International Health Council

AN ALTERNATIVE TO THE WORLD HEALTH ORGANIZATION



THE CASE FOR CHANGE

Structural problems and an alternative model

01



David Roach
President & CEO,
Action on World Health Foundation

The World Health Organization (WHO) was founded on noble principles in the aftermath of World War II; bringing the world together to ensure the attainment by all peoples of the highest possible level of health.

Today, however, the UN's health agency is failing in its core mission - and several attempts to reform it have failed too.

In the biennium budget for 2024-2025, roughly one quarter of the WHO's US$7.1 billion of funding came from non-state actors. Its largest funder was the billionaire philanthropist Bill Gates, and its second was GAVI, the Vaccine Alliance. It also took 10s of millions of dollars from pharmaceutical companies.

Not only has the WHO been captured by private and corporate interests, but the influence that the Chinese Communist Party (CCP) has over the agency, as we witnessed during COVID-19, is also of great concern.

Mission creep is challenging the notion that the WHO is led by Member States, as is the increasing use of instruments of international law that pose direct threats to national sovereignty and the autonomy of free people.

At times, the WHO resembles a Left-wing campaign group, instead of a health agency, and this is alienating governments and people.

Our aim therefore is to replace the WHO with a completely new body, and the publication of Professor Carl Heneghan and Dr Tom Jefferson's Global Health Assessment and Recommendations Report is an important step towards making that happen.



Professor Karol Sikora
Chairman of the Board of Fellows
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.

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. 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.

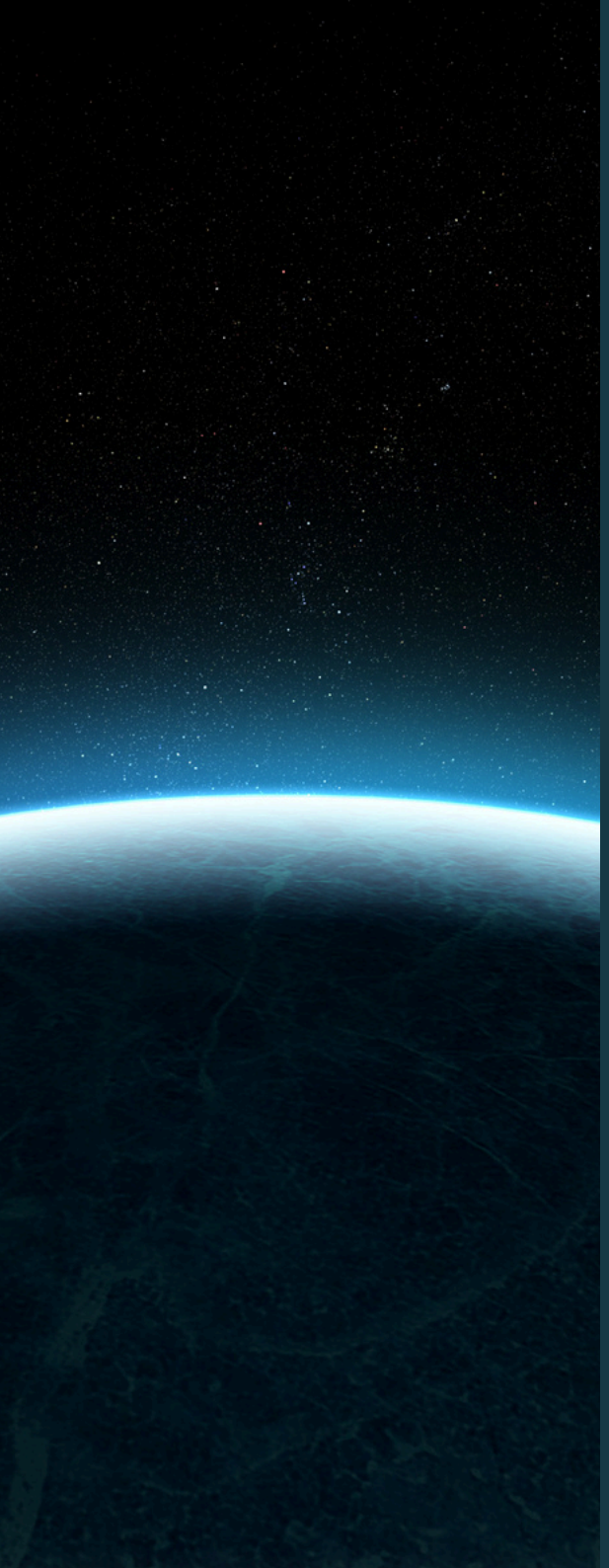


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OUR MISSION

03

A new era for international health cooperation

> *"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."*

Two Principal Domains

The IHC would concentrate its work within 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 would 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.



