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Commentary

Philanthrocapitalism in a time of global health austerity

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As high-income nations retreat from global health governance and financing, philanthropic foundations and corporate interests are rapidly filling the vacuum. This shift has ushered in an era of philanthrocapitalism, reframing donations as investments engineered to yield measurable social and financial returns. As a result, global health interventions increasingly prioritise short-term technical fixes over long-term structural change, while concentrated private influence within multilateral bodies obscures deep conflicts of interest between commercial agendas and public health priorities. By relocating stewardship from sovereign states to private boardrooms, this pivot establishes parallel governance structures that successfully bypass democratic scrutiny and public accountability. Dismantling these dynamics requires a radical reform of global health philanthropy. Only by empowering communities to govern their own health futures can health systems foster the flexibility needed to build resilient infrastructures. We propose three interconnected transitions to achieve this: increasing downward accountability to give local communities a real voice in funding decisions; using trust-based flexible financing to move away from rigid, short-term metrics; and strengthening regulatory oversight of philanthrocapitalist foundations to safeguard the public interest.

The Shifting Global Health Landscape

Global health governance is fracturing under the combined weight of escalating geopolitical rivalries, resurgent economic nationalism, and shrinking aid budgets. As established international norms erode, this retreat from multilateralism puts decades of health equity progress at risk, leaving the world's most vulnerable populations dangerously exposed to collapsing healthcare systems. In 2025, Official Development Assistance (ODA) provided by the Development Assistance Committee (DAC) experienced its sharpest contraction on record, falling by 23% to USD 174 billion (OECD 2026). The United States alone accounted for three-quarters of the decline, with its ODA falling 57% from 2024 (OECD 2026). Projections suggest that such drastic funding cuts to global health initiatives could result in 22.6 million additional deaths in low-income countries by 2030, including 5.4 million children under five (Ferreira da Silva et al. 2026).

While major private philanthropists – most notably the Gates Foundation and the Novo Nordisk Foundation – have expanded their global health portfolios, they lack the capital to offset state

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retrenchment, accounting for just 10% of total ODA. Yet, this modest financial footprint belies their outsized influence on global health governance, which frequently eclipses that of sovereign nations. By driving a new wave of philanthrocapitalism, these foundations reframe humanitarian aid through the lenses of corporate efficiency and venture-style investments that demand scalable business models and tangible financial returns.

This Commentary explores the complex implications of this shifting landscape, analysing how private foundations have transitioned from auxiliary funders into powerful agenda-setting architects of contemporary global health policy. This institutional pivot raises critical governance and accountability questions, shifting strategic control away from sovereign states and multilateral institutions and effectively relocating long-term stewardship of global health to private boardrooms. To safeguard the future of global health equity and protect vulnerable populations, we propose a series of targeted structural reforms for global health philanthropy. First, we recommend increasing downward accountability to grant local communities a genuine voice in funding decisions. Second, we advocate for trust-based, flexible financing to move away from short-term metrics. Finally we call for enhanced regulatory oversight to monitor and govern philanthrocapitalist foundations, ensuring their investments align with public needs rather than private interests.

The Retreat from Multilateralism

The shift in global health priorities towards private philanthropy accelerated following the United States' withdrawal from the World Health Organisation (WHO) in January 2026, which positioned the Gates Foundation as WHO's primary funder (WHO 2026). Explaining this transition requires a broader political economy perspective. Specifically, the United States has sought to undermine more traditional forms of multilateral aid in order to facilitate its financial retreat from global health policy while simultaneously attempting to reassert its geopolitical hegemony (Galvão et al. 2026). According to Alami et al. (2026), this is achieved via four distinct strategies: i) *sabotage* (deliberately attacking existing multilateral institutions, such as by underfunding organisational budgets); ii) *bypass* (creating ad hoc, non-multilateral, "minilateral" coalitions designed to circumvent traditional consensus-building); iii) *diversion* (co-opting or structurally capturing of multilateral mechanisms); and iv) *disengagement* (partially or completely withdrawing from multilateral pacts and agreements). As shrinking state contributions hollow out the WHO's core budget, the organisation relies precariously on earmarked voluntary funding (WHO 2026). This shift significantly expands the political leverage of private actors in multilateral spaces, empowering philanthropic foundations to act as strategic policy architects that subtly replace multilateral consensuses with their own agendas (Kennedy & Thakrar 2025).

