

CHAPTER 12



Turbulence in the World Health Organization: Implications for EU-US Cooperation in a Changing International Order

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Abstract

This paper examines the World Health Organization (WHO) within the broader context of the post-1945 liberal international order. It begins with a brief historical account of the establishment and development of WHO, emphasizing its role as a central institution for global health governance. Particular attention is given to the role of the European Union's (EU) member states and the United States (US) in supporting the WHO through financial contributions, personnel secondments, crisis assistance and capacity-building measures. The paper then explores more recent developments, notably the US withdrawal from the WHO during the first and second Trump administrations and the termination of key US aid programs. Finally, the implications of this withdrawal are analysed, both for WHO's operational capacity and for transatlantic relations, with consequences for challenges such as the global fight against HIV/AIDS, antimicrobial resistance, drug and vaccine development and emergency preparedness.

Keywords: *World Health Organization; United States; European Union; COVID-19; public health emergency; International Health Regulations*

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Introduction

The World Health Organization (WHO) has been the key coordinating authority in global health governance within the post-Second World War liberal international order. Both the United States and Europe have been important supporters and contributors to the WHO. However, the future of both the WHO and the transatlantic partnership is currently uncertain. This paper explores the WHO's evolution and its recent crises, focusing specifically on the United States' notification of withdrawal. It further analyses what these events mean for the future of transatlantic cooperation.

The establishment and development of the WHO

The WHO was established in 1948 as a specialized agency of the United Nations (UN). The World Health Assembly, comprising all 194 member states (soon reduced to 193), is the supreme decision-making body and determines the organization's policies and priorities. The assembly also appoints the director-general. The executive board facilitates the work of the assembly, provides advice and gives effect to its decisions and policies. It is composed of 34 members that are technically qualified in the field of health and represent the WHO's regional offices: the Regional Office for Africa, the Regional Office for the Americas, the Regional Office for South-East Asia, the Regional Office for Europe, the Regional Office for the Eastern Mediterranean, and the Regional Office for the Western Pacific. The WHO's main objective is 'the attainment by all peoples of the highest possible level of health' (World Health Organization 1946, art. 1), which is to be achieved by, among other things, the core function of acting 'as the directing and co-ordinating authority on international health work' (World Health Organization 1946, art. 2(a)).

The WHO was seen as a major achievement in the evolution of international health institutions, thanks to its expertise and willingness to address intractable health problems (Youde 2012, 29). However, early on, the WHO's reputation began to decline, reaching a low point in the 1980s and 1990s, when it was heavily criticized by member states and in public discourse for being too bureaucratic, ineffective and corrupt. Nevertheless, at this point the WHO could also point to some very successful initiatives in its effort to improve global health – including the eradication of smallpox (Brown et al. 2006; Yamey and Titanji 2025).

The organization resumed much of its authority as a prominent and leading

force in international health work under the leadership of former Director-General Gro Harlem Brundtland (1998–2003), resulting in more action, such as finalizing negotiations on the Framework Convention on Tobacco Control, the rebuilding of capacities for addressing HIV/AIDS, and a more prominent and visible presence on the international stage. Thus, even though the WHO's role was still contested, some of the organization's reputation was rehabilitated, paving the way for its continued role in global health governance (Brown et al. 2006).

The United States played a central role in the development of the liberal international order after the Second World War, which included the establishment of a multilateral framework comprising numerous international agreements and organizations, including the United Nations (Hopewell 2021; Lake et al. 2021; Hylke et al. 2024). The United States also played a key role in the WHO, not least as the largest financial contributor for much of the organization's history. The member states of the European Union (EU) have also been active supporters of and contributors to the WHO, through financial support, personnel secondments, crisis assistance and capacity-building measures. In 2020, when the United States withheld some of its funding, the member states were collectively the largest donors to the WHO. The EU itself is not a member of the WHO and did not engage actively with the organization for a long time, even though a framework for cooperation between the two organizations has been in place since 1972 (with subsequent revisions), based on a series of exchanges of letters.

