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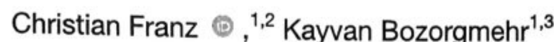
US divestment in global health: disruption, uncertainty and response



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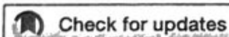

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ABSTRACT

The decisions of the US administration under Donald Trump in January 2025 to divest from many development activities have severely disrupted the state of affairs in global health. We analyse the extent of this disruption from two perspectives. First, we show that about 45 out of every 100 dollars spent on global health from 2019 to 2022 came from the US. Using data on bilateral official development assistance for health from the US, we identify recipient countries and health areas that will be most affected. We demonstrate differential sectoral impacts in more than a dozen countries—mainly within WHO's Africa region—which have been heavily reliant on US aid and other external sources to fund their health services. Severe fiscal constraints and/or ongoing conflicts and fragility in these countries further exacerbate potential impacts. Second, we analyse US contributions to UN organisations and other multilateral bodies most relevant to global health. This combined analysis provides a baseline for countries and organisations to understand the immediate financial fallout and the future risks within a changed global health financing system.

SUMMARY BOX

⇒ This analysis assesses the extent to which bilateral and multilateral recipients of US development assistance for health are exposed to major disruptions in global health resulting from the Trump administration's divestment decisions.

⇒ The US contributed around 45% of all development assistance for health from 2019 to 2022, making its withdrawal highly significant for some recipient countries and organisations.

⇒ Over a dozen countries face particularly severe impacts on their health system due to their heavy reliance on US development assistance for health, while simultaneously confronting conflict, social fragility and fiscal constraints.

⇒ The reliance of several multilateral organisations on US funding has led to a simultaneous disruption of the global health governance landscape.

⇒ This baseline assessment aims to help policymakers understand the financial fallout and navigate future risks in a fundamentally altered global health financing landscape.

INTRODUCTION

For over three decades, the US has dominated global health through its agenda-setting power, research output and financial contributions. The US administration under Donald Trump disrupted this state of affairs across all these dimensions.[1] The announcement to withdraw from the WHO has disrupted the institutional setup of global health.[2] Normative policy priorities that have long been central to global health programmes worldwide—such as diversity, equity and inclusion—have suddenly been made suspect by executive orders.[3 4] Stop-work orders ground to a halt the work of most global health programmes under the US Agency for International Development (USAID),[5 6] the US Centre for Disease Control and Prevention and US Refugee Admissions Programme, with immediate consequences for those relying on US funding.[7] At the time of writing, analyses of lists of USAID awards confirm that 80 per cent of global health awards would be terminated.[8 9] The US administration has also implemented substantial funding reductions to domestic institutions in the USA that have international health duties, particularly within the Department of Health and Human Services, which affected agencies such as the National Institutes of Health and the US Centre for Disease Control and Prevention.[10–13] Overall, the actions of the second Trump administration constitute the largest divestment intervention in the history of global health.

Such disruptions create shock and uncertainty, particularly when returning to the previous 'normal' appears neither attainable nor desirable, as recent African officials' statements suggest.[14]

To be clear: it did not take the US administration under Donald Trump to highlight the flaws of the global health financing system, which has been heavily reliant on development assistance for health and (enlightened) self-interest of donor countries. Structural critiques are extensive: donors have failed to align aid with partner country priorities;[15]

power asymmetries in global health financing institutions perpetuate donor preferences rather than recipient preferences;[16] external health aid creates problematic incentives that may undermine domestic health spending priorities, reflected in increasing dependency among low-income and middle-income countries.[17]

Beyond these structural issues, quantifying global health's reliance on its largest financier is urgently needed. Here, we analyse historical data on development assistance for health to countries and financing of multilateral organisations to describe the US divestment. In the short term, it is of the essence to support those who are made vulnerable by the 'immediatism' of the US government's decisions. In the medium term, global health policy makers must also find effective ways to navigate uncertainties caused by US divestment, anticipate risks, plan for different scenarios and proactively shape a more resilient and sustainable global health financing architecture.

SCALE OF THE DISRUPTION AND UNCERTAINTY

While the divestment did not come as a surprise,[18] the decisions represent, in effect, an attack on multilateralism and its institutions that develop and implement global rules, standards and norms.[19] The scale of this disruption has already been felt by tens of thousands of people, and modelling studies across various disease control programmes indicate potential adverse health effects for millions.[20–22]

Official development assistance data shows the significance of US funds for global health. Between 2019–2022, US global health contributions averaged US$ 13.4 billion annually (see box 1 for methodological details). The 32 Organisation of Economic Cooperation and Development Assistance Committee countries contributed a total of US$ 29.3 billion annually. In other words, about 45 of every 100 dollars spent on global health in the period of 2019–2022 came from the US. This spending includes projects funded bilaterally in recipient countries, projects implemented by multilateral organisations in various countries or regions, and core funding to multilateral organisations.

