fragmentation and duplication that limit country ownership, impact and equity." [6]

These structural problems can be particularly important for LMICs. International priorities influenced by external financing, donor preferences and centrally determined programmes may not always correspond with the disease burden, infrastructure needs, health-system capacity or opportunity costs facing individual countries.

The issue is not that international assistance or scientific cooperation lacks value; for many countries it provides capabilities that would otherwise be difficult to obtain. The institutional challenge is to ensure that international cooperation strengthens rather than substitutes for national priority-setting. LMICs should have access to high-quality scientific evidence, surveillance, laboratory expertise and technical support while retaining authority to determine how limited national resources are allocated according to their own health needs and circumstances.

International health cooperation is necessary: Infectious diseases and other health threats can cross national borders, and surveillance, scientific information, laboratory cooperation and rapid communication can generate benefits that individual states cannot always achieve acting independently. Furthermore, an evidence-based approach is better served through cooperation and collaboration.

The difficult question that arises is: Which functions genuinely require international coordination? Which institutions should perform them? How should those institutions be financed and governed? And where should the boundary between international cooperation and national responsibility lie?

These questions provide the basis for the assessment that follows and, ultimately, for considering whether a different institutional model could provide international cooperation while maintaining clearer Treaty limits, scientific independence, transparency and national sovereignty.

1.2 Original Purpose and Evolution of the WHO

The WHO emerged from the global reconstruction that followed the Second World War. During the 1945 San Francisco Conference at which the UN was established, representatives of Brazil and China proposed the creation of a new global health organisation. The UN Economic and Social Council subsequently convened an International Health Conference in New York in 1946, at which the Constitution of the World Health Organization was drafted and adopted. [7] The Constitution was signed on 22 July 1946 by representatives of 61 states and entered into force on 7 April 1948 following the required ratifications. The first World Health Assembly convened in Geneva on 24 June 1948. [1]

The WHO was therefore established as a specialised agency of the UN at a time when governments were seeking permanent mechanisms for global cooperation in areas that could not readily be managed by individual states acting alone.

[7] History of WHO. WHO.
https://www.who.int/about/history/

The Original Constitutional Purpose

Article 1 of the WHO Constitution established an exceptionally broad objective:

"the attainment by all peoples of the highest possible level of health." [1]

The Constitution also adopted a broad conception of health, encompassing physical, mental and social well-being, and recognised the highest attainable standard of health as a fundamental human right with no groups left out.

The organisation's constitutional functions were correspondingly extensive. Article 2 authorised WHO, among other things, to:

- Act as the directing and coordinating authority on global health work;
- Establish and maintain effective collaboration with the United Nations, specialised agencies, governmental health administrations, professional groups and other appropriate organisations;
- Assist governments, upon request, in strengthening health services;
- Provide appropriate technical assistance and, in emergencies, necessary aid when requested or accepted by governments;
- Establish and maintain administrative and technical services, including epidemiological and statistical services;
- Stimulate and advance work to eradicate epidemic, endemic and other diseases;
- Promote cooperation among scientific and professional groups;
- Propose conventions, agreements and regulations and make recommendations concerning global health matters;
- Promote and conduct research;
- Develop global standards for diagnostic procedures, pharmaceutical and biological products and related matters; and
- Provide information, counsel and assistance in the field of health.

The WHO Constitution, from the outset, combined global coordination, scientific and technical cooperation, standard-setting, research, technical assistance, and the capacity to develop international legal instruments. This distinction is particularly relevant, as any assessment of subsequent institutional expansion must distinguish between activities that constitute the exercise of powers already contemplated in the original Constitution and activities that constitute a significant widening of the interpretation or application of those powers.

Early International Health Coordination

International cooperation on infectious diseases had existed before the WHO, particularly through nineteenth- and early twentieth-century sanitary conventions designed to reduce the international spread of diseases while limiting unnecessary disruption to travel and trade. Following the WHO's establishment, these arrangements were consolidated through the International Sanitary Regulations of 1951. They subsequently evolved into the International Health Regulations (1969) and, following substantial revision, the International Health Regulations (2005), which have been further amended in 2014, 2022 and 2024. [4]

This strand of WHO's development reflects one of the clearest rationales for international health cooperation: infectious disease can cross national borders, while surveillance, notification and

coordinated responses can generate benefits that individual states cannot fully achieve independently.

Disease Control and Smallpox Eradication

The eradication of smallpox became one of the most significant demonstrations of international health cooperation under WHO, which launched an intensified global smallpox eradication programme in 1967. The programme combined vaccination with increasingly sophisticated surveillance, case identification and containment strategies. The last naturally occurring case was recorded in Somalia in 1977 [8] and following global certification, the 33rd WHA formally declared smallpox eradicated in May 1980. [9]

Smallpox remains the only human infectious disease to have been eradicated globally. Its eradication demonstrated the potential value of an international institution performing a focused coordinating role around a clearly defined cross-border health objective. It also illustrated several functions that would become recurring features of international health cooperation: common scientific objectives, international surveillance, laboratory capability, standardisation, information sharing and coordination between sovereign national health authorities.

From Disease Control to Primary Health Care

A major milestone came with the International Conference on Primary Health Care, jointly convened by WHO and UNICEF at Alma-Ata in 1978. The resulting Alma-Ata Declaration identified primary health care as central to achieving “Health for All”. It linked health outcomes to broader questions of social and economic development, inequality, community participation and access to essential services. [10]

The Declaration described primary health care as scientifically sound and socially acceptable essential health care that should be universally accessible and form an integral part of national health systems.

Alma-Ata therefore represented a significant development of WHO's institutional role. International health was increasingly conceived not only to control diseases that cross borders but also to strengthen national health systems, improve access to health services, and address the broader conditions that affect population health. This broader conception was compatible with significant elements of WHO's original Constitution, which had already defined health expansively and authorised WHO to assist governments in strengthening health services. [1]

Nevertheless, it marked a significant shift in emphasis: the organisation's practical agenda increasingly encompassed domestic health-system organisation and broader social determinants, alongside traditional international disease-control functions.

[8] Smallpox. WHO. https://www.who.int/emergencies/situations/smallpox/

[9] World Health Assembly. WHA33.3 — Declaration of Global Eradication of Smallpox. 8 May 1980. WHO. https://www.who.int/publications/i/item/WHA33-3

[10] World Health Organization and UNICEF. Declaration of Alma-Ata / Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. WHO. https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata

Expansion of Normative and Standard-Setting Functions

Over subsequent decades, WHO increasingly exercised its role as a producer of global norms, standards, technical recommendations and policy guidance across a widening range of health issues. Normative activity was not itself a departure from the WHO Constitution. Article 2 expressly authorised the organisation to propose conventions, agreements and regulations, make recommendations concerning global health matters, and develop global standards. [1]

However, the significance lies instead in the scale, subject matter and practical influence of these functions as the global health system developed. WHO increasingly became an institution capable of shaping the frameworks, standards and policy approaches used by national governments and health systems.

International Legal Instruments

The evolution of WHO's role is particularly visible in its use of international legal instruments. The IHR instrument is legally binding on 197 countries, including 194 WHO Member States. They set rights and obligations, such as designating Responsible Authorities, maintaining core surveillance and response capacities, notifying WHO of public health risks, and verifying information on public health events from various sources. [4]

A further development came with the WHO Framework Convention on Tobacco Control (WHO FCTC), adopted by the World Health Assembly in 2003 and entering into force in 2005; the FCTC was the first global treaty negotiated under the auspices of the WHO. [11]

The Convention addressed matters including tobacco advertising, promotion and sponsorship, product labelling, exposure to tobacco smoke, taxation and illicit trade. The WHO describes the Convention as providing a new legal dimension to global health cooperation.

The FCTC therefore represented a significant institutional development. WHO's global role extended to facilitating the creation of a legally binding treaty to influence national policies and regulatory approaches to a major non-communicable disease risk factor. Whether such developments represent the appropriate use of WHO's original constitutional powers or an expansion of global health governance beyond the functions that should properly be undertaken globally is a separate question examined in the following section.

From International Health to Global Health

Over its history, WHO's operating environment has changed substantially: International travel and trade have expanded; new infectious diseases have emerged; as the population has aged, multimorbidity has increased in prevalence; health technologies and pharmaceutical markets have become increasingly globalised; global development financing has grown; and the number of philanthropic, commercial and non-governmental actors participating in health has increased substantially.

[11] WHO Framework Convention on Tobacco Control. Adopted 21 May 2003; entered into force 27 February 2005. WHO. https://fctc.who.int/convention

Alongside these changes, the WHO's activities have evolved to include the promotion of universal health coverage, coordination of responses to health emergencies, promotion of healthier populations, development of norms and standards, technical assistance, research and evidence, and cooperation with governments, civil society, global organisations, foundations, researchers and health workers. [12]

In its attempts to 'promote health, keep the world safe and serve the vulnerable – so everyone, everywhere can attain the highest level of health,' its activities have become even broader. It aims to expand universal health coverage, direct and coordinate the world's response to health emergencies, and promote healthier lives for all. Its ambitious Triple Billion target aims to provide Universal Health Coverage for 1 billion more people, better protect 1 billion more people from health emergencies and crises, and enable 1 billion more people to enjoy better health and overall well-being.

The targets have faced criticism for being largely off-track, relying on gaps in routine data collection, and oversimplifying complex systemic health issues.

The result is an institution whose contemporary activities span a considerably wider operational landscape than the international health system in 1948. However, historical expansion in activity should not automatically be equated with constitutional expansion. The WHO Constitution was drafted broadly from the outset; it expressly contemplated disease control, research, health-system assistance, standard-setting, international agreements, and cooperation on the wider determinants of health. [1]

The relevant institutional question is therefore how a broadly drafted constitutional mandate, over time, translates into an increasingly extensive range of programmes, policy recommendations, legal instruments, and activities affecting matters traditionally determined by individual states.

Answering that question requires examining how institutional priorities developed, how boundaries were interpreted, how programmes were financed, and what mechanisms existed to constrain or authorise such expansion.

1.3 Expansion of Institutional Mission

The WHO's activities have expanded substantially since its establishment. What began within a post-war international health system, heavily concerned with communicable disease, epidemiological information, technical cooperation, and international sanitary coordination, has developed into an organisation operating across a much broader range of health, social, economic, environmental, regulatory, and behavioural issues.

This development cannot be understood simply as WHO exceeding its original Constitution. As discussed in Section 1.2, the Constitution adopted in 1946 was broad from the outset; it authorised WHO to coordinate international health work, assist governments in strengthening health services, promote research, develop global standards, make recommendations and propose conventions and agreements. [1]

[12] About WHO. WHO. https://www.who.int/about/

The relevant question is therefore how broadly those constitutional powers have subsequently been interpreted and applied, and whether the institutional boundaries between international scientific cooperation, technical assistance, normative guidance and domestic policy have become progressively less distinct.

From Disease-Specific Cooperation to Health Promotion

The 1978 Declaration of Alma-Ata had already situated health within a broader social and economic context. [10] This approach was developed further through the Ottawa Charter for Health Promotion, adopted at the First International Conference on Health Promotion in 1986. [13]

The Ottawa Charter presented health promotion as extending beyond the provision of health services and identified a range of prerequisites for health, including peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. It called for coordinated action involving governments, health and other social and economic sectors, non-governmental and voluntary organisations, local authorities, industry and the media.

This represented a central evolution in the practical conception of global health. If social, economic and environmental conditions substantially determine health, then an organisation mandated to improve health will have an interest in a very wide range of public policy domains. The logic is understandable from a population-health perspective. It nonetheless creates an institutional boundary problem: if almost every major area of public policy affects health, what limits should apply to the range of issues an international health organisation addresses?

Social Determinants of Health

In 2005, WHO established the Commission on Social Determinants of Health to examine the social causes of ill health and health inequalities. Chaired by Sir Michael Marmot, the report, published in 2008, recommended improving daily living conditions, addressing the unequal distribution of power, money, and resources, and strengthening measurement and understanding of health inequalities. [14]

The overarching recommendations of the Commission were to improve daily living conditions; tackle the inequitable distribution of power, money, and resources; measure and understand the problem and assess the impact of action.

This framework extended the analysis of health beyond health services and disease prevention into questions concerning economic conditions, education, employment, housing, social protection and the distribution of resources that have substantial effects on health and are legitimate subjects of scientific investigation.

This raises an important institutional issue for the WHO: at what point does analysing determinants of health become recommending how sovereign governments should organise economic and social policy? A distinction that is central to the proposed International Health Council model developed later in this report.

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[13] Ottawa Charter for Health Promotion. First International Conference on Health Promotion, Ottawa, 21 November 1986. WHO. https://www.who.int/publications/i/item/WH-1987

[14] Commission on Social Determinants of Health, 2005–2008. WHO. https://www.who.int/teams/social-determinants-of-health/equity-and-health/world-report-on-social-determinants-of-health-equity/commission-on-social-determinants-of-health

Tobacco Control and Regulatory Policy

Adopted by the World Health Assembly in 2003, the FCTC became the first global treaty negotiated under WHO auspices. [11] Its provisions address matters including tobacco advertising, sponsorship and promotion, product labelling, exposure to tobacco smoke, taxation, illicit trade and regulation of tobacco products.

The Convention illustrates a shift from international coordination focused primarily on communicable diseases and technical standards towards global cooperation aimed at influencing domestic regulatory and fiscal policy in response to a non-communicable disease risk factor. WHO justified the global dimension partly by reference to the globalisation of the tobacco epidemic, including transnational advertising, international trade, foreign investment and illicit movement of tobacco products.

The FCTC therefore illustrates the difficulty of drawing a clear boundary around global health action. Tobacco consumption primarily occurs within states, but production, marketing, trade and corporate activity can cross borders. The institutional issue is not whether tobacco damages health; the evidence that it does is well established. The central issue is which elements of the response genuinely require international coordination, and which properly remain matters for national governments.

Sharing of scientific resources—including systematic evidence reviews, methodological standards, clinical guidelines, and technology assessments—benefits from international collaboration, as producing reliable evidence once can reduce duplication across countries.

Other decisions are inherently more dependent upon national circumstances. The organisation and financing of health services, the allocation of resources, public health legislation, and the implementation of interventions vary across settings due to differences in demographics, health system capacity, affordability, legal frameworks, and public preferences. These decisions also carry political and democratic consequences for which national governments remain accountable to their populations.

Reproductive and Sexual Health

In 2004, the 57th WHA adopted a global reproductive health strategy intended to accelerate progress towards international development goals. The strategy addressed reproductive and sexual health services, inequalities associated with poverty and gender, adolescent health and rights-based approaches to reproductive health. [15]

WHO has subsequently maintained substantial programmes relating to sexual and reproductive health and research. Again, there are clear health and scientific dimensions to these issues. However, reproductive and sexual health can intersect with domestic law, ethics, culture, education, family policy and questions on which Member States may hold substantially different political or

[15] Reproductive Health Strategy to Accelerate Progress Towards the Attainment of International Development Goals and Targets. Adopted by the 57th World Health Assembly, 2004. WHO/RHR/04.8. https://www.who.int/publications/i/item/WHO-RHR-04.8/

moral positions. Expansion into such areas, therefore, increases the importance of distinguishing among scientific evidence, technical assistance requested by states, and normative policy advocacy.

Climate Change and Health

The WHO has increasingly treated climate change as a major health issue arising from heatwaves, floods, storms, food-system disruption, infectious diseases, air pollution, water insecurity and other environmental pathways. WHO also argues that policy choices in sectors including energy, transport and food can produce health benefits through reductions in greenhouse-gas emissions and air pollution. [16]

At the same time, climate policy extends far beyond the health sector; it involves energy systems, taxation, industrial policy and global environmental agreements. The resulting institutional question is again one of boundary rather than scientific relevance: Should an international health organisation restrict itself to assessing and communicating the health consequences of climate change, or should it also advocate particular policies in sectors such as energy, transport, agriculture and emissions reduction?

Behavioural Science and Behavioural Interventions

WHO's Behavioural Sciences for Better Health Initiative seeks to promote and enable the systematic use of behavioural and social sciences throughout WHO and among its partners. WHO states that behavioural evidence can be used to improve the design of policies, programmes, communications, products and services. The disciplines involved include psychology, sociology, anthropology, communications, marketing, economics, systems thinking and design. [17]

The institutional use of behavioural evidence raises additional questions concerning the distinction between informing individuals and governments, on the one hand, and attempting deliberately to influence population behaviour, on the other. Questions that become particularly significant when behavioural interventions are developed or promoted by global institutions rather than by governments directly accountable to the populations affected.

The Essential Medicines List: Scientific Assessment and National Priority-Setting

The WHO Model List of Essential Medicines illustrates both the value and the institutional complexity of international scientific guidance. Established in 1977, the List identifies medicines considered important for priority healthcare needs and is intended to guide countries in developing or adapting their own national lists. More than 150 countries have developed national essential medicines lists based on the WHO model.

A WHO Expert Committee undertakes the selection and considers public health relevance, evidence of efficacy and safety, comparative costs, and cost-effectiveness. Applications and supporting

[16] Climate Change and Health. WHO. 12 October 2023.
https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health
[17] WHO Pandemic Agreement. WHO.
https://www.who.int/health-topics/who-pandemic-agreement

material are published, and applicants may include researchers, NGOs, patient groups, pharmaceutical companies and WHO departments.

The EML nevertheless illustrates an important boundary between global evidence assessment and national priority-setting. Countries differ substantially in disease burden, available resources, prices, health-system capacity and opportunity costs. A medicine considered important globally may therefore have a different priority within individual national systems.

Published commentary has also identified ongoing questions concerning the transparency of decision-making rationales, financial independence, conflicts of interest, industry-initiated applications and affordability across different income settings.

For the IHC, the appropriate lesson is not to abandon international medicines assessment. It is to strengthen it. International scientific assessment should transparently establish comparative benefits, harms, evidence certainty, and relevant economic evidence, while decisions concerning essential status, procurement, reimbursement, and affordability remain with Member States.

Increasing Use of International Legal Instruments

The FCTC demonstrated WHO Member States' ability to negotiate a treaty under Article 19 of the WHO Constitution. [11] Following COVID-19, Member States initiated negotiations on a further international legal instrument addressing pandemic prevention, preparedness and response.

On 20 May 2025, the 78th WHA adopted the WHO Pandemic Agreement by consensus. The agreement followed more than three years of negotiations initiated in response to issues identified during the COVID-19 pandemic. [18]

As of 2026, work on the associated Pathogen Access and Benefit-Sharing (PABS) system remains part of the process required before the Agreement can proceed to signature and ratification in accordance with the agreed framework. [19] The Agreement will officially enter into force 30 days after 60 countries have ratified it.

The Pandemic Agreement therefore represents a further evolution of WHO-related global governance: from technical coordination and international sanitary regulations towards negotiated legal frameworks covering pandemic prevention, preparedness, surveillance, access to pathogens, supply chains and equitable access to pandemic-related products.

Importantly, these agreements are negotiated and adopted by WHO Member States, not imposed unilaterally by the WHO Secretariat. Any assessment of institutional authority must preserve this distinction. Nevertheless, the increasing use of international legal instruments heightens the significance of decisions made through WHO's governance structures. It raises legitimate questions about accountability, national ratification, sovereignty, and the appropriate scope of international health law.

[18] World Health Organization. World Health Assembly Adopts Historic Pandemic Agreement to Make the World More Equitable and Safer from Future Pandemics. 20 May 2025. https://www.who.int/news/item/20-05-2025-world-health-assembly-adopts-historic-pandemic-agreement-to-make-the-world-more-equitable-and-safer-from-future-pandemics

[19] WHO Pandemic Agreement. WHO. https://www.who.int/health-topics/who-pandemic-agreement

Expansion Through Financing and Programmes

WHO is financed through assessed contributions from Member States and voluntary contributions from Member States and other partners. WHO reports that voluntary contributions have accounted for more than three-quarters of its financing in recent years. [5]

WHO's 2024–2025 results report acknowledges that all three of its technical strategic priorities remain heavily dependent on specified voluntary contributions and that specified funding cannot simply be redistributed to underfunded areas. [20]

The WHO acknowledges that relying on a limited number of donors or short-term funding leaves initiatives vulnerable to disruptions. While the solution is seen as increasing domestic investment, it also includes expanding the range of donor and partner contributions, creating a critical tension for the WHO: Where an organisation depends substantially upon voluntary and earmarked financing, the priorities for which funding is available may influence which programmes can expand, which activities remain underfunded, and where organisational capacity develops.

Mission Expansion or Institutional Adaptation?

One interpretation is that WHO has appropriately adapted to changing knowledge about the causes of ill health. Non-communicable diseases, environmental risks, social conditions, commercial determinants and individual behaviours all affect mortality and morbidity. An international health organisation that ignored them could therefore be accused of adopting an artificially narrow understanding of health.

A second interpretation is that WHO's broad constitutional objective creates few effective boundaries around institutional activity: if health is defined broadly and almost every area of social, environmental, and economic policy affects health, then the organisation can justify involvement in an exceptionally wide range of policy domains.

Both propositions can be true simultaneously: an issue may genuinely affect health while still raising a separate question about whether an international health institution is the appropriate body to determine or advocate the policy response.

A more disciplined framework for international health activity would require three questions to be addressed.

First, does the proposed activity fall within a clearly defined international purpose?

Second, does undertaking it at the international level provide demonstrable added value—whether through cross-border necessity, shared scientific capability, reduced duplication or access to specialist expertise?

Third, does the proposed level of international involvement satisfy subsidiarity, so that responsibility remains with states, national institutions or other appropriate bodies wherever they can achieve the objective effectively?

[20] WHO Results Report 2024–2025: Executive Overview. WHO. https://www.who.int/about/accountability/results/who-results-report-2024-2025/executive-summary

These principles anticipate the Treaty Remit and Subsidiarity Test proposed later in this report for the International Health Council. They provide a structured basis for determining not only whether international action is justified, but how far that involvement should extend. Reserved governmental competences and individual autonomy would remain separate limitations on institutional authority.

1.4 Funding and Donor Dependence

The way an international organisation is financed affects more than its balance sheet. Funding arrangements can influence institutional stability, strategic flexibility, programme development and the relationship between an organisation and those who provide its resources. For the WHO, this issue is particularly relevant because the organisation's formal governance and financial structures are not identical.

Formally, WHO is governed by its Member States through the World Health Assembly; financially, however, the organisation has for many years depended predominantly on voluntary contributions rather than on mandatory membership fees. [5]

This distinction creates one of the central governance questions examined in this report: Can an international institution remain fully responsive to collectively agreed Member-State priorities when a substantial proportion of its resources is provided voluntarily and may be designated for particular purposes by individual contributors?

Assessed Contributions

WHO receives funding from two principal sources: assessed contributions and voluntary contributions. Assessed contributions are mandatory membership payments made by WHO Member States and Associate Members. The assessment scale is calculated by the United Nations based mainly on a country's GDP, adjusted for WHO membership, and approved every two years by the World Health Assembly. [21]

Because assessed contributions are not generally earmarked for individual projects by the states providing them, they offer WHO comparatively predictable and flexible resources that can be allocated according to the Programme Budget approved collectively by Member States. The principal advantages of assessed contributions include providing predictable financing, reducing dependence on a narrow donor base and aligning resources with the Programme Budget. [21]

However, their relative importance has declined considerably over the organisation's history. The WHO reports that assessed contributions have for several years represented less than 20% of the organisation's financing, with the balance mobilised predominantly through voluntary contributions. [21] A substantial departure from WHO's original financing model. When the organisation was founded, almost all its funding came from assessed contributions. [22]

The practical consequence has been a transition from an organisation financed predominantly through collectively determined membership dues to one in which voluntary financing has become

[21] Assessed Contributions. WHO.
https://www.who.int/about/funding/assessed-contributions
[22] WHO Investment Round — Frequently Asked Questions. WHO.
https://www.who.int/about/funding/invest-in-who/investment-round/frequently-asked-questions

essential to programme delivery.

Voluntary Contributions

Voluntary contributions are additional funds provided to WHO beyond mandatory assessed contributions. They are supplied principally by Member States but may also come from UN organisations, other intergovernmental organisations, philanthropic foundations, the private sector and other contributors. [5]

Not all voluntary funding has the same implications for institutional independence or flexibility. At one end of the spectrum are core voluntary contributions, which provide WHO with considerable discretion over how funds are allocated within its approved programme. At the other end are specified voluntary contributions, in which funding is associated with designated programmes, geographical areas, activities or purposes. The critical governance issue is how much discretion WHO retains over its use of voluntary funding.

The Problem of Earmarking

The WHA can collectively approve the WHO Programme Budget and strategic priorities. However, earmarking creates a structural difference between the authority to approve priorities and the ability to finance them, because specified voluntary contributions often do not correspond evenly with the collectively agreed priorities.

WHO itself acknowledges this problem. Its 2024–2025 results reporting states that all three of WHO's technical strategic priorities remained highly dependent upon specified voluntary contributions and that these resources could not readily be reprogrammed to address emerging needs or persistent funding shortfalls. [23] WHO further reports that dependence on specified funding results in unbalanced financing across the organisation, because earmarked resources cannot simply be redistributed towards underfunded areas. [23]

In 2022–2023, Member States' assessed contributions covered only 13% of WHO's budget, which left the Organisation reliant on voluntary, often earmarked contributions to fund its work. The WHO reports that in recent years, over 70% of the revenue WHO has received has been earmarked for specific areas of work or countries by the Member State or partner who provides the funds. [22]

This is a significant institutional constraint as the conditions attached to funding can constrain the organisation's ability to distribute resources according to its own assessment of organisational need.

Member States retain formal authority over WHO through the WHA; they approve the Programme Budget, determine policy and exercise the constitutional powers established under WHO's governing framework. However, financial influence operates differently. A contributor does not necessarily need formal decision-making authority to affect institutional activity. Where funds are provided for particular programmes, the availability of resources can determine which approved activities develop staff, infrastructure and operational capacity and which remain comparatively underfunded.

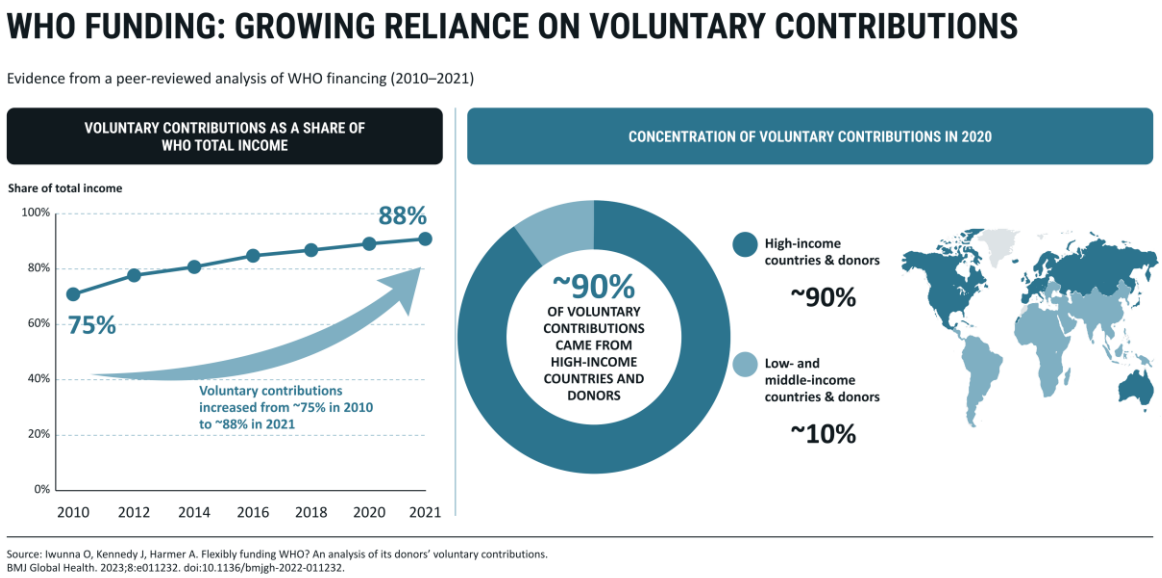
[23] World Health Organization. WHO Investment Round — Commitments. WHO. Data updated 21 April 2026. https://www.who.int/about/funding/invest-in-who/investment-round/commitments

This creates a distinction between formal governance power — the legal authority to make institutional decisions — and resource-allocation influence — the ability to affect which activities receive sufficient resources to be implemented at scale.

The existence of the second does not prove the displacement of the first. It does, however, create a principal-agent problem. Member States collectively determine the organisation's mandate and programme, while individual Member States and other contributors may determine separately where significant voluntary resources are directed. Where the two processes diverge, institutional priorities and financial incentives may cease to align perfectly.

Concentration of Funding

The issue is intensified when voluntary financing is concentrated among a relatively small number of contributors; WHO itself has acknowledged that its historical dependence on voluntary contributions has often rested on a comparatively narrow donor base. Its sustainable-financing reforms explicitly identify broadening the donor base as necessary to improve the organisation's resilience. [5]



A peer-reviewed analysis of WHO voluntary contributions between 2010 and 2021 found an increase from approximately 75% to 88% of WHO's financing. The study also found that high-income countries and donors based in high-income countries accounted for approximately 90% of voluntary contributions in 2020. [24]

The authors concluded that WHO remained significantly constrained by conditions attached to much of the voluntary funding it received. These findings do not demonstrate improper influence by any individual donor. Still, they do demonstrate a structural asymmetry: formal voting authority within WHO is broadly distributed among Member States, while voluntary financial resources have historically been considerably more concentrated. This difference is relevant to institutional legitimacy even where no evidence of improper conduct exists.

[24] Iwunna O, Kennedy J, Harmer A. Flexibly funding WHO? An analysis of its donors' voluntary contributions. BMJ Global Health. 2023;8(4):e011232. doi:10.1136/bmjgh-2022-011232.