Recently, and particularly after the outbreak of the COVID-19 pandemic, the EU has shown much more interest in the WHO (European Commission 2010, 2025; European Union 2022). There are several reasons for the delayed EU interest in the WHO. First, health policy has been (and still is) primarily the competence of the member states, which limits both the scope and form of health cooperation in the EU. Second, cooperation on health issues was not politicized and put high on the EU agenda until the 1990s onwards, when a series of health and security related crisis – such as the outbreak of bovine spongiform encephalopathy (BSE, also known as 'mad cow disease'), the 9/11 terrorist attacks, the severe acute respiratory syndrome (SARS) and swine flu emergencies, and the volcanic ash cloud from Iceland in 2010 – contributed to raise the attention towards the need for collective preparedness and action (Greer and Jarman 2021; Brooks et al. 2023). Third, it was not until the 1990s and 2000s that the EU treaties provided a legal basis for the EU to more actively supplement and assist member states in health policy. Prime among these are article 152 of the Amsterdam Treaty (the 'public



health' article), renumbered as article 168 in the Lisbon Treaty of 2009, article 222 of the Lisbon Treaty (the 'solidarity clause') – which 'requires the EU and Member States to collectively assist any Member State affected by a terrorist attack or a natural or man-made disaster' – and the Charter of Fundamental Rights (including the right to life and the right to healthcare) which gained equal status to treaty law in 2009 (Ekengren et al. 2006; Brooks et al. 2023).

Partly because of this specification of the EU's role in health, the European Commission issued a document in 2010 signalling a more active role for the EU on the international stage in health cooperation. Regarding the relationship with the WHO, the document stated:

At global level, the EU should endeavour to defend a single position within the UN agencies. The EU should work to cut duplication and fragmentation and to increase coordination and effectiveness of the UN system. It should support stronger leadership by the WHO in its normative and guidance functions to improve global health. The EU should seek synergies with WHO to address global health challenges. It should decrease the fragmentation of funding to WHO and gradually shift to fund its general budget (European Commission 2010, 6).

In line with the intentions stated above, the EU delegation in Geneva (where the WHO headquarters are located) began coordinating common positions on WHO matters among the EU member states in 2010 (Bergner et al. 2020, 3).

Thus, when the COVID-19 pandemic broke out in 2020, health policy had already moved higher up the EU's political agenda, as reflected in earlier initiatives to strengthen transatlantic health cooperation with the United States. The agreement on mutual recognition between the European Community and the United States of America was set up in 1999 (Official Journal of the European Communities 1999). The agreement lays down the conditions under which the EU and the United States will accept conformity assessment results (e.g., testing or certification) from the other party's designated conformity assessment bodies. In this way they can show compliance with each other's requirements, essentially by replacing double testing with mutual trust. The 1999 agreement covered (through sectoral annexes) pharmaceutical goods manufacturing practices (GMPs) and medical devices. Other technical health areas were later included, such as inspections of manufacturing sites for human medicines in their respective territories, which

were fully implemented in 2019. The Global Health Security Initiative was set up in the wake of the September 11 terrorist attacks in 2001. Delegations from the United States and the European Commission (as well as from EU member states) were included in this initiative.

The WHO was allowed to meet as an observer in the Global Health Security Initiative. In 2009, the EU and the United States created the Transatlantic Taskforce on Antimicrobial Resistance to address the urgent, growing global threat of antimicrobial resistance. Negotiations between the United States and the EU on a Transatlantic Trade and Investment Partnership (TTIP) began in 2013 (Khan et al. 2015). These negotiations included extensive plans for transatlantic cooperation on health issues, including health services, pharmaceuticals, and other health-related regulatory matters (Jarman 2014).

However, these negotiations were abandoned when Trump became president in 2016 and in April 2019 the EU declared that TTIP was ‘obsolete and no longer relevant’ (Council of the EU 2019). Following the experiences of the COVID-19 pandemic and the war in Ukraine, the EU and the United States issued a joint statement in the fall of 2022 urging the strengthening of transatlantic cooperation on health, particularly in the context of health emergencies. In 2023, the EU–US Health Task Force was set up to prioritise three avenues for cooperation: combating cancer, addressing global health threats, and strengthening the global health architecture. These initiatives were launched during the Biden administration. The election of Trump in 2024 for a second term has raised new questions about the future of global and transatlantic cooperation on health, in general, and the role of the WHO in these efforts, in particular.

Turbulence in the WHO: Funding, crisis management and US withdrawal

Even though the WHO’s authority was partially restored in the early 2000s, the organization continued to experience turbulence. Ansell and Trondal (2017, 4) identify three aspects of turbulence that are relevant here. Turbulent organizations refers to factors embedded within organizations, such as factional conflicts, staff turnover, funding, conflicting rules and internal reforms. Turbulence of scale appears when actions at one level of authority or scale of activities affect actions at another level or scale. Thus, what appears to be a ‘good’ solution at one level might



be considered a ‘bad’ solution at another. Turbulent environments speaks to factors external to organizations, such as crisis, rapid technological change, protests and partisan conflict. Here, attention is directed towards three challenges creating turbulence: the fragmented funding of the WHO, the handling of the Ebola disease outbreak in West Africa in 2014–2016, the WHO’s handling of the COVID-19 pandemic, and the subsequent notification of the United States to withdraw from the organization, first in 2020 and then again in 2025.