ANTICIPATE FINANCIAL IMPACTS

Preparedness and resilience to shocks start with assessing and anticipating risks. Two analytical perspectives are necessary: first, to understand the magnitude of *bilateral* health aid from the US to determine which countries, health systems and health services will be most affected. Second, to examine the extent of the divestment among multilateral organisations to understand impacts on norm-setting, coordination and implementation planning actors.

Heavily affected: conflict-affected and fiscally constrained countries

Most US funds for global health are provided through bilateral assistance. Bilateral US health aid averaged over US$ 9.4 billion annually during 2019–2022. Two-thirds of these funds were disbursed via USAID, with a further 20% through the Department of Health and Human Services. The defunding of these organisations will ultimately affect recipient countries by drying up funds, and it will

Box 1 Publicly verifiable financing data for global health

- ⇒ Throughout this article, we present our results as average annual figures from 2019 to 2022. This four-year average offers a more reliable estimate of financial flows from the US because development assistance volumes and payments to UN organisations can vary from year to year due to different fiscal years or budget considerations.
- ⇒ We selected the period of 2019–2022 because of the data availability of the different data sources. While some data sources already offer data for 2023, other data, such as official development assistance channelled through the multilateral system or data on total health expenditures, are only available for all countries for 2022. online supplemental appendix
- ⇒ **Analysis of bilateral official development assistance for health to recipient countries:** the Development Assistance Committee (DAC) of the Organisation of Economic Cooperation and Development (OECD) collects, harmonises and publishes donor-reported data at the level of project activities through the Creditor Reporting System (CRS). Each activity in the CRS data is assigned a sector code, which we use to identify health-related projects (120, 121, 122, 130). The resulting bilateral disbursements of official development assistance for health are displayed as average annual disbursements.
- ⇒ **Analysis of multilateral contributions to the multilateral development system:** the OECD also provides data on the 'total use of the multilateral system'. It combines information on bilateral official development assistance that is channelled through multilateral organisations, development banks and public-private partnerships with data on 'core contributions' (ie, non-earmarked contributions) to these entities. To identify those projects and payments that are relevant for global health, we combined all health-related projects identifiable with the sector codes (120, 121, 122, 130) with all projects from eight entities that are exclusively active in global health (WHO, PAHO, UNAIDS, WOAH, GAVI, GFATM, the International Finance Facility for Immunisation and the International Vaccine Institute). Unfortunately, the data is reported only with some time lag. The most recent data ends with the calendar year 2022.
- ⇒ Analysis of contributions to the United Nations system: the UN System Chief Executives Board for Coordination (CEB) secretariat collects 'revenue' figures for all UN organisations. These data are not limited to development assistance but include funds provided to the UN system for 'peace operations' and 'global agenda and specialised assistance'. We use this dataset to provide a complete picture to UN agencies that are relevant to health programmes or health determinants.
- ⇒ Limitations of data and comparability across datasets: the OECD and the UN CEB datasets cannot be assumed to be directly comparable. For instance, the UN CEB reports that only 15 of the 43 UN organisations reported their expenses using OECD CRS purpose codes.[18] This, of course, restricts the scope for direct comparison. Additionally, the OECD DAC only records financial flows to developing countries (or related activities), so it only provides a lower bound of a country's contribution to global health. Despite these limitations, the underlying sources constitute the 'best available data' and offer valuable insights for the current analysis.
- ⇒ A detailed description of each chart in the publication and the underlying data is provided in the online supplemental appendix.

