

Global Health in Crisis: Challenges and Options for Action

Six Theses on the Role of Private Actors

by Karolin Seitz | May 2026

Global health is in the midst of a profound structural crisis. Massive cuts in public funding, coupled with an already growing dependence on private actors, weak multilateral institutions and rising inequalities, are jeopardising the human right to health. 4.5 billion people have no access to basic health services. Against this backdrop, new ways of mobilising funds are being discussed. Many see an opportunity in the even greater involvement of private actors.

However, this should be carefully examined and structured so that it actually has a sustainable impact, particularly for the poorest and most marginalised populations worldwide, and does not primarily serve the interests of private actors. Against this backdrop, Brot für die Welt, Global Policy Forum Europe and Misereor have formulated six theses on the role of private actors in global health and recommendations for action for the German government and the Bundestag in this briefing paper.

Democratic oversight, human rights-based policies, strong public institutions and genuine civil society participation are crucial to realising the right to health worldwide. Only by strengthening the World Health Organization, ensuring greater transparency, regulating private influence and investing in public health systems and social security systems can a just global health order for all be achieved.

The withdrawal of the USA and others from global health policy, financing and humanitarian aid has significantly weakened the international order. The resulting gap has exposed the vulnerability of multilateral institutions and the global health system. **Estimates** suggest that over 14 million preventable deaths are to be expected as a result of the drastic cuts to the US development budget. The *World Health Organization* (WHO) must carry out mass redundancies to avert insolvency and reprioritise its tasks. Under current conditions, it can only fulfil its role as the central governing body in the global health architecture to a limited extent.

The global funding crisis in the health sector is being further exacerbated by additional cuts to *Official Development Assistance* (ODA) from other donor countries, including Germany, France and

the United Kingdom. The *Organisation for Economic Co-operation and Development* (OECD) estimates that ODA for health will have fallen by up to 29 per cent in 2025 compared with 2024. This would see funding levels fall back to those of the mid-2000s. Given that **4.5 billion people** still lack access to basic health services and that the achievement of *Sustainable Development Goal 3* (SDG 3), ‘Good health and well-being for all’, remains a distant prospect, this is a disastrous trend.

Against the backdrop of declining public funding, new ways of mobilising funds are being discussed. Many see an opportunity in the greater involvement of companies and philanthropic foundations, for example through so-called *blended finance instruments*, in which public or philanthropic funds are used to mobilise private investment for devel-

opment goals (e.g. through guarantees, low-interest loans, risk-sharing). Added to this are new public-private partnership (PPP) projects and the privatisation of health services. The German government has also adopted this approach in its coalition agreement. With the action plan ‘Strong Partnerships for a Successful Global Economy’, presented on 7 October 2025, and the reform plan ‘Shaping the Future Together Globally’ from the Federal Ministry for Economic Cooperation and Development (BMZ), dated 12 January 2026, the German government is setting out in concrete terms the announced measures to strengthen cooperation with the private sector in the field of development cooperation.

However, numerous **analyses**, including those by Brot für die Welt, Misereor and the Global Policy Forum Europe, suggest that greater involvement of private actors – be they companies, their stakeholders or philanthropic foundations – in global health policy can entail risks and unintended consequences. This should therefore be carefully examined and structured so that economic activities are steered towards sustainability and cooperation actually has a sustainable impact, particularly for the poorest and most marginalised populations worldwide.

Six theses on the role of private actors in global health and recommendations for the Federal Government, the Bundestag and the democratic parties:

1 Ensuring equitable global access to medicines and research findings

Thesis: The existing pharmaceutical system hinders equitable access to essential medicines, including vaccines and technologies such as diagnostics, particularly in the Global South and during global health crises such as pandemics.

Key issues:

Large pharmaceutical and medical technology companies (“Big Pharma”) play a central role in global health because they research and develop many new vaccines, medicines and technologies. However, this role is often used to legitimise enormous profits, political influence and far-reaching market power. On closer inspection, these profits and structures of influence are difficult to justify, even when taking into account high R&D costs and risks.

The pharmaceutical and healthcare products industry is one of the most powerful lobbyists worldwide. In the USA alone, it spent around **340 million** US dollars on lobbying in 2025, more than any other sector. In the EU, too, it is one of the most financially powerful interest groups in Brussels, with estimated annual expenditure of at least **21.8 million** euros and over **1,600** registered companies and associations. The primary aim of these lobbying activities is to secure and expand patent-protected monopolies, prevent strict price regulations, and maintain the status quo in international patent law — for instance within the framework of the *World Trade Organization* (WTO) or during the COVID-19 pandemic.