WHO funding

The WHO’s funding comes from two primary sources: assessed contributions (i.e., membership dues paid by member states) and voluntary contributions from member states and non-state actors. Assessed contributions enable the WHO to prioritize and allocate resources to measures and activities considered most effective in fulfilling the organization’s mandate. Voluntary contributions are typically earmarked for the donor’s preferred project, which does not guarantee that the resources will be channelled to where they are most needed. The more the WHO depends on voluntary contributions, the less freedom of manoeuvre it has to fulfil its mandate.

Over time the share of assessed contributions to the WHO has been reduced in favour of voluntary contributions. In the mid-1980s, the share of voluntary contributions had almost caught up with the regular budget, which consisted of assessed contributions (Brown et al. 2006, 68). In the 2014–2015 budget 77% came from voluntary donations – these were, moreover, heavily dependent on rich donors such as the Gates Foundation and the United States (Gostin 2015, 6). In the 2022–2023 budget, the share of assessed contributions was only 12.1% of the WHO’s total revenue, whereas the share of voluntary contributions was 87.5% (KFF 2025, 8).

This fragmentation of funding and shift towards earmarked voluntary contributions has created problems for the WHO’s ability to fulfil its mandate, as priorities and policies are set by the World Health Assembly. In contrast, the larger share of the budget has been controlled by the most powerful donors of voluntary contributions (Brown et al. 2006). The assembly – in recent times, numerically dominated by poor and developing countries – is only in a position to control the use of the regular budget, consisting of assessed contributions. This situation has created turbulence within the organization, raising concerns about the WHO’s independence from internal and external actors and its capacity to follow up on prioritized health areas and thus achieve its objectives. Moreover, the possible withdrawal of the United States means that the WHO loses its historically largest

financial contributor. Therefore, other states can fill this void.

The Ebola outbreak 2014–2016 and the call for reform of the WHO

The Ebola epidemic outbreak in West Africa in 2014–2016 was ‘one of the largest, most devastating, and most complex outbreaks in the history of infectious disease’ (Park 2022, 1). The outbreak put the WHO’s designated role in the global health response system to a severe test – according to many observers, a role that the WHO failed to fulfil (Gostin 2014, 2015; Park 2022). The WHO headquarters was criticized for responding too late to the outbreak, for placing too much responsibility on the Regional Office for Africa, and for hesitating to respond amid political and religious pressures in the affected countries. According to the International Health Regulations (IHR) – a binding agreement administered by the WHO – the WHO director-general has the exclusive power to declare a so-called Public Health Emergency of International Concern (PHEIC), a mechanism that triggers a coordinated international response. During the Ebola outbreak the director-general did not declare a PHEIC until five months after the Ebola virus began to spread internationally and a long time after receiving warnings about the urgency to act, from local experts as well as from non-governmental organizations (NGOs) such as Doctors Without Borders (Park 2022).

The WHO’s handling of the Ebola outbreak drew heavy criticism and calls for reform. The reform proposals included: increasing the WHO budget and shifting the budget towards assessed contributions, empowering the director-general at the expense of the regional offices to ensure that the WHO speaks with one voice, and to exert the WHO’s constitutional authority as a normative organization by setting an ambitious agenda for negotiation of health treaties and voluntary codes (Gostin 2015). Some reforms were implemented, such as the creation of the Health Emergencies program, a Contingency Fund, and a dedicated global emergency workforce to be deployed rapidly to outbreak zones, the improvement of how the WHO assesses and communicates risks, strengthening of the implementation of the IHR and the enabling of rapid activation of research and development activities during epidemics to help fast-track effective tests, vaccines and treatments for subsequent outbreaks. Having established these initiatives, the WHO was assumed to be better prepared for the next international health emergency.

The COVID-19 pandemic and the subsequent withdrawal of the United States from the WHO

The COVID-19 pandemic was a massive health and societal crisis, which showed



how an infectious disease can spread around the globe in weeks, killing millions of people, as well as having devastating consequences economically and socially, and seriously setting back sustainable development (Independent Panel for Pandemic Preparedness and Response 2021). The pandemic also underscored the importance of international cooperation in combating the virus, including the development and availability of vaccines and other essential medical countermeasures. The WHO played an important role in managing the pandemic – by declaring the outbreak of the COVID-19 virus a PHEIC, by assisting affected countries with knowledge, equipment and personnel, providing recommendations and advice on health measures, coordinating surveillance and control, and by its joint leadership of the multilateral efforts in the COVID-19 Vaccines Global Access (COVAX) initiative to develop and manufacture vaccines and to guarantee fair and equitable access to these vaccines all around the world.