TREATY RESTRAINT AND SCIENTIFIC INDEPENDENCE

04

Broad Scientific Inquiry, Narrow Institutional Power

The IHC would exercise only those functions expressly conferred upon it by its Treaty Articles. Every significant programme, initiative or service would be required to satisfy the Treaty Remit and Subsidiarity Test, containing three key requirements:

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.

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.

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. Treaty-based limitations would focus on the institution's powers rather than on the legitimate scope of scientific inquiry. However, assessments would not grant the IHC policy-making authority.

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

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

GOVERNANCE, FUNDING AND PERFORMANCE

05

Sovereign equality and Member-State financing

Member States would govern the IHC through a Governing Council operating on the principle of sovereign equality. 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. Independent oversight would include an Ethics Commissioner, Inspector General, Independent Auditor and Scientific Ombudsman.

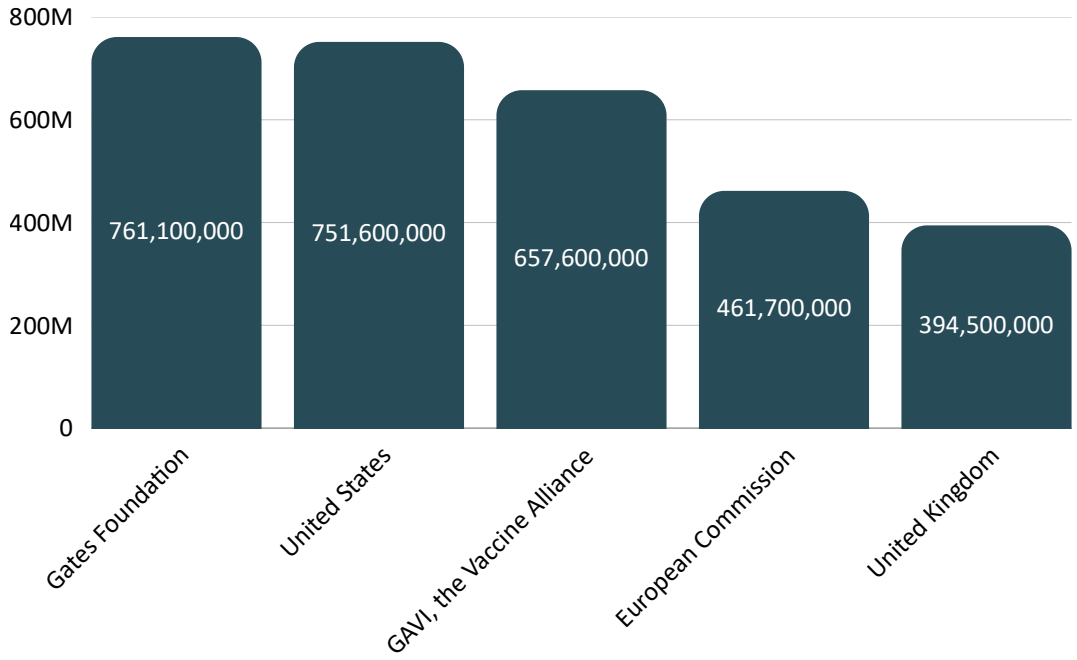
In contrast to the WHO, commercial entities, philanthropic foundations, NGOs, professional organisations, and other non-state interests would not finance its Treaty-defined functions.

While external organizations may submit evidence, expertise, and scientific information through transparent processes, they cannot influence scientific priorities through financial means.

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 five largest contributors to the WHO's 2024–2025 programme budget, by total reported funding (US$)