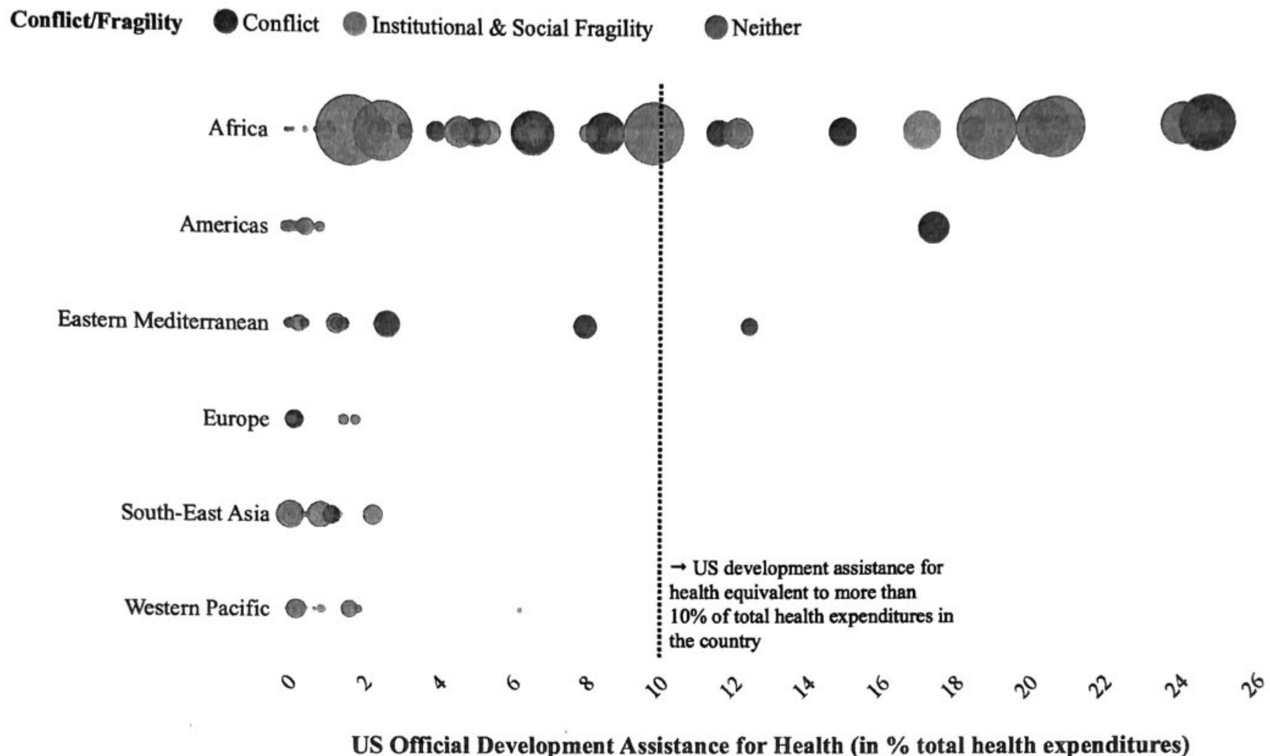

Figure 1 Reliance on US Official Development Assistance for Health by Context of Recipient Country Legend: size of bubbles indicates average annual volume of bilateral US Official Development Assistance for Health (2019–2022). Reading example: in the period of 2019–2022, South Sudan received about US$ 87 million annually in bilateral official development assistance for health from the US—equivalent to 14.9 per cent of South Sudan's average annual health expenditures in the same period. The World Bank currently classifies South Sudan as a conflict-affected country. Notes on the indicator 'US Official Development Assistance for Health (in % total health expenditures)': the indicator represents the average annual official development assistance disbursements from the US for health-related projects in the respective country (nominator) in relation to the total health expenditure in the country (denominator). For details, see online supplemental appendix. Sources: Creditor Reporting System (flows), WHO's Global Health Expenditure Database, Country classifications from World Bank and WHO. Authors' analysis and visualisation. An interactive and downloadable version of this graphic is available at https://public.flourish.studio/visualisation/21545769/

be vital to anticipate, monitor and evaluate the impacts of this tragic natural experiment.[23] Three insights are crucial:

First, 14 countries received US official development assistance for health equivalent to ten per cent or more of their annual total health expenditures. The World Bank categorises five of these countries as conflict-affected situations (Mozambique, Haiti, South Sudan, Somalia, Mali). Zimbabwe is classified as a country facing institutional and social fragility.[24] For at least half of these 14 countries, fiscal space for health can be seen as significantly restricted. World Bank analysts project government health expenditures per capita to contract or stagnate until 2029 for Lesotho, Mozambique, Malawi, Zimbabwe, Swaziland, Haiti, Madagascar and Mali.[25] In a scenario where donor countries would compensate 100% of the funds to these countries alone, approximately US$ 670 million would be required annually (figure 1).

Second, some health systems are at particular risk of a funding shock. Their health systems receive substantial funding from the US, and they rely heavily on external sources for financing health expenditures in general. More than 30 countries receiving US bilateral assistance derive more than 20 per cent of their total health expenditures from external sources. In 13 of these countries, more than ten per cent of their total health expenditures came from US bilateral assistance for health (see upper right quadrant figure 2). All except Haiti and Somalia are in the WHO African Region. Eight of the countries are classified as 'low income' by the World Bank. By volume, many of these countries receive significant amounts: Uganda received on average US$ 426 million annually; Mozambique about US$ 360 million. For perspective, Norway's total annual bilateral health assistance averaged US$ 439 million during 2019–2022. In another twelve countries, mainly in the WHO African Region, between five and ten per cent of their total health expenditures came from US bilateral assistance for health (figure 2).