However, the WHO's role during the pandemic was met with mixed evaluations. Central to the negative assessments were that the director-general could have declared the PHEIC earlier (a PHEIC was declared 31 January 2020 – one month after the coronavirus was identified), that the WHO was too soft on China, that the COVID-19 outbreak should have been declared a pandemic earlier (it was declared a pandemic by the WHO on 11 March 2020), that the communication of public health measures as well as the risks related to the virus were inconsistent, and that the system for funding was insufficient. The WHO received positive evaluations, particularly for its efforts to develop and make vaccines available – an effort that was nominated for the Nobel Peace Prize – as well as for its technical guidance and ability to deliver hands-on support to affected states.

One of the harshest critics of the WHO in recent times has been the United States (Chorev 2020; Yamey and Titanji 2025). On 14 April 2020, President Trump announced the suspension of United States contributions to the WHO pending an investigation into the organization's alleged mismanagement of the COVID-19 pandemic (The White House 2020). In a letter to the WHO's director-general dated 18 May 2020, Trump criticized the organization for sounding the alarm too late when the coronavirus was identified, for having a 'China-centric' bias and failing to hold China to account, and for providing inaccurate or misleading information (The White House 2020). He also cited the vast difference between the United States' contributions to the WHO and China's. Moreover, the WHO's general advice against travel restrictions was heavily criticized – advice that basically reflects the IHR's general discouragement against broad travel bans as well as the scope and purpose of IHR

(article 2), which says that a public health response to international spread of disease should avoid unnecessary interference with international traffic and trade. In the letter, Trump delivered an ultimatum: make necessary reforms, or the United States would redraw its funding permanently and reconsider its WHO membership:

It is clear the repeated missteps by you and your organization in responding to the pandemic have been extremely costly for the world. The only way forward for the World Health Organization is if it can actually demonstrate independence from China. My Administration has already started discussions with you on how to reform the organization. But action is needed quickly. We do not have time to waste. That is why it is my duty, as President of the United States, to inform you that, if the World Health Organization does not commit to major substantive improvements within the next 30 days, I will make my temporary freeze of United States funding to the World Health Organization permanent and reconsider our membership in the organization. I cannot allow American taxpayer dollars to continue to finance an organization that, in its present state, is so clearly not serving America's interests. (The White House 2020, 4)

On 6 July 2020, President Trump announced that the United States would formally withdraw from the WHO, effective 6 July 2021. The Biden administration suspended notification of a withdrawal in 2021. That same year, the Independent Panel for Pandemic Preparedness and Response published its evaluation of pandemic management. The report included praise and criticism of the WHO and called for several reforms, including 'strengthen[ing] the independence, authority and financing of the WHO' (Independent Panel for Pandemic Preparedness and Response 2021, 48). In line with the intentions of strengthening the global health framework, two sets of negotiations were initiated. In December 2021, talks on a new WHO Pandemic Agreement were launched. The goal was to strengthen pandemic prevention, preparedness and response globally. In May 2022, negotiations on revising the IHR were initiated. These were based on the same goal. Then, on January 20, 2025 – on the day of his inauguration – President Trump once again notified that the United States would withdraw from the WHO, effective one year later (The White House 2025). In this letter, he repeated the criticism he made in 2020. The withdrawal was met with intense criticism and warnings about the long-term health consequences, both globally and in the United States (Horton 2020; Yamey and Titanji 2025). The negotiations and revisions to the IHR were finalized and adopted on 1 June 2024.



After finalizing negotiations in April 2025, the WHO adopted the new Pandemic Agreement on 14 May 2025. The United States will not be part of either.

We can summarize turbulence in the WHO in a few brief words. The WHO has experienced severe turbulence in the last decades. Some of the turbulence has been caused by internal factors, such as funding (turbulent organization) and questions about decisions at different administrative levels, including the director-general, the Head Office, and the regional offices (turbulence of scale). Even more serious turbulence, however, has been caused by external factors, where the political situation in the United States and its withdrawal from the WHO stand out as pivotal (turbulent environments).

Implications for EU-US cooperation on health

The United States has been central to the development and operation of the WHO for much of the organization's history. The EU did not engage actively in the WHO until the early 2000s, and particularly after 2010 – reflecting the parallel strengthening of the EU's general engagement in health policies. The EU's increased support for international health cooperation can also be seen in connection with the EU's role as a 'soft superpower' (Meunier and Milada 2018). This role implies gaining influence internationally through attraction and persuasion rather than coercion or military force, by means of 'soft measures' such as humanitarian aid and health assistance in capacity-building and knowledge-building. Health cooperation can thus be used as both 'soft' and 'smart' power to advance foreign policies (McInnes and Lee 2012, 54–55).