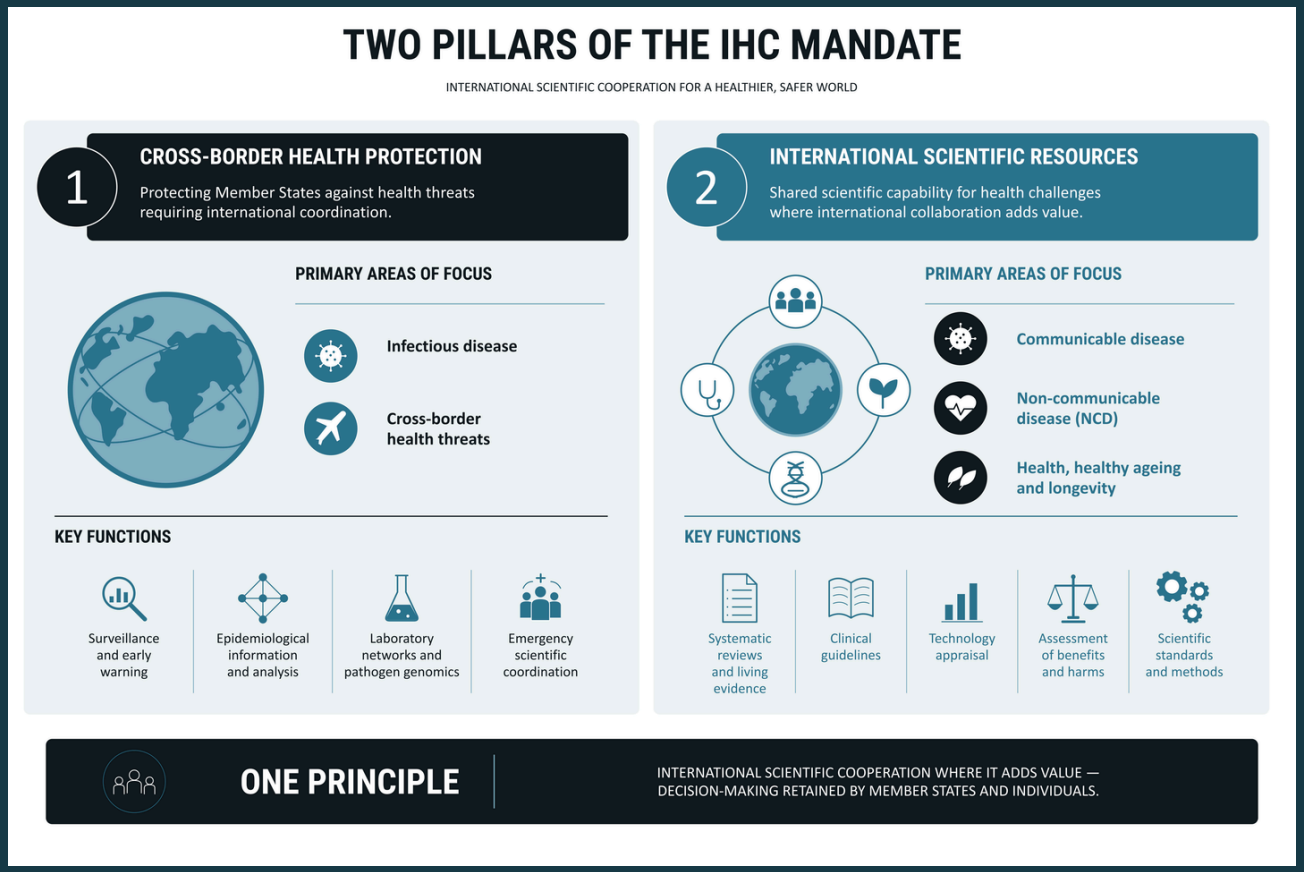


The IHC's Treaty-defined functions would be funded through collectively determined Member-State funding only.

PURPOSE AND FOUNDING TREATY PRINCIPLES

06

Scientific coordination and shared international capacity



The purpose of the IHC is to undertake scientific work in which cooperation between states can produce greater value, efficiency, or reliability than unnecessary duplication by individual countries.

It would enable Member States to share scientific capability where cooperation improves the quality, speed or efficiency of health protection and evidence assessment.

Universities, academic medical centres, national public health institutions, laboratories, evidence synthesis organisations, and other centres of scientific excellence would be designated as IHC collaborating centres for defined areas of expertise.

Scientific groups would be convened remotely and internationally based on the expertise required for a particular assessment, guideline, technology appraisal, or emerging health threat.

All Member States would have access to the IHC's core scientific resources irrespective of population size, income or domestic technical capacity.

"The IHC coordinates and assesses the science, while Member States retain the authority to make decisions based on that science."