Third, the bilateral health assistance data also reveal which health services and areas are particularly affected if the US changes its policy priorities. Figure 3 illustrates the composition of US bilateral health aid as a whole and to

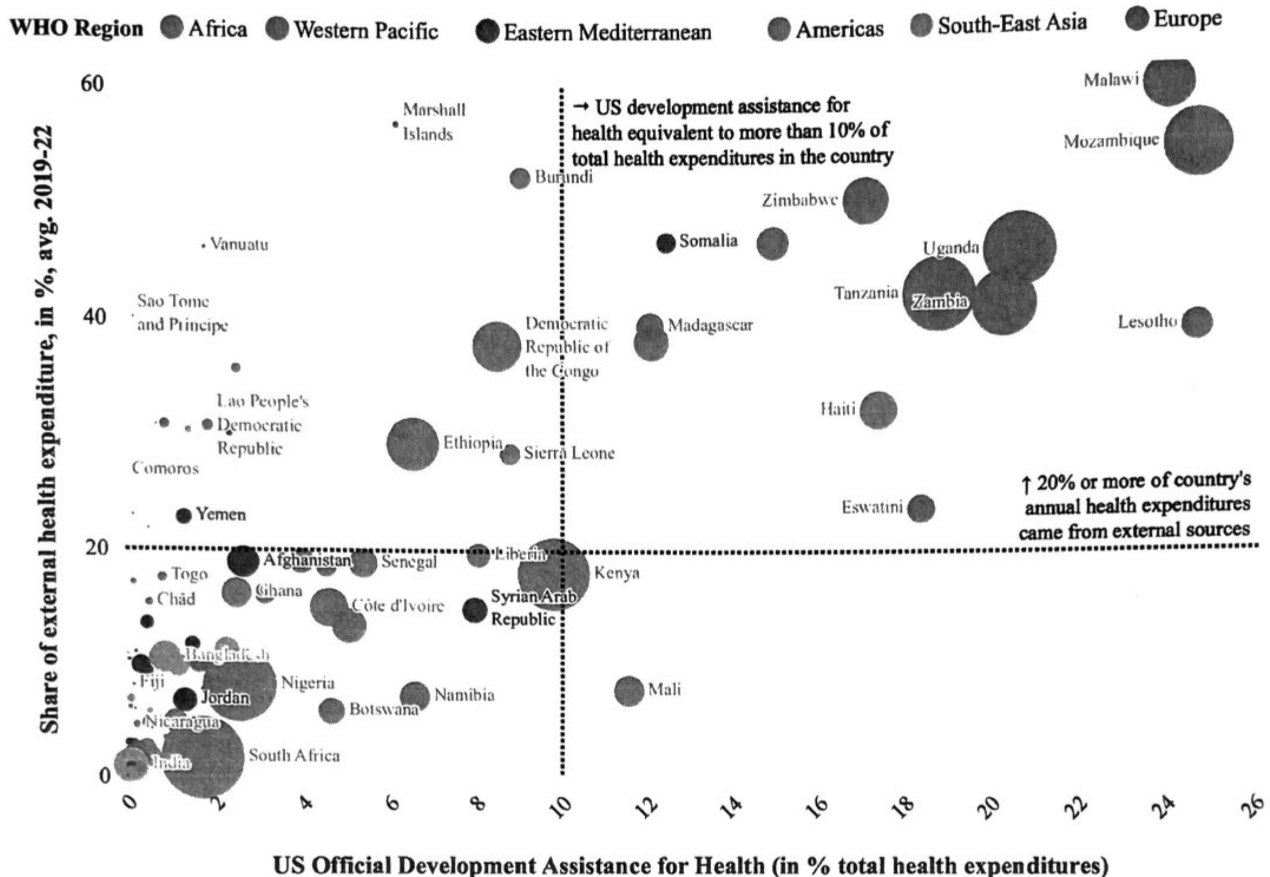

Figure 2 Reliance on US Official Development Assistance for Health versus Overall Reliance on External Sources Legend: size of bubbles indicates the average annual volume of bilateral US Official Development Assistance for Health (2019–2022). Reading example: in the period of 2019–2022, almost 46 per cent of Uganda's health expenditures came from external sources. In the same period, Uganda received about US$ 426 million annually in bilateral official development assistance for health from the US—equivalent to 20.5 per cent of the country's average annual health expenditures. Notes on the indicator 'US Official Development Assistance for Health (in % total health expenditures)': the indicator represents the average annual official development assistance disbursements from the US for health-related projects in the respective country (nominator) in relation to the total health expenditure in the country (denominator). Notes on the indicator 'Share of external health expenditures (EXTs)': represents the 'EXT as % of current health expenditure' from the Global Health Expenditure Database of WHO. Excluded for better readability: Micronesia, where the Share of EXTs is above 75% in the observed time period. For more details, see the online supplemental appendix 1. Sources: Creditor Reporting System (flows), WHO's Global Health Expenditure Database, Country classifications from World Bank and WHO. Authors' analysis and visualisation. An interactive and downloadable version of this graphic is available at https://public.flourish.studio/visualisation/25145780/.

the respective country by programme area for the top 10 recipients in 2019–2022. Evidently, funding for sexually transmitted diseases, including HIV projects, represents a substantial share across countries. Almost 57 per cent of all US bilateral health assistance was allocated to this purpose, mainly due to the President's Emergency Plan for AIDS Relief—a programme whose future remains unclear.[26 27] Even where overall US reliance is low relative to total health expenditures, significant adjustment may be needed in these programme areas. Among those are South Africa, which received an average of US$ 590 million annually (equivalent to 1.7 per cent of total health expenditure), and Nigeria, which received US$ 427 million annually (equivalent to 2.6 per cent of total health expenditure).

