

The Global Health policies of the EU and its Member States: a common vision?¹

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ABSTRACT

This paper assesses the coherence between the global health policy of the European Union (EU) and those of its individual Member States. So far EU and public health scholars have paid little heed to this, despite the large budgets of the member states in this area. While the European Commission has recently attempted to define the 'EU role in Global Health', EU member states would like to keep a grip on the domain of global health as well. Therefore, this paper questions the existence of a common EU vision on global health by comparing the global health policy documents of the European Commission with those of four EU Member States (France, Germany, the UK and the Netherlands). The comparative analysis has been informed by a typology of four 'global health frames', namely *social justice, security, investment* and *charity*. Our findings show some general trends, including a broad interpretation of global health and an increasing ministerial cooperation in this area. Nevertheless, a common EU frame seems to be lacking. The European Commission largely fits the social justice frame, by stressing values and supporting health system strengthening. This social justice paradigm is to a certain extent present in all strategies, but the security and investment arguments are however dominating in the British, Dutch and German strategies. Furthermore, due to the financial crisis and the role of (vertical) multilateral aid for health, it is likely that the European focus on health systems strengthening remains a dead letter. Supplementary research that investigates the implementation of the global health strategies and examines the global health coordination mechanisms within the EU will be necessary to further elaborate on this topic.

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1. Introduction

During the past 20 years, global health has undergone a radical transformation. There has been an unprecedented growth in global health funding, several new partnerships and initiatives were launched², philanthropic foundations such as the Bill and Melinda Gates Foundation gained importance and health emerged on the agenda of high-level fora such as the UN and the G8. This 'global health revolution' has also been accompanied by "a re-conceptualization of health as more than a technical, humanitarian concern and as relevant to the vital interests of States in security and economic well-being"(Fidler, 2009, p. 2).

This paper questions the existence of an 'EU' vision on global health, by doing a comparative analysis of the policy documents on global health of the European Commission and four EU member states. The EU has been trying to find its place in the growing global health arena, in addition to the global health efforts of its member states (Rollet & Chang, 2013). In 2002 already, the Communication from the European Commission on *Health and Poverty Reduction in Developing Countries* established for the first time "a single Community policy framework to guide future support for health, AIDS, population and poverty within the context of overall EC assistance to developing countries" (European Commission, 2002, p. 2). While recognizing the "differing histories and experiences in framing development policy" (p. 15) of Member States, the increasing convergence of general development objectives was mentioned as an opportunity to improve coordination of EU Member States' policies and approaches in the health sector. In 2007, the importance of a European contribution to the global health debate was recognized in the first EU strategy, which called for strengthening the EU voice in global health (European Commission, 2007). Recognizing that global health is influenced by several policy domains, the Directorate-General (DG) Health, DG Development and DG Research initiated a consultation process with several stakeholders in 2009, which resulted in the launch of a joint Commission communication on *the EU Role in Global Health* in 2010 (European Commission, 2010). This communication stated that "the EU should apply the common values and principles of solidarity towards equitable and universal coverage of quality health services in all external and internal policies and actions" (p. 5). By focusing on universal coverage of basic quality care, health systems strengthening and policy coherence, the Communication proposed a clear vision on global health. The Commission communication was followed by Council conclusions (Council of the EU, 2010) and the establishment of a Global Health Policy Forum, bringing together several stakeholders to discuss a wide range of global health issues.

The attempts of the EU to claim a role in global health are clearly linked with current debates on the EU's role in development policy. Given the specificities of the European construction, the EU plays a unique double role in development. It is not only an international donor in its

² e.g. GAVI, the Vaccine Alliance in 2000, the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002 and the US President's Emergency Plan For AIDS Relief (PEPFAR) in 2003.

own right, the EU also has a 'federalizing' role in coordinating and harmonizing the aid policies of its Member States. Since the 2000s, the European Commission has increasingly stressed this latter role, fostering European aims, European approaches and European actions in development policy (Bretherton, 2013; Orbie, 2012; Carbone, 2013). With the adoption of the European Consensus on Development in 2005, the Member States and EU institutions committed to a common vision on international development. Stressing the EU's value-based identity, the consensus introduced 'a European way of doing development policy', which however did not necessarily imply that the supranational level would take over all policy authority (Carbone, 2013). With the adoption of the EU Code of Conduct on Division of Labour in Development Policy in 2007, the European Commission further attempted to operationalize the EU vision on development (Bretherton, 2013). To some extent, the Commission communication and Council Conclusions on the EU Role in Global Health of 2010, can thus be seen as a follow-up of these ongoing coordination efforts, specifically focusing on the health sector.