The result is a **highly concentrated global pharmaceutical market** in which a small number of corporations dominate entire therapeutic areas. This market concentration leads to high prices, less diversity in innovation, and a focus in research on profitable products rather than those that are socially necessary, for example at the expense of vaccines and medicines for neglected tropical diseases such as leishmaniasis. A prime example of a pharmaceutical market driven by profits rather than need is the inadequate production of cholera vaccines. Although cholera broke out in **32 countries** in 2025 and effective vaccines have long been available, after the patents have expired, they are produced in insufficient quantities due to **a lack of profitability**, to the extent that the WHO at times even recommended administering just one dose with reduced protection instead of two. If the current study on the manufacture of cholera vaccine in South Africa yields positive results, a vaccine could be approved in 2028 and then be ready for use in Africa.

A significant proportion of basic pharmaceutical research and clinical development is publicly funded. In Germany alone, between 2010 and 2016, an average of **0.14 billion US dollars** in public (academic) funding was spent per drug developed. An

analysis from the USA shows that between 2010 and 2019, all 356 newly approved medicines were based at least in part on publicly funded research, in particular by the National Institutes of Health (NIH), which invested around 187 billion US dollars during this period. Despite this public investment, private companies secure exclusive exploitation rights through patents and set prices which, as various examples have shown, far exceed the actual development and production costs, the exact figures for which usually remain opaque.

At the same time, pharmaceutical companies generate **exceptionally high profits** compared to other sectors of industry. During the COVID-19 pandemic, the seven largest vaccine manufacturers scored around around 86 billion US dollars in revenue in 2021 alone and achieved net profits of approximately **50 billion US dollars**, a profit margin of around 57 per cent. A significant portion of the revenue did not flow back into research, but into dividends, share buybacks and lobbying. These dynamics exacerbate profound global inequalities in access to medicines, including vaccines. The market power of large pharmaceutical companies and higher profit margins mean that wealthy countries are given preferential supply, whilst access in the Global South often remains limited – a pattern that was particularly evident during the COVID-19 pandemic. It should be noted that around **a quarter** of the world's population lacks access to essential medicines; in the poorest parts of Africa and Asia, this figure rises to as much as half the population.

At the same time, the major pharmaceutical companies focus primarily on markets in countries with higher purchasing power and neglect the research and development of medicines to combat diseases that are particularly prevalent in low-income countries, including, for example, poverty-related and neglected tropical diseases. Yet around **1.5 billion** people worldwide require preventive or therapeutic measures against these diseases. Patents and strict intellectual property regulations also block the local production of essential medicines in the Global South and increase dependence on a handful of multinational corporations. The African pharmaceutical market, for example, is highly dependent on imports, as more than **70 per cent** of the medicines required are sourced from abroad. The existing inequalities in the global pharmaceutical system constitute both a market failure, as research and development are driven by profit motives, and a political failure, because governments have so far failed to intervene with sufficient regulation to ensure equitable access.

Patent thickets in oncology: the example of Roche and the consequences for global access to cancer medicines

The current patent system in the pharmaceutical sector can significantly restrict access to medicines, particularly when companies use strategies to artificially extend their market exclusivity. One common example is so-called 'evergreening', whereby, in addition to an original patent, numerous so-called secondary patents are filed for minor changes such as dosage, manufacturing processes or forms of administration. This creates a 'patent thicket' that delays the market entry of generics or biosimilars and can extend the duration of monopoly pricing significantly beyond the originally intended 20 years.

One **example of this is the Swiss pharmaceutical company Roche**, which has built up around 100 patents relating to its antibody therapies for HER2-positive breast cancer. HER2-positive breast cancer is a particularly aggressive form of the disease, affecting over 400,000 new people worldwide every year. Although the original drug, Herceptin, was launched as early as the 1990s, decades later, numerous additional patents still protect these products, thereby extending the monopoly in some cases into the 2040s. This practice delays competition from cheaper biosimilars and keeps prices high, which in turn makes access massively difficult in countries of the Global South and places a massive strain on public health systems in the Global North. According to an **analysis** by Public Eye, this 'patent wall' has already enabled Roche to generate revenues of over 156 billion Swiss francs.

Approaches to overcoming structural inequality in the global pharmaceutical system:

- » **Limiting monopolies and price abuse:** The Bundestag and the Federal Government should make targeted use of competition and tax policy to prevent market concentration, monopolisation and excessive prices. To support this, the Monopolies Commission can carry out independent assessments and issue recommendations.
- » **Expand public research and production capacities:** Countries in the Global South, in particular, need stronger public research and production structures to reduce their dependence on large pharmaceutical companies in the Global North. The Federal Government should provide greater technical and financial support for building these capacities. EU and UN programmes should support the necessary invest-

ments and the transfer of knowledge, data and technology.

