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Viewpoint

Whose Sovereignty? Financing and Partnerships in the European Union's Global Health Resilience Initiative

Qi Shao*

***Correspondence to:** Qi Shao, Email: 598152706@qq.com

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The European Commission's Global Health Resilience Initiative (GHRI), adopted on May 13, 2026, reveals how the European Union (EU) is reinterpreting health: as a domain where security, economic competitiveness, supply-chain strategy, and international partnership converge.[1] Building on the EU Global Health Strategy,[2] it links global health resilience to investment and partner countries' health sovereignty. These objectives may reinforce one another, but investment does not necessarily redistribute control. The central question is whether the GHRI's financing and partnership models expand partners' capacity to govern essential health functions, or replace aid dependence with investment dependency.

Here, health sovereignty means the effective capacity of countries and regions, through accountable public institutions and participation by affected communities, to set health priorities, sustain essential services, and govern health financing, technologies, and data. It is a sector-specific analytical concept, distinct from legal state sovereignty or national self-sufficiency: regional cooperation can increase this capacity. Nor is it synonymous with EU strategic autonomy, which prioritizes the Union's own resilience and security. The EU is not a unitary health sovereign; Article 168 of the Treaty on the Functioning of the EU preserves Member States' responsibilities for health policy and service delivery while providing for complementary Union action.[3] Shared action therefore coexists with different national priorities. Viberg and colleagues identify the need for horizontal governance and local input beyond coordination among EU institutions and Member States, informing the democratic emphasis adopted here.[4]

This viewpoint offers an interpretive reading of the Commission's communication and factsheet, supported by selected literature, rather than a systematic review or an evaluation of implementation outcomes.[1,5] Policy architecture denotes the connections between stated objectives, delivery instruments, and institutional responsibilities. Table 1 maps the factsheet's five priority areas to its nine flagships, cross-checked against the communication; labels are shortened without adding categories. The three tests below are the author's normative framework, not indicators validated by the Commission.

The Promise of Health Sovereignty

Three health-system issues make the sovereignty promise consequential: continuity of essential services, reliable access to health products, and the capacity to detect threats and maintain public trust. These are selected because they connect the GHRI's priorities to capacities needed both during crises and in routine care. Countries should be able to finance, govern, and deliver essential health services; maintain primary healthcare during crises; and produce or

Table 1. Global Health Resilience Initiative Priority Areas and Flagship Initiatives

GHRI Priority Area	Related Flagship Initiatives
More effective and coordinated global health architecture	1. Enhanced EU coordination
Country-led resilient health systems	2. Sustainable financing and shared expertise for health sovereignty
Prevention, preparedness, and response	3. Global networks; 4. Medical countermeasures; 5. Global health and resilience tracker
Diversified supply chains and manufacturing	6. Manufacturing and resilient supply chains; 7. Partnerships and knowledge exchange; 8. Clinical research networks
Societal resilience and trust in science	9. Access to science and data

Abbreviations: EU, European Union; GHRI, Global Health Resilience Initiative.
Source: Author's synthesis of the Commission's GHRI factsheet, cross-checked against COM(2026) 197 final.1,5 Labels are abbreviated; numbers follow the communication. This descriptive mapping covers all five priorities and nine flagships; it does not assess implementation.

Huaibei Normal University, Huaibei, China.

procure critical health products. Manufacturing matters here because service continuity depends on access to medicines, vaccines, diagnostics, and other supplies, not simply on having facilities.

The Team Europe Initiative on manufacturing and access to vaccines, medicines and health technologies in Africa (MAV+) illustrates this approach. Its activities span production, demand, regulation, skills, and access to finance.[6] The GHRI factsheet reports approximately €540 million invested in African health manufacturing, leveraging up to €2 billion under MAV+; these figures should not be read as €2 billion in direct grants.[5] Local and regional production may reduce vulnerability to external shocks and strengthen governments' response capacity. This complements arguments that countering vaccine nationalism requires addressing scarcity and production capacity as well as political incentives.[7,8]

The GHRI also broadens preparedness through surveillance, One Health, medical countermeasures, and public communication. Its proposed global health and resilience tracker could make financing gaps more visible.[1] Yet indicators can privilege measurable spending and infrastructure over institutional capacity or community trust. Country comparisons may reflect reporting capacity rather than need; funders could overinvest in highly scored settings and underinvest in fragile ones. These are foreseeable design risks, not documented effects of this proposed tracker. Country and community participation in indicator selection, publication of definitions and missing-data limitations, and qualitative review would help. The tracker should inform deliberation rather than automatically rank countries for funding, with periodic review of its distributional consequences.