Although the WHO Foundation (WHOF) was launched in 2020 to diversify the organisation's revenue base, an analysis of funding disclosures from May 2020 to December 2023 revealed that less than half of the received funds were transparently attributed, while also highlighting severe inequalities in resource allocation (Maani et al. 2025). Specifically, private donors frequently directed voluntary contributions toward narrow, earmarked initiatives – most notably, vertical vaccination campaigns – that are often misaligned with national health agendas. The authors conclude that this reliance on earmarked voluntary contributions means that global health challenges favoured by major donors are well funded, while other, less-favoured, areas remain neglected (Maani et al. 2025). Indeed, evidence suggests that the establishment of the WHOF has effectively presented private philanthropy as being depoliticised. It achieves this through the 'fictional expectations' of accountability and transparency that obscure deep-seated conflicts between commercial interests and WHO's core public health mandate (Ralston et al. 2024). This exposes a fundamental tension in contemporary global health governance. While private capital delivers urgently needed resources to underfunded initiatives, its underlying profit motive aligns with a neoliberal political rationality (Powell 2014, Wolff 2026). This alignment serves to erode the sovereignty and long-term sustainability of health systems in low- and middle-income countries (LMICs) and leaves them structurally dependent on volatile external financing (Osborne 2025). However,

characterising LMICs as passive observers of these geopolitical shifts misrepresents their growing agency. Williams (2025), for example, highlights how African nations are moving past traditional dependency models to secure health sovereignty through significantly increasing domestic health spending. Similarly, Afriyie et al. (2026) argue that current geopolitical fragmentation offers a critical opportunity to dismantle colonial legacies and to reimagine global health equity as a practice of shared power. At this critical juncture, establishing robust regulatory frameworks for private philanthropy and capital in a post-multilateral era is essential for unlocking the progressive potential of a rapidly evolving post-multilateral landscape.

The Business of Charity

As McGoey (2012) notes, 'philanthrocapitalism' is a term coined by Bishop (2006), although it has echoes of earlier regimes of moral capitalism. Philanthrocapitalism describes a post-millennial shift in charitable giving wherein wealthy donors apply core business principles to the social sector. This approach treats philanthropic donations as investments designed to yield measurable social and financial returns, utilising market-based techniques, such as venture philanthropy and impact investing, to address global issues (Koot & Fletcher 2025). The blueprint of this model relies on key mechanisms that actively reshape traditional charity (Farnsworth & Irving 2026). First, the model integrates market-based mechanisms, leveraging private-sector principles, commercial business models, and profit incentives to drive social change rather than relying on conventional grant-making. However, these market-driven frameworks often result in a technical rather than a structural focus; interventions are increasingly redirected toward short-term, easily measured fixes at the expense of deeply entrenched structural inequalities. To scale these solutions, philanthrocapitalists treat donations as risk capital, funding innovative social ventures with the explicit goal of scaling them globally across multiple markets. This model enforces a regime of rigorous metrics, demanding highly quantifiable outcomes where donors actively track strict return on investment (ROI) and key performance indicators (KPIs) (Farnsworth & Irving 2026).