SOVEREIGNTY OF NATIONS AND PEOPLE

07

The Subsidiarity Test and individual autonomy

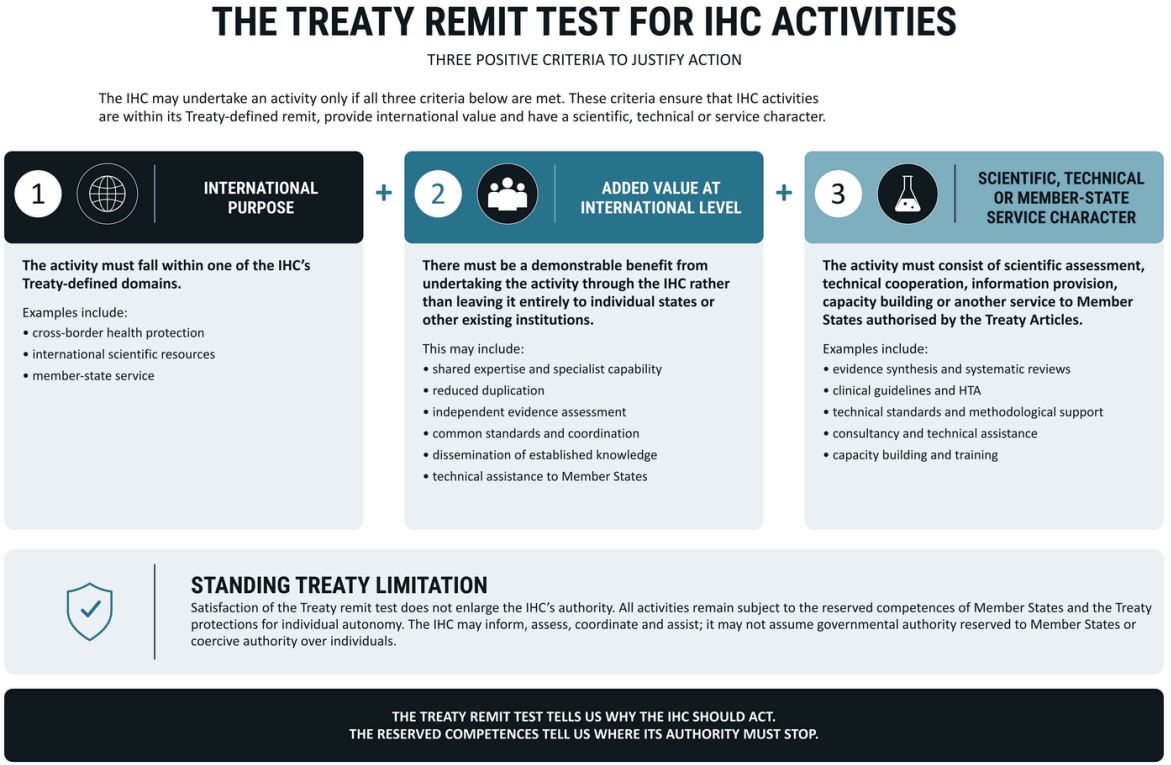
Every activity undertaken by the International Health Council would require a clear basis in its Treaty Articles. The purpose of the Treaty Remit and Subsidiarity Test would be to determine when activity at IHC level is justified, while preventing the gradual accumulation of functions simply because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

The 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.

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.

Scientific disagreement would not constitute non-compliance with IHC guidance.

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.



"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."

TREATY-DEFINED REMIT AND CORE FUNCTIONS

08

Cross-border surveillance, permanent international evidence capability, and independent appraisal

The IHC would maintain a permanent international capability for the detection, verification, assessment and communication of health threats with potential cross-border significance. Its primary output will be reliable, rapidly updated information that enables Member States to make their own decisions regarding preparedness and response.

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. Pathogen genomics would be a key component of this capability. The goal is to establish a distributed international laboratory capability without replacing national laboratories.

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.

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. For important questions where evidence changes frequently, the IHC would maintain living systematic reviews. During emerging health threats, rapid evidence reviews could be produced when conventional review timelines were impractical, but their accelerated methods and additional uncertainty would need to be stated explicitly in the Treaty.

IHC clinical guidelines would translate scientific evidence into recommendations for prevention, diagnosis, treatment, and care. Recommendations would identify the certainty of the supporting evidence and distinguish between strong recommendations and those made conditionally or under substantial uncertainty. Significant scientific disagreement would be preserved in the record.

The IHC would provide independent scientific appraisal of medicines, vaccines, diagnostics, medical devices and other health technologies. 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.

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





TREATY-DEFINED REMIT AND CORE FUNCTIONS

09

Medicines, standards, technical assistance and emergency scientific coordination

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.

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.

The IHC would develop scientific and technical standards that establish common methods to improve reliability, comparability, or interoperability between Member States. IHC standards will remain technical rather than serve as international regulations.

Member States may request technical assistance from the IHC, within the scope of the institution's mandate. 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. Whenever possible, the goal will be to transfer capability rather than create ongoing dependence on the institution. Technical assistance would not be used to influence domestic legislation. Technical missions will be time-limited, scientifically focused, and conducted with the agreement of the respective state.

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.

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

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.

TREATY EXCLUSIONS AND RESERVED COMPETENCES

Scientific competence does not confer policy jurisdiction

The Treaty Articles would expressly distinguish between the limited scientific and technical functions conferred upon the IHC and governmental competences reserved to Member States.

"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 powers listed in the table would be expressly excluded.