- » **Reform of the global patent system:** In global health emergencies, the German government should advocate within the WTO for an extended TRIPS waiver (i.e. the temporary suspension of certain patent rights) that covers not only vaccines but also therapeutics, diagnostics and, where applicable, other pandemic-related products. The existing TRIPS flexibilities should be reformed so that all countries, particularly developing and emerging economies, can make effective use of them in a simplified manner and without political or trade-related pressure. The German government should push for structural reforms in international patent law (such as shorter terms or limited patent protection for medicines that are crucial for global health crises). These are urgently needed to ensure that intellectual property rights no longer hinder the production of and access to essential medicines in the Global South, particularly during global health crises such as pandemics.
- » **Binding access conditions and price transparency for publicly funded research:** The Federal Government should ensure through contractual agreements that research findings and innovations resulting from public funding benefit everyone; patents and licences should be subject to clear access and pricing conditions, as well as the disclosure of research and development costs. The Federal Government should advocate for uniform, systematic and accessible reporting on direct and indirect public funding at national and European level.
- » **Recognising medicines as a public good:** The German government should recognise essential medicines and technologies as public goods that should be made available to everyone, regardless of income or origin, and particularly during global health crises. The German government should advocate for such recognition at EU level and within the World Health Assembly.
- » **Enact legal regulations rather than voluntary commitments:** In general, the German government should advocate for binding regulations at national and international level to ensure equitable access to essential medicines and technologies.

2 Limit the power and influence of private actors in global health policy

Thesis: Private actors, companies and their interest groups are increasingly shaping global health policy. Their influence jeopardises democratic decision-making processes and weakens the WHO. Multi-stakeholder initiatives can exacerbate imbalances and fragment international health governance.

Key issues:

Private actors, including major pharmaceutical companies, the food and beverage industry ('Big Food') and the tobacco industry, along with their trade associations and lobby groups, use a variety of tools to influence public discourse and political decision-making processes in global health. They do this, amongst other things, through lobbying governments and international organisations, global advertising campaigns, funding research, their operational activities (e.g. through product selection, supply contracts and pricing) or through direct funding of and partnerships with international organisations such as the WHO for implementation. This increasing influence is leading to growing power and interest asymmetries in global health governance.

This is particularly evident in the case of non-communicable diseases (NCDs), such as liver and lung diseases, obesity, type 2 diabetes and cardiovascular diseases, where industry players from the alcohol, tobacco, sugary drinks and highly processed food sectors have for years been attempting to **water down** binding regulations or replace them with voluntary commitments. In Germany, for instance, **lobbying by the food industry** has prevented the regulation of sugary foods through measures such as a ban on advertising to children or a sugar tax, which the country is currently discussing. The picture is similar at the international level: due to intensive **lobbying**, all mandatory references to the taxation of tobacco, alcohol, sugary drinks and highly processed foods were removed from the final UN declaration on non-communicable diseases (NCDs) in September 2025. Even the **WHO**

leadership felt compelled to criticise this influence and called on governments to ensure that important health reforms for the benefit of the population and public health are not undermined by pressure from companies.

The **WHO Secretariat of the Framework Convention on Tobacco Control (FCTC)** has for years been issuing explicit warnings about **systematic influence by the tobacco industry**, for example through targeted lobbying ahead of negotiations at the Conference of the Parties.

During negotiations on a pandemic treaty within the WHO framework, too, the **pharmaceutical industry** in particular exerted considerable influence to avoid commitments on technology transfer, transparency and equitable access to medicines for prevention, treatment and diagnosis, as well as their manufacture.

Studies and analyses by civil society organisations demonstrate, using the USA as an example, how massive industry lobbying shapes national positions on WHO processes, such as those relating to pharmaceutical regulation and the pandemic treaty. Furthermore, lobbying is specifically directed against key WHO recommendations on health promotion, including measures against the misleading marketing of infant and toddler foods, as well as recommendations to reduce sugar and alcohol consumption. Spending on WHO-related lobbying in the USA averaged 14.2 million US dollars per year between 2016 and 2019 and rose to around 46 million US dollars during the COVID-19 pandemic (2020). Comparable analyses regarding EU and German positions on WHO matters are currently lacking. Overall, the study concludes that private-sector lobbying in the USA not only influences individual WHO processes in the interests of commercial interests, but systematically aims to undermine the credibility and scope of action of global health governance, going as far as (successful) political demands for the US government to withdraw from WHO funding.

The establishment and funding of so-called global multi-stakeholder partnerships (MSPs)¹ are further instruments that grant private-sector actors influence over the discourse, agenda-setting and policy decisions of governments and UN organisations.

Global MSPs are collaborations between public and non-public actors who pursue common goals on a voluntary basis. Examples such as the Gavi Vaccine Alliance, the Coalition for Epidemic Preparedness Innovations (CEPI) or the Access to COVID-19 Tools Accelerator (ACT-A), in whose highest governing bodies companies and philanthropic foundations are also represented, show that these entities have a say in how public funds are used. Furthermore, MSPs often lack transparency regarding their funding and effectiveness, as well as accountability to democratic institutions and the affected populations. A small number of financially powerful actors from the Global North (governments, companies, philanthropic foundations) dominate the setting of priorities within the MSPs. At the same time, governments, particularly health ministries in the Global South, must fulfil numerous parallel administrative and reporting obligations when applying for external financial or technical assistance.