In some countries, reproductive healthcare and family planning account for substantial shares of US foreign assistance to health. In Ethiopia, approximately 25 per cent of US bilateral assistance for health addressed these priorities; in the Democratic Republic of the Congo, the share exceeded 30 per cent.

These figures illustrate the extent and geographical implications of the divestment, which will vary by country. For example, ceasing US funds for global health will impact control of sexually transmitted diseases, including HIV/AIDS programmes in South Africa; the Democratic Republic of the Congo will primarily face financial impacts in malaria control programmes and reproductive healthcare. Prospects for the future global health landscape without the US as a leader need to consider

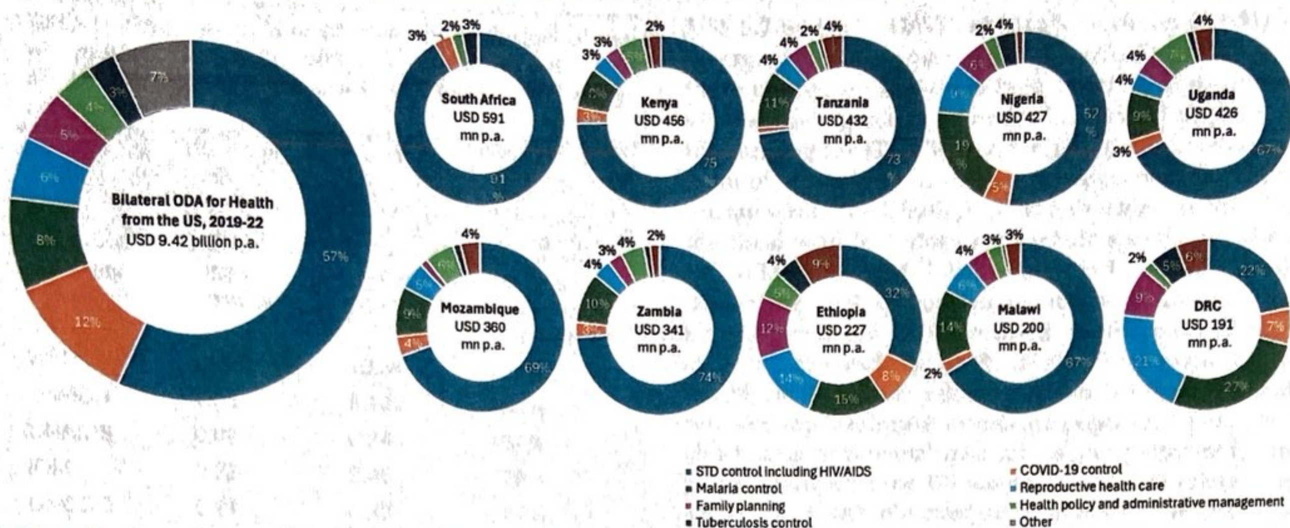

Figure 3 Focus Areas of US Official Development Assistance for Health in the Top 10 Recipient Countries Legend: average annual bilateral US Official Development Assistance for Health by Purpose (in % of total bilateral Official Development Assistance for Health received 2019–2022). Reading example: between 2019–2022, bilateral US Development Assistance for Health to Nigeria was primarily directed to the control of sexually transmitted diseases, including. HIV/AIDS (52 per cent); 19 per cent were directed to Malaria control projects. Notes on data: purpose codes at the project level as provided by the donor country to the Organisation of Economic Cooperation and Development (OECD) Creditor Reporting System. For more details, see the online supplemental appendix. Source: OECD Creditor Reporting System. Authors' analysis and visualisation.

these facts. These insights can also help identify regional priorities and develop mitigation plans.

Multilateral funding

Besides bilateral health aid, the multilateral system in global health has been seriously disrupted. While the US government's decision to exit the WHO has received most attention in public, several other organisations work on global health within their respective mandates. We first analyse US funding reliance among UN health-related agencies before quantifying the reliance of other multilateral development organisations.

In early February 2025, the Trump-US administration decided to halt funding to the UN Human Rights Council and Relief and UN Works Agency for Palestine Refugees in the Near East and put further organisations under review.[28] UNAIDS funding cessation followed in late February and the organisation has since then cut staff by 54 per cent.[29 30] Recent decades have seen an increasing dependence of the UN system on voluntary contributions—payments beyond assessed contributions.[31] While enabling the fulfilment of strategic objectives, this makes institutions more reliant on large donors funding these expanded activities, creating vulnerabilities when donors shift their strategic policy directions. The US often plays a prominent financing role in major UN entities crucial to global health[32] (table 1).