Non-State Funding

WHO's funding structure also permits contributions from non-state actors, including philanthropic foundations, global organisations and private-sector entities, subject to WHO's applicable governance arrangements, such as its Framework of Engagement with Non-State Actors (FENSA). [25]

Recent WHO resource-mobilisation initiatives illustrate the diversity of potential contributors. The WHO Investment Round for 2025–2028 has accepted or sought commitments from Member States, as well as from multilateral, philanthropic, and private-sector partners.
Commitments include contributions from governments and from organisations such as philanthropic foundations and other non-state entities. The total base budget for the next 4 years is US$11.1 billion. Membership fees to WHO will cover US$4 billion of this total, leaving a funding requirement of US$7.1 billion (64%) to be met through voluntary contributions. [23, 26,]

Accepting funding from organisations that may themselves have interests in health policy creates an additional governance requirement. An institution that produces scientific guidance, technical standards, and policy recommendations must be able to demonstrate not merely that its conclusions are independent, but also that its financing arrangements do not create reasonable grounds to question that independence.

Funding and Scientific Independence

Claims that particular guidance was produced because of donor interests would exceed what financing data alone can establish. However, the absence of evidence of direct interference does not eliminate the institutional risk created by financial dependence.

Scientific organisations generally seek to minimise both actual conflicts of interest and circumstances that could create a reasonable perception of influence. For an international organisation whose authority depends substantially upon confidence in the neutrality of its scientific advice, perceived independence is itself an institutional asset.

Case Study: WHO, Pandemic Influenza and Scientific Independence

The 2009 H1N1 influenza pandemic provides a relevant case study of how conflicts of interest can affect confidence in the scientific independence of an international health organisation.

In 2010, Deborah Cohen and Philip Carter, writing in the BMJ following a joint investigation with the Bureau of Investigative Journalism, reported that scientists involved in WHO pandemic influenza planning had undertaken paid work for pharmaceutical companies that stood to benefit from recommendations concerning influenza vaccines and antiviral medicines. The investigation's principal concern was that relevant conflicts had not been adequately disclosed publicly by WHO.

[25] Framework of Engagement with Non-State Actors (FENSA). WHO. https://www.who.int/about/collaboration/non-state-actors
[26] World Health Organization. WHO Investment Round — How to Pledge. WHO. https://www.who.int/about/funding/invest-in-who/investment-round/pledging

[27]

The significance of the case demonstrates the institutional consequences of inadequate transparency where scientific recommendations have substantial commercial implications. Governments responding to the pandemic purchased vaccines and stockpiled antiviral medicines, making confidence in the independence of the advice essential.

WHO subsequently subjected its response to review, examining the implementation of the International Health Regulations and WHO's response to H1N1, and considering the organisation's decision-making and governance arrangements. [28]

The episode illustrated that undisclosed or inadequately managed competing interests created reasonable doubts about independence and consequently undermined institutional trust.

For the proposed IHC, the lesson is straightforward: declarations of interest should be comprehensive and public; significant conflicts should trigger independent assessment and, where necessary, recusal; and the evidence, methodology and expert membership underlying recommendations should be transparent. Scientific independence should not merely be asserted. The institutional arrangements should make it demonstrable.

WHO's Sustainable Financing Reforms

WHO and its Member States have recognised weaknesses in the existing financing model and have begun addressing them. A significant reform was to progressively increase assessed contributions, to finance half of WHO's approved base budget by the 2030–2031 biennium. The purpose is to provide a larger proportion of predictable and flexible funding and reduce excessive dependence upon earmarked voluntary resources.

The Investment Round seeks to make voluntary financing more predictable, flexible and resilient, including broadening the donor base and encouraging contributors to provide funding with fewer restrictions. In November 2024, the WHO reported that the Investment Round generated 70 pledges of more than US$1.7 billion, including substantial contributions from first-time voluntary contributors. [29]

These reforms are essential because they amount to institutional recognition of the underlying financing problem. WHO is explicitly seeking a different quality of financing: resources that are more predictable, less narrowly specified and derived from a broader range of contributors.

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[27] Cohen D, Carter P. Conflicts of interest. WHO and the pandemic flu "conspiracies". BMJ. 2010;340:c2912. doi:10.1136/bmj.c2912.

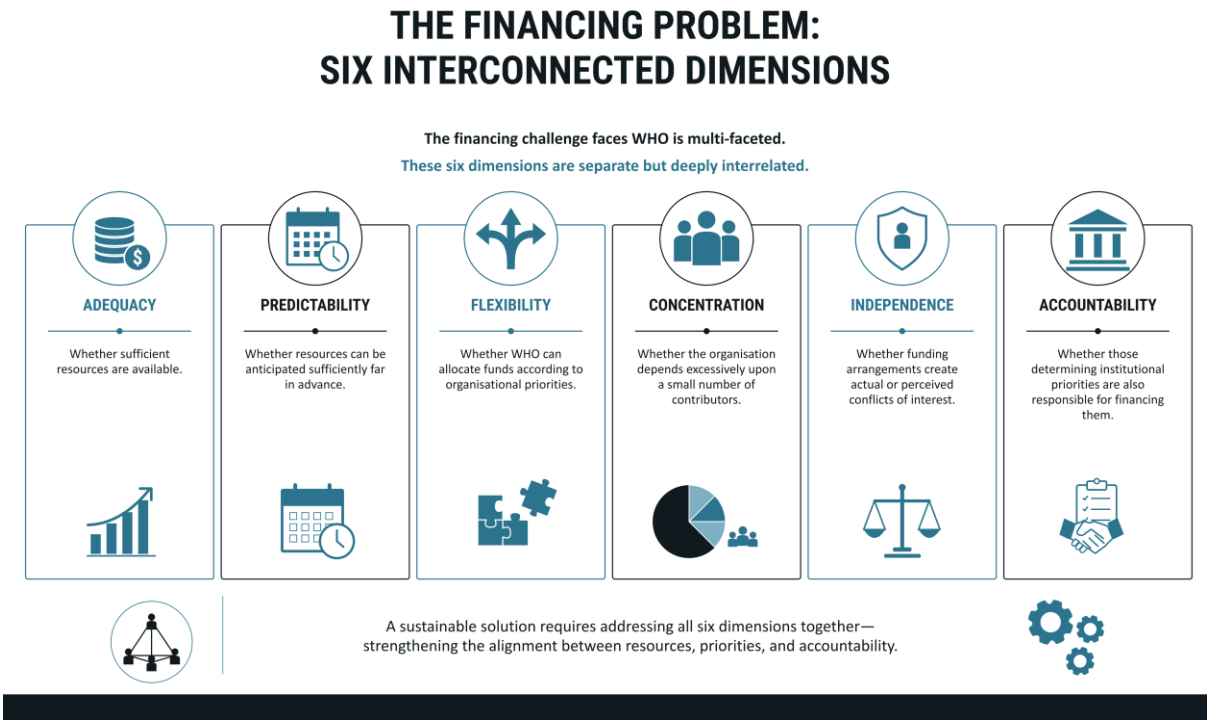
[28] WHO. Strengthening Response to Pandemics and Other Public-Health Emergencies: Report of the Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza (H1N1) 2009. WHO; 2011. https://www.who.int/publications/i/item/strengthening-response-to-pandemics-and-other-public-health-emergencies (Accessed 21st August 2026)

[29] WHO Director-General's Remarks at the WHO Investment Round Press Conference. 19 November 2024. WHO. https://www.who.int/news-room/speeches/item/who-director-general-s-opening-remarks-at-the-media-briefing---28-november-2024
(Accessed 21st August 2026)

Continuing Financial Constraints

Despite these reforms, substantial constraints remain. For the 2024–2025 biennium, WHO reported that flexible funding was still insufficient to achieve equitable financing across its base programmes. Its technical priorities continued to depend heavily upon specified voluntary contributions. By the end of the biennium, WHO reported that highly earmarked and unpredictable financing continued to limit its ability to direct resources to areas where they were most needed. [30]

The financing problem occurs across six interconnected dimensions: Adequacy, Predictability, Flexibility, Concentration, Independence, and Accountability. The six dimensions are separate yet related, and all require attention to strengthen alignment among resources, priorities, and accountability.



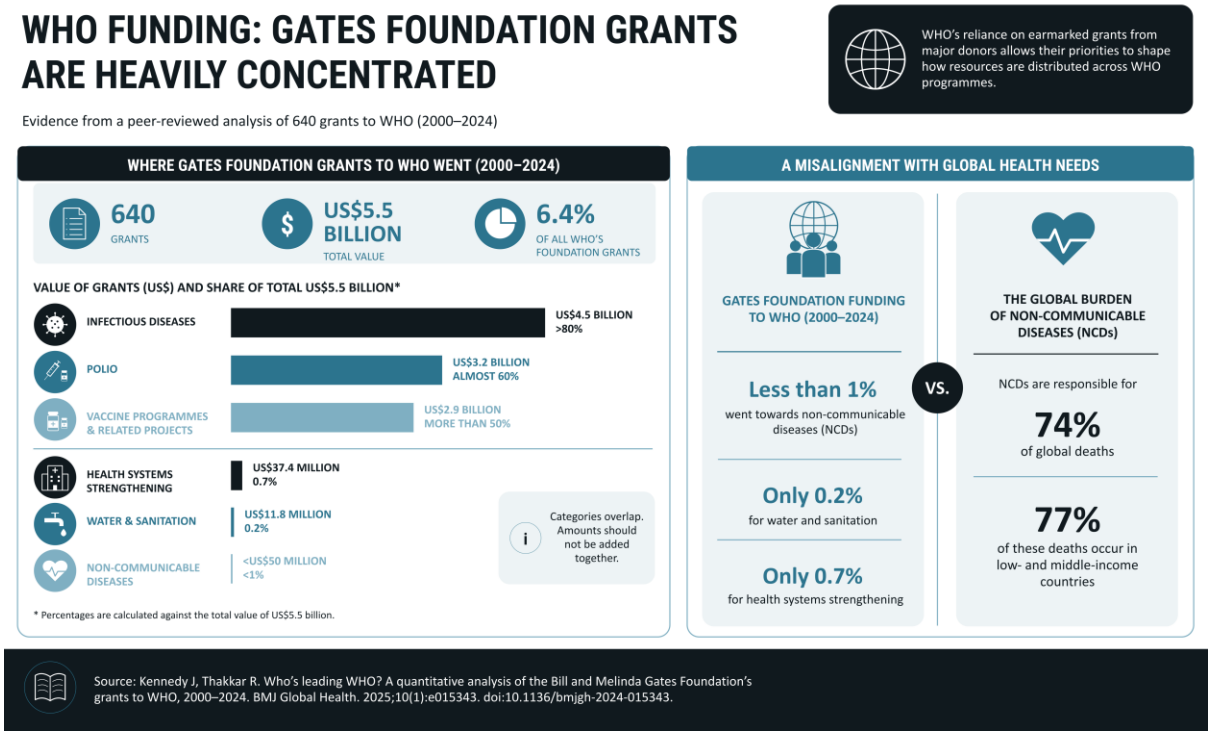
Donor Dependence Versus Donor Capture

Donor dependence can be demonstrated when an organisation relies substantially on voluntary funding from external contributors.

Donor capture is a stronger proposition: It implies that contributors have succeeded in directing the organisation to pursue their interests rather than its formally established purpose. Because much of the voluntary financing is earmarked, contributors can determine the programmes, diseases or activities for which their resources may be used.

[30] WHO Results Report 2024–2025: End-of-Biennium Executive Overview. WHO. https://www.who.int/about/accountability/results/who-results-report-2024-2025-eob (Accessed 21st August 2026)

A 2025 analysis reported by the BMJ Group examined approximately US$5.5 billion in Gates Foundation grants over two decades and concluded that the Foundation's funding priorities were heavily concentrated in areas, especially infectious diseases and vaccines. In contrast, health-system strengthening, water and sanitation, and non-communicable diseases received substantially smaller shares. [31] The Bill and Melinda Gates Foundation (BMGF) continues to be a significant contributor to WHO and therefore an important part of the organisation's financing environment. The authors conclude that 'As one of WHO's biggest donors, BMGF contributes to this problem by pursuing its narrow approach to global public health.'



WHO itself acknowledges the underlying problem: an analysis of its current financing model finds that assessed contributions account for only a minority of its resources. In contrast, voluntary contributions allow donors to direct funding according to their priorities. [32]

The appropriate institutional question is: why should an international scientific organisation create a financing structure in which such a conflict of interest, or the reasonable perception of one, can arise at all?

This distinction has direct implications for the proposed IHC. An institution financed exclusively by its sovereign Member States would substantially reduce the capacity of commercial, philanthropic or other non-state interests to influence institutional priorities through earmarked financing.

[31] Kennedy J, Thakrar R. Who's leading WHO? A quantitative analysis of the Bill and Melinda Gates Foundation's grants to WHO, 2000–2024. BMJ Global Health. 2025;10(10):e015343. doi:10.1136/bmjgh-2024-015343.

[32] Current State of WHO's Financing. WHO Investment Case. https://www.who.int/about/funding/invest-in-who/investment-case-2.0/current-state

The Governance and Financing Problem

An international organisation governed collectively by sovereign states should ideally have a financing model that reinforces, rather than complicates, its governance structure. Where collectively agreed mandatory contributions provide only a minority of resources and substantial additional financing must be negotiated from individual contributors, a potential tension arises between collective governance and decentralised financing.

WHO's current reforms seek to reduce this tension by increasing assessed contributions and encouraging more flexible voluntary funding. The question for this report is whether those reforms are sufficient, or whether the financing model of an international scientific institution should be designed differently from the outset.

The IHC model developed later in this report proposes a substantially stricter principle: The institution should be financed by its Member States and should not depend upon commercial entities, philanthropic foundations, non-governmental organisations or other non-state actors for the performance of its Treaty-defined functions.

The objective is not to imply misconduct by existing donors; it is to remove a structural source of actual or perceived influence and establish a direct relationship between those who govern the institution under its Treaty framework and those who finance it.

1.5 Political and Geopolitical Pressures

The WHO is expected to provide objective scientific and technical leadership while operating within an inherently political environment governed by its current 194 Member States. Its principal decision-making body, the WHA, brings together governments with different political systems, strategic interests, alliances and foreign-policy objectives.

International health cooperation requires governments to share information, provide access to data, finance collective activities and cooperate during emergencies. Yet the same governments may have political, economic or security interests that affect what information they are willing to disclose, which institutional decisions they support and how they respond to WHO's conclusions.

The institutional question is how far political and geopolitical pressures should be permitted to affect scientific assessment, technical cooperation and the operational priorities of an international health organisation.

Dependence on Member-State Cooperation

WHO’s ability to investigate disease outbreaks, obtain epidemiological information and understand events occurring within a country depends substantially upon cooperation from national governments. WHO may have a responsibility to assess a global health threat, but much of the evidence required to do so remains under the control of individual states.

The investigation into the origins of SARS-CoV-2 illustrates this problem. WHO established the Scientific Advisory Group for the Origins of Novel Pathogens (SAGO) to assess the available evidence concerning the origins of COVID-19. In its 2025 report, SAGO concluded that vital information

required to evaluate the competing hypotheses had still not been provided. [33] WHO stated that it had requested hundreds of early viral genetic sequences from China, more detailed information on animals sold in Wuhan markets, and information on work and biosafety conditions in Wuhan laboratories. According to WHO, these materials had not been provided to SAGO or WHO. The WHO Director-General Tedros Adhanom Ghebreyesus consequently stated that all hypotheses concerning the origins of SARS-CoV-2 must remain open and continued to call upon China and other countries possessing relevant information to share it. [34]

The significance of this case extends beyond the unresolved question of its origins. It demonstrates a fundamental limitation of international scientific coordination: an international organisation can be responsible for reaching scientific conclusions without possessing independent authority to obtain the evidence necessary to reach them.

COVID-19 and China

The early COVID-19 response also generated intense geopolitical controversy regarding WHO's relationship with China. Critics, including the United States Government, argued that the WHO had been insufficiently independent in its handling of information provided by Chinese authorities. WHO rejected accusations that its decisions were politically directed and subsequently continued publicly to demand greater transparency and data sharing from China. These later public requests for information demonstrate that dependence upon Member-State cooperation materially constrained the scientific investigation.

The institutional lesson is therefore broader than the question of whether WHO was politically influenced in a particular decision. A scientific organisation whose access to evidence depends upon the consent of governments will inevitably be vulnerable when scientific transparency conflicts with perceived national interests.

Health Emergencies and International Conflict

Geopolitical pressures are also evident in the responses of the WHO's governing bodies to the health consequences of armed conflict. Following the Russian Federation's full-scale invasion of Ukraine in February 2022, the World Health Assembly adopted resolutions and decisions concerning the resulting health emergency. In 2025, Member States voted to continue measures intended to support and strengthen Ukraine's health system. Amendments proposed by the Russian Federation and several other states were rejected. [35] The issue remained before the World Health Assembly in 2026, when delegates again approved continued implementation of the existing resolution concerning the health emergency in Ukraine. [36] WHO's operational work, meanwhile, includes

[33] WHO Scientific Advisory Group Issues Report on Origins of COVID-19. WHO. 27 June 2025. https://www.who.int/news/item/27-06-2025-who-scientific-advisory-group-issues-report-on-origins-of-COVID-19

[34] WHO Director-General's Opening Remarks at the Media Briefing. 17 March 2023. WHO. https://www.who.int/news-room/speeches/item/who-director-general-s-opening-remarks-at-the-media-briefing---17-march-2023

[35] Seventy-eighth World Health Assembly — Daily Update: 22 May 2025. WHO. https://www.who.int/news/item/22-05-2025-seventy-eighth-world-health-assembly---daily-update--22-may-2025

[36] Seventy-ninth World Health Assembly — Daily Update: 20 May 2026. WHO.

documenting attacks on health care, supplying medicines and equipment, supporting health facilities, and maintaining essential health services. [37]

Decisions concerning conflicts necessarily take place within wider disputes over sovereignty, responsibility, terminology and international law. Member States may therefore divide along geopolitical lines even when the immediate subject before WHO is health.

Similar issues arise in relation to the occupied Palestinian territory. The WHA has repeatedly considered reports and resolutions concerning health conditions in the occupied Palestinian territory, including East Jerusalem. In 2026, Member States agreed to continue formal reporting on those conditions to the subsequent Assembly. [38]

Again, the underlying health consequences are substantial and require international attention. The institutional problem is that humanitarian health questions and geopolitical disputes cannot always be separated cleanly within an intergovernmental organisation.

The World Health Assembly as a Political Forum

These examples reveal a significant distinction between WHO's scientific functions and its intergovernmental governance functions. A laboratory standard, a systematic evidence review, or a disease-surveillance report can, in principle, be evaluated primarily on scientific criteria. A WHA resolution concerning an armed conflict, an international treaty, a territorial dispute, or a politically contested policy necessarily involves considerations that extend beyond scientific evidence.

The more an international health institution operates across both domains, the greater the risk that perceptions arising from its political functions affect confidence in its scientific functions. Consequently, an institution can become politically contested even when individual scientific assessments remain technically sound. This poses a significant reputational problem for the WHO: scientific authority depends on evidence, methods, and reproducibility. Political authority depends on representation, negotiation, and agreement among governments. Combining these forms of authority within the same institution creates uncertainty about which process is operating in any decision.

The geopolitical vulnerability of WHO is particularly apparent when major powers disagree over the organisation itself. The relationship between the US and WHO provides a recent example.

In 2025, the US notified its intention to withdraw from WHO, with a stated effective date of 22 January 2026. [39] The US Government accused WHO of mishandling COVID-19, failing to demonstrate

https://www.who.int/news/item/20-05-2026-seventy-ninth-world-health-assembly---daily-update--20-may-2026

[37] WHO Regional Office for Europe. WHO's Response to Health Emergencies in Ukraine: Annual Report 2024. 21 July 2025. https://www.who.int/europe/publications/i/item/WHO-EURO-2025-12500-52274-80390

[38] Seventy-ninth World Health Assembly — Daily Update: 22 May 2026. WHO. https://www.who.int/news/item/22-05-2026-seventy-ninth-world-health-assembly-daily-update-22-may-2026

[39] WHO Statement on Notification of Withdrawal of the United States. WHO. 24 January 2026. https://www.who.int/news/item/24-01-2026-who-statement-on-notification-of-withdrawal-of-the-united-states

sufficient independence from inappropriate political influence by Member States, and demanding disproportionately large payments from the United States. [40]

The WHO rejected these allegations. In January 2026, WHO stated that it remained impartial, served all Member States and operated "without fear or favour". It also emphasised the US's historical contribution to WHO programmes and argued that US withdrawal would make both the United States and the wider world less safe. [39]

The merits of the competing claims can be debated; however, for institutional-design purposes, the episode demonstrates something more fundamental. A global health organisation whose capabilities depend heavily upon participation and financing by major powers can itself become an object of geopolitical competition. Political disagreement can therefore affect not only individual WHO decisions but the resources, membership and institutional stability of the organisation itself. Evidence that WHO operates under political pressure does not necessarily demonstrate that individual governments control WHO. But political pressure can instead arise structurally through several interconnected factors.



These mechanisms can influence the environment in which WHO operates without directly demonstrating political control over its scientific conclusions. The appropriate institutional objective should therefore be to reduce the opportunities for geopolitical disputes to interfere with scientific functions.

[40] The White House. Withdrawing the United States from the World Health Organization. Presidential Action. 20 January 2025. https://www.whitehouse.gov/presidential-actions/2025/01/withdrawing-the-united-states-from-the-world-health-organization/

Implications for Scientific Independence

Governments may have incentives to delay disclosure of outbreaks, minimise evidence of domestic failures, protect economically vital industries, avoid international criticism or promote interpretations consistent with national interests.

An international scientific institution must be capable of assessing evidence independently of those pressures. Yet WHO faces an inherent difficulty: the states from which it must remain scientifically independent are also its members, governors, information providers and major funders.

This creates a form of principal-agent tension: Member States collectively create and govern WHO to perform international health functions. Individually, however, a state may have interests that conflict with complete transparency or with the organisation's conclusions. No governance system can eliminate this tension; however, it can design safeguards to limit its effects.

Lessons for the International Health Council

The proposed International Health Council should recognise geopolitical pressure as a permanent feature of international cooperation rather than assume it can be removed. Its institutional design should therefore separate scientific processes from intergovernmental political processes as far as practicable. Scientific assessments should be based upon published methods, transparent evidence, predefined standards and explicit grading of uncertainty.

Member States should govern the institution but should not be able to determine scientific conclusions through political resolutions. Where evidence is incomplete because a state has not provided the requested information, the IHC should publicly report that fact and incorporate the resulting uncertainty into its assessment.

The IHC should also avoid functions that unnecessarily transform a scientific organisation into a forum for adjudicating wider geopolitical disputes. Its role during conflicts should focus on matters with a demonstrable international health dimension: surveillance, verification, scientific information, laboratory cooperation and technical assistance requested within its Treaty-defined remit.

Institutional neutrality ensures that the organisation's scientific conclusions are determined by evidence and transparent methods rather than by the geopolitical positions of individual Member States.

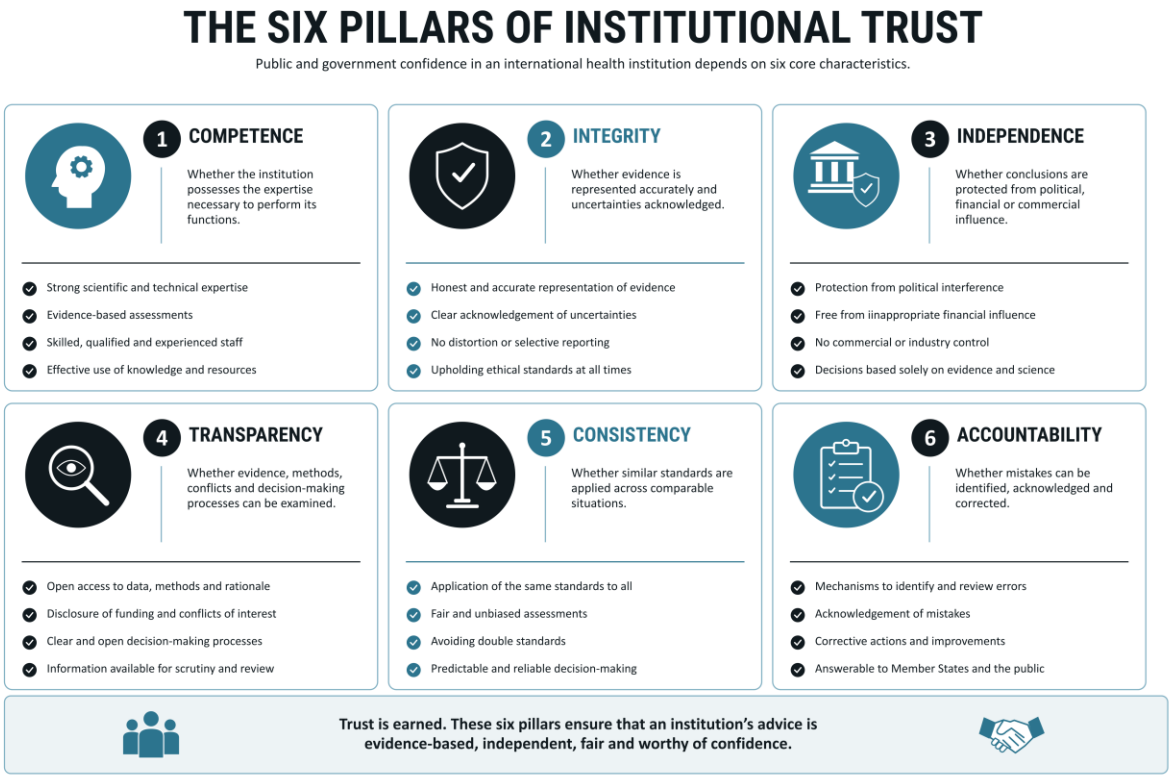
International health cooperation inevitably occurs between sovereign states with competing interests. The challenge is therefore not to create an institution without politics; it is to create one in which political disagreement cannot determine scientific truth.

1.6 Public Confidence and Institutional Trust

The WHO does not ordinarily compel populations directly, as much of its influence derives from scientific authority, institutional reputation and the willingness of governments, health professionals and the public to regard its advice as credible. Trust is therefore not peripheral to WHO's effectiveness - it is an operational necessity.

During an international health emergency, governments may rely upon WHO assessments when making decisions concerning surveillance, travel, vaccination, medicines and emergency preparedness. Health professionals may use WHO guidance, while populations may encounter WHO recommendations directly or through national authorities. If confidence in the organisation declines, the practical value of its scientific advice can decline with it.

Individuals and governments can disagree with a particular recommendation while continuing to regard the institution producing it as competent and independent. Trust, instead, depends on several interconnected characteristics, including Competence, Integrity, Independence, Transparency, Consistency, and Accountability.



An institution may possess substantial scientific expertise yet lose confidence if its decision-making processes appear opaque. Conversely, transparency about uncertainty and disagreement can strengthen credibility even when scientific conclusions subsequently change.

COVID-19 and the Polarisation of Trust

Decisions concerning the declaration of an international emergency, pandemic characterisation, testing, viral transmission, face masks, vaccines, therapeutics, travel measures and the origins of SARS-CoV-2 became subjects of intense scientific and political debate.

Evidence from the United States illustrates how strongly perceptions of WHO became politically polarised. Bayram and Shields examined a representative sample of Americans during the pandemic and found substantial differences in trust by political affiliation, ideology, nationalism, and attitudes

towards international cooperation. [41] Only around 41% of respondents agreed or strongly agreed that the WHO had acted independently of the political agendas of its Member States, while approximately 33% disagreed. Similarly, around 42% considered WHO information accurate, unbiased and unaffected by Member-State political agendas, while approximately one-third disagreed.

These results demonstrate a recurring institutional problem: assessments of an international scientific organisation can become closely tied to its political identity. Once scientific institutions become incorporated into wider political divisions, disagreements over evidence can increasingly be interpreted as disagreements over political allegiance, leading to fragmentation of trust in the organisation.

The H1N1 influenza case showed how inadequately disclosed conflicts of interest among scientific advisers could generate concerns about commercial influence even though the subsequent independent review found no evidence that commercial interests had influenced WHO's pandemic decisions.

COVID-19 produced a different but related problem. WHO's dependence upon governments for epidemiological information and access meant that crucial evidence concerning the origins of SARS-CoV-2 remained unavailable. In 2025, WHO's Scientific Advisory Group for the Origins of Novel Pathogens reported that significant information requested from China had still not been provided. [34]

The consequence is not merely scientific uncertainty. Where an international institution cannot obtain or disclose the evidence necessary to resolve significant questions, public audiences may find it difficult to distinguish between evidence that does not exist, evidence that has not been supplied, evidence that remains uncertain and evidence that an institution is unwilling to disclose.

Changing Scientific Advice

During a novel health emergency, changing guidance is not necessarily evidence of scientific failure. Evidence accumulates, disease characteristics become clearer, technologies develop, and estimates are revised. Scientific institutions should be flexible and expected to change conclusions when better evidence becomes available.

Case Study: COVID-19 Vaccines, Transmission and Changing Evidential Claims

The pivotal COVID-19 vaccine randomised controlled trials were designed primarily to assess protection against symptomatic COVID-19 rather than person-to-person transmission. Therefore, prevention of transmission was not established by the principal RCTs' efficacy endpoints.

Evidence concerning transmission subsequently came largely from observational and household studies. These studies produced varying estimates and were subject to several limitations, including confounding, differences in prior infection and behaviour, differential testing, uncertain identification of transmission chains, waning immunity and the emergence of new variants.

[41] Bayram AB, Shields T. Who Trusts the WHO? Heuristics and Americans' Trust in the World Health Organization During the COVID-19 Pandemic. Social Science Quarterly. 2021;102(5):2312–2330. doi:10.1111/ssqu.12977.

A prospective UK household study of the Delta variant by Singanayagam and colleagues found secondary attack rates of 25% (95% CI, 15–35) from fully vaccinated index cases and 23% (95% CI, 15–31) from unvaccinated index cases. The authors concluded that fully vaccinated individuals with breakthrough infections could efficiently transmit Delta within households. [42]

Contemporary and subsequent health guidance increasingly distinguished protection against severe disease from prevention of infection and transmission. Current Mayo Clinic guidance, for example, emphasises that COVID-19 vaccination protects against serious illness, hospitalisation and death. [43]

The case illustrates why scientific institutions should carefully distinguish among endpoints: symptomatic disease, severe disease, infection, and onward transmission are not interchangeable outcomes.

Where claims of reduced transmission justify restrictions or policies affecting third parties, the evidential standard supporting that claim should be stated explicitly. Institutions should distinguish results demonstrated in randomised trials from associations subsequently observed in non-randomised studies and should communicate how conclusions change as immunity wanes and new variants emerge.