In some cases, the establishment of new MSPs has led to tasks and decision-making processes being outsourced from the intergovernmental organisations under the UN umbrella that are actually responsible for them. MSPs therefore frequently undermine the exclusive decision-making authority of the WHO and its member states, compete with it for scarce public resources, and thus contribute to fragmentation in global health governance. The hopes placed in MSPs for additional funding from the private sector have, with a few exceptions, so far hardly been fulfilled. Furthermore, existing power imbalances and conflicts of interest among the private-sector actors involved are frequently ignored.

As a result of the growing influence of private-sector actors in global health governance, whether within the framework of MSPs or through other instruments of influence, health policy challenges are increasingly being depoliticised and assessed from a market-economy perspective, rather than openly addressing structural causes such as unequal trade and patent systems or regulatory shortcomings. The focus is on medical-technical and market-based approaches, as well as the so-called 'charity' approach and voluntary commitments, whilst binding political and legal solutions are pushed into

¹ MSPs encompass a wide variety of forms of cooperation, which differ significantly in terms of funding, membership, thematic focus and degree of institutionalisation. They can fulfil various functions. They can influence policy discourse and exchange knowledge, set international norms and standards, mobilise public and private resources, provide technical cooperation and services (e.g. in the form of public-private partnerships), and coordinate governmental and non-governmental activities. MSPs often perform several of these functions simultaneously.

the background. Profit interests are given priority over the realisation of the right to health.

Privatised pandemic policy: ACT-A as an example of a shift in power and discourse

The Access to COVID-19 Tools Accelerator (ACT-A) was established in 2020 by the European Commission, the French government, the Bill & Melinda Gates Foundation and the WHO to coordinate the global response to the pandemic. One central element was the COVAX Facility, which was intended to support the development of COVID-19 vaccines through advance agreements with pharmaceutical companies and to coordinate the distribution of vaccines to all countries worldwide. However, due to voluntary participation, unilateral national actions and serious governance deficits, ACT-A fell far short of its distribution and coordination targets. An [external evaluation](#) commissioned by the WHO criticised the insufficient involvement of poorer countries and civil society, a lack of transparency and unclear accountability structures. Philanthropic foundations and companies gained considerable influence over decisions regarding billions in public funds, whilst governments and the WHO lost ground. The WHO was merely one of several partners in this context. Multi-stakeholder partnerships such as Gavi acted simultaneously as decision-makers and recipients of funds, which created conflicts of interest. Overall, ACT-A shifted global COVID-19 crisis management away from state regulation towards voluntary, market-oriented approaches, whilst structural solutions such as the suspension of patent rights were sidelined.

Approaches to regaining democratic control in global health governance and ensuring a focus on the public good:

» **Establish rules and minimum standards for cooperation with private-sector actors:**

The German government should advocate for the creation of binding guidelines and minimum standards at UN level regarding cooperation with private-sector actors and their involvement in MSPs. The existing guidelines are highly [inconsistent](#) and inadequate, and are not being implemented sufficiently. In addition to key guiding principles, the new rules should include minimum standards, such as detailed

selection and exclusion criteria, systematic impact assessments and independent evaluations. The WHO has established the Framework of Engagement with Non-State Actors (FENSA), a set of rules which, however, has weaknesses and is inadequately enforced. To ensure the implementation of the rules by the UN secretariats and at the intergovernmental level, there is a need to strengthen human resource capacities and establish an intergovernmental UN body for partnerships with the private sector. It could operate in a similar manner to the NGO Committee of ECOSOC.

» **Limiting private-sector lobbying influence on national WHO positions:**

Furthermore, governments must effectively limit the influence of private-sector lobbyists on national WHO positions, for example by strictly separating policy formulation from stakeholder consultation. In addition, for policy areas particularly susceptible to lobbying — such as drug pricing, intellectual property, regulation surrounding the prevention of non-communicable diseases, or pandemic preparedness — strict ‘firewall’ rules could apply, excluding direct influence from industry actors. The model for this is Article 5.3 of [the WHO Framework Convention on Tobacco Control \(FCTC\)](#)². In addition, government delegations should be required to disclose external influences by formally stating which stakeholders were consulted in advance and what positions they put forward.

» **Ensuring greater transparency regarding lobbying influences and ending excessive lobbying:**

The German government should further develop the German lobby register, support the EU in developing Transparency Register and advocate for a comparable register at UN level.

» **Strengthening the WHO as a central institution:**

The German government should continue to advocate for the financial and political strengthening of the WHO, in particular through higher mandatory government contributions.

» **Limiting the role of global multi-stakeholder partnerships (MSPs):**

The German government

² Article 5.3 of the WHO Framework Convention on Tobacco Control obliges States Parties, when formulating and implementing their public health measures for tobacco control, to protect these measures, in accordance with their national law, from commercial and other self-serving interests of the tobacco industry. The WHO has issued specific [guidelines](#) for the implementation of this requirement.

and the WHO should participate exclusively in MSPs that are limited to dialogue. MSPs must not assume any rule-making or steering role in global

health governance. Membership of existing MSPs should be reviewed.