As data from the UN indicates, the US has contributed on average about 13 per cent of WHO's total revenue in the period from 2019 to 2022, equivalent to about US$ 500 million annually. This includes both 'membership fees' (assessed contributions)[33] and voluntary contributions, making the US the largest individual donor to WHO. The US contribution to UNAIDS has been smaller in volume than that of WHO (US$ 90 million p.a.), but it accounted for almost 40 per cent of the total funds in the period from 2019 to 2022. UNICEF—as an organisation that spends at least 40 per cent of its programme budget on health programmes[34]—received about 14 per cent of its budget from the US (US$ 1.14 billion p.a.). Three organisations that have a significant impact on major determinants of health display a high reliance on the US: 44 per cent of the funds available to World Food Programme (WFP) came from the US (US$ 4.5 billion p.a.), and 38 per cent of UNHCR's funds (US$ 1.96 billion p.a.). International Organisation for Migration (IOM) received around US$ 720 million annually from the US—almost 30 per cent of its total funding. A US divestment will hence severely impact programmes devoted to fighting hunger in humanitarian crises (WFP), existential human needs including health services for displaced people fleeing war and persecution (UNHCR), as well as programmes dealing with managed and orderly human migration, including humanitarian response to large-scale displacement in crises (IOM).[35] Even without complete funding cuts, certain health areas will likely be affected. While WFP's work on food assistance received a waiver of the 'pause to all foreign assistance', US officials stated in the Executive Meeting mid-February that programmes promoting 'gender ideology' or 'radical and wasteful diversity, equity and inclusion (DEI' should stop immediately.[36]

The multilateral system in global health has expanded far beyond UN organisations—with so-called vertical funds such as the GFATM and GAVI managing

Table 1 Reliance on US funds of multilateral organisations with relevance for global health, 2019–2022. Average annual contributions in US$ billion (assessed and voluntary contributions)

	Average annual revenue from the US	Average annual total from all sources	Reliance on US funds revenue from the US
UN entity	US$ billion 2019–2022	US$ billion 2019–2022	% of total revenue 2019–2022
WFP	4.50	10.34	44%
UNHCR	1.96	5.10	38%
UNAIDS	0.09	0.24	37%
IOM	0.72	2.46	29%
UNODC	0.11	0.42	27%
FAO	0.33	2.04	16%
UNRWA	0.17	1.11	15%
IARC	0.01	0.05	14%
UNICEF	1.14	8.21	14%
WHO	0.51	3.96	13%
WTO	0.03	0.23	11%
PAHO	0.11	1.35	8%
UNWOMEN	0.03	0.61	5%
UNFPA	0.07	1.51	5%
UNDP	0.22	5.57	4%
UNOPS	0.02	1.21	2%
UNITAID	0.00	0.21	0%

Reading example: in the time period 2019–2022, the US contributed US$ 1.4 billion annually to UNICEF, which received US$ 8.1 billion annually in total in the same period. On average, 14 per cent of UNICEF's funds came from the US.
Data: UN System Chief Executives Board for Coordination (CEB). Authors' analysis. For more details, see the online supplemental appendix.
FAO, Food and Agriculture Organisation; IARC, International Agency for Research on Cancer ; IOM, International Organisation for Migration ; PAHO, Pan American Health Organisation ; UNAIDS, Joint United Nations Programme on HIV/AIDS; UNDP, United Nations Development Programme; UNFPA, United Nations Population Fund; UNHCR, United Nations High Commissioner for Refugees ; UNITAID, UNITAID; UNODC, United Nations Office on Drugs and Crime ; UNOPS, United Nations Office for Project Services; UNRWA, United Nations Relief and Works Agency for Palestine Refugees in the Near East; UN Women, United Nations Entity for Gender Equality and the Empowerment of Women ; WFP, World Food Programme; WTO, World Trade Organisation.