Treaty exclusion	Reserved authority and institutional limits
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. Furthermore, the IHC would lack independent authority to regulate medicines, medical devices, consumer products, professional practices, or national health services.
No Executive or Emergency Powers over Member States	No authority to enforce border closures, quarantine, vaccination or testing programmes, school or business closures, procurement of specific products or other domestic emergency measures. Additionally, the IHC could not impose sanctions, penalties, or financial consequences for failing to adhere to its recommendations.
No Domestic Policy Supervision or Programme Management	The IHC would not oversee the domestic health policies of Member States. Typically, the IHC would not manage domestic health, development, or humanitarian programmes. Responsibility for national programmes would remain with domestic institutions. Assistance from the IHC would not be contingent upon the adoption of unrelated policy recommendations.
No Political Advocacy, Campaigning or Control of Lawful Expression	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.
Scientific Inquiry Without Policy Jurisdiction	Treaty-based restraint would apply to institutional authority rather than to legitimate scientific inquiry. The scientific relevance of these subjects would not confer policy jurisdiction upon the IHC. However, it would not thereby gain the authority to determine policy, require implementation, regulate conduct, advocate for legislation, or penalise non-compliance.

TREATY SAFEGUARDS

11

Lasting limits on remit, funding, appointments and emergency powers

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 IHC's Treaty-defined functions would be financed through collectively determined Member-State funding, calculated under a formula agreed within the governing framework. 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.

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.

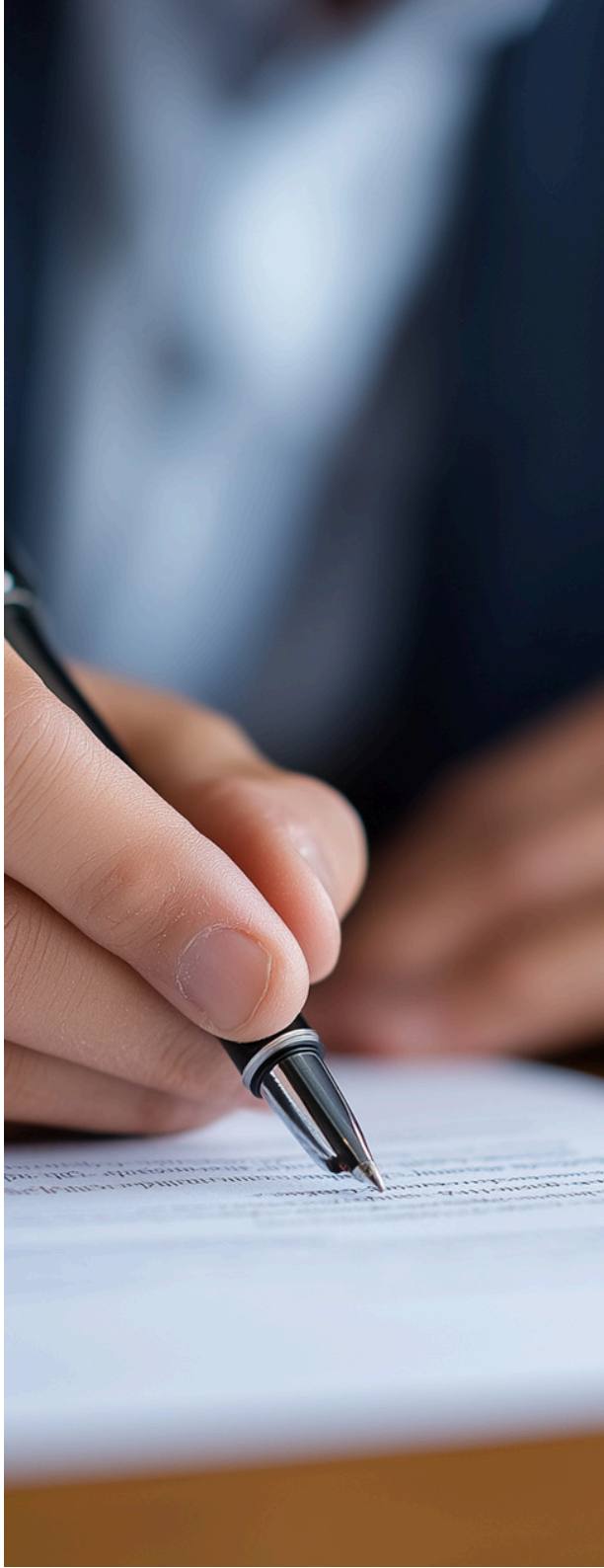
Member States would retain the right to propose new scientific activities, but approval would depend on evidence, international need, and compliance with the Treaty Articles rather than on the availability of funding from the proposing state. All income, expenditure, contracts and significant financial commitments would be publicly reported and independently audited.

The Founding Treaty framework would therefore establish explicitly that an emergency accelerates authorised functions but does not enlarge IHC authority. Temporary emergency committees, programmes and administrative arrangements would have defined purposes and automatic sunset provisions.

Changes affecting the IHC's Treaty-defined functions, powers, funding principles or exclusions would require formal amendment. 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.

