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Building a resilient European Health Union: From European interests to mutually beneficial partnerships

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The European Union (EU) has launched the European Health Union and developed an EU Global Health Strategy as well as a Global Health Resilience Initiative to strengthen the global health architecture and health systems in its member states and worldwide. These efforts are, however, highly constrained by critical dependencies on external inputs, most prominently medical products and financial contributions to the global health architecture. The EU must overcome these dependencies through mutually beneficial partnerships with countries facing similar challenges. Europe's ability to forge these partnerships will depend on overcoming the "donor-recipient" mindset, enabling local value creation and creating multilateral structures that also serve new allies, ensuring that these partners are not merely a means to an end but part of a shared and mutually beneficial strategic agenda.

From shared dependencies to resilient partnerships

The EU's critical dependencies regarding (global) health system resilience can be mapped along two axes: firstly, medical products together with the digital infrastructure surrounding pathogen surveillance and analysis, and, secondly, financial contributions. Regarding product dependencies, close to 80 percent of active pharmaceutical ingredients, mostly for generic medicines, come from only five countries, China foremost among them. At the same time, the sequencing, cloud and analytical platforms that guide public health decisions, along with a share of patented products, are primarily owned by companies from the US. As regards financing, the funding base of global health is narrow and has recently lost its largest contributor owing to the US withdrawal from the World Health Organization (WHO), leaving the Gates Foundation as the single largest voluntary funder.

These dependencies are not unique to the EU. Other countries are equally dependent on pharmaceutical imports from China and large single donors that carry the global health architecture. For example, 78 percent of the foreign production facilities that export Active Pharmaceutical Ingredients (APIs) to Brazil are located in China and India. Hence, Brazil shares Europe's vulnerabilities even as it builds its own industry. Moreover, just like the EU, Brazil's health system is embedded within the global health architecture, which means that a weakening global health system – due to funding cuts – directly weakens its national health system. Read this way, dependence is a common problem and can be a basis for new partnerships. The EU should thus see these shared dependencies as an opportunity rather than only as a risk to be managed. The ultimate objective of resilient supply chains, diversified partnerships and sustainable financing remains improved health outcomes and equitable access to prevention, diagnosis and treatment.

Attractive to whom, and on what terms

If concentration-induced EU dependencies are the problem, the answer from a European perspective is diversification. Regarding products, several low- and middle-income countries (LMICs) have the potential to broaden the European supply chain, mainly for generics and their ingredients, while keeping costs reasonably low. Credible partner countries for diversification are, for example, Brazil and South Africa, since these countries already possess production capacities.

However, certain goods, such as antibiotics, cannot be diversified at present and instead require targeted local European capacity-building. The Mercosur countries in particular offer latent manufacturing capacity that Europe can co-develop through, for example, the Global Gateway initiative, Horizon Europe research cooperation and closer regulatory recognition between the European Medicines Agency and local regulatory authorities.

On finance, untapped capacity lies with large economies that, relative to their economic output, invest little in multilateral structures that promote global health. Brazil illustrates this point sharply, with comparably small voluntary contributions to the WHO. This also goes for other countries, which for one reason or another do not contribute as much as they could to multilateral structures that promote global health. Securing additional financial contributions – from Brazil, for example – also hinges on the question of why a country such as Brazil has thus far refrained from committing larger sums to the global health architecture. A possible answer could be that multilateral institutions are designed – or at least perceived to be designed – to serve the interests of high-income countries, providing few incentives to LMICs to support structures not working for – or even against – their interests.

Partnerships capable of reducing strategic dependencies require long-term political trust, transparency and predictability, not just economic incentives. Whether Europe is looking for trading partners or new financial contributors to the global health architecture, partners will carefully evaluate the appeal of the EU's offer. This offer establishes a relationship of equals rather than a donor-recipient arrangement, pursued through concrete frameworks such as the Coalition for Equity, local production by Brazilian companies and a renewed dialogue with the CELAC region, as well as a partnership with Mercosur.

A partnership of equals with a price tag

Attractiveness comes with a price tag, and this is where interests could potentially collide. Partners, in Latin America and Africa, for example, are not looking for assistance, but rather for local production, local value creation, and a genuine voice in the multilateral system. This can clash with Europe's defence of intellectual property on patented products and its own vision of the global health architecture. These cleavages came to light most prominently during the negotiations on the WHO Pandemic Agreement from 2021 to 2025 and the ongoing negotiations relating to the Annex.

On the one hand, the EU pushed for a strong One Health approach to pandemic prevention –recognising the interdependence of human, animal, plant and environmental health – which was perceived by developed countries as being imposed on LMICs. On the other hand, the EU advocated for comprehensive access to pathogens while remaining reluctant to accept binding commitments on waiving intellectual property rights and transferring technology in the event of a pandemic. While the former issue can be addressed through common but differentiated responsibilities, the key question in resolving the latter is how to share technology and facilitate access to medicine without destroying the incentive to innovate. One model that could be built on further is the WHO's mRNA Technology Transfer Programme with the Medicines Patent Pool, which pools voluntary licenses. This allows innovators to keep a return while know-how passes to producers, paired with advance market commitments to guarantee that there are buyers for this capacity.

The same honesty applies to money, where the price is more concrete than a general call for reform. The global health architecture is – not least due to the US withdrawal – in turmoil at a time when strengthening global health is more important than ever. The EU and its member states have their own vision of the future, which sometimes clashes with the demands of LMICs. LMICs are critical of the concentration of decision-making on donor-dominated boards and the earmarked funding that imposes donors' priorities over country-led ones.

A credible response already exists in the form of the 2023 Lusaka Agenda, agreed by major global health initiatives and partner countries, which establishes country-led priorities and promotes recipient voices through board seats, reducing fragmentation and

shifting from earmarked towards flexible funding. Backing the agenda and giving contributors such as Brazil genuine co-decision rights rather than donation slots would persuade them to step up.

France and Germany as drivers of Europe's new offer

France and Germany can become important drivers in making a new offer to potential partners to jointly diversify supply chains and finance the global health architecture. The honest starting point is a unified European and, in particular, a unified Franco-German voice. Divided messages and ambiguity undercut credibility and make the EU less attractive as intentions become opaque. France and Germany's global health financing commitments are already diverging. In this vein, France substantially exceeded Germany in cutting its funding for the Global Fund to Fight AIDS, Tuberculosis and Malaria.

What is needed is a strong strategic alignment with clearly defined goals, fewer bureaucratic hurdles and more pragmatic framework conditions. An overly cautious approach to technology and data-sharing and intellectual property – alongside procurement rules – blocks the possible win-win arrangements that diversification requires. Furthermore, attractiveness is partly a matter of communication regarding what Europe wants and what each side gains. A successful Franco-German approach would combine France's diplomatic reach and Germany's scientific and industrial capabilities into a coherent European health partnership strategy.

Above all, the two governments can anchor health within a wider strategy of new alliances. A European third way distinct from both Washington and Beijing – drawing on a strong academic sector, cross-sectoral cooperation including shared data through the European Health Data Space, and on trust built over time rather than capacity handed down from above – is beneficial. France and Germany can present a single credible new offer focusing on joint manufacturing partnerships abroad, predictable financing and a shared position on reform.

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