The Risk of Investment Dependency

The financial architecture matters because it allocates risk and decision-making power. The GHRI connects to Global Gateway and proposes guarantees and blended financing.[1,9] Blended finance combines concessional or public support with other finance; a public-private partnership (PPP) is a contractual arrangement for delivering assets or services. They may overlap but are not interchangeable. Private participation can bring capital and expertise, and public procurement also carries risks. The relevant comparison is therefore whole-life cost, service quality, affordability, and the allocation of controllable risks across feasible financing options, rather than an assumption that public or private provision is inherently superior.

Healthcare evidence illustrates the trade-off. Hellowell's case study of Lesotho's hospital PPP found relatively high service quality alongside government costs exceeding forecasts, with weaknesses in contract design and management.[10] A later observational study reported lower overall hospital mortality in 2018 than in 2012 (6.5% versus 8.0%). Separate observations in 2013 and 2020 found declines in timely triage and crash-cart stock completeness.[11] These studies show that improvements in some observed outcomes can coexist with fiscal and operational pressures; they do not establish how a GHRI project would perform. Beyond healthcare, the European Court of Auditors examined 12 EU-supported transport and information-technology PPPs and identified unbalanced risk sharing. It assessed as ineffective almost €1.5 billion in additional public spending needed to complete five audited motorway projects in Greece and Spain.[12] Its sectoral and historical scope limits direct generalization to health partnerships.

Evidence on blending raises a separate issue: whether public subsidies add value. In a 2014 audit of 30 projects receiving EU grants blended with financial-institution loans, the Court found that projects were relevant and blending generally effective, but that 15 cases lacked convincing analysis demonstrating that the grant was necessary to secure the loan.[13] This does not prove that the subsidies had no benefit, or describe current GHRI performance. It supports explicit additionality assessments, disclosure of subsidy terms, and monitoring of who benefits. Stein's analysis of COVAX further connects financing arrangements to control over vaccine access, without serving as a direct evaluation of infrastructure PPPs.[14]

Investment dependency is thus a conditional risk: financing, purchasing commitments, or licensing terms may restrict public choices without delivering compensating public capability. The GHRI's simultaneous pursuit of partners' health sovereignty and EU competitiveness makes agenda-setting power central.[1] The Commission frames the initiative; EU delegations coordinate country implementation; Member States, financial institutions, and partner authorities bring distinct resources and responsibilities. This multilevel arrangement can pool expertise but can also diffuse accountability. If EU officials and financiers prioritize commercially attractive proposals, partner health needs may receive less weight. Accountability within EU institutions alone cannot ensure accountability to affected populations abroad. Partnerships therefore need explicit allocations of responsibility, disclosure duties, and routes for partners and communities to challenge decisions.

Manufacturing hubs are necessary but insufficient. A factory without secure demand, skilled personnel, usable know-how, and regulatory capacity cannot ensure independent access to affordable products. The GHRI already recognizes governance, public financial management, and regulatory strengthening; its commitment to voluntary technology transfer on mutually agreed terms also leaves the scope of transfer dependent on negotiation.[1] The concern is not the absence of institutional ambitions, but whether financing and agreements make them enforceable. Infrastructure has identifiable assets and revenue streams; negotiating expertise, regulatory independence, and participatory oversight do not necessarily generate investor returns. Physical investment alone cannot be assumed to redistribute authority. These capacities need dedicated recurrent funding, staff, and decision rights alongside capital investment.