3 Curbing the dominance of philanthropic foundations

Thesis: The growing dominance of philanthropic foundations in global health policy jeopardises the independence of the WHO and distorts priorities in the global health agenda.

Key issues:

In recent decades, the philanthropic sector has gained considerable significance worldwide. Both the number of philanthropic foundations and their funding volume and reach have risen sharply. According to the [OECD](#), 32 private foundations alone spent a total of 11.7 billion US dollars on development cooperation purposes in 2023, primarily in the areas of global health and education. The Gates Foundation (formerly the Bill & Melinda Gates Foundation) is by far the largest and most influential player in shaping global health. It provides around **8 billion US dollars** in funding annually for development purposes, a large proportion of which goes to the health sector. Since the USA withdrew from the WHO, the Gates Foundation has been the organisation's largest donor, contributing over US\$820 million and funding around 13 per cent of the WHO's 2024–2025 budget (**761 million US dollars**) – significantly more than Germany, for example, **which contributes 361 million US dollars**. As its funds are allocated for specific purposes, the foundation directly influences how the WHO uses its resources.

Philanthropic foundations are not only playing a growing role in development financing. They also influence public discourse and political decisions. In addition to direct financial support, they use various instruments to exert influence, such as linking grants to government funding commitments (*matching funds*), seconding staff to government agencies and international organisations, supporting selected research programmes, or establishing global multi-stakeholder initiatives. Furthermore, they engage in active lobbying at the highest political level.

The funding logic of many philanthropic foundations is strongly technology- and market-oriented. They often favour projects with short-term measurable successes (*quick wins*) and increasingly support vertical programmes with a strong focus on infectious diseases and technological solutions, as well as the involvement of the private sector. This

would be less problematic if the foundations' activities were complementary to longer-term measures. However, through lobbying and by linking their funding commitments to public funds, scarce public resources are also channelled into areas favoured by foundations. Structural and long-term measures, such as the establishment and expansion of public health systems, as well as the diagnosis and treatment of chronic diseases, are consequently neglected, not to mention measures to prevent the causes of disease (e.g. improving access to clean drinking water). In some cases, projects funded by foundations contribute to the privatisation of essential public services in the health and education sectors, both in countries of the Global South and in industrialised nations such as the USA.

It is striking that major foundations such as the Gates Foundation, the Rockefeller Foundation and the Wellcome Trust should allocate **the majority of their funding for global health issues to non-governmental organisations in high-income countries**, particularly in the USA. As a result, a significant proportion of so-called development funds ultimately flows back into the structures and markets of the Global North. Foundations also frequently provide funding to private, for-profit companies. Between 2018 and 2020, around **12 per cent** of the Gates Foundation's health-related funding went to companies, including, for example, BioNTech. In addition, there are direct investments in numerous firms. Against this backdrop, it is not surprising that **Bill Gates** argued vehemently against the temporary suspension of patents for Covid-19 vaccines during the Covid-19 pandemic. Conflicts of interest also frequently arise from holdings in companies whose products are harmful to health. For instance, the Gates Trust, which manages the Gates Foundation's assets, is one of the largest shareholders in the Mexican Coca-Cola subsidiary and bottler **Coca-Cola FEMSA**.

Another problem is the lack of accountability among philanthropic foundations. They are usually

accountable only to their own governing bodies or founders, but not to the public or the recipients of their funding, which fosters a democratic deficit and a lack of transparency.

The central problem, however, is that billionaires' wealth is insufficiently taxed. Foundation models are in some cases specifically designed to facilitate tax avoidance, and the funds pooled there are subsequently used to exert political influence beyond democratic legitimacy.

The German government, too, works with numerous foundations on a variety of issues. In 2023, the BMZ alone cooperated with the Gates Foundation on **nine projects**, whilst the German government as a whole collaborated on over 20 further projects with international philanthropic foundations and on over 250 with German ones. Yet to this day, the German government has no specific rules governing cooperation with philanthropic foundations, and there is a lack of transparency regarding these cooperation projects, for example with regard to their funding and effectiveness.

How the Gates Foundation influences the WHO's priorities

Between 2000 and 2024, the Gates Foundation donated more than 5.5 billion US dollars to the WHO. Over **80 per cent** of these funds were earmarked for the fight against infectious diseases, in particular the eradication of polio (3.2 billion US dollars). Funding for WHO programmes aimed at strengthening health systems and tackling non-communicable diseases, which pose a huge challenge to global health, plays a secondary role for the Gates Foundation. In the period 2024–2025, a total of more than **10 per cent** of the WHO budget was earmarked for the eradication of polio. However, the Gates Foundation influences the WHO's agenda not only through the funding of programmes, but also by 'seconding' staff to the WHO or funding consultancy firms. For example, the **Gates Foundation funded McKinsey** to advise the WHO in 2015 on its process to reform the Roll Back Malaria (RBM) partnership. The reform led to a less representative governance structure for the partnership and to the transfer of RBM from the WHO to the United Nations Office for Project Services (UNOPS), a more economically oriented UN organisation.