In public health emergencies, scientific advice must not remain fixed. Evidence supporting each claim, its limitations and its degree of certainty should remain visible as the advice evolves.

The trust problem arises when the reasons for changes are not communicated clearly. If uncertainty is initially understated, subsequent revision can appear inconsistent or politically motivated. Conversely, if an institution explains the quality of the available evidence, identifies uncertainties and states the conditions under which recommendations might change, revision becomes part of the scientific process rather than evidence against it. The distinction is fundamental: scientific uncertainty does not necessarily undermine trust; unexplained certainty followed by reversal can.

Misinformation and Institutional Distrust

WHO also identifies misinformation and disinformation as significant threats to public confidence. In its 2024 review, WHO stated that inaccurate information concerning diseases, treatments and vaccines can undermine trust in science and public health, distort perceptions and erode confidence in evidence-based policies. [44]

This is a genuine problem; however, misinformation should not become an all-purpose explanation for declining institutional trust. Some distrust may arise from demonstrably false information. Other

[42] Singanayagam A, Hakki S, Dunning J, et al. Community transmission and viral load kinetics of the SARS-CoV-2 Delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study. Lancet Infectious Diseases. 2022;22(2):183–195. doi:10.1016/S1473-3099(21)00648-4.
[43] Mayo Clinic Staff. Debunking COVID-19 myths. Mayo Clinic. Updated 1 July 2026. https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/coronavirus-myths/art-20485720
[44] World Health Organization. WHO Looks Back at 2024 — Battling Misinformation and Disinformation. 23 December 2024. https://www.who.int/news-room/spotlight/who-looks-back-at-2024

sources of distrust may result from political polarisation, inconsistent communication, undisclosed conflicts, previous institutional failures, or genuine scientific disagreement. Declining trust also occurs when messaging communicates certainty when the evolving evidence remains highly uncertain.

An institution seeking to restore confidence must therefore distinguish between false claims that require correction and legitimate questions that require answers. Treating reasonable criticism as misinformation risks reinforcing rather than resolving distrust.

Trust Between Member States

The WHO depends upon the confidence of its Member States. Governments must be willing to provide data, participate in surveillance, share pathogen information, finance the organisation and cooperate during international emergencies. The United States' decision to withdraw from the WHO, discussed in Section 1.5, therefore represents more than a financing problem; it demonstrates that institutional confidence can deteriorate to the point that a major Member State questions continued participation.

The adoption of the WHO Pandemic Agreement by the World Health Assembly in May 2025 demonstrates continuing support among participating Member States for a global framework for pandemic cooperation. [19] As a consequence, the evidence does not support a simple conclusion that all governments have collectively lost confidence in WHO. Rather, WHO increasingly operates within a contested environment in which strong support for health cooperation coexists with substantial criticism of the institution through which much of that cooperation is organised.

Trust Cannot Be Demanded

Scientific institutions sometimes respond to declining confidence by attempting to communicate more forcefully. But institutional trust cannot ultimately be created through messaging alone. Trust is more likely to be sustained where institutional arrangements make trustworthy behaviour observable.

This requires publication of the evidence underlying recommendations; the explicit communication of uncertainty; the disclosure and independent management of conflicts of interest; and transparency regarding funding. These mechanisms allow governments, researchers, journalists and the public to evaluate institutional claims rather than simply accept them.

An organisation that is transparently financed, clearly limited in its institutional authority, scientifically open and willing to expose its reasoning to external scrutiny creates conditions under which confidence can develop. An organisation whose processes are difficult to inspect may instead require audiences to rely upon institutional authority itself.

For the proposed International Health Council, this distinction should be foundational. The IHC should not seek authority principally by asking governments or populations to trust the institution. It should establish procedures that enable them to verify why its conclusions should be trusted.

Scientific recommendations should therefore identify the evidence considered, methods used, relevant conflicts of interest, uncertainties and areas of expert disagreement. Major conclusions should be capable of independent scrutiny and revision when new evidence emerges. The

achievable objective is to create an institution whose authority is earned through competence, transparency, methodological rigour and demonstrated independence rather than presumed from its institutional status.

1.7 Lessons from COVID-19

COVID-19 constituted the most severe test of the global health architecture in generations. It exposed weaknesses not only in individual institutions but in the mechanisms through which governments detect threats, share information, assess evidence, communicate uncertainty and coordinate responses across borders.

The central question is what form that cooperation should take and how international institutions should operate when evidence is incomplete, governments have competing interests, and decisions can produce substantial consequences from both action and inaction.

COVID-19 demonstrated the limitations that arise when an international organisation is responsible for assessing a threat but depends on Member States for much of the underlying evidence. International surveillance of communicable disease requires rapid access to epidemiological data, genomic sequences, laboratory findings and information concerning unusual disease clusters.

Where governments delay, restrict or selectively provide information, international assessment becomes correspondingly weaker. The continuing uncertainty surrounding the origins of SARS-CoV-2 illustrates the same structural problem. As discussed in Section 1.5, WHO reported in 2025 that key information requested for its origins assessment had still not been provided.

Therefore, a future international system should make transparent reporting of missing evidence a routine part of its scientific assessments. Where requested data are unavailable, the institution should state:

- What information was requested;
- From whom it was requested;
- Whether it was provided, wholly or partly;
- Its reliability;
- How its absence affects the assessment; and
- What conclusions cannot reliably be reached without it.

Evidence standards must remain visible during emergencies that create pressure to act before high-certainty evidence is available. Urgency should not erase the distinction between different forms of evidence. Randomised controlled trials, prospective observational studies, retrospective database analyses, mechanistic evidence, modelling and expert judgement answer different questions and carry different risks of bias. The distinction becomes especially important where interventions have substantial social, economic or legal consequences and unintended consequences.

As the COVID-19 vaccine transmission case study in Section 1.6 illustrates, the pivotal vaccine efficacy trials were not designed primarily to establish prevention of person-to-person transmission. Later transmission estimates relied substantially upon non-randomised evidence, which means that the evidential basis and corresponding degree of certainty should remain explicit when scientific claims are translated into policy.

COVID-19 also demonstrated the danger of treating related outcomes as interchangeable. For vaccines, protection against infection, symptomatic disease, severe disease, hospitalisation, death, and onward transmission all represent distinct endpoints. Similarly, evidence that an intervention affects viral transmission does not automatically establish its effect on hospitalisation or mortality, while evidence of individual benefit does not necessarily establish population-level benefit.

Scientific recommendations should therefore specify precisely which outcome has been measured, over what period, in which population and against which variant or epidemiological conditions. This principle should apply beyond vaccines to diagnostics, therapeutics and non-pharmaceutical interventions.

Models Are Tools, Not Observations

Models can help decision-makers explore possible epidemic trajectories, estimate resource requirements and compare potential scenarios where direct evidence is unavailable. However, models are not observations of what will occur. Their outputs depend on assumptions about transmission, behaviour, intervention effectiveness, immunity, and other uncertain parameters.

Future international guidance should therefore distinguish clearly between observed data, estimated effects, modelled scenarios, and policy judgements. Model assumptions, uncertainty intervals and sensitivity analyses should be published wherever modelling materially influences recommendations.

Case Study: When Pandemic Models Fail to Translate to the Real World

Mathematical models played a major role in shaping COVID-19 policy, including decisions concerning non-pharmaceutical interventions and restrictions. However, model outputs depend on the quality of the underlying data and the assumptions and estimates incorporated into them.

In a 2022 analysis, Heneghan and Jefferson, the authors of the present report, used systematic-review search methods to examine early COVID-19 modelling and its application to UK policy. They identified 42 estimates of the basic reproduction number (R_0) published up to March 2020, of which 39 were based on Chinese data. Estimates ranged substantially, from 2.1 to 6.47, demonstrating considerable uncertainty in one of the principal parameters being used to characterise the emerging epidemic. [45]

The authors identified several further problems. Early estimates were based on limited and potentially overlapping case data; methods differed across models; estimates derived from one population were not necessarily generalisable to another; reporting delays meant estimates could already be outdated by the time they were used; and the sources of some intervention-effect assumptions incorporated into models were unclear.

The paper also highlighted limited external validation and the absence of reporting and quality-assessment frameworks comparable with those routinely expected for clinical trials and systematic reviews.

The appropriate conclusion is not that mathematical modelling has no role in emergencies. Models can help explore scenarios when direct evidence is incomplete. However, models are

[45] Heneghan CJ, Jefferson T. Why COVID-19 modelling of progression and prevention fails to translate to the real-world. Advances in Biological Regulation. 2022;86:100914. doi:10.1016/j.jbior.2022.100914.

conditional projections rather than observations of what will happen, and their usefulness depends upon the validity of their inputs and assumptions.

Where models materially influence public policy, their assumptions, source evidence, uncertainty, sensitivity analyses and subsequent performance should therefore be publicly available and independently scrutinised. Models should support evidence generation rather than substitute for it.

Assessing Both Benefits and Harms

Pandemic interventions can have effects that extend beyond the disease they are intended to control. WHO's excess-mortality methodology explicitly recognises that pandemic-associated mortality includes both deaths directly caused by COVID-19 and indirect deaths resulting from the pandemic's effects on health systems and society. [46]

This principle should be extended to the evaluation of interventions. School closures, restrictions on movement, disruption to routine health services, border measures and other societal interventions may produce both intended benefits and unintended consequences.

An evidence-based response should therefore consider total effects rather than a single disease-specific outcome. This requires assessing health benefits alongside potential effects on:

- Non-COVID healthcare;
- Childhood development and education;
- Mental health;
- Employment and income;
- Social isolation;
- Inequalities;
- Civil liberties; and
- Other health outcomes.

The existence of an emergency does not remove the obligation to assess proportionality; it makes that assessment even more vital.

COVID-19 generated legitimate scientific disagreement over transmission routes, population risk, masking, vaccination, school closures, therapeutics, natural immunity and other questions. Scientific disagreement is not evidence that science has failed; it is frequently the mechanism through which knowledge evolves. International institutions should therefore avoid creating the impression that scientific questions have been definitively resolved where material uncertainty or expert disagreement remains. Therefore, a future institution should publish significant minority opinions, explain areas of disagreement and state what evidence would be required to resolve them.

[46] World Health Organization. Global Excess Deaths Associated with COVID-19, January 2020–December 2021. WHO; 2022. https://www.who.int/data/stories/global-excess-deaths-associated-with-covid-19-january-2020-december-2021

Recommendations Must Be Distinguished from Decisions

One of the chief institutional lessons from COVID-19 concerns the boundary between scientific advice and political authority. Scientific institutions can estimate risks, review evidence and identify possible consequences, while governments must make decisions involving values, trade-offs, economic consequences, legal authority and democratic accountability.

These functions should not be conflated. An international scientific body should therefore be able to say: "This is what the evidence indicates." It should be more cautious about saying: "Therefore every government must adopt this policy."

Different countries may reasonably make different decisions when epidemiology, demographics, health-system capacity, economic circumstances and social preferences differ. International scientific cooperation should support those decisions rather than displace them.

Case Study: Testing, Infectiousness and the Limits of a Containment Strategy

Early in the COVID-19 pandemic, WHO advocated an active containment strategy based on identifying suspected cases, testing, isolation and contact tracing. On 16 March 2020, the Director-General summarised the approach with the repeated instruction: "test, test, test", recommending that every suspected case be tested and confirmed cases isolated. [47]

WHO recommended nucleic-acid amplification tests, principally RT-PCR, for laboratory confirmation of SARS-CoV-2 infection. [48] PCR is highly sensitive for detecting targeted viral RNA sequences. However, detection of viral RNA does not imply the presence of replication-competent virus or that an individual is infectious.

A systematic review by Jefferson and colleagues examining RT-PCR alongside viral culture concluded that RT-PCR detection alone could not distinguish infectious virus from non-infectious RNA. That interpretation should consider factors such as the time from symptom onset and cycle-threshold values. [49] Viral culture, although considerably less practical for routine diagnosis, provides more direct evidence of replication-competent virus.

WHO itself subsequently cautioned that weak positive PCR results required careful interpretation. In January 2021, it reminded laboratories that the cycle threshold is inversely related to viral load, that declining disease prevalence increases the risk that positive results may be false positives, and that test results should be interpreted alongside clinical presentation, patient history, and epidemiological information.

The institutional lesson extends beyond PCR. A test can be technically appropriate for detecting a

[47] WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 — 16 March 2020. WHO. https://www.who.int/news-room/speeches/item/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---16-march-2020

[48] World Health Organization. Laboratory Testing for Coronavirus Disease (COVID-19) in Suspected Human Cases: Interim Guidance. 19 March 2020. WHO/COVID-19/laboratory/2020.5. https://www.who.int/publications-detail-redirect/10665-331501

[49] Jefferson T, Spencer EA, Brassey J, Heneghan C. Viral Cultures for Coronavirus Disease 2019 Infectivity Assessment: A Systematic Review. Clinical Infectious Diseases. 2021;73(11):e3884–e3899. doi:10.1093/cid/ciaa1764.

pathogen without answering every question required for public-health policy.

Detection of viral RNA, diagnosis of disease and demonstration of infectiousness are related but distinct questions. Where testing is used to justify isolation, contact tracing, or population-level restrictions, scientific institutions should explicitly state what the test measures, what it does not establish, and how results should be interpreted in their clinical and epidemiological contexts.

After an emergency, major recommendations should be independently evaluated against what subsequently occurred. This should include whether:

- Forecasts were accurate;
- Recommended interventions achieved their intended outcomes;
- Harms were adequately anticipated;
- Evidence was represented accurately;
- Conflicts of interest were properly managed;
- Dissenting evidence was considered; and
- Institutional mistakes were acknowledged and corrected.

The purpose should not be retrospective blame; it should be institutional learning. An organisation that cannot examine its own failures cannot reliably improve before the next emergency.

The Central Institutional Lesson from the COVID pandemic

COVID-19 demonstrated that international health cooperation is necessary, but it also demonstrated that cooperation alone is insufficient. The quality of cooperation depends upon the institutional arrangements through which evidence is obtained, evaluated and communicated. A credible international health institution therefore requires:

- Rapid international surveillance;
- Transparent access to evidence;
- Explicit reporting of missing information;
- Rigorous evidence assessment;
- Visible uncertainty;
- Publication of scientific disagreement;
- Independent conflict-of-interest management;
- Assessment of benefits and harms;
- Clear separation between scientific advice and political decision-making; and
- Retrospective evaluation of major recommendations.

These principles lead to a broader conclusion: The authority of an international health institution should derive primarily from the quality and transparency of its scientific processes rather than from its ability to direct national policy. The experience of COVID-19 provides both the strongest argument for international health cooperation and one of the strongest arguments for reconsidering how that cooperation should be institutionally organised.

A credible international health institution therefore requires:



1.8 Implications for Future International Health Cooperation

The preceding assessment demonstrates that international health cooperation remains a necessary function for international health. Infectious diseases cross borders; scientific information sometimes requires rapid sharing; and surveillance, laboratory networks, and early-warning systems can deliver benefits that individual states cannot achieve acting independently. The central question is therefore how cooperation should be organised.

The experience of WHO, and particularly the lessons of COVID-19, identifies several principles that should inform any future institutional model.

1. International Functions Should Be Clearly Defined

International institutions should concentrate on problems that genuinely require international coordination. Activities should have a demonstrable cross-border purpose and should not be undertaken internationally where they can be performed effectively by individual states. This reflects the principle of subsidiarity: responsibility should remain at the lowest effective level.

2. Scientific Advice Should Be Independent and Separated from Political Authority

An international health institution should collect evidence, coordinate surveillance, assess risks and provide technical advice. National governments should remain responsible for decisions involving legislation, restrictions, expenditure and competing social priorities. Scientific evidence can inform such decisions. It cannot determine the political and ethical trade-offs inherent within them.

Funding, political pressure and conflicts of interest can create actual or perceived threats to independence. Safeguards should therefore be structural rather than discretionary. Any funding arrangements should minimise dependence upon interested non-state actors; expert conflicts should be publicly disclosed and independently managed; and Member States should not be able to determine scientific conclusions through political processes.

3. Evidence and Uncertainty Should Be Transparent

The COVID-19 experience demonstrated the risks of making high-consequence decisions based on incomplete evidence, observational estimates, modelling assumptions, or rapidly changing scientific knowledge. International scientific assessments should therefore identify:

- What is known
- What remains uncertain
- What evidence is missing
- What study designs support the conclusions
- Where significant scientific disagreement exists
- What new evidence could change the assessment.

Authority should derive from the transparency and quality of the scientific process rather than institutional status.

4. Recommendations Should Be Advisory

International scientific recommendations should clearly state their evidential basis and degree of certainty but should not acquire authority merely because they originate from an international institution. There should be no automatic progression from international scientific assessment to an international recommendation for domestic obligation. Sovereign governments should, therefore, retain responsibility and accountability for domestic health policy.

Future international health cooperation should also recognise the distinction between population-level scientific advice and decisions affecting individual persons. Scientific institutions may assess the benefits and harms of medical interventions, but their international scientific authority should not extend to compelling their use. Bodily autonomy, informed consent and established principles of medical ethics should therefore remain explicit boundaries around international health authority.

5. Subsidiarity and Sovereignty

This approach embodies subsidiarity in both directions: centralising scientific tasks where collaboration yields clear efficiencies or quality improvements, while decentralising decision-making when national circumstances and accountability are at play. Future corporations must clearly differentiate between international scientific cooperation and national political authority.

6. Institutions Must Be Capable of Learning

Major recommendations made during emergencies should subsequently be evaluated against observed outcomes. Errors should be acknowledged, assumptions revisited, and guidance corrected where necessary. Scientific disagreement should be preserved within the institutional record rather than retrospectively obscured by consensus. Accountability should therefore be understood as a mechanism for institutional learning rather than institutional punishment.

These principles point towards a narrower but potentially more credible model of international health cooperation that seeks influence through competence rather than authority, transparency rather than assertion, and service rather than direction.

Its principal functions would be targeted to where international coordination provides clear added value requested by Member States. Its legitimacy would depend not on the accumulation of international power but on the reliability of the services it provides. This leads directly to the institutional alternative examined in the remainder of this report: the International Health Council.

The proposed IHC begins from a simple constitutional principle: **International cooperation should be strongest where cooperation is necessary, and international authority should stop where national responsibility can operate effectively.**



Part I

2. Why WHO Reform May Not Be Sufficient

2.1 History of Governance Reform - Reform of the WHO Organisation

For several decades, WHO and its Member States have recognised weaknesses in financing, governance, priority-setting, organisational efficiency, emergency preparedness, and the relationship between WHO's constitutional responsibilities and the resources available to fulfil them. The main issue in international cooperation is whether successive reforms have addressed the underlying structural problems or primarily modified how those problems are managed.

Repeated Reform

By the 1990s, concerns had developed about WHO's effectiveness, leadership and increasingly fragmented programme structure. The growth of voluntary and earmarked funding had contributed to a proliferation of programmes whose resources did not necessarily correspond with priorities determined collectively by Member States.

The election of Gro Harlem Brundtland as Director-General in 1998 initiated a substantial organisational reform programme intended to strengthen WHO's strategic direction, improve management and reposition the organisation within an increasingly complex global health system. [50] Reorganisation of consolidated programmes strengthened central management and sought greater coherence across the WHO.

The goal of reform was to create health systems that can:

- Improve health status;
- Reduce health inequalities;
- Enhance responsiveness to legitimate expectations;
- Increase efficiency;
- Protect individuals, families and communities from financial loss;
- Enhance fairness in the financing and delivery of health care.

Noteworthy was the recognition that governments should retain responsibility for setting broad policy directions, creating an appropriate regulatory environment, and providing finance. However, organisational restructuring did not resolve the underlying financing problem. Voluntary contributions continued to grow in importance, while WHO increasingly operated alongside new global-health organisations, public-private partnerships and philanthropic funders.

[50] World Health Organization. The World Health Report 1999: Making a Difference. WHO; 1999. https://iris.who.int/bitstream/handle/10665/42167/WHR_1999.pdf?sequence=1

Reform After the Financial Crisis

A further major reform process followed WHO's financial difficulties after the 2008 global financial crisis. In 2010–2011, Member States initiated a broad programme of reform covering three areas: programmes and priority setting; governance; and management. [51]

The reform programme sought greater predictability of financing, clearer priority setting, improved accountability and more effective governance. WHO subsequently introduced measures, including programme-budget reforms, financing dialogues with donors, improved evaluation arrangements, and greater transparency regarding organisational expenditure. Yet the underlying distinction between collective priority-setting and donor-directed financing persisted.

Member States could collectively approve WHO's programme, while contributors retained substantial discretion over the activities for which voluntary resources would be made available. As demonstrated in Section 1.4, this remains a significant feature of WHO financing.

Ebola and Emergency Reform

The 2014–2016 West African Ebola epidemic generated another major reform cycle. WHO faced substantial criticism for the speed and effectiveness of its response. The independent Ebola Interim Assessment Panel concluded that the crisis had exposed significant weaknesses in WHO's capacity, organisational culture and emergency response arrangements. [52]

The response led to further institutional reform: WHO established the Health Emergencies Programme in 2016, creating a dedicated operational structure intended to integrate outbreak and humanitarian emergency functions across the organisation. [58] [53] This represented a significant attempt to correct identifiable operational weaknesses.

Nevertheless, COVID-19 demonstrated that emergency preparedness depended on more than WHO's internal structure. International warning systems could identify threats, but effective response still depended on national governments providing information, maintaining preparedness, and acting on warnings—institutional reform within WHO could improve operational capability without eliminating weaknesses arising from the wider international system.

Transformation Under the Thirteenth General Programme of Work

Following the election of Tedros Adhanom Ghebreyesus as Director-General in 2017, WHO initiated another substantial transformation programme. The reforms sought to make WHO more effective, efficient and results-focused, built around the objectives of the Thirteenth General Programme of Work (GPW13) and its “triple billion” targets: one billion more people benefiting from universal

[51] World Health Organization. The World Health Report 1999: Making a Difference. WHO; 1999. https://iris.who.int/bitstream/handle/10665/42167/WHR_1999.pdf?sequence=1
[52] World Health Organization. Report of the Ebola Interim Assessment Panel. July 2015. https://www.who.int/publications/m/item/report-of-the-ebola-interim-assessment-panel---july-2015
[53] World Health Organization. Reform of WHO's Work in Health Emergency Management: WHO Health Emergencies Programme. WHA69.10. 2016. https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_R10-en.pdf

health coverage, one billion better protected from health emergencies and one billion enjoying better health and well-being. [54]

Changes included a new operating model, organisational restructuring, increased emphasis on measurable outcomes, digital transformation and efforts to align headquarters, regional and country operations. Again, these reforms addressed important issues of management and organisational performance; however, they did not fundamentally alter WHO's broad constitutional mandate or its dependence upon voluntary financing.

COVID-19 and Another Reform Cycle

COVID-19 generated a further wave of reviews and institutional reform. The Independent Panel for Pandemic Preparedness and Response concluded in 2021 that the global system had been inadequately prepared and called for major changes to global pandemic preparedness and response. [55]

Subsequent reforms have included amendments to the International Health Regulations, adopted in 2024, and negotiation and adoption of the WHO Pandemic Agreement in May 2025. [18, 56] These changes aimed to strengthen global pandemic prevention, surveillance, and response, addressing major systemic gaps exposed during the COVID-19 pandemic.

WHO's financing arrangements have also entered another reform cycle. Member States agreed to progressively increase assessed contributions to finance half of WHO's approved base budget by 2030–2031, while the organisation's Investment Round seeks broader, more predictable and flexible voluntary financing from a board group of donors. [57]

These changes were meant to address genuine weaknesses identified during COVID-19. However, they also illustrate a recurring institutional pattern: when weaknesses emerge, the usual response is to expand, strengthen or modify the existing institution rather than reconsider the assumptions underlying its design.

Case Study: Ebola, COVID-19 and the Limits of Successive Reform

Following criticism of WHO's response, an independent Ebola Interim Assessment Panel concluded that the organisation lacked the capacity or organisational culture necessary to deliver a full emergency public health response. The review identified weaknesses in leadership, decision-making, financing and coordination across different levels of WHO. [52]

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[54] World Health Organization. Thirteenth General Programme of Work 2019–2023. WHO. https://www.who.int/about/general-programme-of-work/thirteenth

[55] Independent Panel for Pandemic Preparedness and Response. COVID-19: Make It the Last Pandemic. May 2021. https://theindependentpanel.org/mainreport/

[56] World Health Organization. International Health Regulations: Amendments Adopted at the Seventy-seventh World Health Assembly. June 2024. https://www.who.int/news/item/01-06-2024-seventy-seventh-world-health-assembly---daily-update--1-june-2024

[57] Sustainable Financing. WHO. https://www.who.int/about/funding/invest-in-who/investment-round

WHO responded with substantial reform, including establishment of the WHO Health Emergencies Programme in 2016, intended to create a more integrated and operationally capable emergency structure. [58]

COVID-19 represented a major real-world test of the post-Ebola reforms.

In 2021, the Independent Panel for Pandemic Preparedness and Response again identified substantial weaknesses in the global system and WHO's governance. It concluded that the Executive Board had failed to perform effectively as an executive body and recommended further reforms including greater WHO financial independence, increased unearmarked Member-State financing, stronger Executive Board governance, greater independence for the Director-General and depoliticisation of senior appointments. [55]

The sequence is institutionally significant: Ebola exposed weaknesses; WHO underwent major reform, then COVID-19 exposed further governance weaknesses and another programme of reform followed.

So, if successive crises repeatedly produce recommendations concerning financing, independence, governance, authority and accountability, the problem may extend beyond individual management failures. The history of Ebola and COVID-19 suggests that evaluating WHO reform requires asking not simply whether reforms were implemented, but whether the institutional structures that produced recurrent weaknesses were themselves changed, or whether they merely created further cycles that did not address the underlying weaknesses in the organisation.

Reform Versus Institutional Design

The history of WHO reform reveals substantial capacity for organisational adaptation. WHO has changed its management structures, emergency arrangements, financing mechanisms, programme priorities, accountability systems and international legal frameworks on several occasions.

Some reforms have produced meaningful improvements. The difficulty is that the problems identified decades ago remain recognisable today:

- Dependence upon voluntary and earmarked financing;
- Uneven alignment between resources and collectively agreed priorities;
- A broad and expanding institutional mandate;
- Political dependence upon Member States;
- Difficulties obtaining information from sovereign governments;
- Tensions between scientific and political functions; and
- Recurring concerns about transparency, accountability and institutional independence.

This persistence raises a critical distinction between management failure and structural failure. Management problems can potentially be corrected through better leadership, procedures, staffing and oversight, whereas structural problems arise from the constitutional and financial arrangements within which the organisation operates.

[58] WHO Health Emergencies Programme. WHO Regional Office for Africa. https://www.afro.who.int/about-us/programmes-clusters/who-health-emergencies-programme

If an institution's mandate is exceptionally broad, its financing depends heavily on voluntary contributors, its scientific work depends on information controlled by Member States, and its governing body simultaneously performs political and health-policy functions, improvements in management may reduce, but cannot necessarily eliminate, the resulting tensions.

The history of reform leads to the central question for Part 2: Are WHO's principal weaknesses failures of implementation that can be corrected through further reform, or are they consequences of the institution's underlying design?

2.2 Assessed versus Voluntary Funding

Section 1.4 highlights a significant weakness in the WHO's financing model: responsibility for establishing institutional priorities lies with Member States. In contrast, a considerable portion of the resources needed to implement those priorities has historically depended on voluntary, often earmarked, contributions.

Both WHO and its Member States acknowledge this problem. In 2022, the World Health Assembly agreed to progressively increase assessed contributions so that they would cover 50% of WHO's base budget by 2030–2031 at the latest. [59] WHO characterised the existing model as misaligned between organisational priorities and available funding, expressing concerns that excessive reliance on earmarked voluntary contributions could jeopardise the integrity and independence of its work.

This reform is significant; however, the question remains whether it goes far enough.

Increasing assessed contributions provides WHO with more predictable and flexible resources, which should diminish the imbalance mentioned in Section 1.4. This change aims to strengthen the link between the priorities agreed upon by Member States and the resources available to implement them. Nonetheless, the reform does not eliminate the mixed financing model.

WHO's goal is for assessed contributions to cover half of its base budget, meaning funding from other sources will still be necessary. To help secure this balance, WHO established its Investment Round, partially to mobilise broader, more predictable, and more flexible voluntary financing.

Reform aims to manage donor dependence more effectively rather than eliminate it. While earmarked voluntary financing creates a structural tension between collective governance and contributor preferences, reducing this dependence may alleviate some issues without fully resolving the underlying governance concerns.

Despite reform, the problem persists, and WHO's latest financial reports illustrate this limitation. At the end of the 2024–2025 biennium, WHO's base programme was approximately 96% financed. However, WHO reported that this seemingly strong overall position concealed ongoing structural difficulties, as specific voluntary contributions could not be readily redirected to underfunded priorities. In other words, the organisation can be nearly fully funded overall while still being unable to finance its agreed priorities evenly.

[59] World Health Organization. World Health Assembly Agrees Historic Decision to Sustainably Finance WHO. 24 May 2022.
https://www.who.int/news/item/24-05-2022-world-health-assembly-agrees-historic-decision-to-sustainably-finance-who

This issue is precisely what was identified in Section 1.4; the persistence of this problem during the financing-reform process suggests that the central issue lies not only in the amount of funding available but also in the conditions under which that funding is provided.

Can Voluntary Financing Be Made Sufficiently Flexible?

The WHO's reform strategy assumes that voluntary financing can be managed more effectively. The Investment Round aims to attract a broader donor base and to secure more predictable and flexible contributions, which could significantly enhance WHO's financial stability; however, voluntary financing remains just that—voluntary. Contributors retain the discretion to decide whether to participate, how much to provide, and, depending on the type of contribution, the specific purposes they are willing to support.

This situation creates an institutional tension: Member States collectively determine the organisation's priorities, while individual contributors can influence which parts of those priorities are most appealing for financing.

Given that an international organisation may have a limited set of functions deemed necessary by its Member States, should those functions be financed as part of the membership obligation? For the proposed International Health Council, the answer is yes.