In 2022, the EU published its new Global Health Strategy, signalling its intention to play a more active role on the international stage and to provide strong support for the WHO and other multilateral organizations (European Union 2022). The report states that global health is an 'essential pillar of EU external policy, a critical sector geopolitically and central to the EU's open strategic autonomy' and that 'the EU intends to reassert its responsibility and deepen its leadership in the interest of the highest attainable standards of health based on fundamental values, such as solidarity and equity, and the respect of human rights' (European Union 2022, 4). The strategy also points to the need for 'a new focus to maintain a strong and responsive multilateral system, with a World Health Organization (WHO) at its core which is as sustainably financed as it is accountable and effective' (European Union 2022, 7). Two of the strategy's guiding principles

emphasize the importance of international institutions. Guiding principle 14 states the support for ‘a stronger, effective and accountable WHO’ and lists several prioritized actions the EU will take, such as seeking

formal EU observer status with full participation rights as a first step towards full WHO membership, contribut[ing] to making the financing of WHO more sustainable, advanc[ing] WHO reform to strengthen its governance, efficiency, accountability and enforcement of rules, and strengthen[ing] the WHO’s focus on its normative role in areas of global relevance’. (European Union 2022, 21)

Furthermore, guiding principle 16 states the general intention to ‘ensure a stronger EU role in international organisations and bodies’ (European Union 2022, 22). The EU also signals its intention to use a ‘Team Europe’ approach to follow up on the Global Health Strategy. Team Europe brings together a variety of relevant actors, such as EU institutions, member states and their diplomatic networks, financial institutions and other relevant organizations, to strengthen coordination, coherence and complementarity of actions and ensure the EU’s influence and impact.

Thus, in recent decades, there has been a paradoxical development in the positions of the EU and the United States towards global health governance in general and the WHO in particular. Whereas the EU has engaged more actively and stated strong support for the WHO and other multilateral organizations, the United States has retracted from international organizations and agreements, thus prioritizing attempts at using its power to gain influence through unitary action and bilateral agreements (Hopewell 2021; Lake et al. 2021; Hylke et al. 2024; Flint 2025). This retreat from the liberal international order implies abandoning the recognized relevance and authority of common values, ideas and norms, which have been incorporated into and are an essential part of this order since the Second World War.

The question of the consequences of the United States’ retreat for the transatlantic relationship thus arises. Is the relationship breaking down, or is it being renewed? Or is it ‘muddling through’ by adjusting cooperation based on issues seen as mutually advantageous? To make such assessments, it is necessary first to analyse the kinds of changes we are witnessing in the approaches of the EU and the United States to international health cooperation. In this context, two sets of concepts are relevant: bilateralism vs. multilateralism and transactionalism versus reciprocity (Keohane 1986; Bashirov and Yilmaz 2020; Flint 2025).



Table 12.1: Ideal types of approaches to international cooperation

	Bilateralism	Multilateralism
Transactionalism	Zero-sum games outside of international institutions (Approach 1)	Zero-sum games within international institutions (Approach 2)
Reciprocity	Plus-sum games outside of international institutions (Approach 3)	Plus-sum games within international institutions (Approach 4)

Reciprocity here refers to the principle of mutual exchange and equal treatment, often involving shared values and long-term cooperation. At the same time, transactionalism is a pragmatic, short-term approach focused on immediate, tangible gains in a zero-sum ‘give and take’ scenario. Reciprocity implies a relationship built on mutual respect and consistent, predictable behaviour where cooperation is assumed to serve the interests of all (‘plus-sum game’). In contrast, transactionalism views relations as a series of discrete, one-off ‘deals’ in which each party seeks to maximize its immediate benefit, often with no expectation of future cooperation beyond the current exchange. It is important to note that the approaches presented in Table 12.1 represent ideal types; in practice, states may use one or more approaches, or a combination of them, in different settings and at different times.

Approach 1 refers to a state’s emphasis on using its power to achieve (asymmetrical) bilateral agreements with short-term gains. The approach implies a lack of support for international institutions and unpredictable cooperative relationships, where common norms and values are downplayed in favour of relative gains. The Trump administration’s approach, particularly in its second term, shares many of these characteristics.