Central to philanthrocapitalism is the strategic use of capital to de-risk private investments in developing markets (Sklair & Gilbert 2022). For instance, large-scale charitable funders (most notably the Gates Foundation), now leverage blended finance and social bonds to bridge funding gaps and deploy their capital as a 'first-loss' guarantee. By shielding mainstream private investors from risk and facilitating their entry into global health projects, this mechanism effectively enrols state agencies and multilateral organisations to underwrite private capital and shoulder market risks. This structural reconfiguration ensures that private enterprises capture the financial upside while public and charitable entities absorb the downside liabilities (Sklair & Gilbert 2022). Advocates assert that such business-driven strategies bypass bureaucratic inertia, thereby addressing global health challenges more efficiently than the allegedly slow-moving state apparatuses (see OECD 2015). Yet detractors argue this model grants undue moral legitimacy to corporate actors whose commercial practices frequently exacerbate the very health inequalities they claim to solve (McGoey et al. 2021, Vivek 2025). This commodification of health subordinates the long-term needs of vulnerable populations to the strategic interests of private shareholders, transforming essential services into opportunities for extractive profit (Wolff 2026). For instance, the Gates Foundation often requires collaboration in government innovation projects to be conditional on the involvement of the private sector (Eckl 2014). These blurred boundaries create significant conflicts of interest, particularly when corporate donors profit directly from the initiatives they subsidise or when philanthropic interests intersect with industries known to harm public health, such as the junk food sector in the context of the commercial determinants of health (Herrick 2008, Stuckler et al. 2011), in echoes of what McKinlay (1979) called 'manufacturers of illness'. Ultimately, this model functions less as genuine aid and more as a conduit for Western market penetration, prioritising capital extraction for international shareholders over critical infrastructure necessary for local self-sufficiency (Mannion & Speed 2025).

Epistemological Capture

Philanthropic organisations are also increasingly shaping global governance by constructing the empirical and intellectual frameworks used to identify, prioritise, and manage global health challenges (Littoz-Monnet 2026). For instance, the Gates Foundation has invested over $300 million in the Institute for Health Metrics and Evaluation (IHME), which publishes the influential Global Burden of Disease reports (Reubi 2018). This financial backing enables the IHME to develop the dominant metrics and forecasting tools that shape how global health problems are understood. International bodies increasingly rely on these privately generated metrics for their sense-making and agenda-setting. Using complex data models and economic calculations, global health institutions determine which health interventions are the most cost-effective and capable of 'saving the most lives' (Littoz-Monnet & Garate 2024). While this may confer purported scientific rigour to resource allocation, it creates an environment where only quantifiable outcomes are valued, and in which complex social challenges are reduced to standardised economic units, such as Disability-Adjusted Life Years (DALYs). As a result, funding is disproportionately directed toward medicalised, measurable interventions, allowing private donors to demonstrate tangible impact to their boards and stakeholders, bounded within a utilitarian logic which is favoured in neoliberalism.

Reimagining Global Health Philanthropy

Safeguarding global health equity demands radical reform in global health philanthropy (Grant-Poitras et al. 2026). This is not to deny that a severe funding crisis in global health exists – but addressing it requires a concerted shift in financial resources and decision-making authority, moving them much more directly to local leaders and grassroots organisations (Reich 2018). It also requires a rethinking of multilateralism, moving away from strategies that sabotage, bypass, or fragment local efforts (Alami et al. 2026). Empowering communities in this manner can begin to foster the flexibility needed to build resilient systems and aims to enable them to govern their own health futures. To operationalise this vision, we propose three interconnected transitions: increased downward accountability, increased trust-based flexible financing, and enhanced regulatory oversight of philanthrocapitalist foundations.

Increased Downward Accountability

To rebalance power dynamics, global health philanthropy should transition from top-down decision-making to shared power models that hold philanthropic foundations accountable to the communities they impact, rather than just their boards (Noble et al. 2025). A note of caution is necessary regarding the downward framing of this transition; the terminology is deployed here to challenge the dominance of philanthrocapital foundations, rather than to position local actors as subjugated. To actively disrupt this dominance, target populations must be adequately represented on trustee boards and investment committees. For example, the Global Fund stipulates that individual countries should determine their own responses to HIV, TB, and malaria (Afriyie et al. 2026). Grounded in principles of radical transparency, this shift requires foundations to publicly disclose granular data on grant distribution, leadership demographics, and investment portfolios to verify that resource flows align with stated equity goals. Indeed, Afriyie et al. (2026) detail a model of 'structural audacity' in financing, whereby funding mechanisms shift from donor-controlled models to LMIC-led pools. Similarly, they argue for a new compact founded on 'governance for agency'. This compact is predicated on the principle of subsidiarity, ensuring all decisions are made at the most local and appropriate level. Elsewhere, Grude et al. (2026) offer a qualitative comparative analysis of 11 major global health reform initiatives, including the Accra Reset and the Africa CDC Health Security and Sovereignty Initiative, which call for increasing domestic

spending on healthcare and country-led priority-setting. Their review identifies four key reform domains: Financing and Funding, Country Sovereignty, Capacity Building and Alignment, and Efficiency – and assesses the extent to which these domains underpin each respective reform programme. The core of their analysis assesses the precise degree to which these distinct domains underpin, constrain, or accelerate the implementation of each respective reform programme, offering a rigorous blueprint for the more equitable development of global health policy.