Essential functions such as surveillance, early warning systems, evidence synthesis, laboratory coordination, and other core responsibilities would be funded collectively by Member States. The organisation would not shape its essential functions based on its ability to attract voluntary funding from external sources.

This approach would impose a necessary discipline on the institution. Member States would need to determine which international functions are genuinely required and what they are collectively willing to finance. This relationship effectively creates a natural constraint on institutional expansion.

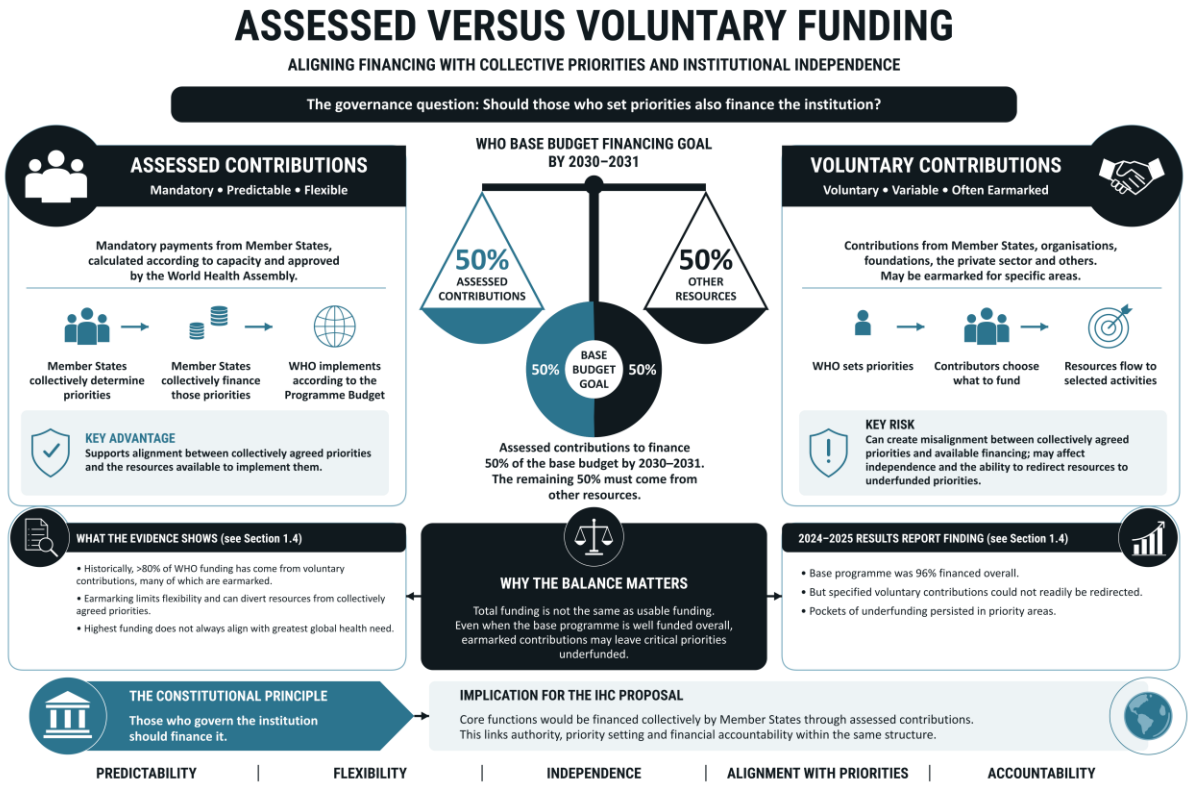
A new function could not simply develop just because external funding became available. Expansion would require Member States to agree that the activity falls within the institution's Treaty-defined remit and to accept the associated financial responsibility.

Why WHO Reform May Not Be Sufficient

WHO's sustainable-financing reforms address a real weakness and should increase financial independence. But they leave intact the fundamental architecture of assessed funding supplemented by substantial voluntary financing.

The central problem remains the tension between the independence of an international scientific institution and its structural dependence on voluntary financing for its core constitutional functions.

The IHC proposal takes a different approach: those who determine the institution's mandate should also bear responsibility for its financing, thereby linking authority, priority-setting, and financial accountability within a single constitutional structure.



2.3 Secretariat Incentives

Sections 1.2 and 1.3 demonstrate that the WHO operates under a broadly drafted constitution that encompasses coordination, technical assistance, research, standard setting, recommendations, and international agreements. Over time, this has allowed the WHO's activities to expand across an increasingly wide range of health and health-related policy areas.

The key concern for reform is whether management reform can effectively constrain institutional expansion, given that the constitutional mandate itself provides few clear boundaries on what the organisation may undertake.

WHO's Member States exercise its principal governance functions. Through the World Health Assembly, they determine policy, approve the programme budget, and appoint the Director-General. The Secretariat, led by the Director-General, provides the technical and administrative capacity needed to implement these decisions. This dynamic inevitably creates the principal-agent problem.

Member States cannot continuously supervise every technical assessment, programme, partnership, or operational decision. Therefore, they delegate significant responsibility to a permanent specialist bureaucracy that possesses greater technical knowledge and institutional information than the collectively overseeing governments. Such discretion is essential for WHO to function effectively. Still, it also matters when the organisation's mandate is broad, as the Secretariat needs to continually interpret what broad constitutional objectives mean in practice.

As Section 1.3 illustrates, developments in public health thinking have increasingly connected health with behavioural, environmental, social, and economic determinants. Within WHO's existing

constitutional framework, many such activities can plausibly be characterised as contributing to health.

This creates a significant asymmetry: there may be strong institutional reasons to initiate a new health-related activity, but relatively weak constitutional criteria for determining when WHO should refrain from undertaking one. Once programmes are established, they generate expertise, staffing, partnerships, budgets, and organisational capacity, leading to an embedded existence within the institution, regardless of individual motivations. The issue is one of institutional accumulation, not personal intent.

The Experience of "One WHO"

WHO's reform history highlights this challenge. The reforms initiated by Director-General Gro Harlem Brundtland in 1998 aimed to create greater coherence across the organisation under the concept of "One WHO." However, Tine Hanrieder's institutional analysis concluded that the reform did not reverse WHO's fragmentation. Attempts to centralise budgets and strengthen corporate control encountered established organisational structures, while new disease-specific programmes and layers continued to develop alongside them.

Restructuring the organisation proved easier than reversing the already established structures and programmes. This helps explain why repeated management reforms can change how WHO operates without necessarily establishing durable limits on what the organisation does.

Management Reform Versus Treaty-based restraint

Management reform can enhance efficiency, coordination, reporting, and accountability. However, it cannot easily provide an objective test for determining whether a proposed activity belongs within the institution. That requires a different mechanism: Treaty-based restraint.

The IHC proposal reverses the institutional presumption. Instead of permitting activities merely because they can reasonably be connected to health, the IHC would exercise only functions expressly conferred upon it by its Treaty.

A stronger institutional constraint would require WHO to demonstrate that an activity falls within a clearly defined international purpose, provides demonstrable added value at the international level and satisfies subsidiarity. Such a framework would require the organisation to justify not only why international involvement is warranted, but also why the proposed level of involvement is necessary

This approach does not eliminate administrative discretion, as it confines that discretion within Treaty-defined boundaries.

The distinction ultimately lies between attempting to restrain an institution through better management and restricting it through institutional design. WHO's broad constitutional mandate means that successive Secretariats can legitimately interpret the organisation's responsibilities differently as concepts of health and public health evolve. Management reform cannot resolve that ambiguity because it originates at a level above management. If Member States seek an international health institution with a deliberately limited remit, they must consider these foundational issues carefully.

2.4 Political Dependence

Can WHO be made scientifically independent of political pressure when Member States are simultaneously its governors, funders, information providers and subjects of its assessments?

The WHO is an intergovernmental organisation: the World Health Assembly, made up of Member States, determines its policies, appoints the Director-General, oversees financial policies, and approves the programme budget. [66] [60] This structure provides democratic legitimacy among the Member States. Governments that fund and participate in the WHO hold formal authority over the institution they established; however, this also creates an unavoidable tension in the discussion.

WHO is expected to deliver objective scientific assessments while remaining accountable to governments whose actions may be under scrutiny. For instance, during an outbreak, WHO may require information from a member state while concurrently assessing the adequacy of that state's response. In politically sensitive investigations, WHO may rely on the cooperation of governments whose transparency is problematic. This situation is not necessarily political interference, but it creates a structural dependence on political considerations.

The Director-General is WHO's chief technical and administrative officer but is nominated through the Executive Board and appointed by Member States through the WHA [67] [61] As a consequence, political accountability is embedded in the appointment process.

Following the COVID-19 pandemic, the Independent Panel for Pandemic Preparedness and Response recommended strengthening the Director-General's independence by replacing the renewable five-year appointment with a single seven-year term and making similar reforms for Regional Directors. The current Director began his second term on 16 August 2022, which will conclude on 15 August 2027. The current election process began in April 2026 when the Director-General invited Member States to submit candidatures for the post of Director-General.

Governance Reform Recognises the Problem

The Independent Panel's recommendations went further, concluding that the Executive Board had failed to perform effectively as an executive body during COVID-19, and recommended stronger governance capacity, greater WHO financial independence, and the depoliticisation of recruitment, particularly at senior levels. [68] [62]

These recommendations are relevant because they identify political independence not as an external criticism of the WHO but as a recognised institutional design problem. WHO itself rejects claims that Member States improperly determine its scientific conclusions. In 2025, the Director-

[60] World Health Assembly. WHO.
https://www.who.int/about/governance/world-health-assembly
[61] World Health Organization. Election of the WHO Director-General. Updated 30 April 2026.
https://www.who.int/about/governance/election-of-the-who-director-general
[62] Independent Panel for Pandemic Preparedness and Response. COVID-19: Make It the Last Pandemic — The Independent Panel's Recommendations. 2021.
https://recommendations.theindependentpanel.org/main-report/05-the-independent-panel/

General stated that WHO is impartial and that when governments request actions unsupported by scientific evidence, the organisation refuses, “politely”. [69] [63]

In response to the loss of US funding, the WHO is conducting a strategic alignment of resources with activities; freezing recruitment, except in the most critical areas, and significantly reducing travel expenditure.

Case Study: WHO Independence, Sovereignty and the 2025 Political Debate

WHO's political independence became a prominent issue during the 2025 World Health Assembly and the adoption of the WHO Pandemic Agreement.

On 30 May 2025, Director-General Tedros Adhanom Ghebreyesus publicly addressed claims that the Agreement transferred national decision-making powers to WHO. He emphasised that WHO makes recommendations based on scientific evidence, while sovereign states retain responsibility for deciding whether and how those recommendations are implemented. [70] [64]

The intervention occurred against a wider challenge to confidence in WHO's political independence. In January 2025, the United States announced its intention to withdraw from the organisation. The White House cited several reasons, including what it described as WHO's failure to demonstrate independence from inappropriate political influence by Member States. [40]

WHO rejected such allegations and continued to emphasise its impartiality and technical independence.

The relationship among WHO's technical authority, Member States' political control, and national sovereignty had become sufficiently contested that the Director-General considered it necessary to publicly clarify the limits of WHO's authority while a major Member State was simultaneously seeking withdrawal, in part on grounds of political independence.

“Let me be clear once again: the Pandemic Agreement will not infringe on national sovereignty, period. And the Pandemic Agreement does not give WHO any powers, period,” Dr Tedros said. “WHO’s job is to make recommendations to governments, but what governments do with those recommendations is entirely up to them. WHO is not even a party to the Agreement. This is an agreement between sovereign nations, and it will be ratified and implemented by sovereign nations that choose to do so. The intentional distortion of the Pandemic Agreement as ceding power to WHO must stop.”

This suggests that independence cannot depend solely upon institutional assurances. The respective roles of Member States, governing bodies, and scientific processes should be clearly separated and transparent, enabling independence to be demonstrated through institutional design.

[63] World Health Organization. WHO Director-General's Opening Remarks at the 156th Session of the Executive Board. 3 February 2025. https://www.who.int/news-room/speeches/item/who-director-general-s-opening-remarks-at-the-156th-session-of-the-executive-board-3-february-2025

[64] World Health Organization. WHO Director-General: Member States Reaffirm Commitment to WHO and Global Health at Historic World Health Assembly. 30 May 2025. https://www.who.int/news/item/30-05-2025-who-director-general--member-states-reaffirm-commitment-to-who-and-global-health-at-historic-world-health-assembly

A single non-renewable term as Director-General could reduce incentives associated with re-election. Merit-based senior appointments could limit political bargaining. Greater financial independence could reduce leverage associated with funding. But none changes the fundamental character of WHO as an intergovernmental organisation.

Nor should reform attempt to remove Member-State control entirely. An international organisation exercising functions on behalf of sovereign governments requires political accountability. The challenge is to distinguish legitimate Member-State governance from inappropriate influence over scientific processes.

That boundary is difficult to maintain when political and scientific functions operate within the same institutional structure. The continuing investigation into the origins of SARS-CoV-2 illustrates the limitation. WHO's independent scientific advisory group reported in 2025 that essential information required to evaluate competing hypotheses remained unavailable, and WHO continued to publicly request further information from China. [35] However, internal WHO governance reform cannot guarantee access to evidence controlled by a sovereign state.

Why Reform May Be Insufficient

The issue isn't simply that the WHO needs to become “less political.” Politics is an inherent aspect of an organisation governed by 194 sovereign states. Instead, can political governance be separated more clearly from scientific judgment?

The IHC model would allow Member States to maintain control over the institution's constitution, budget, appointments, and authorised functions. However, Member States would not influence scientific findings through resolutions or political negotiations.

In such a model, scientific assessments would follow predefined methods, publish the evidence considered, identify missing information, disclose uncertainties, and preserve significant dissenting opinions. If a government withheld relevant evidence, the institution would report that fact rather than negotiate the scientific conclusion in light of that absence.

The goal is to ensure the independence of scientific judgment within an institution that they still govern. Political dependence must be limited by the institution's design: governments should oversee the institution, but scientific conclusions should be based on evidence.

2.5 Risks of Donor Capture

Section 1.4 established that WHO has historically depended heavily upon voluntary contributions and that much of this funding has been earmarked. Section 2.2 showed that current reforms seek to reduce this dependence through higher assessed contributions and more flexible voluntary financing. However, these reforms do not adequately address the risk of donor capture and raise concerns about donor influence.

Donor dependence exists when an institution requires substantial resources from voluntary contributors.

Donor influence can arise when contributors determine which programmes or activities their funding supports.

Donor capture is a stronger proposition: institutional priorities, decisions or outputs become systematically aligned with donor interests rather than the purposes established through the organisation's legitimate governance processes.

The principal institutional risk is more subtle than a donor instructing WHO to reach a particular conclusion. WHO reports that voluntary contributions account for more than three-quarters of its financing and that 87% of voluntary contributions in 2022–2023 were specified, meaning they were tightly earmarked to particular purposes, and must be spent within a specified timeframe. [5]

Iwunna, Kennedy and Harmer argue that this structure can divert resources from WHO's strategic priorities, complicate organisational coherence, weaken the practical authority of its democratic structures and give a relatively small group of wealthy contributor's disproportionate influence. [24]

Influence can occur through agenda-setting, which attracts external funding to recruit staff, commission research, develop partnerships, and expand institutional expertise. An equally influential programme that attracts little funding may struggle to do the same. No donor needs to interfere with a scientific committee for this imbalance to occur.

The Kennedy and Thakrar analysis discussed in Section 1.4 illustrates the problem. For 640 Gates Foundation grants to WHO, worth approximately US$5.5 billion between 2000 and 2024, more than 80% was directed towards infectious diseases, almost 60% towards polio, and more than half towards vaccine-related programmes and projects. [31]

The study demonstrates something narrower but institutionally significant: a major voluntary contributor can concentrate substantial resources within selected areas of WHO activity. The question is whether WHO's collectively agreed priorities can remain fully determinative when individual contributors retain substantial capacity to determine where additional resources are concentrated.

Can Governance Safeguards Solve the Problem?

The WHO has implemented safeguards to manage the risks associated with its funding, including transparency requirements, financing reforms, and regulations governing engagement with non-state actors.

Increased transparency is intended to allow for scrutiny of funding relationships, while a rise in assessed contributions should enhance WHO's financial independence. More flexible voluntary contributions aim to limit donors' ability to dictate how resources are used. However, these safeguards mainly address the consequences of relying on voluntary funding and do not eliminate the fundamental issue. If the WHO depends significantly on voluntary resources, it has an institutional incentive to maintain relationships with organisations that can provide these funds. Furthermore, if contributors can specify or influence the intended uses of their donations, financial preferences can affect the organisation's capacity, even without any improper interference.

Why WHO Reform is Insufficient

The relevant standard for an international scientific institution should extend beyond simply demonstrating that a donor has not directly influenced a specific recommendation. The institution's scientific authority also relies on its credible independence.

An organisation that formulates international standards and scientific recommendations must minimise any arrangements that could reasonably lead to doubts about whether financial relationships affect its priorities. The WHO's current reforms aim to reduce this risk while still relying heavily on voluntary financing. In fact, WHO's sustainable financing model proposes that assessed contributions will ultimately cover half of its base budget, with the remaining funding sourced through other mechanisms. [57]

In contrast, the IHC proposal adopts a different approach. Its Treaty-defined functions would be funded exclusively by Member States. While commercial entities, philanthropic foundations, NGOs, and professional organisations may provide evidence and technical information, they would not be permitted to finance the institution or its work.

Although this structure does not guarantee complete scientific independence, it would help eliminate one clear pathway through which external interests could influence the institution's capacity and priorities. Nonetheless, challenges such as political influence, intellectual conflicts, and methodological bias would still necessitate separate safeguards.

The guiding principle here is precautionary: an international scientific institution shouldn't just manage financial conflicts when they occur; rather, its constitutional design should, where feasible, prevent such conflicts from arising in the first place.

2.6 Mission Creep and Constitutional Constraints

Sections 1.2 and 1.3 established two key points: First, the Constitution of the WHO was broad from the beginning, authorising international coordination, technical assistance, research, standard setting, recommendations, and international agreements. Second, WHO's activities have since expanded to cover an increasingly wide range of health, behavioural, environmental, social, and regulatory issues. However, the Constitution did not provide sufficiently clear boundaries to prevent the ongoing expansion of the organisation's mandate.

The WHO has a constitutional objective to achieve the highest possible level of health for all people. Its functions, as outlined in Article 2, are quite broad. This creates a challenge, as nearly every significant area of government policy can potentially influence health. These areas include housing, education, taxation, employment, transport, energy, agriculture, environment, and individual behaviour. If establishing a connection to health is enough to justify the involvement of international institutions, it becomes unclear where the WHO should draw the line in its activities.

Therefore, the issue may not be about the WHO expanding its mission beyond what is constitutionally allowed; rather, it may involve an expansion of its mission that the Constitution permits.

Case Study: International Legal Authority and the Framework Convention on Tobacco Control

WHO's constitutional powers illustrate how a broad health mandate can develop into international legal authority.

Article 19 of the WHO Constitution permits the World Health Assembly to adopt conventions or agreements concerning "any matter within the competence of the Organisation", subject to acceptance by Member States through their respective constitutional processes. Article 21 separately allows the Health Assembly to adopt regulations in specified areas, including measures intended to prevent the international spread of disease. [1]

These are significant powers because the scope of WHO's "competence" is itself defined by an exceptionally broad constitutional health mandate.

The WHO Framework Convention on Tobacco Control (FCTC) demonstrates how this authority can operate. Adopted in 2003 and entering into force in 2005, it was the first global treaty negotiated under WHO auspices. [11]

The Convention extends beyond scientific assessment of the health effects of tobacco. It establishes a global framework addressing measures such as taxation, advertising and sponsorship, product packaging and labelling, exposure to tobacco smoke, and illicit trade—areas implemented primarily through domestic legislation and public policy. [11]

The constitutional matter is more fundamental than whether tobacco use causes harm: What makes a health problem sufficiently global to justify a global policy instrument rather than national action informed by international scientific evidence?

WHO's Constitution provides no general subsidiarity test requiring international necessity to be demonstrated before such activity is undertaken.

The FCTC illustrates the distinction between constitutional legality and constitutional restraint. An activity may legitimately fall within WHO's broadly defined competence while still raising the institutional-design issue of where international health authority should end, and sovereign domestic policymaking should begin.

Governance reform can enhance oversight of the WHO's functions. Member States can demand greater transparency, improve programme evaluation, strengthen scrutiny from the Executive Board, and modify financing arrangements. However, none of these reforms directly address the fundamental question of whether the organisation engages in this activity at all.

Governance mechanisms typically assess whether programmes are authorised, funded, and effectively delivered. They do not impose a substantive constitutional requirement on the WHO to explain why a specific activity should be conducted at the global rather than the national level. As a result, there exists an institutional tendency to favour the possibility of taking action. If an activity can be reasonably linked to WHO's broad health mandate and is supported by Member States, the organisation's Constitution allows for considerable latitude in pursuing it.

2.7 Structural versus Managerial Failure

The preceding sections highlight an important distinction in evaluating reform within the WHO: Some failures can be categorised as managerial, while others are structural.

Managerial failures occur when an institution fails to carry out its established functions effectively. These can include ineffective leadership, poor coordination, inadequate staffing, weak communication, inefficient procedures, or implementation failures. Such issues can potentially be addressed through conventional reform measures, including improved leadership, clearer responsibilities, enhanced management systems, stronger auditing, and increased accountability.

However, structural problems stem from the rules, incentives, and constitutional arrangements governing the organisation. The history of WHO reform indicates that it is crucial to differentiate between these two types of failure.

What Management Reform Can Achieve

The WHO has undergone several reorganisations to improve its programmes, enhance emergency response capabilities, establish new accountability mechanisms, revise financing arrangements, improve reporting, and continuously adjust its governance structures.

For instance, the establishment of the Health Emergencies Programme after the Ebola outbreak addressed specific weaknesses in WHO's operational capacity. Similarly, the current financing reforms aim to provide a larger share of predictable and flexible resources.

When issues arise from how a specific function is carried out, management reform can be a suitable solution. However, challenges arise when the problems stem from the organisation's structural framework itself.

Problems That Recur Across Reform Cycles

Sections 2.2 to 2.6 highlight that the WHO financing reforms increase assessed contributions while still relying heavily on voluntary financing. Although reforms in the Secretariat can enhance management, they cannot establish constitutional boundaries that are absent from the organisation's founding mandate. Changes to the appointment process may reduce political incentives, but they cannot eliminate WHO’s reliance on Member States for governance, funding, information, and access. While conflict-of-interest rules can help manage relationships with donors, they cannot entirely remove the influence that arises from continued financial dependence on voluntary contributors. Enhanced oversight can examine the expansion of missions, but it does not create a general constitutional requirement for the WHO to justify why certain activities should be undertaken at the global level. These limitations are inherent to the design of the institution.

This situation can be referred to as a reform paradox: When weaknesses in an institution become apparent, additional mechanisms are often established to address them. These can include new committees, reporting requirements, financing methods, programmes, review processes, and governance structures. While each of these may address a legitimate concern, the overall effect can be increased complexity without addressing the root causes of the initial weaknesses.

As a result, an organisation may be governed more extensively without having clearer constitutional constraints. In other words, more governance does not necessarily lead to clearer limitations.

A Test for Structural Failure

A useful way to distinguish between managerial and structural problems is to ask: Would this problem still exist even if the organisation were exceptionally well managed? If the answer is no, the problem is likely managerial. If the answer is yes, then the institutional design needs to be examined.

Even with excellent management, issues such as voluntary contributors earmarking resources, Member States withholding information, governmental participation in WHO governance, and the WHO's broad constitutional mandate, which allows for extensive interpretation, could persist. Additionally, programmes might still develop based on available funding and institutional priorities, and the coexistence of scientific and political functions within the same organisation would continue.

Good leadership can mitigate these problems, but it cannot eliminate their underlying causes. Reforming the institution or redesigning the rules does not imply that WHO is incapable of further reform. In principle, Member States could fundamentally redesign WHO's financing, constitutional mandate, governance, and scientific processes. However, at this point, the distinction between reform and institutional redesign becomes increasingly semantic.

If effective reform required narrowing the organisation's mandate, introducing a binding subsidiarity test, separating scientific assessments from political decision-making, prohibiting non-state financing, and defining expressly limited functions, the resulting institution would differ significantly from WHO's current structure.

The Case for Considering an Alternative

The argument presented in this report does not claim that the WHO’s challenges stem solely from poor leadership or administrative incompetence. Additionally, it does not suggest that every reform undertaken by WHO has failed. However, several recurring weaknesses arise from institutional arrangements that standard management reforms leave largely unchanged.

This differentiation alters the policy question. Rather than simply asking, “How can WHO be managed better?” governments should also consider, “What institutional design could minimise the recurrence of these issues in the first place?”

This serves as a bridge from diagnosing the problems to exploring potential institutional alternatives. The aim of discussing the International Health Council is not to imply that a new institution would be immune to failure—no institution can guarantee this. Rather, it is to examine whether implementing clearer Treaty limits, more focused functions, member-state financing, scientific independence, and subsidiarity reduces the likelihood of specific types of institutional failures by design, rather than relying on repeated attempts at correction through reform.

2.8 Why an Alternative Institutional Model Should Be Considered

The preceding analysis establishes several recurring weaknesses of the WHO that arise not simply from how the organisation is managed, but from the institutional architecture within which it operates. WHO has undergone repeated reform; emergency structures have been reorganised, financing arrangements have been revised, governance mechanisms have been strengthened, and accountability systems have been expanded. Further reforms are ongoing.

Yet the underlying tensions identified in this report remain clearly recognisable.

WHO continues to operate under an exceptionally broad constitutional mandate. It remains politically governed by Member States while expected to provide independent scientific judgement. Its core programmes continue to depend substantially upon voluntary financing. Its ability to investigate international health threats depends upon information and access controlled by sovereign governments. And its scientific, normative, advisory and political functions coexist within the same institutional structure.

Replacing or significantly redesigning an established global institution requires a strong justification. The WHO has extensive expertise, established surveillance networks, relationships with national governments, technical infrastructure, and decades of institutional knowledge. Creating an alternative would involve considerable costs, risks, and transitional challenges.

Consequently, the burden of proof lies with those proposing the change. Any alternative institution should show that its structure effectively addresses recurring problems that typical WHO reforms have failed to resolve.

Institutional Design Around Necessary Functions

The starting point should be the function rather than the institution. The key issue is which health functions genuinely require ongoing international cooperation.

Activities such as disease surveillance, early warning systems, laboratory coordination, evidence synthesis, and technical assistance are clear examples in which cooperation among states can yield benefits that individual nations cannot achieve on their own.

Other health decisions can primarily remain national. This distinction allows for a smaller international institution with a more clearly defined purpose.

Institutional design is pertinent because rules influence behaviour. An organisation with specifically limited functions has different incentives compared to one with an open-ended health mandate. An institution funded by its Member States has a different relationship with external donors compared to one reliant on voluntary contributions. An organisation focused solely on scientific and technical cooperation occupies a different position than one that combines scientific assessment, normative guidance, advocacy, and international policymaking.

These differences do not guarantee institutional success; however, they do affect the types of failures the institution is likely to encounter. This is the central reason for exploring an alternative model.

The limitations of successive WHO reform programmes become evident when considering their focus on management, financing, appointments, accountability, and procedures, while leaving the institution's constitutional scope largely unchanged. If the expansion of its mission occurs in part because the founding mandate allows a broad interpretation of its competencies, then managerial reform merely addresses symptoms of a more profound issue.

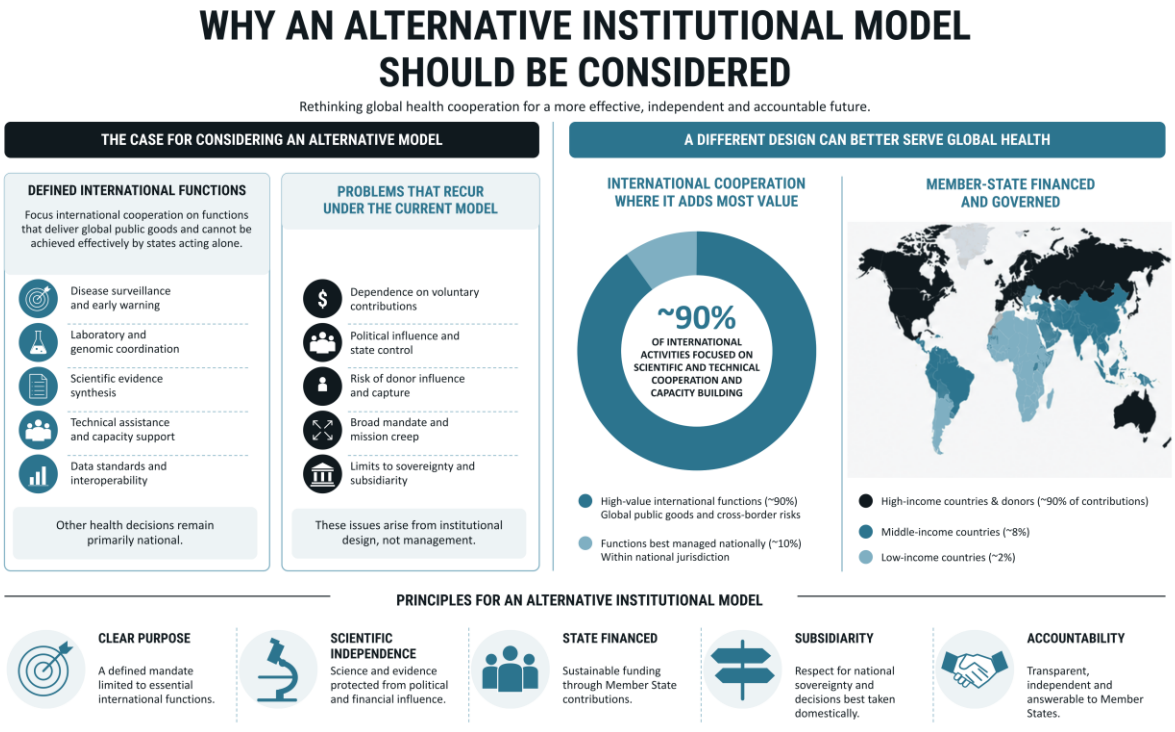
In contrast, the proposed IHC adopts a fundamentally different constitutional approach. The IHC would have only the functions explicitly granted to it by treaty, clarifying and justifying whether there is a compelling reason for a particular activity to be carried out at the international level. This

distinction offers something that governance reform alone cannot provide: a constitutional boundary that defines how the institution should operate and where its authority should end.