However, despite the attempts to coordinate EU action on global health, member states want to keep a grip on this domain as well. This can be illustrated by the Council Conclusions on the EU role in Global Health, which stressed that the stronger EU voice on global health should be endeavored "without prejudice to the respective competencies"(p.3). As development is part of their diplomatic bilateral relations, EU donors have their own approaches regarding (health) development policy. In line with this, several member states have recently released their own global health strategies (the UK in 2008 and 2011, France in 2012 and Germany in 2013), which might not necessarily echo the central objectives of the 2010 Commission communication. As member states remain important actors in development policy in general, and in global health more specifically, the question remains to what extent a common 'EU' vision on global health exists.

The relationship between global health policies of the EU and its member states has so far received little attention among EU and public health scholars. The limited literature on the role of the EU in global health mainly focusses on the developments regarding global health at the level of the European Commission (Aluttis, Krafft, & Brand, 2014; Emmerling & Heydemann, 2013; Rollet & Chang, 2013) and the representation of the EU towards the World Health Organization (WHO) (Battams, van Schaik, & Van de Pas, 2014; Van Schaik, 2011). Nevertheless, as both health and development are shared competencies, the role of the EU in global health also depends on the policies of its member states.

By comparing the global health policy documents of the European Commission with those of four EU Member States (France, Germany, the UK and the Netherlands), we aim to identify differences and similarities which might impede or strengthen the EU's added value in global health. In addition, these findings will add to the literature on the federator role of the EU on development. Given the relevance of health in the post-2015 discussions, as well as the

discussions on the international and European response towards the current Ebola crisis in West-Africa, this issue becomes even more important.

Besides the European Commission, four member states were selected for our comparative analysis, namely: France, Germany, the UK and the Netherlands. These member states were selected because they are the biggest players in global health, which can be illustrated by the highest ODA (Official Development Assistance) for health.

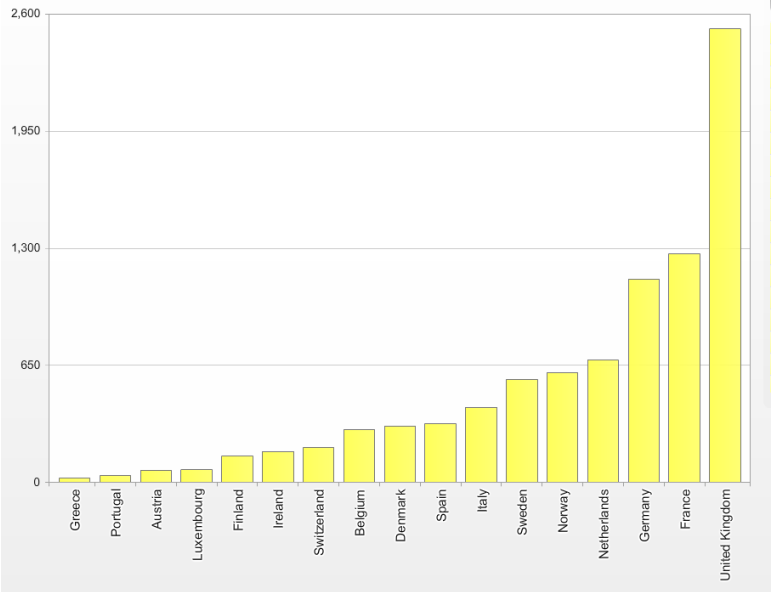


Figure 1: Total Transfers, incl. Lending, Current US dollar, million (2011). (Source: Action for Global Health ODA health tracker)