Policies for an independent WHO and global health governance that prioritises public interests and needs:

- » **Strengthen the WHO's financial independence:** The German government should advocate that only untied donations from large private foundations and companies to the WHO are permitted.
- » **Develop specific cooperation guidelines for foundations in Germany:** The German government should develop clear cooperation guidelines for dealing with private foundations, including principles and forms of cooperation, transparent rules on, amongst other things, the handling of conflicts of interest, lobbying and staff exchanges (*secondments*), as well as rules on transparency, accountability and evaluation. The cooperation guidelines should be based on the **BMZ's project criteria** for development partnerships with the private sector, the principles of the **Paris Declaration** on Aid Effectiveness, or the **WHO's framework for cooperation with non-state actors** (FENSA).
- » **Increase transparency regarding financial flows and funding recipients:** The German government should disclose financial flows, funding agreements and recipient data, including the geographical distribution of funds, from and with foundations, governments and international organisations, and should also advocate for such disclosure at the international level.
- » **Reform tax policy:** The German government should shape tax law in such a way as to limit excessive concentration of wealth and the resulting political influence, and should also advocate internationally, for example, for a global minimum tax for billionaires.

4 Stop financialisation and privatisation – safeguard public healthcare

Thesis: The increasing financialisation and privatisation of the healthcare sector are restricting universal access to high-quality healthcare services, particularly for the poorest sections of the population.

Key issues:

Many official development assistance donors and international organisations are currently placing greater emphasis on blended finance instruments, public-private partnerships or Advance Market Commitments (AMCs)³ to mobilise private capital for global health. These approaches, as applied for example by the Gavi Vaccine Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) or the World Bank's Pandemic Emergency Financing Facility (PEF), reflect a growing financialisation of the health sector, in which private actors, financial actors and markets, as well as profit-driven logic, are playing an ever-greater role.

Through privatisation, commercialisation and the treatment of health as an investment opportunity, investment decisions, pricing and care structures are increasingly being subordinated to the interests of financial actors. Instead of pursuing health policy objectives, the health sector is being guided more and more by expectations of returns, which can lead, amongst other things, to overpriced treatments, a decline in quality and pressure on wages and working conditions in the health sector, not only in the Global South but also in the Global North. In the pharmaceutical and biotechnology sectors, this leads to research into the treatment of diseases that promises little or no profit being neglected.

Furthermore, these market-based models often prove to be **more expensive** in the long term for patients and public budgets. In low-income countries in particular, they can **exacerbate** unequal access to healthcare services, for example because of charges for treatment or medicines. Instead of mobilising additional private funds for health systems, governments in the Global South often have to transfer large sums of public money back to financial actors in the Global North as interest and fee payments under market-based financing mechanisms, as in the case of the vaccine bonds issued by the **International Finance Facility for Immunisation** (IFFIm) and used by Gavi. Similar experi-

ences have been seen with PPPs such as the **Queen Mamohato Hospital** in Lesotho, whose repayments placed a heavy burden on the national health budget.

In practice, these market-based financing mechanisms therefore often lead to the privatisation of profits whilst simultaneously socialising risks. Whilst returns flow to private investors, states and public institutions bear the financial risks, for example in the event of a lack of success or inefficient use of funds. At the same time, financialisation leads to a lack of transparency and accountability in the health sector. Private financial flows often escape public scrutiny because of commercial and banking secrecy.

When public funds become private profits: How IFFIm vaccine bonds restrict access to vaccines

Since 2006, the International Finance Facility for Immunisation (IFFIm) has been mobilising private funds through so-called vaccine bonds, which are regarded as 'innovative financing instruments'. To date, over 3.1 billion US dollars has flowed to Gavi, the Vaccine Alliance, to finance global vaccination campaigns more quickly. However, the funds must be repaid to private investors, plus interest. According to a 2022 [study](#), private investors, predominantly from the Global North, received over 879 million US dollars million in interest over a 13-year period alone, paid for out of government development aid funds. A further 55 million US dollars went to banks, lawyers, auditors and consultants for the management of the bonds. As a result, there is less money available for vaccinations, whilst private profits and administrative costs rise.

Approaches to ensure that healthcare is safeguarded as a public good and not treated as a financial investment:

- » **Creating fiscal scope for public investment in health:** The German government should advocate for debt relief and debt forgiveness for economically disadvantaged countries, great-

³ Under Advance Market Commitments (AMC), pharmaceutical companies receive financial commitments or subsidies to develop and produce medicines or vaccines against diseases that occur primarily in low- and middle-income countries.

er international cooperation in combating tax evasion and profit shifting, and a fair global tax system. Taxes on products and industries that pose a health risk, such as tobacco, alcohol, sugary drinks, highly processed foods or fossil fuels, should be specifically used to fund public health systems. In general, healthcare, as a public good, should be at the heart of national budgets.