The choice should not be presented simply as WHO versus no international cooperation. There is a third possibility: Retain international cooperation while redesigning the institution through which it is delivered. Such an institution could preserve functions that clearly benefit from international coordination while establishing stronger boundaries around activities better determined nationally.

Its legitimacy would derive principally from the quality of its science, the transparency of its processes, and its usefulness to its Member States, rather than from an expanding international mandate. The option consists of maintaining international cooperation while redesigning the institution responsible for delivering it. This new institution could retain functions that clearly benefit from international coordination while establishing stronger boundaries around areas that are better managed at the national level.

Its legitimacy would primarily stem from the quality of its scientific output, the transparency of its processes, and its usefulness to its Member States.



The IHC serves as a different model of international cooperation—one founded on principles such as subsidiarity, Treaty-based restraint, scientific independence, service to Member States, and clearly defined international roles.

Part II

3. Mission, Purpose and Founding Treaty Principles

3.1 Mission

The mission of the International Health Council is to strengthen health through independent scientific cooperation between sovereign states, providing cross-border health protection and producing trusted scientific evidence and resources for the benefit of all Member States.

The IHC would pursue this mission through two principal areas of activity:

Cross-border health protection would provide the scientific and technical infrastructure required for international surveillance, early warning, epidemiological information sharing, laboratory cooperation and common reference standards.

International scientific resources would provide independent evidence synthesis, systematic reviews, clinical guidelines, comparative effectiveness assessments, technology appraisals and methodological standards relevant to both communicable and noncommunicable diseases.

These functions share a common purpose: undertaking scientific work in which cooperation between states can produce greater value, efficiency, or reliability than unnecessary duplication by individual countries.

The IHC's authority would derive from the independence, transparency and usefulness of its scientific work. Its scientific assessments, guidelines and technology appraisals would be advisory. They would inform national regulators, health technology assessment bodies, health systems, clinicians and governments without replacing their authority.

The IHC would not legislate, determine national reimbursement, mandate procurement, direct domestic health policy or acquire additional powers merely because an issue affects health. Consequently, Member States would retain responsibility for translating scientific evidence into decisions appropriate to their populations, health systems and constitutional arrangements.

The mission therefore combines international scientific capability with national decision-making authority; producing and sharing reliable evidence internationally while preserving responsibility for its application at the appropriate national or clinical level.

3.2 Cross-Border Health Cooperation and International Scientific Resources

The IHC would concentrate its activities in two areas where international scientific cooperation can provide substantial added value: cross-border health protection and international scientific public goods.

Cross-Border Health Protection

Health threats capable of crossing national borders require effective mechanisms for cooperation between sovereign states.

The IHC would provide the scientific and technical infrastructure required for:

- International disease surveillance and early warning;
- Rapid sharing of epidemiological information;
- Pathogen genomic surveillance and sequence sharing;
- International laboratory networks;
- Common laboratory reference methods and standards;
- Verification and confidence grading of outbreak reports;
- Assessment of emerging cross-border health threats; and
- Rapid communication of scientific information to Member States.

These functions would enable states to identify and assess emerging threats without transferring responsibility for domestic health policy to an international institution.

Surveillance should be designed primarily to inform rather than direct. The IHC would collect, verify, analyse and communicate information, including uncertainty and limitations in the available evidence. Decisions concerning the domestic response would remain with Member States.

International Scientific Resources

The second area concerns scientific work that can be undertaken collaboratively and made available for the benefit of all Member States. This is particularly important because the greatest international burden of disease arises from noncommunicable diseases, rather than cross-border infectious threats.

The IHC would provide shared scientific infrastructure for:

- Systematic reviews and living evidence synthesis;
- Clinical guideline development;
- Comparative effectiveness assessment;
- Evaluation of benefits and harms;
- Medicines, biologics, diagnostic and device assessment;
- Health technology appraisal;
- Methodological and reporting standards;
- Assessment of diagnostic and prognostic evidence; and
- Identification of important evidence gaps.

Producing such assessments internationally could reduce unnecessary duplication while giving countries without extensive evidence-assessment capacity access to high-quality independent scientific work.

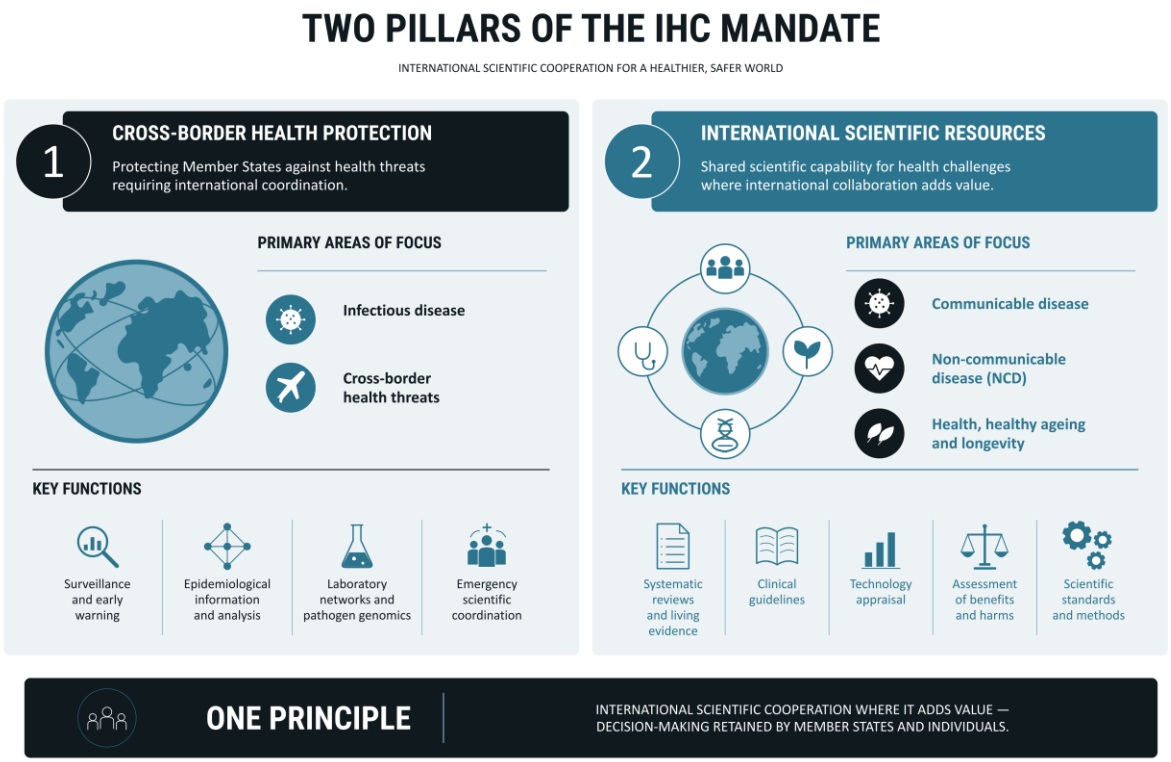
The Treaty framework distinction between scientific assessment and national decision-making would remain explicit. IHC guidelines and technology appraisals would provide evidence and scientific

recommendations. They would not constitute marketing authorisation, determine reimbursement, mandate procurement or require adoption within national health systems.

Together, these two functions establish the scientific rationale for the IHC: International coordination where health threats cross borders, and international collaboration in instances where producing reliable evidence once can benefit all Member States. Both are forms of scientific cooperation. Neither requires the transfer of domestic health-policy authority to an international institution.

National regulators, health technology assessment agencies, clinicians, and governments would retain responsibility for decisions within their respective jurisdictions.

This model allows the IHC to address the major burden of noncommunicable disease while maintaining Treaty-based restraint. Its international role would derive from the efficiency and value of producing reliable scientific evidence once and making it available to all, rather than from directing how sovereign states use that evidence.



Distributed International Scientific Expertise

Expertise will be networked internationally, not unnecessarily centralised institutionally.

The IHC will operate through a distributed international network of scientific expertise rather than seeking to concentrate specialist capability within a large permanent Secretariat. Universities, academic medical centres, national public health institutions, laboratories, evidence synthesis organisations, and other centres of scientific excellence could be designated as IHC collaborating centres for defined areas of expertise.

These centres would provide access to specialist capability across Member States and regions, allowing the IHC to draw upon expertise where it already exists rather than routinely reproducing it internally. Scientific groups could be convened remotely and internationally based on the expertise required for a particular assessment, guideline, technology appraisal, or emerging health threat.

The model would broaden participation, strengthen access to expertise across different regions and health systems, reduce unnecessary institutional duplication and help maintain a small permanent Secretariat. Designation as an IHC collaborating centre would confer a scientific service role rather than institutional authority, with participating centres remaining subject to the IHC's standards for transparency, scientific independence and conflicts of interest.

3.3 Scientific Coordination

Scientific coordination would underpin both principal areas of IHC activity established in Section 3.2. The purpose would be to enable Member States to share scientific capability where cooperation improves the quality, speed or efficiency of health protection and evidence assessment. Scientific conclusions would be determined through evidence and transparent methods rather than political negotiation.

Effective cross-border health protection relies on countries' ability to swiftly identify, characterise, and communicate emerging threats using standardised methods.

The IHC would oversee national and international scientific networks focused on surveillance, epidemiology, laboratories, and pathogen genomics. While Member States would maintain their own national surveillance and laboratory systems, they would contribute relevant information to a shared international framework. Scientific coordination would emphasise:

- Agreed-upon definitions for surveillance and reporting standards
- Interoperable epidemiological data
- Prompt sharing of information regarding emerging threats
- Genomic sequencing and comparison of pathogen variants
- Common laboratory reference methods and quality standards
- Verification of unusual or conflicting outbreak reports
- Evaluation of the reliability and completeness of available information
- Rapid scientific risk assessments for Member States

International alerts would differentiate between observations, preliminary signals, verified findings, and scientific interpretations. Any instances of incomplete, unavailable, or withheld information would be explicitly stated. Assessments would highlight resulting uncertainties rather than treating the absence of information as evidence of nonexistence.

The IHC would communicate the scientific assessment of a cross-border threat, addressing its severity, transmissibility, affected populations, and level of uncertainty. Decisions regarding border measures, testing policies, isolation, vaccination, or other domestic interventions would remain under the jurisdiction of Member States.

Coordination of International Scientific Resources

The second stream would coordinate the production of scientific evidence and resources that can be shared across Member States. This would include systematic evidence assessment, guideline development, comparative effectiveness research and technology appraisal across both communicable and noncommunicable diseases.

Producing these resources collaboratively would reduce unnecessary duplication and allow Member States to draw upon a common evidence base while retaining responsibility for regulatory, reimbursement, clinical and policy decisions.

Common Scientific Standards

Both streams would operate under the same core scientific principles. Scientific questions would be defined clearly and methods established prospectively wherever practicable. Data sources, analytical methods, conflicts of interest and judgements concerning certainty would be transparent.

Different forms of evidence would be identified separately. Surveillance observations, randomised trials, observational studies, diagnostic studies, modelling, mechanistic evidence and expert judgement would not be treated as equivalent. Scientific outputs would distinguish between:

- Findings directly supported by evidence;
- Estimates and extrapolations;
- Assumptions incorporated into models;
- Missing or unavailable information;
- Important uncertainties; and
- Expert interpretation.

This would be particularly important during emerging health threats, when decisions may need to be made before higher-quality evidence is available.

Scientific Disagreement and Updating

Scientific coordination does not require complete agreement among all parties. Any material disagreements regarding interpretation, methodology, or recommendations will be documented. Minority scientific opinions may be published alongside the majority assessment when significant disagreements remain.

Furthermore, scientific outputs should be open to revision as new evidence emerges. Major assessments, guidelines, and appraisals will include transparent version histories that detail what changes were made, when they occurred, and the reasons for those changes.

Coordination Without Centralisation

The IHC would function through distributed scientific networks, avoiding the need to concentrate expertise within a large international bureaucracy. Various contributors, including national public health agencies, laboratories, universities, evidence organisations, clinical networks, and other qualified experts, could share data and expertise through transparent arrangements.

The IHC would establish common methods, coordination, and independent assessment necessary to integrate these contributions. This model combines a distributed scientific capability with consistent international standards.

For cross-border threats, the goal is to achieve faster and more reliable detection and assessment. In terms of international scientific resources, it aims to produce rigorous evidence that can be collaboratively generated and utilised by all Member States.

In both instances, the Treaty boundary remains unchanged: the IHC coordinates and assesses the science, while Member States retain the authority to make decisions based on that science.

3.4 Member-State Service

The IHC will be established as a service organisation for its Member States. Its purpose is to provide scientific capabilities that are better organised collectively. This includes cross-border surveillance, early warning systems, laboratory and genomic coordination, evidence assessment, guideline development, technology appraisal, setting technical standards, and access to specialised expertise.

The relationship among Member States will be based on support rather than supervision. All Member States would have access to the IHC's core scientific resources irrespective of population size, income or domestic technical capacity. This is particularly important where countries lack the resources to maintain extensive specialist capabilities of their own.

A Member State should be able to draw upon:

- International surveillance and threat assessments;
- Laboratory and genomic networks;
- Systematic reviews and living evidence;
- Clinical guidelines and technology appraisals;
- Methodological and technical standards; and
- Specialist scientific or technical assistance.

Shared international capacity would therefore complement national institutions rather than replace them.

In addition to its primary international roles, technical assistance in individual countries is typically offered at the request of the respective Member State. This support may encompass various areas, including laboratory capabilities, surveillance systems, evidence assessment, guideline development methods, data infrastructure, and other scientific and technical functions within the IHC's Treaty mandate.

The IHC would deliver expertise and evidence, while the Member State would maintain responsibility for implementation.

The IHC will not serve as an international inspector of national health systems. It will not regularly rank Member States, evaluate domestic health policies, monitor compliance with preferred policy approaches, or use technical assistance to influence domestic legislation. When comparable international data is published, its purpose will be scientific analysis and shared learning, rather than political ranking.

This distinction is crucial for maintaining the relationship between the institution and its members. Member States should be able to request scientific assistance without thereby accepting external control over the policy decisions that follow.

The long-term goal of the IHC's assistance is to strengthen the scientific capacity of nations rather than create a reliance on the international institution. Consequently, methods, analytical tools, protocols, training materials, and evidence resources developed through the IHC will be made available to Member States wherever possible.

Countries with significant scientific capacity can share their expertise and infrastructure for collaborative international projects. Meanwhile, countries with fewer resources can leverage these shared capabilities while also focusing on their own development. This relationship should be reciprocal rather than hierarchical. The IHC is designed to empower Member States scientifically, rather than to make them institutionally subordinate.

The success of the IHC should be measured by the quality and usefulness of the services it provides, as well as by the Member States' ability to make informed decisions for themselves.

Benefits for Low- and Middle-Income Countries

A significant purpose of the IHC would be to make high-quality scientific capability available to Member States regardless of national income or technical capacity. This could be particularly valuable to low- and middle-income countries (LMICs), which may have fewer resources to maintain extensive surveillance, laboratory, evidence-synthesis and health technology assessment capabilities independently.

The IHC's contribution should extend beyond responding to disease once it occurs. International scientific cooperation can help Member States identify effective preventive investments before avoidable disease develops. For example, where cholera, typhoid and other waterborne diseases remain important risks, the IHC could synthesise evidence on water and sanitation interventions, establish technical standards, assess comparative benefits and harms, and provide scientific assistance requested by Member States.

The distinction is important. The IHC would help countries determine what works, where preventive investment is likely to provide greatest value, and what evidence supports that conclusion. Member States would determine priorities, financing and implementation.

For countries with more limited scientific resources, this model could provide capabilities that would otherwise be expensive to develop or procure independently. Membership would provide access to shared international surveillance infrastructure, laboratory and genomic networks, systematic reviews, technology assessments, technical standards and specialist scientific expertise. Member States could also request technical consultancy through the IHC's international network of collaborating centres. The objective would be to give countries access to high-quality independent scientific capability without requiring them to reproduce that capability nationally or surrender control over the decisions made using it.

For LMICs, the model therefore offers shared scientific capacity while preserving national ownership of development decisions.

Technical Consultancy for Member States

The IHC would provide Member States with access to independent scientific and technical consultancy on request. Governments could commission or request support for specific health questions, drawing on the IHC's international network of collaborating centres and specialist expertise rather than procuring equivalent capabilities independently.

Such services could include evidence reviews, epidemiological analysis, evaluation of health technologies, development of technical specifications, assessment of surveillance systems, methodological advice and support in evaluating alternative approaches to health-service or public-health problems, and may include water, sanitation and preventive infrastructure as examples of requested scientific/technical consultancy.

The model would resemble professional technical consultancy in one important respect: the Member State would define the problem for which assistance is required. At the same time, the IHC would assemble the expertise necessary to provide an independent, evidence-based assessment. Unlike commercial consultancy, however, the service would form part of the shared scientific capability, financed collectively by Member States, and would operate under the IHC's requirements for transparency, scientific independence, and conflict-of-interest management.

3.5 Treaty-Based Restraint

Treaty-based restraint will be a fundamental principle of the IHC, which will only have the functions explicitly granted to it by its founding treaty. Its mandate cannot be expanded merely because a proposed activity is related to health, attracts funding, or has support within the organisation. This principle is designed to establish a lasting boundary around the organisation.

The founding treaty will outline the permitted functions of the IHC, focusing on two main areas defined in Section 3.2: Cross-Border Health Protection and International Scientific Resources.

Activities within these areas must remain scientific or technical in nature and align with the institution's established purposes. The mere existence of a health benefit will not automatically grant the institution authority. Any new programmes will require a clear Basis in the Treaty Articles rather than development through a broad interpretation of the organisation’s mission.

Furthermore, institutional authority should not be established through precedent. The fact that the IHC undertook a specific activity during an emergency does not automatically create a permanent function for that activity. Similarly, technical assistance provided at the request of one Member State does not grant the authority to routinely perform that activity for other Member States.

Funding availability should not be seen as a valid reason for expanding the organisation's scope. This is crucial because once institutional programmes gain staff, budgets, partnerships, and organisational constituencies, they can become challenging to reverse. Therefore, authority conferred by the Treaty Articles should be established before any institutional activity, rather than emerging from it.

Activities Expressly Excluded

The founding treaty should clearly outline the functions that the IHC is not authorised to undertake. These exclusions include the following powers:

- *Impose binding health recommendations on Member States;*
- *Determine domestic health legislation or policy;*
- *Monitor compliance with preferred national policies;*
- *Impose sanctions or conditional assistance;*
- *Manage national health programmes;*
- *Undertake political lobbying or public-policy campaigning;*
- *Restrict, require the suppression of, or seek regulatory control over lawful speech or information*
- *Use financial leverage to secure policy changes; or*
- *Acquire regulatory authority over national health systems.*
- Actively promote particular programmes or products.

These detailed exclusions should be enshrined in the Treaty rather than left to administrative convention. An approach that provides clarity for both the institution and the Member States.

Freedom of Scientific Expression and Information

The IHC would not have the authority to regulate lawful speech, suppress information, or instruct Member States, publishers, professional organisations, or digital platforms to remove lawful content. This restriction would be particularly applicable to scientific and medical disagreements.

The IHC should be able to identify inaccurate claims, publish corrections, assess the reliability of evidence, and explain why specific conclusions are unsupported. These are legitimate scientific functions and do not require regulatory authority over what individuals or organisations may say or publish.

Scientific disagreement would not constitute non-compliance with IHC guidance. Researchers, clinicians, and other experts would remain free to challenge IHC assessments, question its methods, publish alternative analyses, and argue for revisions to its recommendations. When substantial criticism identifies errors or important contrary evidence, the IHC would be responsible for considering that evidence through its established scientific processes.

This principle is especially important during health emergencies when evidence is often incomplete, and scientific understanding may change rapidly. Conclusions viewed as well supported at one stage may need revision as new evidence becomes available.

The IHC would therefore differentiate between evaluating information and controlling information. Its role would be to evaluate scientific claims using transparent methods, publish the evidence supporting its conclusions, and make those conclusions available for scrutiny. It would not have the mandate to determine which lawful scientific or public viewpoints can be expressed. This protection would reinforce the scientific governance principles established in Section 3.3, including the publication of uncertainty, preservation of minority opinions, and transparent revision of scientific conclusions. Scientific authority should be exercised through evidence and open challenge, not through the control of lawful expression.

Emergency Powers

Emergencies would not suspend Treaty-based restraint. The IHC could intensify surveillance, accelerate evidence reviews, convene scientific networks and issue urgent technical assessments within its authorised functions. But an emergency declaration would not create new powers over Member States.

Temporary scientific or operational arrangements established during an emergency would expire when their defined purpose ended unless Member States subsequently authorised them through the formal constitutional process. This prevents emergency arrangements from becoming a route to permanent institutional expansion.

Amendment of the Mandate

Treaty-based restraint should not prevent the institution from adapting to new challenges. As new technologies, pathogens, and scientific methods emerge, Member States may reasonably determine that additional international functions are necessary.

Therefore, any expansion should only occur through a formal amendment process that requires explicit approval from Member States. Proponents of a new function must demonstrate that it is appropriate at the international level and aligns with the institution's founding principles. This approach ensures that any institutional expansion is deliberate, transparent, and accountable.

Restraint as a Source of Legitimacy

The authority of the IHC would stem from its ability to perform a specific set of functions exceptionally well, rather than from continuously expanding its range of activities. Member States would clearly understand which powers they have delegated, which they have retained, and how any future changes could be made.

This Treaty-based restraint would provide a solid foundation for scientific independence, subsidiarity, and national sovereignty, which will be elaborated upon in the following sections. The IHC would be empowered to effectively carry out its defined international functions while remaining constitutionally unable to transform scientific expertise into indefinite political or regulatory authority.

3.6 Sovereignty, Subsidiarity and Individual Autonomy

The IHC would be established based on the sovereignty of its Member States. Membership would entail collaboration in specific scientific and technical areas, but it would not transfer overall authority regarding health policy, legislation, or national health systems to the IHC. Member States would continue to be responsible for decisions made within their own jurisdictions and would remain accountable to their populations and Founding Treaty frameworks.

The IHC would clearly differentiate between international scientific cooperation and national political authority. It could offer surveillance information, scientific assessments, clinical guidelines,

technology appraisals, technical standards, and expert advice. While these outputs could inform national decision-making, they would not dictate those decisions.

Concurrent Competences and Reserved Competences of Member States

The IHC Treaty Articles would establish that when acting within its mission as defined in 3.1, the IHC shall have concurrent competence with the Member States rather than exclusive competence. Areas outside the mission defined in 3.1 would remain exclusively within national competence.

The areas of reserved Member State competence include but are not limited to:

- Health legislation and regulation;
- Organisation and financing of health services;
- Approval, reimbursement and national adoption of health technologies;
- Procurement decisions;
- Vaccination and prevention programmes;
- Public-health interventions;
- Emergency measures; and
- Allocation of national health resources.

The IHC could provide scientific evidence, technical standards, systematic reviews, guidelines, technology appraisals and other advisory resources relevant to these matters. Such scientific activity would not transfer the underlying decision-making competence to the IHC.

This distinction would be embedded in the Treaty Articles: functions expressly conferred upon the IHC would constitute its international competence; all other governmental health powers would remain reserved to Member States.

This separation preserves accountability. Governments making decisions affecting their populations should remain responsible for those decisions rather than attributing them to an international institution.

The principle of subsidiarity would reinforce sovereignty. Decisions should be taken at the lowest level capable of addressing the issue effectively.

Applied to health:

- Individual patients and clinicians should make individual clinical decisions;
- Healthcare organisations and professional bodies should perform functions appropriately undertaken at those levels;
- National public-health agencies and regulators should exercise domestic scientific and regulatory responsibilities;
- National governments should determine legislation, expenditure and public policy.

The IHC should act only where scientific cooperation, shared capability or coordination provides demonstrable international added value. Its involvement should extend no further than necessary to realise that value, with functions remaining at national, local or clinical level where they can be performed as effectively and efficiently there. Subsidiarity therefore establishes a presumption in favour of decentralised decision-making while recognising that some functions genuinely benefit from international organisation.

Individual Autonomy and Medical Ethics

The principle of limited international authority would extend beyond the sovereignty of Member States to respect for the autonomy and bodily integrity of individuals.

The IHC Treaty Articles would expressly provide that the institution has no authority to compel an individual to undergo medical treatment, vaccination, testing, screening or other medical intervention.

IHC scientific assessments could evaluate the benefits, harms and uncertainties associated with such interventions and provide evidence to Member States, clinicians and patients. They would not themselves constitute authority to compel their use.

The IHC would conduct its scientific and advisory functions in accordance with established principles of medical ethics, including informed consent, respect for bodily integrity, proportionality, and individual autonomy.

These principles would apply during health emergencies as well as during ordinary operations. An emergency could accelerate scientific assessment and international cooperation but would not enlarge the powers conferred upon the IHC by its Treaty Articles. Scientific evidence may inform decisions affecting individuals; it does not give the IHC authority over the individual.

International Scientific Resources and Subsidiarity

Systematic reviews, evidence assessments for guidelines, technology appraisals, and methodological standards can demand significant specialised resources. Collaboratively producing high-quality assessments could offer more value than having every Member State independently reproduce the same analyses.

The IHC would therefore create international scientific resources while allowing for decentralised application. For instance, a unified technology appraisal could evaluate comparative effectiveness, benefits, harms, and uncertainties once, benefiting all Member States. Subsequently, each country could decide whether and how to approve, fund, or use the technology based on its specific circumstances.

This approach embodies subsidiarity in both directions: centralising scientific tasks where collaboration yields clear efficiencies or quality improvements, while decentralising decision-making when national circumstances and accountability are at play.

Cross-Border Health Protection and Subsidiarity

The same principle applies to Cross-Border Health Protection. International surveillance, standardised laboratory references, and early warning systems require collaboration, as the information generated in one jurisdiction can be vital to others.

The IHC could facilitate these shared scientific functions, while national authorities maintain their responsibility for domestic responses. An international alert would provide information and assessments, but it would not automatically lead to predetermined national restrictions or interventions.

International action should be proportional to the issue at hand. When cooperation is warranted, the IHC should limit its functions to only what is necessary to achieve the international objective. For example, the need for international surveillance does not imply a requirement for international control over domestic disease management policies. Likewise, the value of an international evidence assessment does not grant authority over national reimbursement policies or clinical practices.

The principles of subsidiarity and proportionality work together: subsidiarity determines the appropriate level of action, while proportionality restricts the scope of action at that level.

These principles act as a Treaty safeguard against unnecessary centralisation, while still allowing for the benefits of international scientific collaboration. Scientific capabilities should be shared when they add value, but political and clinical authority should remain as close as possible to those affected by the decisions.

Individual Autonomy, Medical Ethics and State Sovereignty

The IHC Treaty Articles should recognise that international health cooperation operates within two distinct spheres of authority: the sovereignty of Member States and the autonomy of individuals in matters concerning their own health.

Member States would retain responsibility for domestic health law and policy. The IHC would provide scientific evidence and technical advice but would have no authority to impose medical interventions, restrictions, or emergency measures on states or individuals.

The IHC should also operate according to established principles of medical ethics, including informed consent, bodily integrity, proportionality, respect for individual autonomy and transparent assessment of benefits and harms. These principles are particularly important during emergencies, when uncertainty and pressure for rapid collective action can increase the risk that scientific recommendations become conflated with political decisions.

The IHC would therefore distinguish clearly between scientific assessment and the exercise of coercive authority. It could assess the evidence concerning vaccination, testing, quarantine or other interventions and communicate the benefits, harms and uncertainties. Decisions concerning their lawful use would remain with sovereign Member States, subject to their domestic legal and ethical frameworks and applicable international obligations.

This approach does not require the IHC to adjudicate the broader international human-rights system. Its Treaty Articles would instead state directly the principles governing its own conduct: scientific cooperation should inform health decisions without conferring on the IHC authority to override national sovereignty, individual bodily autonomy, or established requirements of medical ethics.

3.7 Treaty Remit and Subsidiarity Test for IHC Activities

Every activity undertaken by the International Health Council would require a clear basis in its Treaty Articles. The purpose of the Treaty Remit and Subsidiarity Test would be to determine when activity at IHC level is justified, while preventing the gradual accumulation of functions simply because they relate to health.

The test would apply to new programmes, scientific initiatives, partnerships, Member-State services and significant expansions of existing activities. It would apply during emergencies as well as during normal operations.

An activity would be justified only where it satisfies three requirements.

1. Treaty-Defined Purpose

The activity must fall within a function expressly authorised by the IHC Treaty Articles.

This would include activities within Cross-Border Health Protection or International Scientific Resources, including scientific and technical services provided to Member States within those domains.

A general relationship with health would not, by itself, provide sufficient authority for IHC involvement.

This first requirement establishes the legal boundary: the IHC could act only within the purposes and functions that Member States have expressly agreed to confer upon it.

2. International Added Value

There must be a demonstrable benefit from undertaking the activity through the IHC rather than leaving it entirely to individual Member States, national institutions or other existing organisations.

International added value could arise in different ways.

Cross-Border Necessity.

Some health functions inherently require cooperation between countries. International surveillance, early warning, epidemiological information exchange, pathogen genomics, and laboratory coordination are examples in which states acting independently may be unable to achieve the same result.

Shared Scientific Capability.

International collaboration may also add value where the underlying health problem is not itself cross-border. Systematic reviews, clinical guidelines, health technology assessments and methodological standards can often be produced more efficiently and independently through pooled international expertise. Producing a high-quality scientific resource once and making it available to all Member States can reduce unnecessary duplication while improving access to specialist capability.

Member-State Scientific and Technical Service.

International added value may also arise where the IHC enables a Member State to access scientific or technical expertise that would otherwise be difficult, inefficient or unnecessarily expensive to obtain independently. This could include evidence synthesis, technical consultancy, capacity building or assistance in applying established scientific knowledge.

International cooperation would therefore not be limited to generating new knowledge. The IHC could also help Member States make better use of existing knowledge.