In **Approach 2**, international institutions are viewed as powerful tools for enforcing a state’s will on others. The approach is based on the precondition that powerful states can dominate and control the international institution at stake. The United States arguably used this approach in the early years of the global trade framework established in 1947 with the General Agreement on Tariffs and Trade (GATT) and its successor institution, the World Trade Organization, established in 1995. Here, the United States used its powers to dominate the shaping of the rules and operation of the framework in favour of specific national economic interests.

Approach 3 refers to the idea of mutual gains through broad long-term cooperation outside of multilateral institutions. The close relationship between the EU and Norway and (until recently) between the United States and Canada can

illustrate this approach. **Approach 4** refers to the core idea of a liberal international order: that states should be governed by agreed-upon legal and political international institutions and norms, rather than solely by power or force, and that such international cooperation may serve the interests of all. Here, possible short-term losses from international commitments are assumed to be offset by long-term gains. This approach has received sufficient support in the post-Second World War period, including from the United States, so that a predominantly liberal international order has been maintained to date. This order has been characterized by a multitude of international organizations and agreements, as well as successive multilateral negotiations, which have provided binding national commitments across a wide range of issues – from trade and health to human rights and climate and environmental protection. However, as stated earlier, this order is now under severe pressure.

Based on the developments in global health cooperation described above, the EU and the United States have arguably moved in opposite directions regarding their approaches to international cooperation. Whereas the EU has become a more vigorous defender of multilateralism, seeking to play a more active role in international organizations, the United States has abandoned multilateralism in favour of bilateralism. The US withdrawal from the WHO, the United Nations Human Rights Council (UNHRC) and the Paris Agreement on climate change, as well as the Trump administration's circumvention of World Trade Organization (WTO) rules through its trade policies, are just a few examples of this. Moreover, whereas the EU emphasizes reciprocity and shared norms and values, Trump has clearly moved the United States further towards transactionalism.

Returning to the consequences for the transatlantic relationship of the United States' retreat from multilateralism, the question arises: How are transatlantic relations changing under the Trump administration? Three scenarios are possible, and I will describe each in turn below.

Scenario 1: A possible strengthening of the transatlantic relationship. One scenario suggests that the transatlantic relationship may move forward and be strengthened in the face of global uncertainty and common challenges, threats and needs. Clearly, there is currently little to support this scenario. When it comes to transatlantic cooperation within the framework of global health governance, we first and foremost see a decline. There were attempts to strengthen health cooperation from the late 1990s onwards. Some of these – such as the TTIP negotiations – while



others succeeded, such as the global health security initiative and the EU–US task forces for health and for antimicrobial resistance (AMR). However, the US withdrawal from the WHO means that the United States has put itself outside the EU’s view of the core pillar of global health cooperation. This approach affects the WHO’s operations and also spills over into transatlantic cooperation, for example, by putting many projects relevant to this cooperation at risk, including humanitarian aid, the fight against HIV/AIDS, and the fight against AMR. The potential to strengthen transatlantic cooperation on health is also undermined by the Trump administration’s general bilateral and transactional approach to international cooperation, its withdrawal from multilateral agreements and organizations that the EU strongly supports, and its frequent shifts in positions and policies toward other countries. In addition, the harsh and distrustful rhetoric of President Trump against the EU does not help, as with his claims, for example, that the EU is a ‘foe on trade’ (BBC 2018), that it ‘was set up to take advantage of the United States’ (Politico 2018), that it ‘was formed to screw the United States’ (France 24 2025), and that it ‘is, in many ways, nastier than China’ (Axios 2025). Such rhetoric does not serve as a sound basis for a trustworthy, strengthened cooperative partnership.

Scenario 2: Maintain the transatlantic relationship by ‘muddling through’.

This scenario suggests that the transatlantic partnership will ‘muddle through’ geopolitical and domestic challenges through functional adjustments, while maintaining cooperation in areas seen as mutually advantageous. Some minor developments could support such a scenario – for example, that cooperation has continued to progress in technical and less political areas of health, such as mutual recognition of conformity assessment. However, the overall transatlantic relationship has been seriously damaged by the Trump administration’s approach, which clearly limits the adjustments that can be made. First, the United States’ withdrawal from the WHO puts many WHO-initiated cooperative projects involving both the United States and the EU at risk. One example is the combat against AMR. Second, many cooperative health projects depend on long-term commitments from involved parties to have any effect. The short-term, unpredictable approach of the Trump administration thus creates significant risks for engaging bilaterally with the United States on such projects. Third, much of the transatlantic cooperation on health is based on mutual trust, including technical cooperation such as mutual recognition of conformity assessment. Such trust has clearly been reduced in recent times.