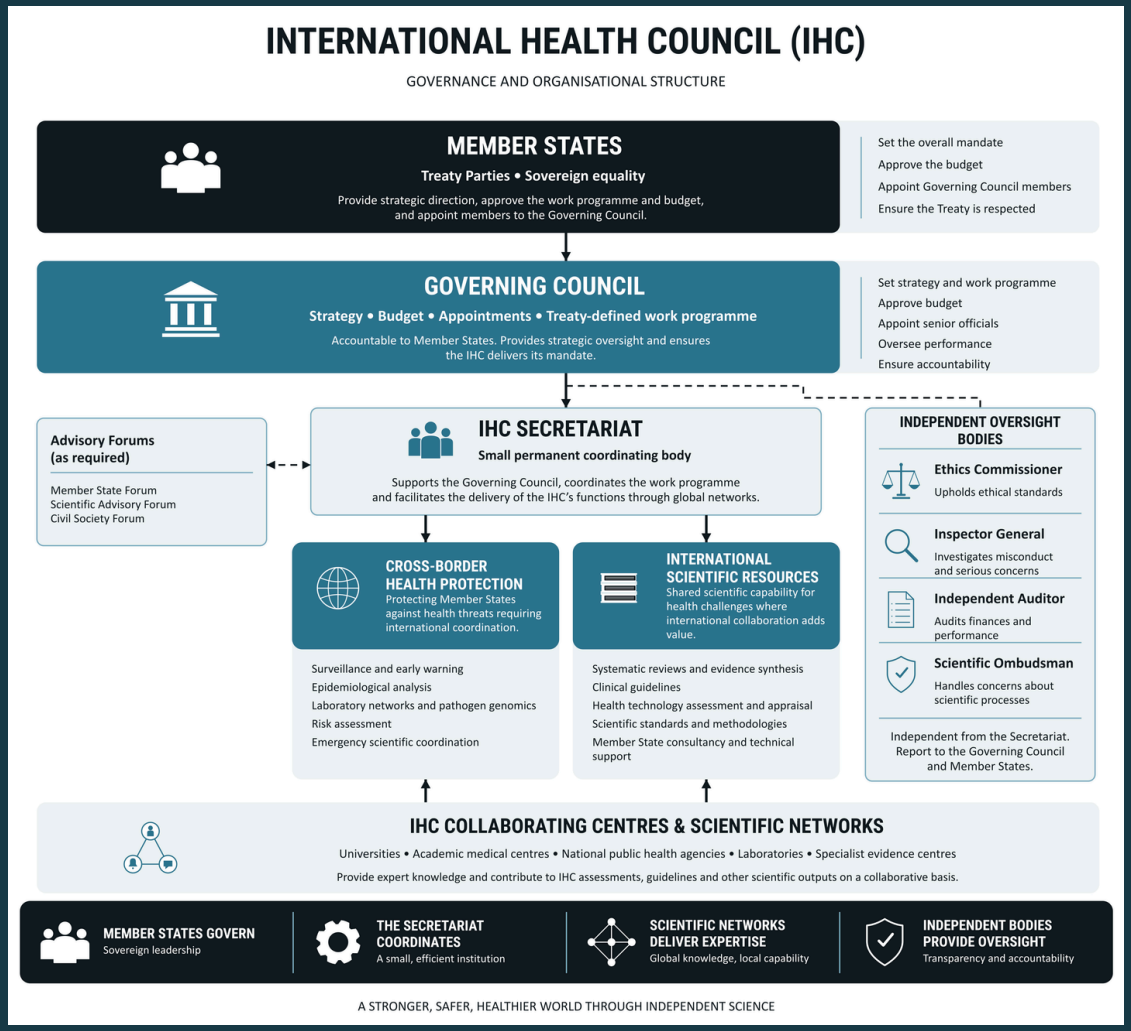
Member States should also have a defined procedure for challenging an IHC activity that is alleged to exceed its Treaty-defined mandate. Such disputes should be considered through an independent Treaty compliance review mechanism, with its reasoning published.

> *"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."*



GOVERNANCE STRUCTURE

The Governing Council and the Secretariat



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

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 Member-State funding, appointing senior leadership, approving the strategic work programme, ensuring compliance with the founding treaty and commissioning independent institutional reviews.

It could not amend a scientific finding through political negotiation or require scientific panels to reach conclusions preferred by Member States.

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.

"The Council would govern the institution rather than its scientific conclusions."

GOVERNANCE AND INDEPENDENT OVERSIGHT

13

Leadership, integrity, accountability and good-faith scientific dissent

Senior leadership should be appointed through an open, competitive, and transparent process based on clearly defined professional criteria. The chief executive should serve a single, non-renewable term.