For example, a Member State seeking to reduce waterborne disease could request an independent assessment of evidence concerning water, sanitation and hygiene interventions. The IHC could synthesise existing evidence, assess likely benefits and harms, compare alternative approaches and provide technical expertise. Decisions concerning infrastructure investment, expenditure and implementation would remain with the Member State.

3. Subsidiarity and Proportionality

Even where an activity falls within the Treaty-defined remit and provides international added value, the IHC's involvement should be no greater than necessary to realise that value.

Where an objective can be achieved effectively by a Member State, a national institution, an existing scientific organisation, or another appropriate body, responsibility should remain at that level.

Where international involvement is justified, the IHC should adopt the least intrusive and most proportionate form of participation.

Subsidiarity and proportionality therefore operate not simply as tests of whether the IHC may act, but also as a test of how far its involvement should extend.

A systematic review may appropriately be produced internationally while decisions arising from it remain national. Technical assistance may be provided to a Member State without the IHC managing the resulting programme. International surveillance may require common information standards without requiring central control of national public-health systems.

The principle is that international capability should supplement national capability where it adds value, rather than displace it.

Standing Treaty Limitation: Reserved Competences and Individual Autonomy

Satisfying the Treaty Remit and Subsidiarity Test would not enlarge the IHC's authority.

The Treaty Articles would separately establish reserved competences of Member States. Governmental powers not expressly conferred upon the IHC—including health legislation and regulation, organisation and financing of health services, national technology adoption and reimbursement, procurement, vaccination and prevention programmes, public health interventions, emergency measures, and allocation of national resources—would remain with Member States.

The Treaty Articles would also protect individual autonomy, bodily integrity and informed consent. Scientific or technical competence would provide no basis for coercive authority over individuals.

The distinction is therefore fundamental:

The Treaty Remit and Subsidiarity Test determines why and when the IHC should act. Reserved competences and individual autonomy determine where its authority must stop.

Applying the Test

Before establishing a significant activity, the IHC would publish an assessment explaining:

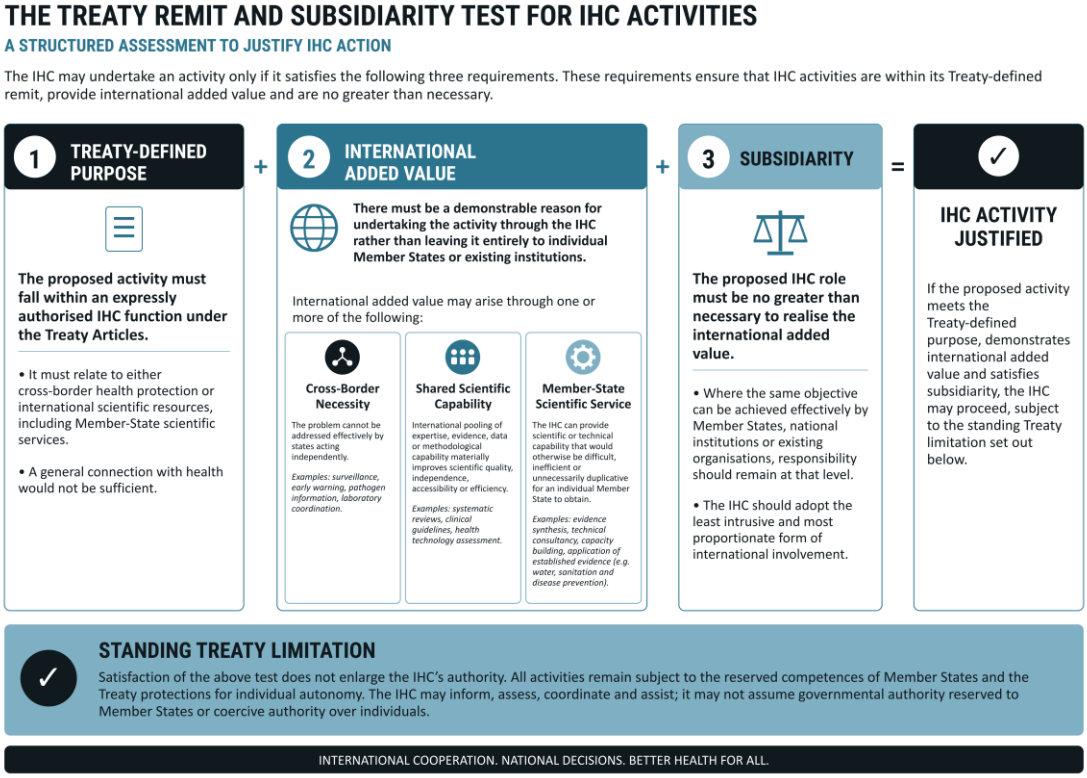
- the Treaty Article authorising the activity;
- the international added value it is expected to provide; and
- why the proposed level of IHC involvement satisfies subsidiarity.

The same assessment should be repeated periodically for continuing programmes.

An activity that no longer demonstrates sufficient international added value, duplicates capabilities more appropriately available elsewhere, or has expanded beyond what is necessary should be reduced, transferred, or discontinued.

This creates an operational safeguard against mission creep without preventing useful international cooperation from evolving.

The governing presumption would be simple: **act internationally only where doing so adds demonstrable value; act no further internationally than necessary; and leave reserved governmental authority to Member States and personal medical decisions to individuals.**



Review of Existing Activities

The Treaty Remit and Subsidiarity Test would apply not only when activities are created but throughout their existence. Major programmes should undergo periodic review to determine whether the original international justification remains valid.

Activities should be discontinued where:

- The international requirement no longer exists;
- Member States can perform the function effectively without IHC coordination;

- The activity has expanded beyond its authorised scientific or technical purpose; or
- Implementation has begun to create direct or indirect pressure on national decision-making.

Emergency programmes would be subject to the same principle and would not automatically become permanent functions of the IHC.

Treaty Oversight

A proposed activity that raises questions about its compatibility with the treaty should undergo an independent Treaty compliance review before implementation. This review must be published and should clearly outline how the activity meets each element of the Treaty Remit and Subsidiarity Test. Approval from Member States alone is insufficient to override the institution's foundational limits. Any expansion beyond these limits would require a formal amendment of the Treaty, following the process established for this purpose.

This approach safeguards the institution against gradual expansion through administrative precedents, temporary emergency measures, or shifting organisational priorities.

The Treaty Remit and Subsidiarity Test converts the principles established throughout Chapter 3 into an operational safeguard:

- Treaty-defined purpose;
- International added value; and
- Subsidiarity.

Reserved Member-State competences and individual autonomy remain standing Treaty limitations on all IHC activity. The goal is to ensure that the IHC remains capable of adapting scientifically without expanding its institutional scope beyond its original purposes.

Part II

4. Treaty-Defined Remit and Core Functions

The Founding Treaty principles outlined in Chapter 3 will be implemented through a targeted set of scientific and technical capabilities organised into two main areas within the IHC: Cross-Border Health Protection and International Scientific Resources. Unified scientific standards, technical assistance, and arrangements for swift coordination during emergencies will support them.

The goal is to maintain a sufficient, permanent international capacity to provide reliable scientific services to Member States without creating a large operational bureaucracy or duplicating functions that can be managed more effectively at the national level.

4.1 Cross-Border Surveillance and Early Warning

The IHC would maintain a permanent international capability for the detection, verification, assessment and communication of health threats with potential cross-border significance.

National public-health authorities would remain responsible for domestic surveillance. The IHC would provide the common infrastructure through which relevant information could be exchanged, compared and assessed internationally. The system would integrate epidemiological reports, laboratory information, genomic data and other scientifically relevant signals. Common data definitions and interoperable reporting standards would enable reliable comparison of information across jurisdictions.

Potential signals would undergo verification before being presented as established threats. IHC assessments would distinguish between:

- Preliminary signals;
- Verified observations;
- Evidence of sustained transmission or other significant risk;
- Scientific interpretation; and
- Unresolved uncertainty.

If important information is missing, delayed, or unavailable, this will be explicitly reported.

Alerts to Member States will include the evidence considered, the level of confidence in the assessment, significant uncertainties, and the reasons for any changes in risk classification. As a result, the system will function as a scientific early-warning service rather than an international command mechanism.

Its primary output will be reliable, rapidly updated information that enables Member States to make their own decisions regarding preparedness and response.

4.2 Laboratory Networks

Cross-border surveillance relies on laboratory findings that can be compared across different jurisdictions. The IHC would coordinate a member network of national and reference laboratories to support the identification, characterisation, and monitoring of pathogens and other relevant biological threats.

This network would develop and maintain standardised reference methods, quality assurance procedures, proficiency testing, and reporting standards for laboratory findings. Pathogen genomics would be a key component of this capability. Participating laboratories would be able to share relevant sequence information quickly, allowing for assessments of changes in pathogen characteristics, geographical spread, and genetic relationships across countries.

The IHC would promote common standards for sequencing quality, metadata, and analytical methods to ensure that genomic information remains interpretable and comparable. International reference laboratories could provide specialised confirmation or technical support when national capabilities are insufficient or when findings need independent verification.

The goal is to establish a distributed international laboratory capability without replacing national laboratories. Data-sharing arrangements would include appropriate safeguards for privacy, security, scientific attribution, and legitimate national interests. However, the principle remains that information necessary to address significant cross-border health threats should be shared as quickly as possible.

4.3 International Evidence Infrastructure

The IHC would maintain a common evidence infrastructure supporting scientific work across both communicable and noncommunicable diseases. At its centre would be an openly accessible International Health Evidence Repository containing the evidence underlying IHC scientific assessments.

Where legally and ethically possible, this would include:

- Systematic reviews and evidence tables;
- Clinical trial registrations and protocols;
- Published and unpublished study information;
- Regulatory and assessment documents;
- Diagnostic and prognostic evidence;
- Surveillance and epidemiological datasets;
- Methodological documentation; and
- Previous versions of IHC assessments.

The objective would be to reduce evidence fragmentation and make the basis for scientific conclusions easier to inspect and reproduce. Emphasis would be placed on identifying missing evidence. Unpublished trials, unavailable datasets, incomplete reporting and inaccessible methodological information can materially affect confidence in scientific conclusions. IHC assessments would therefore record what information was sought, what was available and what remained inaccessible.

The repository would support systematic reviews, guidelines, technology appraisals, and emergency scientific assessments, while also providing a resource for Member States, researchers, and clinicians.

The principle would be straightforward: where scientific recommendations affect important health decisions, the evidence supporting them should be as open to independent scrutiny as practicable.

4.4 Systematic Reviews and Living Evidence

Systematic evidence synthesis would provide the methodological foundation for major scientific outputs in IHC. Reviews would begin with predefined questions and prospectively published protocols wherever practicable. Search strategies, eligibility criteria, analytical methods and judgements concerning risk of bias and certainty would be transparent.

Evidence would be assessed according to the question being addressed rather than through a rigid hierarchy applied without context. Randomised trials would ordinarily provide the strongest basis for causal estimates of intervention effects where such trials are feasible and appropriately designed. Observational, diagnostic, prognostic, mechanistic and surveillance evidence would be assessed according to their respective methodological strengths and limitations.

During emerging health threats, rapid evidence reviews could be produced when conventional review timelines were impractical. Their accelerated methods and additional uncertainty would be stated explicitly.

For important questions where evidence changes frequently, the IHC would maintain living systematic reviews. New evidence would trigger reassessment when it was sufficiently important to alter conclusions. Previous versions would remain accessible, allowing users to see when conclusions changed and why.

The objective would be to replace static institutional positions with an evidence system capable of transparent scientific updating.

4.5 Clinical Guidelines and Evidence-Based Recommendations

IHC clinical guidelines would translate scientific evidence into recommendations for prevention, diagnosis, treatment, and care.

Guideline development would begin with a systematic assessment of evidence and the use of transparent evidence-to-recommendation methods. Panels would include appropriate clinical, methodological and subject expertise. Membership, declarations of interest and procedures for managing conflicts would be published. Recommendations would identify the certainty of the supporting evidence and distinguish between strong recommendations and those made conditionally or under substantial uncertainty.

The guideline process would also separate evidence from judgement. Where recommendations depend upon assumptions concerning patient preferences, feasibility, resource implications or other contextual considerations, those assumptions would be stated explicitly.

Significant scientific disagreement would be preserved in the record. Minority opinions could accompany recommendations where reasonable experts reached materially different interpretations of the evidence.

Guidelines would be maintained as living documents where appropriate and updated when important new evidence emerged. Their value would lie in providing Member States and clinicians with a rigorous, transparent scientific resource rather than establishing a uniform international model of clinical practice.

4.6 Health Technology Assessment and Appraisal

The IHC would provide independent scientific appraisal of medicines, vaccines, diagnostics, medical devices and other health technologies. A common international appraisal could substantially reduce duplication, particularly when many countries independently assess the same clinical evidence.

The core scientific appraisal would examine:

- Clinical effectiveness;
- Comparative effectiveness;
- Benefits and harms;
- Quality and completeness of the evidence;
- Applicability to relevant populations;
- Important uncertainties; and
- Unresolved evidence gaps.

Where appropriate and requested by Member States, the IHC could also develop common methods and evidence models for economic assessment.

However, costs, opportunity costs, willingness-to-pay thresholds and health-system priorities differ substantially between countries. National bodies would therefore remain responsible for translating the scientific assessment into local reimbursement and resource-allocation decisions.

Manufacturers seeking assessment would be expected to provide the evidence necessary for independent evaluation, including relevant protocols, study reports and data where legally and practically available.

The resulting appraisal would make clear both what the evidence establishes and what remains uncertain. This capability would be particularly important for noncommunicable diseases, where medicines, diagnostics and other technologies account for a substantial proportion of healthcare activity and expenditure.

Medicines and Essential-Medicines Decisions

The IHC will undertake scientifically and financially independent assessments of medicines and other health technologies, including systematic evaluations of comparative benefits and harms, the certainty of the evidence, and other relevant scientific considerations. These assessments could provide a shared scientific resource for Member States and reduce

unnecessary duplication of evidence assessment. The IHC would not determine national essential medicines lists, formularies, reimbursement or procurement decisions. These would remain the responsibility of Member States, reflecting national disease burden, resources, health-system capacity, affordability and priorities. Member States could voluntarily share their medicines assessments and national lists through the IHC to support scientific exchange and methodological learning, without implying IHC approval or endorsement.

4.7 International Scientific and Technical Standards

The IHC would develop scientific and technical standards that establish common methods to improve reliability, comparability, or interoperability between Member States.

These could include standards relating to:

- Laboratory methods and quality assurance;
- Surveillance definitions and data interoperability;
- Evidence synthesis and reporting;
- Diagnostic evaluation;
- Guideline methodology; and
- Technology appraisal.

Standards will be developed through transparent scientific processes involving relevant expertise from Member States and external specialists.

When multiple scientifically valid methods exist, the IHC should avoid enforcing unnecessary uniformity. International standardisation should be applied only when compatibility or quality demands it, rather than solely for administrative convenience.

IHC standards will remain technical rather than serve as international regulations. Their purpose is to enable scientific systems to collaborate effectively and to establish reliable methodological benchmarks.

4.8 Technical Assistance and Capacity Building

Member States may request technical assistance from the IHC, within the scope of the institution's mandate. This support may include laboratory methods, surveillance design, genomic capabilities, systematic review methods, guideline development, technology assessment, data systems, and other scientific functions.

The assistance will be tailored to meet the specific needs identified by the requesting Member State. Whenever possible, the goal will be to transfer capability rather than create ongoing dependence on the institution.

Training materials, protocols, software, analytical tools, and methodological resources developed with IHC funds will be made publicly available whenever feasible.

The IHC will also facilitate partnerships between Member States, enabling countries with established specialised capacities to support those seeking to enhance theirs. Technical missions will be time-limited, scientifically focused, and conducted with the agreement of the respective state.

4.9 Emergency Scientific Coordination

A declared international health emergency would accelerate the IHC's existing scientific capabilities rather than create a separate system of authority.

The IHC could rapidly expand surveillance analysis, convene laboratory and genomic networks, commission rapid evidence reviews, coordinate specialist scientific groups and provide frequently updated risk assessments to Member States.

Emergency scientific outputs would identify:

- The evidence currently available;
- Its quality and limitations;
- Important missing information;
- Plausible interpretations;
- The degree of uncertainty; and
- The evidence most urgently required.

Where modelling was used, assumptions, scenarios and sensitivity analyses would be published and clearly distinguished from observed data.

Emergency guidance would be updated as evidence developed, with changes and their reasons recorded transparently.

Scientific disagreement would not disappear because circumstances were urgent. Where important uncertainties or competing interpretations remained, they would be communicated.

The IHC's Treaty limits would continue to apply throughout an emergency. Accelerated scientific coordination would not create authority to impose national restrictions, mandate particular interventions or convert temporary emergency arrangements into permanent functions.

The objective would be speed without abandoning scientific standards, and coordination without transferring national decision-making authority.

Together, these capabilities would give the IHC a focused but substantial international role.

Cross-Border Health Protection would provide surveillance, early warning, laboratory coordination and pathogen genomics.

International Scientific Resources would provide evidence infrastructure, systematic reviews, clinical guidelines and technology appraisal.

Scientific and technical standards, capacity building and emergency coordination would support both domains. The resulting institution would therefore combine rapid international health protection with permanent international evidence capability, while operating within the Treaty limits established in Chapter 3.

Part II

5. Treaty Exclusions and Reserved Competences

The IHC would operate under specific Treaty limitations regarding the powers it can exercise. These limitations would complement the positive functions outlined in Chapters 3 and 4. Their purpose is to ensure that scientific and technical expertise does not evolve into political, legislative, regulatory, or executive authority.

The Treaty Articles would expressly distinguish between the limited scientific and technical functions conferred upon the IHC and governmental competences reserved to Member States. The guiding principle would be as follows:

Having scientific competence to examine an issue does not grant the IHC the institutional authority to regulate, govern, or dictate policy concerning that issue.

The IHC may collect data, review evidence, assess benefits and harms, develop scientific methods, and publish technical findings within the framework of its Founding Treaty. However, the subject matter of any scientific assessment alone does not automatically confer jurisdiction on the IHC over that area. Powers not explicitly granted to the IHC by its founding treaty would remain with the Member States. The following powers would be expressly excluded:

5.1 No Legislative, Treaty-Making or Regulatory Authority

The IHC would not have the authority to legislate for Member States, negotiate treaties on their behalf, or create instruments that impose binding domestic obligations. It would also be unable to convert scientific guidelines, technical standards, or health technology assessments into legal requirements.

Furthermore, the IHC would lack independent authority to regulate medicines, medical devices, consumer products, professional practices, or national health services. While its scientific assessments could guide national regulators and governments, the ultimate regulatory decisions would rest with the competent national authorities.

This distinction ensures that scientific standard-setting is separate from regulatory power. Member States would still have the freedom to cooperate internationally or negotiate agreements outside the IHC when they deem it necessary.

5.2 No Executive or Emergency Powers over Member States

The IHC would not hold any executive authority over Member States. An international health alert or an emergency scientific assessment could initiate increased surveillance, evidence review, and scientific coordination within the IHC. However, this would not automatically result in legal obligations for Member States.

- The IHC would not have the authority to enforce the following measures:
- Border closures or travel restrictions
- Quarantine or isolation procedures
- Vaccination or testing programmes
- The closure of schools or businesses
- The procurement of specific products
- Any other domestic emergency measures

Additionally, the IHC could not impose sanctions, penalties, or financial consequences for failing to adhere to its recommendations. While emergencies would expedite scientific coordination, they would not expand the institution's constitutional powers.

5.3 No Domestic Policy Supervision or Programme Management

The IHC would not oversee the domestic health policies of Member States. It would not have the authority to monitor whether governments have implemented IHC-preferred policies, evaluate countries based on their compliance with these policies, or use international comparisons to ensure conformity.

International comparative data may still be produced when it is scientifically valuable. The goal of such data would be for analysis and shared learning, not for political ranking.

Typically, the IHC would not manage domestic health, development, or humanitarian programmes. However, it can provide technical assistance and capacity building upon request from Member States, as outlined in Section 4.8. Responsibility for national programmes would remain with domestic institutions. Assistance from the IHC would not be contingent upon the adoption of unrelated policy recommendations.

5.4 No Political Advocacy, Campaigning or Control of Lawful Expression

The IHC would not function as a political campaigning organisation. Its role will be to communicate scientific findings, clarify evidence, correct factual inaccuracies, and identify health consequences that are supported by evidence.

It would not lobby governments to adopt political agendas, coordinate public campaigns to achieve legislative changes, or use its resources to promote positions outside its scientific and technical scope. Additionally, the IHC would not have the authority to regulate lawful speech or suppress information. Researchers, clinicians, Member States, and members of the public would remain free to criticise IHC conclusions, publish alternative analyses, and challenge its recommendations.

Any scientific disagreements would be addressed through evidence, methodological scrutiny, and open debate.

5.5 Scientific Inquiry Without Policy Jurisdiction

Treaty-based restraint would apply to institutional authority rather than to legitimate scientific inquiry. The IHC's evaluation of evidence may need to address interventions or exposures in fields such as mental health, behavioural science, environmental health, reproductive health, nutrition, consumer products or other areas that materially affect health. The scientific relevance of these subjects would not confer policy jurisdiction upon the IHC.

The boundary of inquiry pertains to what follows from the assessment. The IHC could, when constitutionally relevant, assess evidence, quantify benefits and harms, identify uncertainties, and publish scientific conclusions. However, it would not thereby gain the authority to determine policy, require implementation, regulate conduct, advocate for legislation, or penalise non-compliance.

For example, the IHC could assess evidence on the health effects of an environmental exposure, a behavioural intervention, or a consumer product without acquiring authority over environmental, behavioural, or consumer policy. Similarly, it could evaluate evidence concerning mental-health interventions without determining how Member States organise, finance or regulate their mental-health services.

This distinction is essential to the IHC model. While the scope of scientific inquiry may be broad when warranted by the evidence, the range of institutional power would remain deliberately narrow. Therefore, scientific expertise would inform sovereign decision-making without becoming a basis for extending global jurisdiction.

Part III

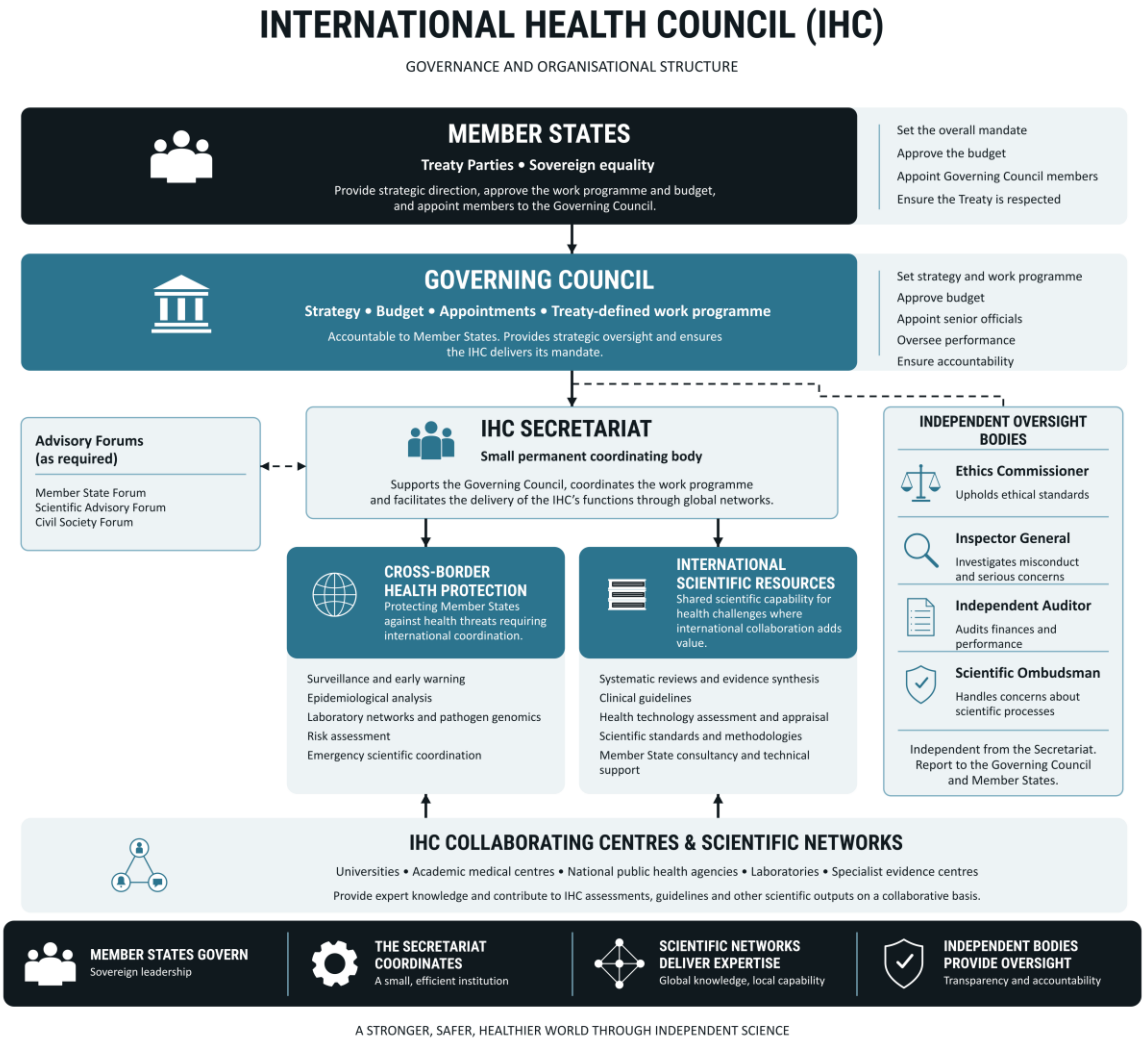
6. Governance Structure

The governance of the IHC would be structured to ensure a clear separation of responsibilities.

Member States would be responsible for governing the institution, while scientific processes would dictate scientific conclusions. Independent oversight would be established to safeguard integrity, accountability, and compliance with Treaty standards.

This separation aims to prevent political governance, administrative management, and scientific judgment from being concentrated within a single institutional structure.

The IHC would intentionally maintain a lean organisational structure. Governance arrangements should ensure effective accountability without creating unnecessary layers of committees and administrative structures that might become self-serving.



6.1 Membership and Member-State Representation

Membership of the IHC is open to sovereign states that accept the founding treaty, its limitations, and the associated financial responsibilities.

All Member States would participate based on sovereign equality. Financial contributions, population size, or economic power will not grant any state additional voting authority. Therefore, states that contribute more financially would not gain greater governance influence over the institution.

Each member state would appoint an authorised representative to participate in the governance of the IHC. It is up to each government to determine how representatives are selected and held accountable.

Membership comes with specific responsibilities, including payment of agreed-upon collectively determined Member-State funding and participation in the scientific cooperation necessary for the institution's core functions. The treaty would establish clear procedures for accession and voluntary withdrawal. Any provisions for suspension would require a high threshold and clearly Treaty-defined grounds.

6.2 Governing Council

The Governing Council would be the principal decision-making body of the IHC and would consist of representatives of its Member States.

Its responsibilities would include:

- Approving the institutional budget;
- Determining collectively determined Member-State funding;
- Appointing senior leadership;
- Approving the strategic work programme;
- Ensuring compliance with the founding treaty;
- Commissioning independent institutional reviews; and
- Considering proposed amendments to the Founding Treaty framework.

The Council would govern the institution rather than its scientific conclusions. It could commission scientific work, determine priorities within the Treaty-defined remit and scrutinise whether appropriate methods had been followed. It could not amend a scientific finding through political negotiation or require scientific panels to reach conclusions preferred by Member States. Scientific assessments would be revised through the scientific process established for that purpose. This boundary would be written into the founding treaty.

6.3 Secretariat

The IHC would maintain a small, permanent Secretariat responsible for the administration, coordination, and delivery of its work programme.

The functions of the Secretariat would include financial administration, coordination of scientific networks, management of evidence systems, organisation of meetings, publication of scientific outputs, and providing administrative support to Member States.

The Secretariat will not have an independent policymaking authority. When specialised capabilities can be provided by national institutions, universities, laboratories, or distributed scientific networks, the IHC should utilise these resources rather than automatically creating permanent internal departments.

This approach will help prevent organisational growth from being the default response to new scientific requirements. Staffing and expenditures would be reviewed periodically to ensure alignment with the institution's authorised functions.

6.4 Leadership, Appointment and Terms of Office

Senior leadership should be appointed through an open, competitive, and transparent process based on clearly defined professional criteria.

Candidates for key executive and scientific positions should publicly disclose their relevant professional interests and financial relationships before their appointment.

The chief executive should serve a single, non-renewable term. This approach would reduce the incentive to seek political support from Member States for reappointment and enhance the independence of the institution's administration.

Similarly, senior scientific appointments should be safeguarded against inappropriate political influence.

Removal from office should be allowed only on specific grounds, such as serious misconduct, incapacity, a material breach of the founding treaty, or a significant failure of fiduciary responsibility. It should not be permissible to remove someone from office simply because their scientific assessment is politically inconvenient for certain Member States.

6.5 Independent Integrity and Oversight Offices

The IHC would maintain independent oversight functions separate from the Secretariat and accountable through four clearly defined roles:

1. Independent Ethics Commissioner

The Ethics Commissioner would oversee declarations of interest, conflict-of-interest procedures, and ethical standards for senior officials, scientific panels, and external experts.

2. Inspector General

The Inspector General would investigate allegations of misconduct, abuse of authority, serious procedural failures, misuse of institutional resources and breaches of internal governance requirements.

3. Independent Auditor

Financial statements, internal controls, and expenditure would be subject to an independent external audit, which would be published in full.

4. Scientific Ombudsman

The Scientific Ombudsman would provide an independent mechanism for concerns involving scientific process, including alleged suppression of evidence, inappropriate interference with assessments, failure to disclose material uncertainty or exclusion of legitimate scientific disagreement.

These functions could share administrative infrastructure while retaining clearly separated responsibilities and independence from those they oversee.

6.6 Whistleblower and Scientific Dissent Protection

Individuals should be able to identify failures within institutions or scientific practices without fear of retaliation. The foundational framework would explicitly protect staff, contractors, scientific advisers, and other participants who report suspected misconduct, financial irregularities, undisclosed conflicts of interest, evidence manipulation, or serious breaches of scientific procedures. This protection would also apply to good-faith scientific disagreements.