tremendously large portfolios and multilateral development banks such as the World Bank taking an increasingly more prominent role. They act as implementing mechanisms that donors use to channel development assistance for health to countries. By volume, the GFATM and GAVI are by far the largest ones. During 2019–2022, the Development Assistance Committee countries provided approximately US$ 5 billion annually to the GFATM and US$ 3.7 billion to GAVI (which also includes COVID-19 emergency funding during this period). The reliance of these entities on the US is high: more than a third of GAVI's funding comes from the US, and 45 per cent of the funding for GFATM. For both entities, the continuation of US support as in the past appears to be out of the question. The US administration's budget request for the fiscal year 2026 does not include specific numbers for GAVI or GFATM.[37] And while the US Congress will decide the final appropriations, it is very unlikely that historic levels can be maintained. Furthermore, investment vehicles such as the Pandemic Fund managed by the World Bank rely significantly on US funding, and renewed replenishment efforts are ongoing.[38] There are also intergovernmental institutions and partnerships in global health that the US has not used for development assistance in the observed time periods. The International Finance Facility for Immunisation, established by France and the UK in 2006 in support of GAVI, is a case in point. Between 2019–2022, the two countries have supported annually with US$ 792 million and US$ 366 million, respectively. In general, finance for development through the multilateral system relies heavily on a small set of countries. In 2022, the latest available data point, three countries accounted for half of DAC members' contributions to the multilateral development system: the US (26 per cent), Germany (17 per cent) and France (7 per cent)[39] (table 2).

MONITOR AND EVALUATE HEALTH IMPACTS

What these sober financial figures hide are the millions of people who may lose access to essential health services or whose lives are at stake as they depend on organisations providing humanitarian assistance during emergencies. This most significant divestment in global health funding, if unmitigated, will come along with a high human death toll. Unpredictable outbreaks of emerging infectious diseases with varying geographical spread and rising preventable morbidity and mortality in affected countries would be sad evidence for the effectiveness of US-funded global health programmes, proven by a tragic natural experiment of an abrupt withdrawal of public health interventions.[23] Nevertheless, monitoring financial implications and evaluating the health impacts of the US divestment will be crucial, not necessarily to evaluate the effectiveness of ceased programmes, but to hold accountable the US administration regarding its extraterritorial obligations related to health as a human right,[40–42] as well as the global health community and national governments to develop and implement mitigation measures.

Acknowledging the impending adverse health effects on people's lives reminds us of another truth behind this disruption: the global health financing architecture has been inherently vulnerable, and the most vulnerable people in countries are likely to be hit the most. At the same time, our analysis shows that the disruption caused

Table 2 Reliance on US funds of Official Development Assistance for health to and through multilateral organisations and public-private partnerships

	Total ODA for health (in US$ billion, const. 2022 prices)		US ODA for health (in US$ billion, const. 2022 prices)		Share of US ODA for health (in % of total ODAH)	
	Mean of ODAH 2019–2022	Mean of ODAH 2015–2018	Mean of US ODAH 2019–2022	Mean of US ODAH 2015–2018	US share 2019–2022	US share 2015–2018
GFATM*	5.12	3.40	2.31	1.29	45.04	37.90
GAVI*	3.79	1.19	1.31	0.30	34.60	24.86
World Bank (IDA, IBRD, IFC, other)	0.46	0.26	0.08	0.01	17.99	3.29
IFFIm	0.42	0.29	n.a.	n.a.	n.a.	n.a.
IVI, Seoul	0.01	0.01	n.a.	n.a.	n.a.	n.a.
WOAH	0.01	0.00	n.a.	n.a.	n.a.	n.a.

Reading example: taken together, donor countries have provided more than US$ 5 billion on average per year to the Global Fund over the period of 2019–2022. The USA alone has contributed an average of US$ 2.3 billion per year. During the comparison period of 2015–2018, the average annual payment was US$ 1.29 billion. On average, the US has contributed 45.04 per cent of the GFATM contributions in the period from 2019–2022. The US share of ODA for health is calculated by dividing the sum of US contributions by the total contributions for the period.
Data: OECD. Total use of the multilateral system. Authors' analysis.
n.a.| Empty cells imply that the US has not channelled any Official Development Assistance for Health through or to these entities.
*Includes COVID-19 emergency funding. For more details, see the online supplemental appendix.
IFFIm, International Finance Facility for Immunisation.

by the US administration's decisions will not affect every country in the same way. Some countries with thriving economies may be able to compensate for the abrupt reduction of foreign assistance with an increase in government health spending. However, for many countries, this will be unfeasible in the post-pandemic economy due to fiscal constraints being so severe that increasing health expenditure often means cutting back on other social services such as education.[43] So far, the actions taken to reduce the weight of debt service, even from the poorest countries, have fallen short.[44–46] Moreover, given the thematic focus of US assistance for health (sexually transmitted diseases, Tuberculosis, Malaria, child and maternal health), it is likely to expect particularly vulnerable population groups within countries to be affected by an immediate cessation of the health programmes.

In light of these observations, the potential harm done by the Trump-US administration's decisions to global health becomes fully clear. In the very moment when dozens of countries have to substitute the US foreign assistance in their health systems, and countries would need to come together to support those in need, the US withdrawal from the WHO damages the centre of the global health architecture where solutions could be discussed in a multilateral forum.