The remainder of this paper is structured as follows. In the next section, we provide a short overview of two fundamental debates regarding global health, namely the transformation from ‘international health’ towards ‘global health’ and the debate regarding horizontal and vertical programs and funding. These two debates capture the contours of global health discourses today and form our conceptual framework. This conceptual framework is translated in part 3 in an analytical framework, which exists of a typology of global health frames. Part four presents the empirical analysis and consists of (4.1) an overview of the global health policy of the European Commission and the selected Member States, (4.2) a description of the institutional set-up regarding global health and (4.3) a discussion tracing the policy discourse back to the global health frames. In conclusion, we summarize our findings and make suggestions for further research.

2. Global health in a nutshell

Global health is a complex policy area which is understood differently by academic scholars and policy makers. For this paper, we will not stick to a strict definition, as the question on how different EU Member States interpret global health is an integral part of the research.

An important distinction made by several authors, however, is the one between international health and global health (e.g. Bozorgmehr, 2010; Koplan et al., 2009). The term international health originated in the colonial period and is associated mainly with infectious and tropical diseases in developing countries. In contrast, global health is understood as a broader concept than international health, focusing on health issues that transcend national boundaries, the health impacts of heightened globalization for all countries (also industrialized countries), and the need for global action and solutions by a wide range of actors.

The distinction between both terms is quite subtle and Labonté (2014) rightly states that “much of what has recently been re-branded ‘global’ is simply old ‘international’ wine in new bottles”(p.48). The understanding of global (or international) health is furthermore largely influenced by the institutional set-up regarding external health policy in countries. Before the global health revolution, external health policy was mainly dealt with through Western countries’ development cooperation policy, growing out of former colonial relations. However, the increasing awareness of Western states’ own interests in global health ‘lifted’ the subject onto the agenda of ministries of health and foreign affairs. In a growing number of countries, a ‘whole-of-a-government approach’ is used to address a broad range of global health themes. Nevertheless, the question remains which ministry is taking the lead and how the interests and objectives of several stakeholders are balanced. Problems might arise in the interaction between various policy areas, which refers to (horizontal) policy coherence (Carbone, 2008). In global health, the problem of policy incoherence is most notable when it comes to the protection of intellectual property in multilateral and bilateral trade agreements, which might impede access to medicines.

Next to the difference between international and global health, another important debate in global health policy is the one between horizontal and vertical health programs and funding. Already in 1965, both approaches were discussed by Gonzalez, who stated that the horizontal approach “*seeks to tackle the over-all health problems on a wide front and on a long-term basis through the creation of a system of permanent institutions commonly known as ‘general health services’*”, while the vertical approach “*calls for a solution of a given health problem by means of a single-purpose machinery*”(Gonzalez, 1965, p. 9 in Mills, 2005). The World Health Organization’s Alma Ata declaration on Primary Health Care (1978) is still a landmark for the ‘health for all movement’ that promotes a horizontal comprehensive approach to health programs, addressing the wider social determinants of health. However, the World Bank and UNICEF’s approach to selective primary health care in the 80’s and 90’s, and the preference by many donors to this targeted approach has resulted in vertical health interventions (Van Schaik & Van de Pas, 2014) .

For decades, the pendulum has shifted between vertical and horizontal approaches (Uplekar & Raviglione, 2007), with the vertical approach being criticized for its selectivity and short-

term view and the horizontal approach for its lack of a clear focus and efficiency. The global health initiatives that were launched after 2000 are all vertical in orientation, as they focus on infectious diseases, with HIV/AIDS being the most important. In 2007, the debate gained new attention when the International Health Partnership Plus (IHP+) was founded “as a response to the problems associated with fragmented development assistance for health, top-down vertical disease-focused programs, weakened ministries of health, and dysfunctional health systems” (McCoy et al., 2011, p. 1835). The IHP+ is the health sector’s response to implement the Paris declaration on Aid Effectiveness and advance and accelerate progress towards the Millennium Development Goals. The IHP +should have led to the creation of a health systems fund that would align the programs by different global health initiatives, World Bank and the WHO. The financial crises in the VS and EU however hindered this initiative (Hill et al, 2011). More recently, the Ebola outbreak in West Africa has led to debate about the need for a more integrated approach to health systems strengthening and global frameworks for coordination and implementation (Gostin, 2014).