Experts should not face institutional disadvantages simply because they challenge a majority assessment or question an established position within the institution. When significant disagreements persist after a scientific review, minority opinions should be eligible for publication, as outlined in Section 3.3.

Confidential reporting mechanisms would be available, with allegations assessed independently of the relevant management structures.

Whistleblower protection would not extend to intentional fabrication, malicious allegations, or violations of legitimate confidentiality obligations. Its primary purpose is to protect good-faith reporting and scientific challenges.

6.7 Independent Review and Institutional Evaluation

The IHC itself would be subject to periodic independent review, which should examine operational performance and whether the institution remains within its Treaty boundaries.

The review would assess:

- Scientific quality and methodological performance;

- Financial management and independence;
- Governance effectiveness;
- Conflicts of interest;
- Effectiveness of core capabilities;
- Organisational size and administrative costs;
- Compliance with Treaty exclusions; and
- Whether existing programmes continue to satisfy the Treaty Remit and Subsidiarity Test established in Section 3.7.

This last function is particularly important: Institutional review should examine whether programmes remain necessary rather than assuming that established activities should continue indefinitely.

Reviews would be conducted by independent panels appointed through a transparent process and published in full. Recommendations would require a formal response from the Governing Council.

6.8 Member-State and National Accountability

The IHC would publish an Annual Accountability Report detailing its activities, expenditures, scientific outputs, performance against agreed-upon objectives, identified failures, and responses to independent oversight. This report will be sent to every Member State.

Each state would have the authority to determine how the report should be scrutinised within its own national constitutional and legal framework, which may include review by national legislatures, audit institutions, or other relevant bodies.

A biennial Member-State Review Conference would serve as a platform for examining institutional performance, finances, and compliance with the Treaty requirements.

This conference would not be used to negotiate scientific conclusions; its primary purpose is governance and accountability.

Major concerns raised by independent oversight bodies will be publicly discussed, alongside the Governing Council's responses.

This structure ensures accountability in both directions: the Secretariat would be accountable to Member States for the institution's administration, while representatives of Member States would remain accountable through their own national governance processes.

The governance model delineates three forms of authority:

I. Member-State authority over the Treaty, budget, appointments, and institutional priorities;
II. Scientific authority governed by transparent evidence and methodological processes; and
III. Independent oversight authority focused on integrity, financial matters, misconduct, and compliance with the Treaty Articles.

No single entity within the institution would have control over all three forms of authority.

This separation aims to safeguard both democratic legitimacy and scientific independence, while also keeping the IHC's administrative authority limited. Member States would govern the institution;

the scientific conclusions will be based on evidence; and independent oversight would ensure accountability for both.

Part III

7. Treaty Safeguards

The effectiveness of the International Health Council's Treaty limits should not depend upon the goodwill or restraint of those temporarily governing the institution.

The safeguards established in this chapter would therefore be embedded within the IHC's founding framework and capable of alteration only through the formal Treaty amendment processes agreed by Member States. They would protect six elements of the institutional model: limited remit, financial independence, scientific independence, independent appointments, restraint during emergencies and Treaty accountability.

7.1 Protection of Mission and Treaty-Defined Remit

The IHC's mission and authorised functions would be defined by its founding treaty. Neither the Governing Council nor the Secretariat could expand that remit through administrative decisions, programme development, funding arrangements or broad interpretation of the institution's objectives.

The Treaty Remit and Subsidiarity Test established in Section 3.7 would apply to every significant new activity and periodically to existing programmes. This would create a continuing requirement to demonstrate:

Treaty-defined purpose — the activity falls within a function expressly authorised by the Treaty Articles;

International added value — undertaking the activity through the IHC provides demonstrable benefit, whether through cross-border necessity, shared scientific capability, reduced duplication, access to specialist expertise or scientific and technical support to Member States; and

Subsidiarity — IHC involvement extends no further than necessary to realise that international added value, with responsibility remaining at national or other appropriate levels where the objective can be achieved effectively there.

All three requirements would need to remain satisfied throughout the life of an activity.

Satisfaction of the test would not enlarge the IHC's authority. Reserved governmental competences would remain with Member States, while individual autonomy, bodily integrity and informed consent would remain protected as standing limitations under the Treaty Articles.

An activity undertaken previously, or temporarily during an emergency, would not become part of the permanent mandate merely because the IHC had acquired experience, staff, or infrastructure

associated with it. Similarly, the availability of funding, political support or institutional expertise should not overrule the Treaty Remit and Subsidiarity Test.

Where an activity no longer satisfies the Treaty Remit and Subsidiarity Test, it should be modified or discontinued. This would create a presumption against institutional accumulation and ensure that the IHC's remit remains determined by its Treaty rather than by the gradual expansion of its activities.

7.2 Financial Independence and Funding Safeguards

Financial independence would be treated as a Treaty safeguard rather than simply a budgeting objective.

The IHC's Treaty-defined functions would be financed through collectively determined Member-State funding, calculated under a formula agreed within the governing framework.

No Member State would acquire additional voting rights, scientific influence or institutional privileges because it contributed a larger financial amount.

The IHC would not accept financial or in-kind contributions for its Treaty-defined functions from commercial entities, philanthropic foundations, NGOs, professional organisations or other non-state interests. This prohibition would remove the distinction between unrestricted and earmarked external funding: neither would finance the institution's core work.

Member States would also be unable to earmark collectively determined Member-State funding for preferred programmes. Priorities would be determined collectively through the agreed budget and work programme.

Member States would retain the right to propose new scientific activities, but approval would depend on evidence, international need, and compliance with the Treaty Articles rather than on the availability of funding from the proposing state.

All income, expenditure, contracts and significant financial commitments would be publicly reported and independently audited. A financial contingency reserve could be maintained for emergencies so that urgent scientific work did not require rapid fundraising from interested external parties.

The principle would be that those who govern the institution under its Treaty framework collectively accept responsibility for financing its authorised functions.

7.3 Scientific Independence, Transparency and Conflicts of Interest

Scientific independence would be protected through procedures that make the basis of IHC conclusions open to scrutiny. Major scientific assessments would publish their methods, evidence sources, protocols, analytical decisions and judgements concerning uncertainty wherever legally and ethically possible. Expert membership and relevant declarations of interest would also be publicly available, and conflicts would be assessed independently rather than solely by the relevant scientific panel.

Disclosure alone would not always be sufficient. A significant direct financial or professional interest could require restriction of participation or recusal from decisions.

Scientific panels would retain control over their findings once appointed. Neither the Governing Council, the Secretariat, nor individual Member States could require the alteration of a scientific conclusion for political or financial reasons. Material scientific disagreement would remain visible through publication of minority opinions where appropriate.

The IHC would also maintain transparent correction and version-control procedures. Changes to major scientific outputs would identify what changed, why it changed, and the evidence supporting the revision. Transparency would therefore function as an operational safeguard for independence, allowing Member States and external researchers to examine how conclusions were reached rather than relying solely upon institutional assurances.

7.4 Appointment and Institutional Independence Safeguards

The appointment arrangements established in Chapter 6 would themselves be protected by the Treaty Articles.

Senior positions would be filled through open competition against published professional criteria. Candidates would need to disclose relevant interests before appointment, and appointment decisions would be documented. The principal executive leadership would serve a single non-renewable term. Senior scientific positions requiring protection from political influence could operate under similar arrangements. Removal would be permitted only for defined causes, including serious misconduct, incapacity, a substantial breach of Treaty responsibilities, or a significant fiduciary failure.

Disagreement with an official's scientific conclusions would not constitute grounds for removal.

Appointments to scientific panels would similarly be based upon expertise and relevant methodological competence rather than geographical or political representation alone. Geographical diversity should be sought, but it should not convert scientific panels into negotiating bodies representing national positions.

The objective would be to ensure that those responsible for institutional management remain accountable. In contrast, those responsible for scientific assessment remain capable of reaching conclusions that may be inconvenient to governments, funders or other interests.

7.5 Emergency Powers and Temporary Measures

Health emergencies pose specific risks to institutional expansion because decisions often must be made rapidly and under conditions of uncertainty.

The Founding Treaty framework would therefore establish explicitly that an emergency accelerates authorised functions but does not enlarge IHC authority.

During an emergency, the IHC could intensify surveillance, expand laboratory and genomic coordination, convene scientific groups, undertake rapid evidence assessments and communicate

frequently with Member States. It could also use pre-authorised contingency funds to support these activities.

Emergency status would not create powers to compel Member States to adopt specific interventions or to bypass the Treaty exclusions established in Chapter 5.

Temporary emergency committees, programmes and administrative arrangements would have defined purposes and automatic sunset provisions. Continuation beyond the specified period would require review against the Treaty Remit and Subsidiarity Test.

Emergency scientific procedures could be accelerated, but changes in methodology would be documented. Uncertainty should be communicated more explicitly when evidence is limited, not concealed because circumstances are urgent. The Founding Treaty framework would therefore seek to provide operational speed without expanding the Treaty.

7.6 Amendment, Review and Treaty Accountability

A limited institution must be capable of adapting without allowing ordinary governance procedures to alter its constitutional boundaries.

Changes to administrative procedures or scientific methods could be approved through normal governance arrangements where they remained within the existing mandate.

Changes affecting the IHC's Treaty-defined functions, powers, funding principles or exclusions would require formal amendment. These proposed amendments would be published in advance together with an explanation of their purpose and implications.

A high threshold of Member-State approval should be required for Treaty change, followed, where necessary, by acceptance through the domestic governance processes of the participating states.

The Governing Council could therefore propose constitutional change but could not accomplish it through ordinary resolutions or administrative practice. Independent review would provide an additional safeguard.

As established in Section 6.7, periodic institutional evaluations would assess whether programmes remained within the authorised remit, whether Treaty exclusions had been respected and whether organisational structures had developed beyond what was necessary for the institution's functions.

Member States should also have a defined procedure for challenging an IHC activity that is alleged to exceed its Treaty-defined mandate. Such disputes should be considered through an independent Treaty compliance review mechanism, with its reasoning published. The purpose would be to ensure that Treaty limits are testable and enforceable, rather than existing solely as statements of institutional intent. Together, these safeguards would create several mutually reinforcing barriers against institutional drift.

Mission boundaries would determine what the IHC may undertake. Financial safeguards would prevent external funding from creating alternative institutional priorities, while scientific safeguards would protect the assessment of evidence from political and financial interference, and appointment safeguards would reduce dependence of senior leadership upon political renewal.

Emergency safeguards would also prevent crises from becoming a mechanism for permanent expansion. Amendment and review safeguards would ensure that changes to institutional authority occur openly and with explicit consent from Member States.

The purpose of these safeguards is to make specific forms of failure more difficult to produce and easier to identify. The model therefore relies upon safeguards rather than institutional trust alone, with clear limits, independent scrutiny, transparent science, predictable financing and formal procedures for constitutional change.

Part III

8. Independence and Funding

Financial independence would be a core feature of the International Health Council. The IHC would be financed collectively by its Member States and would not depend upon commercial organisations, philanthropic foundations, NGOs or other non-state interests to perform its Treaty-defined functions.

The funding model would align governance, responsibility and financing: the states that collectively determine the institution's authorised work would also collectively provide the resources required to undertake it.

8.1 Member-State Funding Model

The IHC would be funded solely through collectively determined Member-State contributions. These contributions would be calculated using an agreed-upon formula that reflects each state's capacity to contribute, ensuring that lower-income countries are not hindered from participating by excessive financial burdens.

The assessments would be approved collectively as part of a multi-year budget.

It is essential to note that financial contributions will not dictate governance authority. Member States that contribute larger amounts would not receive additional voting rights, appointments, or influence over scientific priorities.

The budget should ensure sufficient and predictable financing for the IHC's two main areas: Cross-Border Health Protection and International Scientific Resources, along with the necessary administrative and oversight functions to support these areas.

Additionally, a separately identified contingency reserve would be established to finance rapid scientific activities in response to international health emergencies. This reserve would allow for the expansion of surveillance, laboratory coordination, rapid evidence reviews, and other authorised functions without the need for emergency fundraising from external sources.

Persistent arrears would be managed through transparent procedures outlined in the founding treaty, with particular attention given to those genuinely unable to pay.

The funding model would be based on a simple principle: those who collectively govern the institution should also collectively finance its Treaty-defined functions.

8.2 Prohibition of Non-State Funding and Financial Influence

The IHC would not accept financial sponsorship for its Treaty-defined functions from commercial entities, philanthropic foundations, NGOs, professional associations, or any other non-state interests.

This prohibition extends to any material arrangements that could create financial dependence or exert preferential influence over the institution's priorities.

No external organisation would be able to finance a specific IHC programme, guideline, evidence review, or technology appraisal to secure its initiation or continuation. This is particularly important when an organisation has a commercial, political, or institutional interest in the outcome of the scientific work.

However, these funding restrictions would not prevent scientific participation. Pharmaceutical and medical technology manufacturers may submit clinical trial data, study reports, and other evidence relevant to technology appraisals. Universities and research organisations can contribute their expertise. Professional associations, patient organisations, NGOs, and other interested parties can submit evidence and participate in appropriately structured consultations.

Transparent conflict-of-interest and disclosure procedures would govern such participation. The distinction is clear: interested parties may contribute evidence and expertise, but they may not influence scientific priorities or institutional decisions through financial means.

If specialist expertise, laboratory capacity, or other scientific resources are provided through collaborative arrangements, any material financial interest must be disclosed and assessed under the IHC's conflict-of-interest framework.

Maintaining financial independence is essential to protect scientific judgment while still allowing the institution to benefit from legitimate external expertise.

8.3 Budgetary Governance and Financial Controls

The Governing Council will collectively approve the IHC's budget within the Founding Treaty framework established in Chapter 3.

Individual Member States would not be allowed to earmark their collectively determined Member-State funding for specific programmes. This approach prevents the funding model from replicating the fragmentation that the ban on external earmarking seeks to avoid.

The prohibition on earmarking would not prevent Member States from proposing new programmes or scientific priorities. A Member State seeking additional IHC activity would submit a proposal through the established governance process, supported by evidence demonstrating the scientific or medical need, the added value of international cooperation and consistency with the IHC Treaty Articles.

The proposal would be assessed on its merits and against the Treaty Remit and Subsidiarity Test, independently of the proposing state's willingness or capacity to provide additional funding. If approved, the activity would be added to the collectively agreed work programme, and resources

would be allocated through the IHC budgetary process. A Member State could therefore make the case for a programme; it could not secure that programme simply by offering to finance it.

Therefore, scientific and medical need would determine whether an activity should be undertaken; the availability of earmarked funding would not.

Priorities would be determined through the agreed work programme and budgetary process, within the limits established by the Treaty Articles. Budgets would clearly differentiate between the following categories:

- Core scientific functions
- Administration and governance
- Independent oversight
- Technical assistance
- Capital and infrastructure expenditure
- Emergency contingency reserves

Significant expenditures would be subject to defined authorisation and procurement requirements. Competitive procurement methods would be employed where applicable, with contracts awarded based on published criteria and disclosed, subject to legitimate confidentiality requirements.

Administrative growth would also be monitored. The goal of financial control is not merely to prevent improper expenditures but to ensure that institutional resources focus on the functions for which the IHC was established.

Periodic reviews will assess administrative costs, staffing, programme expenditures, and scientific performance. New programmes that require substantial ongoing expenditures must have a designated budget provision and demonstrate compliance with the Treaty criteria outlined in Section 3.7. The availability of funding alone shall not justify institutional expansion.

8.4 Financial Transparency, Audit and Accountability

The IHC would operate under a presumption of financial transparency. Its approved budget, assessments from Member States, contributions received, significant expenditures, and annual financial statements will be made publicly available.

Reporting would enable Member States and external observers to understand not only how much the institution spends but also where resources are allocated and for what purposes.

Annual accounts will be subject to an independent external audit. The auditor will have access to the financial records necessary to assess expenditures, internal controls, procurement, and compliance with the institution's financial rules. Audit findings will be published along with the IHC's formal response.

The Inspector General, established under Section 6.5, would have the authority to investigate suspected misuse of funds, procurement irregularities, undisclosed financial interests, or attempts to circumvent the prohibition on external funding.

Significant contracts and procurement relationships will be disclosed, including the identities of contractors and the nature and value of the work, subject only to narrowly defined legal or security exceptions.

Financial performance will be included in the Annual Accountability Report described in Section 6.8 and will be considered during the biennial review of Member States.

This combined system will provide four layers of financial protection:

I. Predictable financing from Member States;
II. Prohibition of interested external funding;
III. Collective budgetary control; and
IV. Independent, publicly reported financial scrutiny.

While these arrangements cannot guarantee that financial influence or misuse will never occur, they will remove a significant structural source of potential influence by ensuring that the IHC does not rely on organisations affected by or interested in its scientific work. As such, financial independence would be regarded as a component of scientific independence, rather than as a separate administrative concern.

Part IV

9. Scientific Governance Principles

The International Health Council will require detailed scientific operating procedures for various functions, including surveillance, laboratories, genomics, evidence synthesis, guideline development, and technology appraisal.

These procedures should not be permanently fixed within the founding framework. Since scientific methods, technologies, and data systems evolve, an institution established for long-term international cooperation must differentiate between stable scientific principles and adaptable operational methods.

The governing principle is as follows:

The IHC should be prescriptive through its Treaty Articles regarding scientific principles, while remaining operationally adaptable in its scientific methods.

The founding framework would establish the standards that all IHC scientific work must meet. During its first year, the IHC will translate these principles into a comprehensive Scientific Operating Framework that will cover its two main areas of focus: Cross-Border Health Protection and International Scientific Resources. This framework will be maintained as a transparent and continuously reviewed collection of scientific methods.

The institution would operate under common scientific governance principles that apply to all its activities, whether addressing an emerging infectious threat, laboratory standards, systematic reviews, clinical guidelines, or technology assessments.

9.1 Scientific Independence

While Member States would govern the institution, they would not negotiate the scientific findings. The Secretariat would coordinate scientific work but would not alter conclusions for administrative, political, or reputational reasons.

Commercial organisations, foundations, NGOs, professional organisations, and other interested parties could submit evidence and expertise through transparent processes, but they could not finance scientific work or influence its conclusions. Scientific panels would retain responsibility for their assessments once properly constituted. Attempts to improperly influence conclusions would be reportable to the Scientific Ombudsman and other independent oversight mechanisms established in Chapter 6. Therefore, scientific independence would be protected institutionally rather than relying solely on the integrity of individual experts, with scientific conclusions based on evidence and appropriate scientific methods.

9.2 Methodological Rigour and Evidence Standards

IHC scientific work would utilise methods appropriate to the questions being addressed. Protocols would be established prospectively wherever practical. Methods, eligibility criteria, analytical approaches, and any significant deviations from protocols would be well-documented.

Different forms of evidence would be clearly distinguished. Randomised trials, observational studies, diagnostic studies, surveillance observations, laboratory evidence, genomic information, modelling, mechanistic evidence, and expert judgment would not be presented as if they provided equivalent forms of inference. Scientific assessments would identify the strengths and limitations of the available evidence and the extent to which conclusions depend on assumptions or indirect evidence.

During emergencies, methods could be accelerated, but scientific standards would not be compromised. Rapid assessments would clarify where speed required methodological compromises and how those compromises affected certainty. The objective would be to ensure that urgency alters the speed of assessment, not the meaning of the evidence.

9.3 Transparency, Uncertainty and Scientific Disagreement

Transparency is considered an essential component of scientific methodology. Key outputs from the IHC would clearly identify the evidence reviewed, the methods employed, any critical missing information, and significant limitations that may affect interpretation. Uncertainty in the findings shall be reported explicitly.

Scientific outputs should clearly distinguish among established findings, probable interpretations, preliminary signals, modelled scenarios, and unresolved questions. If crucial evidence requested from Member States, manufacturers, or other stakeholders is not available, this absence will be documented, along with its implications for the assessment.

Scientific disagreements must also be clearly acknowledged. While consensus can aid decision-making, it will not replace the need for evidential certainty. If qualified experts arrive at materially different interpretations, significant minority opinions will be published alongside the principal assessment. Additionally, scientific outputs will maintain version histories to enable tracing of any changes in conclusions back to the evidence that influenced them.

9.4 Conflicts of Interest and External Scrutiny

All individuals who play a significant role in IHC scientific assessments would be required to submit appropriate declarations of interest. Relevant financial, professional, and other interests will be assessed independently. Disclosure of an interest does not automatically grant permission to participate. If an interest poses a significant risk to independence, participation may be restricted, or recusal may be necessary.

External scrutiny would be an integral part of the scientific process. Major methodological frameworks and significant scientific assessments should be open to appropriate external peer review. Researchers and organisations will have the opportunity to submit substantive methodological critiques or contrary evidence through established procedures.

Part IV

10. First-Year Scientific Operating Framework

In its first year, the IHC would create and publish a comprehensive Scientific Operating Framework. This framework will translate the Founding Treaty principles and scientific governance requirements outlined in this report into detailed operational methods. It will be developed before the IHC takes on the full range of scientific functions anticipated in Chapter 4.

10.1 Purpose and Scope

The Scientific Operating Framework would establish common rules governing the commissioning, conduct, review, publication and updating of IHC scientific work.

It would specify:

- Responsibilities for scientific decision-making;
- Minimum methodological requirements;
- Data-access and transparency standards;
- Conflict-of-interest procedures;
- Peer-review processes;
- Uncertainty and confidence classifications;
- Correction and version-control procedures;
- Publication standards; and
- Mechanisms for methodological challenge and appeal.

The framework would distinguish between requirements applicable across the whole institution and methods specific to scientific functions.

Detailed methods would sit below the Founding Treaty and the Founding Treaty framework. They could therefore evolve scientifically without requiring treaty amendment, provided that changes remained consistent with the Founding Treaty principles.

10.2 Cross-Border Health Protection Framework

The first component would establish detailed operating methods for Cross-Border Health Protection. It would cover international surveillance, early warning, epidemiological information exchange, laboratory networks, pathogen genomics and emergency scientific assessment.

The framework would establish procedures for:

- Identifying and evaluating surveillance signals;
- Verifying reports;
- Distinguishing preliminary signals from confirmed findings;
- Grading confidence in available information;
- Sharing epidemiological and genomic data;
- Laboratory quality assurance;
- Common reference methods;
- Communicating international alerts;
- Handling incomplete or conflicting information; and
- Updating assessments as evidence changes.

Attention would be given to interoperability between national systems. The objective would not be to replace national surveillance or laboratory infrastructure, but to establish the common methods required for those systems to cooperate effectively.

10.3 International Scientific Resources Framework

The second component would establish operating methods for International Scientific Resources. It would cover systematic reviews, living evidence, guideline development, comparative effectiveness assessment, technology appraisal and related evidence functions.

The framework would establish methods for:

- Question formulation;
- Prospective protocols;
- Evidence searching and retrieval;
- Assessment of risk of bias;
- Evidence synthesis;
- Evaluation of benefits and harms;
- Certainty assessment;
- Use of regulatory and unpublished evidence;
- Guideline development;
- Technology appraisal;
- Economic evidence where relevant;
- Management of expert judgement;
- Publication of minority opinions; and
- Updating scientific outputs.

Special attention would be given to access to underlying evidence. Where manufacturers or other organisations sought assessment of health technologies, the IHC would establish minimum evidence requirements necessary for independent appraisal.

The framework would preserve the distinction between international scientific assessment and national regulatory, reimbursement or clinical decisions.

10.4 Common Data, Evidence and Transparency Standards

Both scientific domains would operate through common standards for data provenance, evidence transparency and reproducibility.

Scientific outputs should allow an independent qualified reader to understand:

- Where the evidence came from;
- How it was assessed;
- What assumptions were made;
- What information was unavailable;
- How uncertainty was judged; and
- Why the IHC reached its conclusion.

Where confidentiality, privacy, intellectual-property or security restrictions prevented full publication, the restriction and its implications would be stated.

The IHC would seek to minimise dependence upon evidence that could not be independently scrutinised. These common standards would ensure that surveillance assessments, systematic reviews, guidelines and technology appraisals remained recognisably part of the same scientific institution even though their detailed methodologies differed.

Part IV

11. Development and Continuous Review

The development of the Scientific Operating Framework should follow a scientific process. The methods for this framework should not be solely determined by the Secretariat or negotiated politically among Member States.

11.1 Independent Methodological Working Groups

During the establishment year, the IHC would appoint independent methodological working groups to carry out its principal scientific functions. Membership for these groups will include experts from national public health agencies, laboratories, universities, evidence synthesis organisations, clinical research, epidemiology, statistics, health technology assessment, and other relevant disciplines.

These working groups will review existing international and national methodologies instead of assuming that entirely new systems need to be created. The goal is to identify methods that are scientifically defensible, transparent, and suitable for international use. Conflicts of interest will be declared and managed according to the principles established in Chapters 6 and 7.

11.2 Public Consultation and External Peer Review

Draft components of the Scientific Operating Framework would be published for public consultation.

Member States, researchers, clinicians, professional organisations, patient groups, industry representatives, and other interested parties will have the opportunity to submit evidence and provide methodological comments. It is important to note that participation in the consultation process will not grant any decision-making authority.

Additionally, major methodological frameworks would undergo independent external peer review. Responses to substantial comments from the consultation and peer review will be published, including explanations for any recommendations that were not adopted. This process will allow for scrutiny of the operating framework before it becomes institutional practice.

11.3 Pilot Testing and Implementation

Before full implementation, important scientific processes should be tested through pilot exercises. These could include:

- International surveillance simulations
- Laboratory and genomic data-sharing exercises
- Rapid evidence assessments
- Living systematic reviews
- Guideline development exercises
- Technology appraisals

These pilot tests would determine whether the proposed methods are feasible, reproducible, and capable of producing useful outputs in various Member State settings. Any identified weaknesses will be addressed before the methods are adopted for routine use.

The Governing Council would confirm that the development process has been completed properly, is adequately resourced, and remains within the IHC's Treaty-defined remit. However, it will not determine the scientific content of the methods.

11.4 Periodic Review and Methodological Updating

The Scientific Operating Framework would serve as a living methodological system. Formal reviews will occur at defined intervals and may also be prompted by significant advancements in science or technology. New methods should be adopted when evidence shows that they enhance reliability, efficiency, transparency, or scientific validity. This means that technologies such as artificial intelligence, automated evidence surveillance, genomic technologies, and new analytical methods can be incorporated as they develop, without the need to amend the Treaty Articles.

Any substantial methodological changes would be documented, justified, and subjected to appropriate external scrutiny. Previous versions of the methods will remain publicly accessible. The IHC will clearly distinguish between Treaty stability and methodological adaptability. Its mission, powers, exclusions, and scientific principles will be difficult to alter, while its scientific methods are expected to improve over time.

Part IV establishes an operational principle rather than attempting to predetermine the IHC's future technical manuals. The founding framework will set the standards that IHC science must meet. The Scientific Operating Framework for the first year will determine how these standards are implemented across Cross-Border Health Protection and International Scientific Resources. Detailed methods manuals and standard operating procedures will then translate the framework into specific scientific processes, remaining open to continuous improvement.

The resulting hierarchy will be as follows:

I. **Funding Treaty and Founding Treaty framework:** Defines the mission, powers, exclusions, and institutional boundaries.
II. **Scientific Governance Principles:** Establishes the standards applicable to all IHC science.
III. **Scientific Operating Framework:** Developed during Year 1 for the two main scientific domains.

IV. **Methods Manuals and Standard Operating Procedures:** Provide detailed, updatable procedures for individual scientific functions.

This approach allows the IHC to maintain constitutional stability while science continues to evolve. The institution would be grounded in its principles and boundaries but intentionally equipped to change its methods as better evidence and improved scientific practices become available.

Part V

12. Establishment and Implementation Programme

The International Health Council should be established gradually rather than taking on all its functions immediately. The initial priority is to create the Treaty framework, governance, financial, and scientific foundations necessary for a credible international institution. Operational capabilities should then be introduced in phases and assessed before further expansion.

The guiding principle is that institutional credibility must be established before scaling up operations. Therefore, the timeline should be flexible and responsive to readiness rather than strictly adhering to predetermined dates.

12.1 Establishment Principles

Five principles would guide implementation.

I. **Constitution before operations:** The founding treaty, Treaty limits, governance arrangements and exclusions should be established before the institution assumes significant operational responsibilities.

II. **Scientific methods before scientific authority:** The Scientific Operating Framework described in Part IV should be developed, consulted upon and tested before the IHC begins issuing major international assessments, guidelines or appraisals.

III. **Capability before expansion:** New functions should be introduced only when the institution possesses the scientific, technical and governance capacity required to perform them reliably.

IV. **Distributed expertise before institutional growth:** The IHC should, wherever possible, draw on existing national agencies, laboratories, universities, evidence organisations, and scientific networks rather than automatically creating permanent internal departments.

V. **Evaluation before consolidation:** Early operations should be treated as opportunities to test the institutional model. Weaknesses should be corrected before programmes become permanent or substantially expanded.

These principles are intended to prevent the establishment process itself from generating premature institutional growth.

12.2 Establishment Phase — Year 1

The first year would focus primarily on building the institution rather than maximising its operational activity.

Constitutional and Governance Foundations

Participating states would finalise and adopt the founding treaty that establishes the IHC's mission, Treaty-defined remit, exclusions, governance arrangements, and financing principles.

The establishment of the IHC would not necessarily require universal participation at its inception. A group of willing states could negotiate and become parties to the founding Treaty, with accession remaining open to other sovereign states that subsequently wished to participate and accepted the Treaty Articles.

The initial Governing Council would then be constituted. Its early responsibilities would include establishing governance procedures, approving the initial budget and overseeing the appointment of senior leadership. The independent integrity and oversight arrangements described in Chapter 6 would also be established during this phase, including the functions of the Ethics Commissioner, Inspector General, Independent Auditor and Scientific Ombudsman.

The establishment process would also determine the IHC's international legal personality and any strictly necessary functional privileges and immunities, as well as appropriate mechanisms for accountability and redress.

Whistleblower and scientific-dissent protections should be operational before substantive scientific programmes begin.