Scenario 3: The disintegration of the transatlantic relationship. Following the assessments of the two other scenarios, recent developments clearly show a decline

and disintegration in the transatlantic relationship. Two developments are particularly important in this context. First, the United States' withdrawal from the WHO – and from other multilateral arrangements – makes it a less relevant partner for the EU, which prioritizes cooperation through the WHO (and other multilateral institutions). Second, the Trump administration's seemingly abandonment, or at least serious downplaying, of international law and common norms and values, such as human and democratic rights, clashes with the norms, values and principles emphasized by the EU. Third, the Trump administration's performance on the international stage, including its stance against the EU, makes it a less reliable partner – thereby creating high political risk for entering long-term commitments with the United States.

Responding to the turbulence: Four recommendations for the EU

The United States' withdrawal from the WHO creates a void in influence and authority that others can fill. The EU can contribute to filling this void by:

1. Continuing to support and prioritize the WHO and speed up contributions to strengthen the WHO's independence and financial situation.

This can be achieved by contributing to maintaining and strengthening the EU's role as a 'soft superpower' using health to advance foreign policy aims.

2. Building 'coalitions of the willing' within the WHO to strengthen the organization, influence and develop the global health agenda.

Experiences from major transboundary crises, such as the COVID-19 pandemic and the war in Ukraine, as well as the wear and tear on transatlantic cooperation under the Trump administration, have revealed vulnerabilities in Europe and the need to reduce the EU's dependence on other countries.

To address these challenges, the EU needs to:

3. Strengthen its ability to ensure health security and continue to prioritize strategic autonomy in the health area.

4. Downplay transatlantic cooperation on short- and medium-term commitments and avoid long-term commitments.

This way, political risks related to (health) cooperation can be reduced. The strain on the transatlantic partnership and the question of whether the United States can be considered a reliable partner reflect an



uncertain, high-risk situation for the EU. A pragmatic approach is thus needed, where the EU leverages mutually beneficial transatlantic ties while simultaneously developing supplementary and compensatory strategies.

The EU should therefore:

5. Strengthen bilateral health cooperation with like-minded partners, including Canada, non-EU countries in Europe and other trustworthy countries.

Implementing these recommendations would go a long way toward ensuring that the EU retains the ability to exercise independence in health policy and responses to global health emergencies in the long term.

References

- Ansell, Christopher, and Jarle Trondal. 2015. "Governing Turbulence: An Organizational-Institutional Agenda." *Perspectives on Public Management and Governance* 1 (1): 43–57. <https://doi.org/10.1093/ppmgov/gvx013>
- Axios. 2025. "Trump Says European Union Is 'Nastier than China'." May 12. <https://www.axios.com/2025/05/12/trump-european-union-trade-war-china-tariffs>
- Bashirov, Galib, and Ihsan Yilmaz. 2020. "The Rise of Transactionalism in International Relations: Evidence from Turkey's Relations with the European Union." *Australian Journal of International Affairs* 74 (2): 165–84.
- BBC. 2018. "Donald Trump: European Union Is a Foe on Trade." July 15. <https://www.bbc.com/news/world-us-canada-44837311>
- Bergner, Stefanie, Robin van de Pas, Louise G. van Schaik, and Martin Voss. 2020. "Upholding the World Health Organization: Next Steps for the EU." *SWP Comment No. 47/2020*. Stiftung Wissenschaft und Politik. <https://doi.org/10.18449/2020C47>
- Brooks, Eleanor, Anniek de Ruijter, Scott L. Greer, and Sara Rozenblum. 2023. "EU Health Policy in the Aftermath of COVID-19: Neofunctionalism and Crisis-Driven Integration." *Journal of European Public Policy* 30 (4): 721–39.
- Brown, Theodore M., Marcos Cueto, and Elizabeth Fee. 2006. "The World Health Organization and the Transition from International to Global Public Health." *American Journal of Public Health* 96 (1): 62–72.
- Chorev, Nitsan. 2020. "The World Health Organization between the United States and China." *Global Social Policy* 20 (3): 378–82.