THE WAY FORWARD

In the short term, safeguarding those efforts that grant immediate relief to those who are in need after the unravelling of USAID is of the utmost priority. For example, while it is unlikely that all of the US bilateral health aid can be substituted, our analysis can help countries adjust their short-term funding and anticipate the extent of required funding. Of course, this entails critically reviewing and evaluating whether the funds received by US programmes are used efficiently and effectively—whether resources directly address specific population health needs, or whether the required amounts may be less (if efficiencies can be achieved) or more (if more vulnerable populations can or should be targeted). This may offer opportunities for critical review and re-evaluation of health financing systems by affected countries, while acknowledging that many health systems were severely underfunded even before US divestment. Beyond health services, health research will also require attention. As modelling studies have illustrated, the US divestment may lead to an exacerbation of the pre-existing divergence between disease burden and research funding for global health priorities.[47] Thus, key multilateral institutions with specialised technical expertise such as WHO and UNAIDS should be financially ring-fenced while urgently starting complementary reforms.[48]

A more fundamental question, however, needs answering in the near future: what happens after the disruption caused by the divestment of the erstwhile global health leader? It is evident that a mere continuation of the 'old state of affairs' is not feasible, even if other countries and traditional donors were able and willing to attempt to fill the gap left by the US in global health. An automatic way back to a new 'equilibrium', if that ever existed in global health, is far from realistic, and maybe in the long run not even desirable. In fact, it did not take the US retreat from global health to highlight flaws in the status quo. Even if the successes achieved

since the launch of the 2030 agenda need to be celebrated, many of the efforts around financial mobilisation and financial reform have fallen short of their goals. The hope to move 'from billions to trillions' for global development by mobilising private sector funds failed[49 50]—particularly in global health.[51] Moreover, the historically underlying paradigm of official development assistance as North-South development aid, challenges in donor coordination, and the current challenges of managing the crushing debt burdens of many countries are just examples of a system in trouble.

There are ongoing discussions and new thoughts worth serious consideration. For example, a recently published report proposes reforming official development assistance to focus on three key purposes: poverty reduction and economic growth, humanitarian support and crisis response, and global public goods.[52] The past years have seen significant work on reforming the global health financing system (eg, the Lusaka Agenda or the SDG 3 Global Action Plan) and developing ideas for a new system that is not driven by aid (eg, Global Public Investment).[53 54] Certainly, these initiatives and ideas still have to prove their worth and feasibility. However, as 'innovative' financing initiatives have faced challenges (eg, advanced market commitments and public-private partnerships),[55] they represent avenues for the discussions ahead. Other ideas—such as the airline levy France imposed to finance UNITAID in 2006—are currently rediscovered outside the global health space and may help achieve multilateral institutions with a broader funding base.[56] What these mechanisms have in common is that they would reduce reliance on single actors, enhance the reliability and predictability of revenues, and hence increase the resilience of financing systems by diversification and by reducing uncertainty.

Nevertheless, a question that goes beyond considerations on organising and raising funds for global health remains: who will step up in the leadership for global health problems transcending national and regional borders? The WHO's investment round represents an effort by a UN organisation to try to actively manage the difficulties arising from a funding structure that rests increasingly on earmarked funding. However, part of the reality of the first investment round is that 94 per cent of pledges from sovereign donors came from high-income countries, while only about 5 per cent came from upper-middle-income countries.[57] This may appear surprising given that governance body meetings of WHO usually produce many country statements of appreciation of and commitments to WHO's mission. The question is, under which circumstances are countries with powerful economies willing to bolster their political expression of commitment to WHO with actual funding envelopes to this central global health body? While the volumes are still relatively small,[58] there are signs that some are willing to contribute more to international development funding. During the World Health Assembly in May, for example, China pledged additional US$ 500 million over 5 years to WHO.[59]

A *new* normal state of affairs will look different from what it was under US leadership. Every crisis bears opportunities, and this is an opportunity to rethink the current global health order altogether.[16 60] A disruption is no guarantee of a better state of affairs post-disruption, but it would be short-sighted to regard the uncertainty caused by the disruption as purely negative. Mitigating and reducing financial uncertainty for most affected countries is crucial. Still, the present uncertainty caused by the disruption of the governance architecture, and the related openness of the future,[61] could be seen as an opportunity to actively shape the future of global health, while considering the possibilities of different *futures* of global health. The crossroads we stand at may lead to a world with mushrooming bilateral agreements between richer and poorer countries, in which global health funding is devoted to those in need based on 'deals' for the benefit of those with the highest negotiating power. This may become true, especially if domino effects trickle in and other countries follow the US example. Alternatively, we can make decisions today to shape a future for global health that is rule-based, embedded in mutual respect and values of dignity, sustainability and human rights, and ensures reliable funding for health and health systems globally. Countries that still take seriously their commitments to the SDGs and WHO's mission will have to develop alternative strategies and—now more than ever—shape and transform the potential futures of global health to more resilient and sustainable mechanisms in line with solidarity principles.

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