- » **Limiting and regulating private financing instruments:** The Federal Government should ensure at various levels that private-sector involvement in the health sector is primarily used as a procurement and implementation partner. The use of private financing models in the healthcare sector must be restricted to strictly limited exceptional cases and only when they can be shown to be used in line with needs and to strengthen health systems. They must be subject to clear rules on public accountability, transparency and the public good; commercial confidentiality must not be used to justify a lack of transparency.

- » **Establishing effectiveness principles and public interest criteria for public-private partnerships:** Public-private partnerships should only be used in clearly justified exceptional cases and regularly reviewed to ensure that they are in fact efficient, transparent and geared towards public needs. PPPs must demonstrate that they reduce costs in the long term, maintain public control and improve access to healthcare services. Projects that do not meet these criteria should not receive further funding or be reformed. Where private services are procured, traditional PPP contracts should be avoided in favour of clearly defined contractual relationships.
- » **Critically assessing private financing models:** Narratives that portray private financing as a 'win-win' solution often obscure the actual costs, dependencies and inequalities. Political decisions must not be guided by profit interests, but must be oriented towards the right to health and the long-term common good.

5 Driving a paradigm shift towards holistic, equitable health policy

Thesis: The increasing focus on health security, medicalisation and verticalisation of global health policy jeopardises the right to health because it tackles symptoms rather than causes.

Key issues:

Governments' one-sided focus on global health security means that health risks such as cross-border pandemics are viewed as security threats to their own populations and economies, as well as to the stability of entire regions, and must therefore be combated in the same way as terrorism. However, this perspective leads, amongst other things, to other important health issues – such as non-communicable diseases, social inequalities or weak health systems – being neglected, subordinated to the goal of national security, and resources being prioritised for the containment of acute crises.

In the medicalisation of global health, health issues are primarily addressed through medical and technical solutions, whilst structural, social and environmental causes of disease are largely ignored. Instead of focusing primarily on the treatment of diabetes, for example, preventive measures such as regulating sugar advertising and consumption among children should be strengthened to prevent diabetes and other health problems.

Verticalisation in global health focuses on combating individual diseases through technical and short-term measurable measures, which, whilst yielding successes against certain infections, weakens health systems if not integrated into the broader health system. Furthermore, diseases that have not received the attention of donors are overlooked, such as so-called neglected tropical diseases (NTDs) and non-communicable diseases, such as diabetes, chronic respiratory diseases or cardiovascular diseases. Preventive approaches and holistic healthcare that take social determinants of health into account are mostly neglected. Whilst more holistic health programmes have come into focus since 2015 in the context of the Sustainable Development Goals, a shift back towards vertical programmes such as Gavi or GFATM can now be observed, partly due to the sharp reduction in health ODA, including within German development cooperation.

Technical solutions versus structural health promotion: combating malaria with gene-drive mosquitoes

The fight against malaria using genetically modified malaria-carrying mosquitoes is an example of a technical, vertical solution that stands in contrast to the promotion of good environmental and living conditions which provide functioning sanitation systems and protected living spaces. The Gates Foundation, in particular, is relying on this approach, among others, using so-called 'gene drive' technology, and is attempting to gain acceptance for the controversial technology through massive lobbying efforts, as revealed by the so-called [Gene Drive Files](#) at the end of October 2017. Vertical programmes are attractive to donors and political institutions because they deliver rapid, measurable results and are easier to manage than horizontal programmes. Vertical health interventions have contributed to the eradication of smallpox and to significant progress in the fight against tuberculosis and HIV/AIDS. However, they have also concentrated human and financial resources from the already scarce resources of national health systems and international health financing on these disease areas.

Approaches to ensuring that global health policy is designed to be equitable and human rights-based:

» **Putting health as a human right at the centre:**

The holistic concept of health – encompassing physical, mental and social well-being – should form the basis of all health strategies. Health should be understood and implemented as a human right and a public good.

» **Strengthening the One Health approach:** The close connection between humans, animals and the environment requires integrated, holistic

strategies to jointly combat zoonoses, environmental pollution and the impacts of climate change.

» **Tackling the root causes of disease:** Poverty, inequality, climate change, poor nutrition and precarious working conditions are key causes of disease. Policy measures must focus on tackling the root causes rather than treating the symptoms, including through the reduction of greenhouse gases, the regulation of advertising and consumption of products and industries that pose a health risk, such as tobacco, alcohol, sugary drinks, highly processed foods or fossil fuels, as well as improved working and living conditions and social justice.

» **Social security systems** must be expanded to cushion the impact of healthcare costs, loss of income and incapacity to work.

» **Strengthening local public health systems:** Investment in public, public-interest-oriented structures is crucial to ensuring comprehensive care provision. Affected population groups and civil society organisations must be actively involved in planning and implementation to promote needs-based solutions.