Leadership and Secretariat

Senior leadership would be appointed through the open procedures established in Chapter 6. A small initial Secretariat would then be recruited to provide the administrative, scientific-coordination and technical capacity necessary for establishment. Recruitment should be linked to defined institutional requirements rather than assumptions about the eventual size of the organisation. The first-year staffing model should therefore remain deliberately limited.

Financial Establishment

Member States would agree to the initial assessed contribution formula and approve a multi-year establishment budget in accordance with the principles set out in Chapter 8. The budget would provide for the Secretariat, scientific development, governance and oversight, initial infrastructure and an appropriate contingency reserve. The establishment phase should not depend upon non-state fundraising.

Scientific Operating Framework

One of the most important Year 1 deliverables would be the Scientific Operating Framework

established in Part IV. Independent methodological working groups would develop the detailed scientific procedures required for the IHC's two principal domains:

Cross-Border Health Protection, and International Scientific Resources.

Draft methods would undergo public consultation, external scientific review and appropriate pilot testing before adoption. The framework should establish the common standards required for evidence assessment, transparency, uncertainty, conflicts of interest, scientific disagreement and updating.

Scientific Networks and Infrastructure

The IHC would begin developing the distributed scientific networks required for future operations. This would include identifying potential participating national agencies, laboratories, genomic centres, universities, evidence synthesis groups, clinical networks, and health technology assessment expertise.

Initial digital infrastructure would also be developed for secure scientific collaboration, evidence management, publication and transparent version control. The objective would be interoperability rather than centralisation.

Pilot Programme

Selected core processes should be tested before full operational launch.

Pilots could include:

- An international surveillance and signal-verification exercise;
- A laboratory or genomic information-sharing exercise;
- A rapid evidence assessment;
- A living systematic review;
- A clinical guideline exercise; and
- A health technology appraisal.

These pilots would test methodology, governance, transparency, conflicts-of-interest procedures, scientific review and practical usability by Member States.

Readiness Assessment

At the end of the establishment phase, the IHC should undergo a formal operational readiness assessment. The assessment would determine whether the necessary governance, financing, scientific methods, oversight arrangements and technical infrastructure were sufficiently developed for initial operations. Operational launch should depend upon meeting published readiness criteria rather than simply reaching the end of Year 1.

12.3 Initial Operations — Years 2–3

Following successful readiness assessment, the IHC would begin controlled operational rollout. The objective would not be to activate every possible capability simultaneously.

Within Cross-Border Health Protection, the priority would be to establish reliable coordination for surveillance, early-warning assessments, and laboratory collaboration.

In the realm of International Scientific Resources, the IHC would begin producing selected evidence reviews, guidelines, and technology appraisals using the methods developed and tested during Year 1.

Early activities would be selected in part based on their ability to test the institutional model under various scientific conditions. Performance would be monitored using measures such as timeliness, methodological quality, transparency, Member-State utilisation, and compliance with Treaty requirements.

Any scientific and operational problems identified during these years should lead to methodological corrections rather than automatic programme expansion. Additionally, technical assistance and capacity building would commence upon request, with an emphasis on transferring capabilities to Member States.

By the end of Year 3, the IHC should have demonstrated that both key domains can function effectively within the Treaty boundaries and the scientific framework established in the first year.

12.4 Consolidation — Years 4–5

Years 4 and 5 would focus on consolidation rather than rapid institutional expansion.

Scientific networks could be strengthened where there is a demonstrated need, and methods would be refined based on operational experience. At the same time, evidence systems and surveillance infrastructure would mature, enabling Member States to assess better which services offer the greatest international value.

The Governing Council should avoid assuming that successful establishment requires continuous growth in programmes, staffing, or expenditure. Expanding existing functions would require evidence of demand and effectiveness, and any proposed new function must still meet the Treaty criteria established in Section 3.7.

Activities that are ineffective, duplicative, or insufficiently international in scope should be modified or discontinued. Thus, consolidation should involve both institutional re-evaluation and development.

12.5 Five-Year Independent Review

At the end of the fifth year, the IHC would undergo a comprehensive independent review. This would represent a major Treaty-compliance and institutional checkpoint.

The review would assess:

- Compliance with the founding treaty;
- Performance of Cross-Border Health Protection;
- Performance of International Scientific Resources;
- Scientific quality and methodological integrity;
- Transparency and management of uncertainty;
- Financial independence and expenditure;
- Effectiveness of governance and independent oversight;
- Usefulness to Member States;
- Organisational size and administrative burden;
- Evidence of mission creep;
- Effectiveness of Treaty safeguards; and
- Whether existing activities continue to satisfy the Treaty Remit and Subsidiarity Test.

The review should assess whether the IHC is duplicating functions already performed effectively by other organisations and whether there are opportunities to simplify its structure. The findings will be published in full.

The Governing Council must provide a formal public response to the review's findings. Major institutional expansions before the completion of the five-year review should occur only if they are clearly necessary.

12.6 Criteria for Success

The success of the IHC should be assessed against a limited set of principles:

1. Scientific Quality: Are assessments methodologically rigorous, reproducible, and appropriately responsive to new evidence?

2. Timeliness: Does the institution provide useful scientific information when Member States need it?

3. Transparency: Can external observers understand the evidence, methods, assumptions, uncertainties, and conflicts underlying major conclusions?

4. Member-State Usefulness: Are governments, national agencies, regulators, and health systems making practical use of scientific resources in IHC?

5. Independence: Are scientific conclusions demonstrably protected from political, financial, and commercial influence?

6. Compliance with the Treaty Articles: Does the institution remain within its authorised functions and respect the sovereignty and decision-making authority of Member States?

7. Efficiency: Does international cooperation reduce unnecessary duplication and provide scientific capability that is proportionate to the resources committed?

These measures would provide a different conception of institutional success. The objective would not be to create an international health organisation that continually expands its activities. Instead, it would focus on performing a limited set of internationally valuable functions exceptionally well.

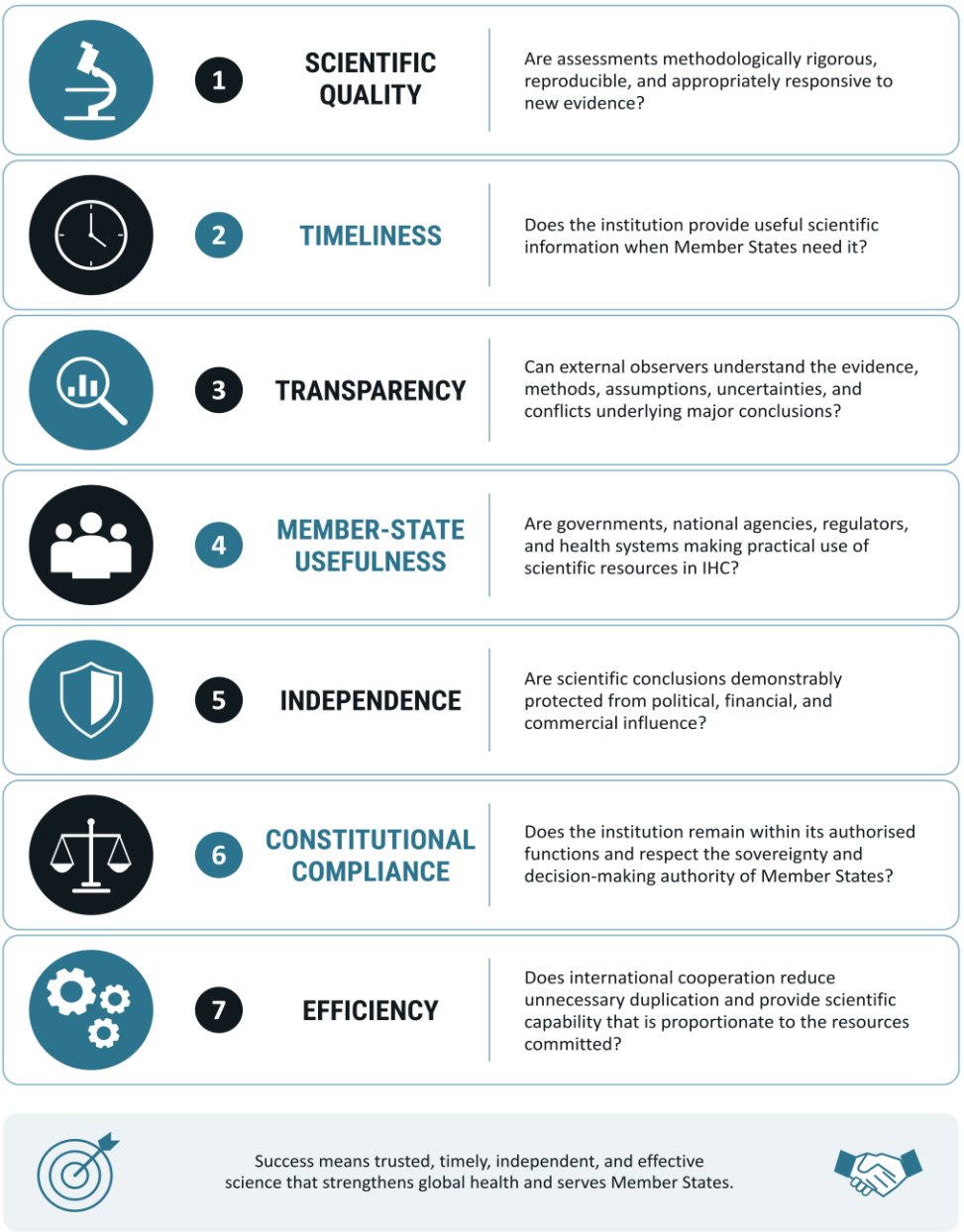
The establishment programme would follow a deliberate progression:

Year 1:	Establish the institution and its scientific operating framework.
Years 2-3:	Introduce and test core operations across the two scientific domains.
Years 4-5:	Consolidate, evaluate, and refine.
End of Year 5:	Conduct an independent institutional review.

The timetable will remain subordinate to institutional readiness. If governance safeguards, scientific methods, or operational systems are not ready, implementation should be delayed rather than rushed to meet an arbitrary deadline. Conversely, functions that can be delivered reliably through existing distributed capacity should not require the creation of unnecessary permanent structures.

12.6 CRITERIA FOR SUCCESS

The success of the IHC should be assessed against a limited set of principles:



Part VI

13. Risks, Criticisms and Responses

When considering the replacement or significant redesign of an established global institution, it's essential to weigh the strongest objections to such a change. The introduction of the IHC would not resolve the inherent challenges of international cooperation; instead, it would establish new institutional arrangements and, consequently, introduce different risks. The purpose of this section is to examine those risks directly.

Is a new international institution necessary?

Not necessarily. If the WHO can effectively address the structural problems identified in Parts I and II through sustainable reform, then creating a new institution would impose substantial, potentially unnecessary costs.

The WHO has established scientific networks, experienced staff, government relationships, and decades of institutional knowledge. These assets should not be overlooked.

The argument for creating the IHC depends on a more specific proposition: several recurring problems arise from WHO's underlying institutional framework rather than solely from management failures. These issues include the broad scope of its constitutional mandate, reliance on voluntary funding, the coexistence of political and scientific functions, susceptibility to geopolitical pressures, and the lack of a strong subsidiarity test that limits international intervention.

Addressing all these issues through reform would necessitate significant changes to WHO's mandate, financing, governance, and operational model. At some point, extensive reforms could lead to a complete institutional redesign.

Therefore, the IHC proposal should be considered alongside serious reforms to the WHO rather than being presented as the sole solution. The appropriate comparison lies between alternative institutional designs and their ability to facilitate necessary international health cooperation while minimising predictable governance failures.

Could WHO simply be reformed?

Some current reforms address genuine weaknesses identified within the WHO. Member States have agreed to increase assessed contributions, governance structures have been revised multiple times, emergency capabilities have been strengthened following the Ebola outbreak, and additional reforms have been implemented following the COVID-19 pandemic.

However, Part II highlighted a recurring issue: reforms often improve the management of structural tensions without addressing their underlying causes.

For example, increasing assessed contributions reduces reliance on donor funding but does not eliminate the mixed financing model. Reforming appointments can diminish political incentives but does not remove the political control held by Member States. Enhanced oversight can examine mission expansion without establishing a Treaty-based subsidiarity test.

WHO could, in theory, adopt much of the institutional architecture proposed for the IHC. It could narrow its mandate, prohibit non-state financing of Treaty-defined functions, more clearly separate scientific assessment from political governance, introduce stronger Treaty exclusions, and restrict global activity through a subsidiarity principle.

Such reforms would materially change the character of WHO. The issue is therefore both practical and theoretical: whether an institution with accumulated programmes, structures, agreements and constituencies can be transformed more effectively than a deliberately limited model can.

Would the IHC duplicate existing institutions?

This presents a significant risk. International health encompasses national public health agencies, regulators, laboratories, universities, evidence organisations, health technology assessment bodies, and international networks.

The IHC should not replicate functions that these organisations already perform effectively. Its model should therefore rely on distributed capabilities rather than institutional duplication.

For Cross-Border Health Protection, national agencies and laboratories will continue to generate much of the underlying information and scientific expertise. The IHC's role would be to provide interoperability, coordination, verification, and international assessment.

Regarding International Scientific Resources, existing evidence organisations, universities, and specialist networks can contribute to systematic reviews, guidelines, and technology assessments.

The IHC should focus on commissioning, coordination, and quality assurance of scientific work rather than assuming that every capability requires a permanent internal department. Periodic institutional reviews should explicitly identify any duplication and recommend withdrawing support where international involvement no longer adds sufficient value. Thus, avoiding duplication is not merely an efficiency objective; it is a Treaty requirement that international activities demonstrate added value.

Could a limited mandate reduce effectiveness?

Yes, Treaty-based restraint involves a genuine trade-off. A narrowly mandated IHC could identify a health problem, assess the evidence, and recommend possible responses, but would lack the authority to implement them at the national level.

While this approach might seem less decisive than one that combines scientific assessment, policy advocacy, and programme implementation, the limitation is intentional. Scientific expertise does not automatically grant legitimacy in determining political trade-offs, which often involve expenditure, civil liberties, legislation, competing priorities, or national values. Therefore, the IHC model prioritises scientific credibility and national accountability over centralised implementation.

This approach might lead to greater variation between Member States. However, such variation should not be viewed as institutional failure. Countries differ in terms of demographics, resources, health systems, epidemiology, and public preferences.

The IHC should establish a robust common scientific foundation while allowing for legitimate national differences in implementation. When binding international action is truly necessary, states can negotiate agreements through appropriate intergovernmental processes outside the IHC framework.

Could sovereignty impede international cooperation?

Sovereign states can withhold information, decline recommendations, underinvest in preparedness, or implement policies that can have consequences for other countries.

The experience of COVID-19 clearly highlighted these limitations. The IHC model does not eliminate these issues. Instead, it acknowledges that international institutions rely on cooperation between sovereign governments and aims to enhance the value and trustworthiness of that cooperation. Member States would agree to certain obligations tied to their membership, including financial commitments and participation in collaborative scientific efforts.

If information necessary for an international assessment is unavailable or withheld, the IHC would transparently report this fact and include the resulting uncertainty in its conclusions.

The institution would encourage compliance through usefulness, reciprocity, scientific credibility, and reputational transparency, rather than relying on coercive authority. While this approach may be less robust than binding enforcement mechanisms, it allows international scientific cooperation to remain separate from global political control.

How would the IHC respond to a major pandemic or international incident?

A major pandemic would activate and enhance the existing capabilities of Cross-Border Health Protection. The IHC would intensify international surveillance, laboratory and genomic coordination, evidence assessment, and scientific communication.

Scientific networks could be convened quickly, surveillance signals verified, genomic information compared internationally, and rapid evidence reviews commissioned.

The institution would publish frequently updated assessments that distinguish between observed evidence, modelling, assumptions, and uncertainty.

Emergency contingency financing would allow these activities to expand without the need for seeking external funding. The IHC could advise Member States on the available evidence regarding interventions, diagnostics, therapeutics, and vaccines. However, it would not gain any additional authority conferred by the Treaty Articles simply because an emergency has been declared.

Decisions concerning border measures, isolation, vaccination, school closures, or other domestic interventions would remain with the individual Member States.

This structure is a deliberate feature of the model: while emergencies heighten the demand for swift scientific coordination, they do not eliminate the need for Treaty-based restraint.

How would scientific disputes be resolved?

Not every scientific dispute can or should be resolved through institutional means. Disagreements in science may arise from incomplete evidence, differing methodologies, or reasonable experts interpreting the same evidence differently. Therefore, the IHC will avoid considering consensus as the sole criterion for scientific validity.

Scientific assessments will adhere to predefined methods, ensure transparent evaluation of evidence, and undergo appropriate external reviews. In cases where disagreements involve methodology or the interpretation of facts, panels will be expected to clarify the basis for the differing positions.

Significant minority opinions may be published alongside the main assessment. Additionally, new evidence could prompt a formal reassessment, with previous versions retained for reference.

The Scientific Ombudsman would provide an independent avenue to address concerns about procedural interference, evidence suppression, or the inappropriate exclusion of scientific dissent. The goal is to resolve disputes through evidence and methodological scrutiny whenever possible, while acknowledging uncertainty and valid disagreement when a resolution is not yet achievable.

How would mission creep be prevented?

Preventing mission creep cannot rely solely on statements of institutional intent. Therefore, the IHC employs multiple safeguards. Its functions would be clearly defined by treaty. Any significant new activities must meet the Treaty requirements established in Section 3.7. Powers that are not explicitly granted would remain with the Member States. Chapter 5 would explicitly reserve authority over legislation, regulation, executive functions, and domestic policymaking. The availability of funding cannot lead to new competencies, and programmes would undergo periodic reviews to assess whether their original international justification remains valid. Emergency activities would be subject to sunset provisions, meaning they would automatically expire after a certain period unless renewed. Any expansion beyond the Treaty limits would require a formal treaty amendment, not just routine administrative or governing-body decisions.

While none of these mechanisms can eliminate mission creep, together they raise the institutional and political costs of expansion and make any changes in mandate more transparent. Thus, this model aims to replace institutional self-restraint with Treaty-based restraint.

How would political influence be controlled?

Member states are responsible for governing the institution, approving its budget, and appointing its senior leadership. The IHC separates political governance from scientific judgment. The Governing Council can establish institutional priorities within the framework of its Founding Treaty, but it cannot alter scientific findings through political resolutions.

Senior leadership would serve fixed, non-renewable terms, thereby decreasing motivation for reappointment. Scientific panels would be appointed based on their expertise and would operate in

accordance with published methods and conflict-of-interest procedures. Any attempts to improperly interfere with scientific work would be subject to independent oversight. Transparency acts as an additional safeguard; if Member States fail to provide relevant evidence, this absence can be reported rather than negotiated away.

The intended boundary is clear: governments govern the institution, while evidence governs its scientific conclusions.

How would funding independence be maintained?

The IHC would be financed through Member-State funding, as specified in Chapter 8.

Commercial organisations, philanthropic foundations, NGOs, and other non-state entities would not be allowed to fund the institution's Treaty-defined functions. Additionally, Member States would not be permitted to earmark their contributions for specific programmes.

This policy removes a significant mechanism that would have allowed institutional priorities to align with individual contributors' preferences.

Manufacturers, foundations, professional organisations, patient groups, and researchers would still be able to submit evidence and engage in transparent consultations. Their expertise can contribute to scientific assessments without influencing the funding.

To ensure accountability, independent audits, public financial reporting, and oversight by the Inspector General would provide additional safeguards. This model clearly distinguishes between participating in the scientific process and exerting financial influence over the institution conducting it.

What are the principal risks of the IHC model itself?

The IHC would come with its own set of risks. A smaller institution may lack the necessary resources or expertise. Treaty limitations could lead to excessive caution in decision-making. Relying on Member State financing might expose the organisation to political pressures or financial instability. Additionally, distributed scientific networks could create challenges in coordination. Evidence assessments produced at the international level may not readily adapt to different national contexts.

Moreover, prohibiting non-state funding could further limit the resources available. A new institution could gradually develop the same bureaucratic incentives identified in other sections of this report. There is also no assurance that governments would participate, fund, or cooperate adequately with the IHC.

These risks should be recognised rather than dismissed as issues that institutional design can simply eliminate. Instead, the proposal for the IHC aims to make these risks visible, reviewable, and correctable.

A limited mandate can help prevent bureaucratic expansion. Distributing expertise can alleviate pressure for organisational growth. Independent oversight can reveal governance failures. The Treaty Remit and Subsidiarity Test allows for the discontinuation of activities if necessary.

Additionally, a five-year independent review provides an opportunity to assess whether the model delivers adequate value to justify its continuation or requires modifications.

Consequently, the IHC should not be established on the premise that its design is infallible. Instead, it should operate under the understanding that institutions can fail and must be designed to enable failure detection, challenge, and corrective measures.

The criticisms considered earlier indicate that the IHC model involves genuine trade-offs. It would trade some potential global authority for the sake of national sovereignty, some possible funding for financial independence, and some institutional breadth for Treaty-based restraint.

These choices are intentional: The core argument of this report is that effective international health cooperation does not necessitate a progressively authoritative institution.

A more focused organisation could gain influence through the quality of its scientific work, the usefulness of its services, and the trust of its Member States. Thus, the justification for the IHC ultimately hinges on one fundamental question:

Does this model provide enough international scientific value to warrant the authority, resources, and responsibilities entrusted to it? If it does not, changes should be made.

This principle of institutional accountability should be applied to the IHC with the same rigour as it is applied to the institutions it aims to replace or reform.

Part VII

14. A Ten-Year Vision for International Health Cooperation

The International Health Council is proposed as a new model for international health cooperation—one that is scientifically ambitious yet institutionally restrained. Its long-term success should not be judged by the number of programmes it runs, the size of its workforce, the scope of its mandate, or the amount of money it spends.

Instead, success would be determined by whether the IHC provides scientific capabilities that Member States find valuable—capabilities they cannot easily reproduce on their own—and whether they can trust that these operations will be free from political, financial, or commercial interference.

The goal, therefore, is not to create a larger international health institution, but to develop one that is better defined and more credible.

14.1 The IHC After Five Years

By the end of its first five years, the IHC should demonstrate that its Treaty-based model is effective in practice.

The Cross-Border Health Protection capability should provide Member States with reliable international surveillance, early warning systems, laboratory coordination, and genomic information. The International Scientific Resources should offer accessible systematic reviews, living evidence, clinical guidelines, and technology appraisals for both communicable and noncommunicable diseases.

The Scientific Operating Framework should have been developed through practical application, external scrutiny, and methodological updates. Member States should clearly understand what the IHC does, what it does not do, and where decision-making responsibility lies.

An independent five-year review should serve as the first significant assessment of whether the institution has adhered to its Treaty mandate, maintained scientific independence, and provided sufficient value to justify continued international investment.

If any programmes have failed, they should be corrected or discontinued. If the institutional model itself proves ineffective, Member States should be open to reconsidering it.

14.2 The IHC After Ten Years

After a decade, the IHC should be a trusted component of the international scientific infrastructure without evolving into a powerful international bureaucracy.

Its surveillance and scientific networks should function seamlessly across national borders, enabling the swift identification and evaluation of emerging threats.

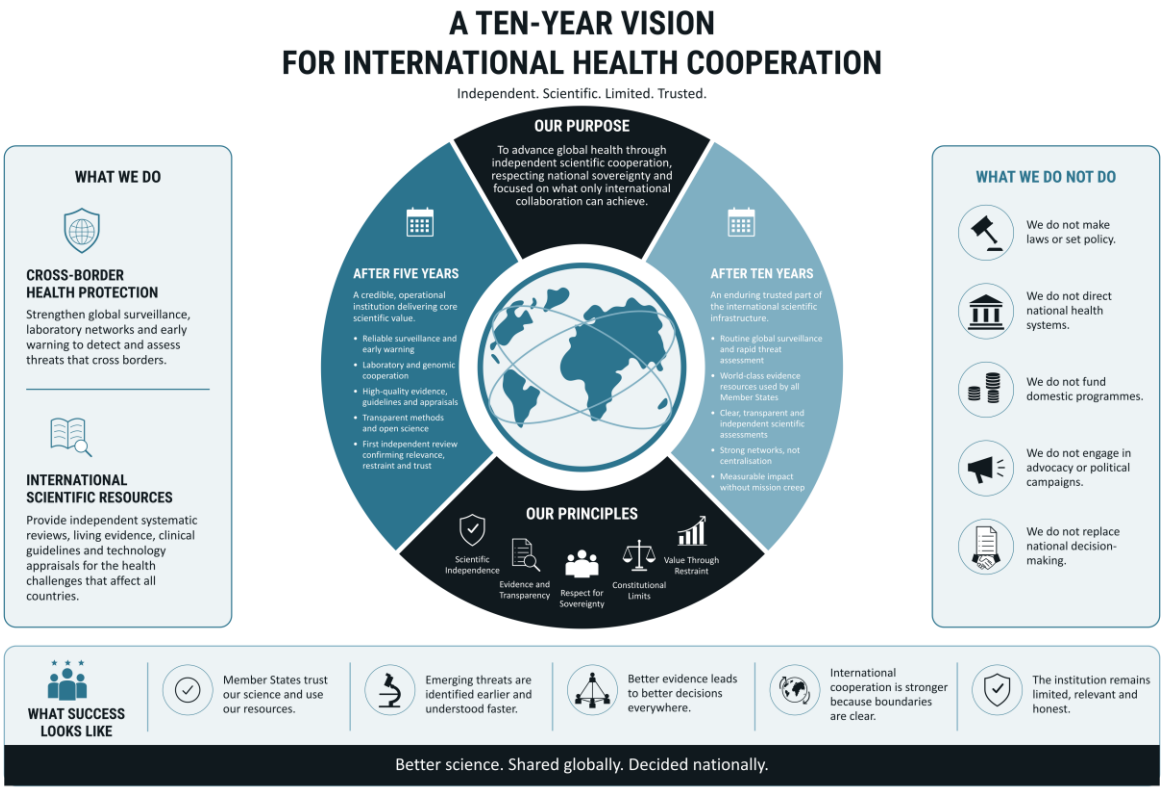
The IHC's evidence infrastructure should provide Member States with access to scientific resources, thereby preventing unnecessary duplication of effort within national systems.

A regulator assessing a new medicine, a health system evaluating a diagnostic technology, a clinician examining a treatment recommendation, or a public health agency investigating an emerging pathogen should be able to access the IHC's scientific work and understand:

- What evidence was considered
- How it was assessed
- What remains uncertain
- Where experts disagreed
- Why the conclusions were reached

The IHC should have established authority in the scientific domain; its assessments should be significant because they are consistently rigorous, transparent, and useful.

This authority should not necessitate any corresponding political power.



14.3 Trust Through Demonstrated Independence

Trust should result from the way institutions operate, rather than being just a goal of communication. Member States and the scientific community should be able to verify that the IHC is financed independently, that conflicts of interest are properly managed, that scientific disagreements are acknowledged, and that political bodies do not have the power to alter scientific conclusions. Errors must be corrected publicly, and any changes to recommendations should be linked to new evidence. Missing information should be openly identified rather than hidden, and uncertainty should be communicated rather than prematurely presented as absolute certainty.

Over time, these practices should build confidence, as the institution consistently demonstrates that its methods can endure scrutiny.

14.4 International Cooperation Between Sovereign States

The IHC model posits that international cooperation and national sovereignty can coexist. States can share surveillance information, laboratory capabilities, genomic data, systematic reviews, guidelines, and technology assessments without relinquishing responsibility for their domestic health policies.

In fact, cooperation is likely to be more sustainable when the boundaries are clearly defined. Member States would understand that participation in international scientific systems does not automatically impose obligations to adopt specific domestic policies.

The model promotes the sharing of evidence and capabilities, as well as decentralised decision-making and accountability. Countries retain the freedom to arrive at different policy conclusions based on varying circumstances, resources, values, or priorities. The key element in this approach is reliance on a robust scientific foundation for all decisions.

14.5 A Different Measure of Institutional Success

International organisations can create incentives to maintain their relevance by expanding their activities. However, the IHC should operate under the opposite assumption: programmes that are no longer necessary should be discontinued.

If a scientific capability can be delivered more effectively by another organisation, it should not be retained merely to maintain institutional activity. Proposed new functions should be rejected if they do not meet Treaty requirements, even if additional resources are available to support them.

The following criteria should measure success:

- Scientific quality
- Timeliness
- Transparency
- Independence
- Usefulness to Member States
- Compliance with the Treaty Articles
- Efficiency

Demonstrating institutional restraint should be seen as a sign that the governance model is functioning as intended.

14.6 A Model Capable of Being Judged

The IHC should not assume that its institutional design is permanently effective. The principles outlined in this report aim to mitigate specific risks, including mission creep, donor dependence, political interference, lack of transparency in scientific processes, and unnecessary centralisation. While these principles can help reduce these risks, they cannot completely prevent institutional failure. Therefore, the IHC should be subject to independent evaluation, methodological scrutiny, and independent Treaty compliance review throughout its existence.

Member States should have the authority to determine whether the institution continues to provide significant international value to justify its costs and authority. This brings us to an important final principle: the institution must remain open to evidence. An organisation focused on evidence-based scientific assessment should apply the same standards to evaluate its own performance.

14.7 A New Model for International Health Cooperation

The International Health Council's long-term proposition is clear and straightforward.

International health cooperation is essential. Emerging pathogens do not recognise national borders, and scientific knowledge can be generated and evaluated more effectively through collaboration. Smaller countries should not be expected to recreate costly scientific capabilities that already exist elsewhere. Shared laboratory standards, surveillance systems, systematic review evidence, and technology assessments can benefit all participating nations.

None of these necessarily require an international institution with an open-ended mandate over health policy.

The IHC therefore proposes a different approach:

- Strong international scientific cooperation
- Clear Treaty limits
- Independent evidence assessment
- Member-State financing
- National sovereignty
- Continuous institutional accountability

Its legitimacy would be based primarily on its contributions rather than on the control it exerts. Its influence would rely on the reliability of its scientific findings rather than the extent of its authority. Additionally, its growth would not be viewed as synonymous with success. Its Treaty-defined boundaries should not be seen as obstacles to international cooperation but as necessary conditions for maintaining trust in it.

The ambition for the first decade is therefore intentionally modest: to establish an international institution that becomes indispensable for the quality of the scientific services it provides, while remaining limited enough to ensure that Member States retain confidence in the authority they have chosen not to relinquish.

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