Three Tests for the Global Health Resilience Initiative

The GHRI should therefore be judged against three tests: fiscal space, technology and authority, and agenda-setting power. They examine control over public resources, technological and regulatory capabilities, and the authority to determine

Table 2. Three Tests of Democratic Health Sovereignty

Test	Core Question	Proposed Safeguards	Proposed Governance and Accountability
Public fiscal space	Does financing strengthen public systems without unsustainable liabilities or displacement of grants?	Protect core grants; assess additionality and whole-life costs; disclose and limit public exposure.	Health and finance ministries jointly review obligations; parliaments and auditors scrutinize commitments; EU funders disclose subsidies and risk allocation.
Technology and authority	Can partner institutions adapt, produce, regulate, and govern technologies over time?	Specify know-how and licensing rights; fund regulatory staff and negotiating capacity; link support to transfer milestones.	Partner regulators and procurement bodies define requirements; independent reviewers assess milestones; joint bodies require remedies for non-delivery.
Agenda-setting power	Can partners and communities shape priorities and challenge decisions?	Provide partner approval rights, representative participation, transparent minutes, and grievance procedures.	Joint bodies include partner governments and regional institutions; civil-society and health-worker representatives monitor delivery; named authorities respond to grievances.

Abbreviation: EU, European Union.

Note: Author's proposed analytical framework and implementation safeguards, not validated indicators or a description of existing GHRI governance. Responsibilities should be specified in agreements at EU, regional, country, and project levels.

health priorities, respectively. Table 2 connects each to proposed safeguards and governance responsibilities. These are recommendations for implementation, not claims about governance mechanisms already established by the initiative.

First, does it expand public fiscal space? Health sovereignty requires predictable financing for primary healthcare, laboratories, workforce development, and essential medicines. Grants for core public functions should be protected. Before approving private finance, finance and health ministries should jointly assess affordability, contingent liabilities, foreign-exchange exposure, and the consequences of demand falling below or exceeding forecasts. EU funders should disclose subsidy additionality and risk allocation; national parliaments and audit institutions should scrutinize long-term commitments and renegotiations. Contracts need enforceable service and affordability obligations, proportionate limits on public exposure, and an allocation of risk to actors able to manage it. Risk cannot simply be eliminated or shifted wholesale to either partner.

Second, does it transfer technology and decision-making authority? Manufacturing partnerships should specify usable know-how, licensing rights, training, regulatory strengthening, and regional procurement arrangements. The World Health Organization (WHO) mRNA technology transfer programme illustrates an approach that extends beyond product donation, although it cannot by itself resolve all commercial or intellectual-property constraints.[15] Partner institutions should be able to adapt, produce, regulate, and improve technologies over time. Agreements should fund regulatory staff, procurement expertise, and public negotiating capacity, with milestones assessed by partner regulators and independent reviewers. Local ownership alone does not guarantee public benefit; affordable access and accountable control must also be secured.

Third, do partner countries and communities have meaningful influence over the agenda? Country-led arrangements require more than consultation after investment priorities have been fixed. Joint governing bodies should give partner governments and regional institutions defined approval rights over priorities and material project changes, with transparent selection of civil-society and health-worker representatives. Published minutes, conflict-of-interest rules, a duty to respond to community concerns, and accessible grievance procedures would make participation consequential. Surveillance agreements should clarify data stewardship, access, privacy safeguards, and permissible reuse. Public communication should sustain trust through responsive services and participation, as well as correcting misinformation. Responsibilities and reporting channels should be specified at project, country, regional, and EU levels.

Conclusion

The GHRI is timely and potentially important. Its strongest contribution is to connect health security with systems, manufacturing, surveillance, trust, and international cooperation. Its sovereignty promise will depend on whether financing and partnerships transfer durable public capability and authority. Evidence from earlier partnerships justifies safeguards, not a prediction that the initiative must fail. Democratic health sovereignty means that accountable institutions and affected communities can shape priorities and govern the resources on which health depends. It can be strengthened through regional cooperation and well-designed private participation. The GHRI should be judged by affordability, institutional capacity, and meaningful partner control, alongside mobilized capital and completed infrastructure.

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Ethical issues

Not applicable.

Conflicts of interest

Author declares that he has no conflicts of interest.

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