3. A typology of global health frames

Previous researchers have identified several ‘frames’ or ‘paradigms’ (Kickbusch, 2011; Labonté & Gagnon, 2010; Stuckler & McKee, 2008; Lencucha, 2013). For the purpose of this paper, we will make a distinction between four frames, namely *social justice*, *charity*, *investment* and *security*. Differences between these frames relate to the purpose, main interest, commitment towards IHA and the main focus (table 1).

	Charity	Social justice	Investment	Security
Purpose	Fight absolute poverty	Reinforce health as a social value and a human right	Maximize economic development	Combat infectious diseases and contribute to social and political stability
Main Interest	Partner Countries	Partner countries	Donor	Donor
Commitment towards IHA	ad-hoc, unpredictable	long-term	long-term	long-term
Main focus	Vertical: popular themes of victimhood & emergencies	Horizontal: Health systems & primary health care	Vertical: disease-specific	Vertical: disease-specific

Table 1: typology of global health frames

The **charity** frame promotes health as a key element in the fight against poverty and prioritizes popular themes of victimhood such as mother and child mortality health and malnutrition (Stuckler & McKee, 2008). Lencucha (2013) links the charity frame also with the periodic engagement with events such as natural disasters or catastrophic events that pose an imminent threat to the health of people. This frame is related to the social justice frame, in the sense that it refers to the interests of the inhabitants of the countries receiving IAH. However framed as charity, IAH is voluntary, temporary and reactive (Lencucha, 2013). The amount of IAH depends entirely on the benevolence or generosity of the contributor, which makes it less reliable than the social justice frame.

The **social justice** perspective aims to “reinforce health as a social value and human right, supporting the UN MDGs, advocating for access to medicines and primary health care, and calling for high income countries to invest in a broad range of global health initiatives” (Kickbusch, 2011). The social justice frame builds on cosmopolitan values that stress the importance of solidarity towards individuals at the global level, notwithstanding their nationality (Lencucha, 2013). According to this frame, the national government is not the sole responsible for realizing the right to health for its population, as countries ‘in a position to assist’ bear a complementary international obligation as well. The level of international assistance for health (IAH) should be based on the needs of the country and aims to fill the gap between what the national government can provide and what is needed to realize the right to health. The funding is largely focused on health systems & primary health care, which links to the horizontal approach.

The **investment** frame considers health as a means of maximizing economic development (Stuckler & McKee, 2008). Nevertheless, it is not only concerned with the economic effects of health on the population of countries receiving IHA, but also with the result of a growing global market in health goods and services (Kickbusch, 2011). The investment frame thus marks a shift from other-interestedness to self-interestedness: if IAH leads to economic growth, the donors will benefit as well, as they will be able to sell more products and services to the countries. This paradigm provides strong incentives for the continuation or even increase of IHA, but with a focus on the control of diseases that mostly affect the economically productive people.

Similar to the investment frame, the **security frame** is also self-interested, as it is mainly concerned with protecting donor countries’ own population. Global health funding can contribute in two ways to security: either by helping to contain infectious diseases in other parts of the world or by contributing to social and political stability (which might be at risk due to bad health conditions). The security frame motivates long-term action, following the logic that sustained support will ensure sustained national security (Lencucha, 2013). Nevertheless, the security-based concerns lead to a main focus on infectious diseases. According to Rushton (2011), health security could also be conceptualized in a less self-interested way, namely as a vital part of ‘human security’, recognizing a broader range of

threats and taking the individual/community as the primary referent object instead of the (western) state. However, the infectious disease-focused and state-centric version of health security is used more frequently.