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.

A biennial Member-State Review Conference would serve as a platform for examining institutional performance, finances, and compliance with the Treaty requirements.

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

Independent Integrity and Oversight Offices

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

Restoring integrity and accountability to international health cooperation will be essential to the future success of the IHC



SCIENTIFIC GOVERNANCE PRINCIPLES

14

Independent assessment, evidence standards, transparency and external scrutiny

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.

IHC scientific work would utilise methods appropriate to the questions being addressed. Protocols would be established prospectively wherever practical. 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.

Transparency is considered an essential component of scientific methodology. 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.

Scientific disagreements must also be clearly acknowledged. 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.

All individuals who play a significant role in IHC scientific assessments would be required to submit appropriate declarations of interest. 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.

"The IHC would be prescriptive through its Treaty Articles regarding scientific principles, while remaining operationally adaptable in its scientific methods."

ESTABLISHMENT AND IMPLEMENTATION PROGRAMME

Treaty before operations; evaluation before consolidation

A group of willing states would negotiate and become parties to the founding Treaty, with accession remaining open to other sovereign states that subsequently wished to participate and accept the Treaty Articles. 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.

Constitution before operations: The founding treaty, Treaty limits, governance arrangements and exclusions should be established before the institution assumes significant operational responsibilities.

Scientific methods before scientific authority: The Scientific Operating Framework should be developed, consulted upon and tested before the IHC begins issuing major international assessments, guidelines or appraisals.

Capability before expansion: New functions should be introduced only when the institution possesses the scientific, technical and governance capacity required to perform them reliably.

Distributed expertise before institutional growth: The IHC should, wherever possible, draw on existing national agencies and scientific networks rather than automatically creating permanent internal departments.

Evaluation before consolidation: Early operations should be treated as opportunities to test the institutional model.

Phase	Implementation programme
Year 1	Participating states would finalise and adopt the founding treaty that establishes the IHC's mission, Treaty-defined remit, exclusions, governance arrangements, and financing principles. Draft methods would undergo public consultation, external scientific review and appropriate pilot testing before adoption.
Years 2–3	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.
Years 4–5	Years 4 and 5 would focus on consolidation rather than rapid institutional expansion. Activities that are ineffective, duplicative, or insufficiently international in scope should be modified or discontinued.
End of Year 5	At the end of the fifth year, the IHC would undergo a comprehensive independent review. The Governing Council must provide a formal public response to the review's findings.

> *"The guiding principle is that institutional credibility must be established before scaling up operations."*

IHC VS. THE WHO

Remit, financing, governance and scientific authority

	The WHO	The IHC
Purpose	WHO continues to operate under an exceptionally broad constitutional mandate.	The IHC would have only the functions explicitly granted to it by treaty.
Legal authority	Conventions, agreements and regulations through the processes established by its Constitution.	No legislative, treaty-making or regulatory authority over Member States.
Domestic decisions	Member States retain domestic authority; obligations depend on applicable instruments of international law.	Scientific assessments, guidelines and technology appraisals would be advisory; national authorities retain decisions.
Financing Sources	WHO receives funding from Member States and non-state actors, such as Foundations and private companies.	The IHC would be funded solely through collectively determined Member-State contributions.
Financing Streams	WHO receives two principal types of funding: assessed contributions and voluntary contributions.	Individual Member States would not be allowed to earmark their collectively determined Member-State funding for specific programmes.
Governance	Member-State governance through the World Health Assembly and Executive Board.	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.
Scientific work	Disease surveillance, technical standards, scientific coordination and support for Member States.	Cross-border surveillance and permanent international evidence capability across communicable and noncommunicable diseases.
Political and policy functions	Its scientific, normative, advisory and political functions coexist within the same institutional structure.	The IHC would not function as a political campaigning organisation. The scientific relevance of these subjects would not confer policy jurisdiction upon the IHC.
Emergencies	Emergency coordination and recommendations within existing international legal frameworks.	Accelerated authorised scientific functions without additional authority over Member States.
Oversight	Existing audit, evaluation, ethics and oversight arrangements.	Separate Ethics Commissioner, Inspector General, Independent Auditor and Scientific Ombudsman; protected good-faith dissent.
Organisation	Headquarters, regional and country structures.	Small permanent Secretariat relying substantially on distributed scientific expertise.
Success	Broad constitutional health objectives and institutional programmes.	Scientific quality, timeliness, transparency, independence, Member-State usefulness, Treaty compliance and efficiency.

WHY IHC?

Shared scientific capability with national ownership of decisions

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 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.