- Council of the European Union. 2019. “Trade with the United States: Council Authorises Negotiations on Elimination of Tariffs for Industrial Goods and on Conformity Assessment.” Press release, April 15.
- Ekengren, Magnus, Nina Matzen, Mikael Rhinard, and Maria Svantesson. 2006. “Solidarity or Sovereignty? EU Cooperation in Civil Protection.” *Journal of European Integration* 28 (5): 457–76.
- European Commission. 2010. *The EU Role in Global Health*. COM(2010)128 final. Brussels, March 31.
- European Commission. 2025. *Report from the Commission ... on the Implementation of the EU Global Health Strategy*. COM(2025) 392 final. Brussels, July 10.
- European Union. 2022. EU Global Health Strategy: Better Health for All in a Changing World. https://health.ec.europa.eu/publications/eu-global-health-strategy-better-health-all-changing-world_en
- Flint, Colin. 2025. “Hegemonic Retreat: Transactionalism as Foreign Policy.” *The Geographical Journal*. <https://doi.org/10.1111/geoj.70007>
- France 24. 2025. “EU Was Born to ‘Screw’ US, Trump Says.” February 26. <https://www.france24.com/en/live-news/20250226-eu-was-born-to-screw-us-trump-says>
- Greer, Scott L., and Holly Jarman. 2021. “What Is EU Public Health and Why? Explaining the Scope and Organization of Public Health in the European Union.” *Journal of Health Politics, Policy and Law* 46 (1): 23–47. <https://doi.org/10.1215/03616878-8706591>
- Hopewell, Kristen. 2021. “Trump and Trade: The Crisis in the Multilateral Trading System.” *New Political Economy* 26 (2): 271–82. <https://doi.org/10.1080/13563467.2020.1841135>
- Horton, Richard. 2020. “Offline: Why President Trump Is Wrong about WHO.” *The Lancet* 395 (April 25): 1330.
- Dijkstra, Hylke, Laura von Allwörden, Leonard A. Schütte, and Giuseppe Zaccaria. 2024. “Donald Trump and the Survival Strategies of International Organisations: When Can Institutional Actors Counter Existential Challenges?” *Cambridge Review of International Affairs* 37 (2): 182–205. <https://doi.org/10.1080/09557571.2022.2136566>
- Independent Panel for Pandemic Preparedness and Response. 2021. *COVID-19: Make It the Last Pandemic*. https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic_final.pdf
- Jarman, Holly. 2014. “Public Health and the Transatlantic Trade and Investment Partnership.” *European Journal of Public Health* 24 (2): 181. <https://doi.org/10.1093/eurpub/ckt201>
- Khan, Usamah, Rory Pallot, David Taylor, and Panos Kanavos. 2015. *The Transatlantic Trade and Investment Partnership: International Trade Law, Health Systems and Public*



Health. Modus Europe Report, London School of Economics.

- Kaiser Family Foundation (KFF). 2025. *The U.S. Government and the World Health Organization*. Factsheet, January 20. <https://www.kff.org/global-health-policy/the-u-s-government-and-the-world-health-organization/>
- Keohane, Robert O. 1986. "Reciprocity in International Relations." *International Organization* 40 (1): 1–27.
- Lake, David A., Lisa L. Martin, and Thomas Risse. 2021. "Challenges to the Liberal International Order: International Organization at 75." *International Organization* 75 (2): 225–57.
- McInnes, Colin, and Kelley Lee. 2012. *Global Health and International Relations*. Polity.
- Meunier, Sophie, and Milada Anna Vachudova. 2018. "Liberal Intergovernmentalism, Illiberalism and the Potential Superpower of the European Union." *Journal of Common Market Studies* 56 (7): 1631–47.
- Official Journal of the European Communities. 1999. "Agreement on Mutual Recognition between the European Community and the United States of America." *OJEU* L 31/3 (February 4).
- Park, Chanwoo. 2022. "Lessons Learned from the World Health Organization's Late Initial Response to the 2014–2016 Ebola Outbreak in West Africa." *Journal of Public Health in Africa* 13 (1254): 1–3.
- Politico. 2018. "Trump: EU Was 'Set Up to Take Advantage' of US." June 28. <https://www.politico.eu/article/donald-trump-eu-was-set-up-to-take-advantage-of-us-trade-tariffs-protectionism/>
- Ruijter, Anniek de. 2019. *EU Health Law and Policy: The Expansion of EU Power in Public Health and Health Care*. Oxford: Oxford University Press.
- The White House. 2020. "Letter to the Director-General of the WHO." May 18. <https://trumpwhitehouse.archives.gov/wp-content/uploads/2020/05/Tedros-Letter.pdf>
- The White House. 2025. "Withdrawing the United States from the World Health Organization." *Presidential Actions*, January 20. <https://www.whitehouse.gov/presidential-actions/2025/01/withdrawing-the-united-states-from-the-worldhealth-organization/>
- World Health Organization. 1946. *Constitution of the World Health Organization*. Geneva: WHO.
- Yamey, Gavin, and Boghuma K. Titanji. 2025. "Withdrawal of the United States from the WHO – How President Trump Is Weakening Public Health." *New England Journal of Medicine* 392 (15): 1457–60.
- Youde, Jeremy. 2012. *Global Health Governance*. Polity.