» **Holding companies accountable for respecting human rights and protecting the climate and environment:** States must oblige companies to respect human rights and protect the climate and the environment through effective legislation, such as the Supply Chain Due Diligence Act, the EU Supply Chain Directive (CSDDD) and the planned UN Treaty on Business and Human Rights.

6 Strengthening civil society and local communities

Thesis: Without the active involvement of civil society organisations and local communities, particularly from the Global South, the existing power imbalances in the health sector between private and public actors cannot be addressed.

Key issues:

Civil society organisations and local communities are facing increasing restrictions worldwide. This so-called 'shrinking space' is evident not only in sensitive areas such as sexual and reproductive health and rights, but also affects other areas, including health, the environment, social and human rights, education and poverty reduction. Non-gov-

ernmental organisations and civil society initiatives are increasingly encountering political, legal or financial barriers that limit their ability to act and marginalise their voice in public debates. They are, however, significant for the health architecture, as they are often the ones who maintain close contact with the population, enjoy their trust, and know their needs and can advocate on their behalf. Civil

society organisations also play an important role in monitoring government action and exposing abuses. It is often civil society actors who uncover and document human rights violations and provide those affected with access to justice and redress.

This trend is also continuing at the international level. In recent years, the scope for meaningful participation by civil society organisations in WHO decision-making processes has **narrowed significantly**. Limited delegation sizes, drastically reduced speaking times, the merging of agenda items and the relegation of statements by non-state actors to the end of debates make effective participation considerably more difficult. In addition, a growing number of informal meetings, side events and non-public discussions are taking place at the World Health Assembly (WHA), to which civil society delegations have no access. As a result, important decisions and discussions are shifting away from the official sessions and are increasingly escaping public scrutiny. The continued existence of UNAIDS, with its strong direct involvement of civil society organisations and affected groups, is in doubt, and there is a fear that a merger of UNAIDS with the WHO could reduce or even eliminate their important active participation.

Overall, many civil society actors are thus deprived of the opportunity to actively participate in decision-making processes at both national and international levels. Health strategies, programmes or policy guidelines are frequently developed without the genuine involvement of the affected communities, meaning that local experiences and needs are not taken into account. Given the growing influence of private actors in global health, this systematic exclusion reinforces existing power imbalances between private interest groups, state actors and civil society organisations, weakens democratic structures and hinders the development of equitable, inclusive policy solutions to health challenges at the global level.

Conclusions for an equitable global health system

Global crises, the ongoing consequences of the COVID-19 pandemic, the effects of climate change, geopolitical tensions and violent conflicts are placing a strain on health systems and affecting the health of millions of people. Furthermore, global health is in the midst of a profound structural crisis, exacerbated by a massive decline in public funding for development aid, increasing privatisa-

Attacks on health activism and the right to health – findings from Global Health Watch 7

The [Global Health Watch Report 7](#) from 2024 illustrates the range of restrictions on civil society in the health sector through various cases. In Turkey, for instance, the Turkish Medical Association was criminalised for its advocacy for the right to health and its criticism of, among other things, Turkish military operations in northern Syria. In the Philippines, so-called ‘red-tagging’ campaigns – i.e. the branding of individuals as communists, subversives or terrorists – have led to intimidation and violence against health activists and healthcare workers, whilst in South Africa, xenophobic tendencies are significantly restricting migrants’ access to medical care.

Approaches to ensure that democratic participation and the inclusion of civil society organisations and affected groups become a cornerstone of health governance:

- » **Ensuring genuine participation:** The German government should ensure that civil society actors at national, European and international level can engage effectively and meaningfully in global health governance, for example when it comes to reforming the WHO or its work programme.
- » **Strengthening and protecting health activists worldwide:** The German government should provide political and financial support to health activists nationally and internationally and promote their protection against repression and violence worldwide.
- » **Adopting a clear political stance in support of a strong civil society:** The Federal government, the Bundestag and democratic parties must consistently defend universal human rights and an independent, effective civil society both nationally and internationally, and advocate for their active participation.

tion and the growing influence of powerful private actors. The withdrawal of state responsibility has increased dependence on companies and foundations, thereby weakening democratic control and the focus on the common good. Instead of the long-term strengthening of public health systems in low- and middle-income countries, technocratic and market-oriented approaches dominate,

often narrowly focused on diseases and ignoring their structural causes and inequality. A just global health order therefore requires the political will of the German government and other WHO member states to strengthen the WHO as a central multi-lateral institution, to establish transparency and accountability, and to limit the privileges and influ-

ence of private actors. Only through public funding, human rights-based policies, democratic oversight and genuine participation by those affected and civil society organisations can the human right to health be realised. Global health must once again be understood as a public good – not as a market.

Since 2013, **Brot für die Welt**, **Global Policy Forum Europe** and **Misereor** have been working on a joint cooperation project examining the role of private actors, including companies, their lobby groups and philanthropic foundations, in relevant policy processes that are essential for socio-ecological transformation. Numerous analyses have been produced as part of this cooperation project. They can be found [here](#).

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