Implementing these systemic changes involves significant practical hurdles. Populations are rarely monolithic and hold competing, nuanced interests, defining community boundaries is a complex and sensitive task. Adams et al. (2019) highlight the tensions global health initiatives face: relying on a strong nation-state to direct social medicine while facing processes that undermine the state through intensifying globalisation and liberalisation. The US withdrawal from the WHO can be read in this light – as a push for liberal market processes to fill the resulting funding gaps. Foundations also face the challenge of reconciling the value of lived experience with fiduciary responsibility. To address this, organisations must embrace participative decision-making, actively involving local stakeholders to ensure tangible, grassroots benefits. Donors must also disclose granular data regarding grant distribution, leadership demographics, and investment portfolios. Simultaneously, they should build robust local systems by investing in technical support and leadership development, equipping community representatives to manage large-scale assets while honouring their localised contextual awareness.

Increased Trust-Based Financing

This second transformation – trust-based funding – complements and builds upon downward accountability processes. Trust-based funding aims to dismantle historical power imbalances in traditional aid structures, shifting global development away from prescriptive, top-down models toward genuine, equitable partnerships (Trust-Based Philanthropy Project 2025). Maradeix et al. (2025) describe trust-based philanthropy models as rooted in six core values: systemic equity, power-sharing, honest relationships, respect and humility, accountability and transparency, and learning. The overlap with increased downward accountability is clear. It is notable that many if not all of these values directly oppose the performance metrics emphasis contained within contemporary business model which we outlined previously. For trust-based philanthropy to succeed, a fundamental shift away from these underlying commercial frameworks is required. To ensure deep, sustainable impact and enable local partners to drive their own agendas, philanthropic donors should transition from volatile, short-term, project-specific grants toward stable, multi-year financing that prioritises durable systemic reform over isolated interventions. Unlike traditional funding models, which remain vulnerable to economic fluctuations and shifting donor priorities, a trust-based financing model presents a more predictable financial horizon that gives partners the security to invest in their own futures. Ultimately, trust-based financing requires shifting healthcare priorities to the local context, where they are co-determined or entirely driven by local experts. This approach also significantly reduces bureaucracy by eliminating the onerous compliance burdens of annual grant cycles, thereby liberating local leaders to focus on long-term impact (Community Force 2026).

Enhanced Regulation of Wealth Extraction and Tax Avoidance

To address systemic funding shortages in global health, governance frameworks should regulate the concurrent wealth extraction and tax avoidance practices that deplete public revenue. Private philanthropies operate under diverse, often inconsistent rules and regulations across different jurisdictions, effectively often working to create loopholes within existing programmes that can be exploited. To be clear, in many instances, the primary motivation for a public health intervention by a philanthrocapital foundation is more about developing opportunities for wealth extraction than about contributing to the social good. Philanthrocapitalist interventions tend to function primarily as wealth-

extraction opportunities, and because of this, global health governance must therefore explicitly recognise financial exploitation as a structural determinant of health (Li Preti & McCoy 2025, Hunter et al. 2025), specifically targeting the under-regulated financialisation that drains vital resources from low-income nations (Hunter et al. 2025).

Rectifying these inequities requires structural reforms: overhauling intellectual property regimes to ensure publicly funded technologies remain accessible to host populations; eliminating the use of tax havens by global health actors; and expanding public fiscal capacity through strategic debt cancellation and progressive taxation (Friel et al. 2024). In the absence of robust regulation and clear accountability mechanisms for beneficiary communities, current models of philanthrocapitalism risk becoming tools for corporate capture and exploitation rather than genuine vehicles for achieving the long-term goal of universal health coverage.

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