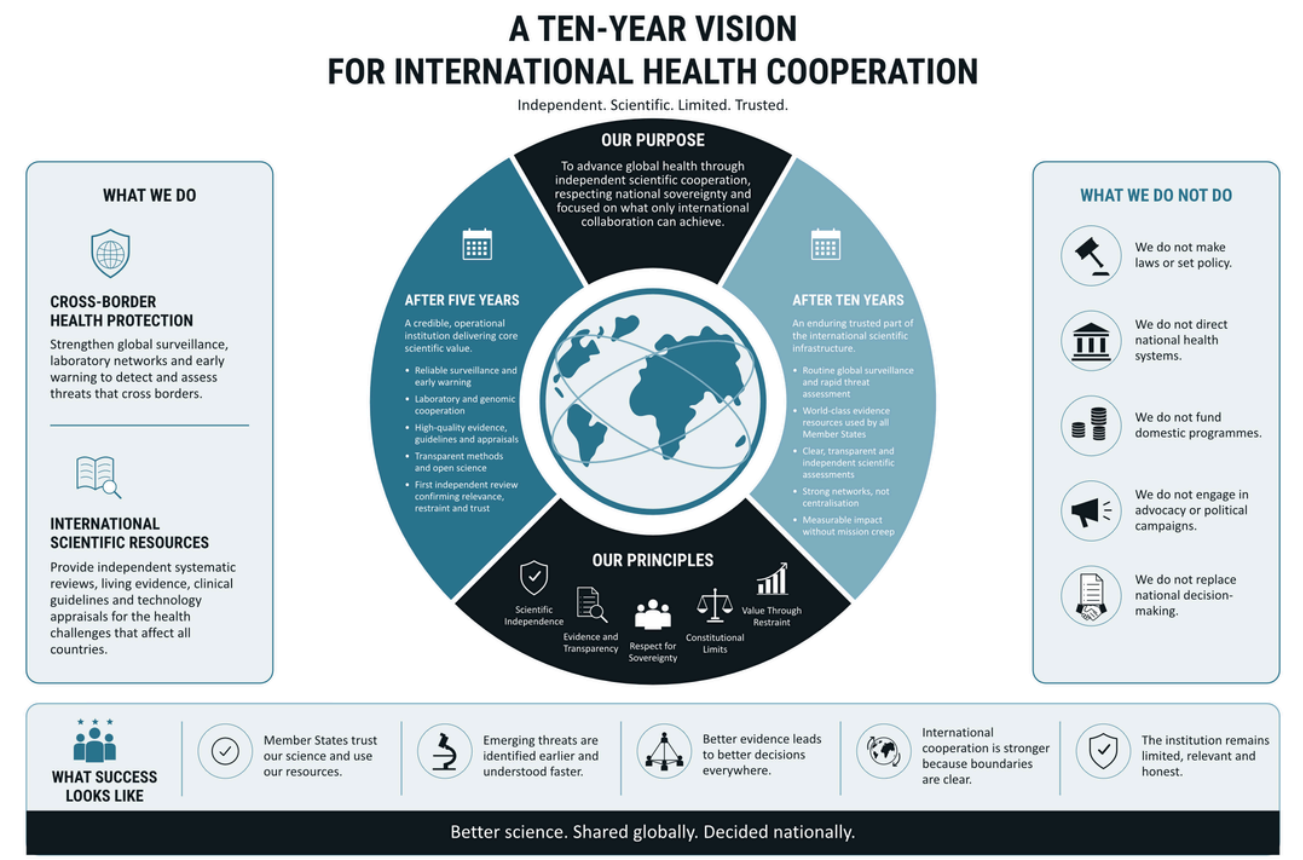
A significant purpose of the IHC would be to make high-quality scientific capability available to Member States regardless of national income or technical capacity. This could be particularly valuable to low- and middle-income countries (LMICs), which may have fewer resources to maintain extensive surveillance,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

For countries with more limited scientific resources, this model could provide capabilities that would otherwise be expensive to develop or procure independently. 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.



A TEN-YEAR VISION FOR INTERNATIONAL HEALTH COOPERATION

The IHC after five years and after ten years



An independent five-year review would 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 would be corrected or discontinued. If the institutional model itself proves ineffective, Member States should be open to reconsidering it.

After a decade, the IHC would be a trusted component of the international scientific infrastructure without evolving into a powerful international bureaucracy.

The IHC would have established authority in the scientific domain; its assessments would be significant because they are consistently rigorous, transparent, and useful.

"The goal, therefore, is not to create a larger international health institution, but to develop one that is better defined and more credible."

IHC SUMMARY

Key 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.

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





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Action on
World Health

Published by the Action on World Health Foundation

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This publication presents proposals for the establishment of an International Health Council, based on the Global Health Assessment and Recommendations Report by Professor Carl Heneghan and Dr Tom Jefferson.

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