4. Findings

In this section, we will first provide a descriptive overview of the global health policy of the European Commission and the four member states, referring to their main strategic documents. Second, we focus on the institutional set-up. Third, we will apply the typology of global health frames to the policy documents and elaborate on the dominance of one or another global health frame among the European donors.

4.1 Global Health policies of the European Commission and EU Member States

Within the **European Commission**, external health policy has been guided by several key documents, which originated both in the policy domains of development and health. In development policy, specific policy documents on health were the communication on 'Health And Poverty Reduction in Developing Countries' (European Commission, 2002) as well as thematic policy documents on human resources for health (European Commission, 2005a) and HIV/AIDS (European Commission, 2005b). Furthermore, the European Consensus on Development (2006) stressed the importance of the Millennium Development goals (MDGs), with a specific focus on the health-related MDGs. Also in its health policy, more attention have been given to global health issues. In the white paper 'Together for Health: A Strategic approach for the EU' (European Commission, 2007), it was stated that *'in a globalized world, it is hard to separate national or EU-wide actions from the global sphere, as global health issues have an impact on internal community health policy and vice versa.'*

In addition to these developments in separate policy domains, there has been a growing urge for a more systematic cross-cutting European strategy on global health. Therefore, the European Commission DG's for international development (DG Devco), research (DG RTD) and health and consumers (DG Sanco) set out an issues paper on "the EU Role in Global health" in 2009, which resulted in the launch of the **EC Communication on 'The EU role Global Health' in June 2010**. The Commission Communication addresses a wide variety of topics, addressing both the process and the outcomes of global health. There are five main areas of action. First, regarding the governance of global health, the Communication aims for a single EU position within UN agencies, stronger leadership of the WHO and full participation of all stakeholders. Second, the Communication states that the EU should work towards universal coverage of basic quality healthcare, by concentrating its support on strengthening of health systems. Third, a lot of attention is given to policy coherence. Fourth, the document emphasizes the need for research that benefits all people and that focuses on all aspects of health. Lastly, the need for coordination among EU member states is stressed, as well as dialogue with key global players.

The Commission communication was followed by Council conclusions, which welcomed the suggestions of the commission but were nevertheless more cautious in formulating the EU role in Global health (Rollet & Chang, 2013). The Commission also foresaw to publish a Program for Action on Global health (Aluttis et al., 2014), but this has not been accomplished thus far. During the Global Health Policy Forum in November 2014, a Program for Action was presented by DG DEVCO, but this was not aimed to be a cross-cutting global health action program.

The **UK** is by far the biggest donor in global health within Europe, and the second donor worldwide (after the United States). The UK has also one of the most detailed and comprehensive formal global health strategies, which dates already from before the launch of the Commission communication . In 2007, Liam Donaldson and Nicholas Banatvala from the Department of health wrote a proposal for a government wide strategy (Donaldson & Banatvala, 2007), which formed the basis of further debate. Via an inter-ministerial working group and extensive public consultation, this resulted in the launch of the '**Health is Global**' **Strategy** in 2008, which intended to span five years, while *"its vision covers a 10-to 15-year period"* (UK government, 2008, p. 7).

The 2008 strategy reflects a broad interpretation of global health, as it has five areas for action: *First*, better global health security is prioritized by focusing on a broad range of issues, including global poverty and health inequalities, climate change, the health effects of conflicts, combating infectious diseases and managing the health of migrants and tackling human trafficking. *Second*, the UK will work towards stronger, fairer and safer systems to deliver health. *Third*, the WHO and EU are supported to play a more effective role in global health and the UK fosters a coherent approach to supporting international agencies and projects and programs in low-and middle income countries. *Fourth*, the strategy aims for stronger, freer and fairer trade, which is crucial for the UK economy and enhances international development. *Lastly*, research for global health is stressed as being crucial to provide evidence for health policy and service delivery.

In 2011, one year after the change of government, the outcomes framework for global health 2011-2015 was launched which focused more on the outcomes than on the process. As mentioned in the document, the Government had *"signaled the need for a radical reprioritization and refocusing of all government activities"* (UK government, 2011, p. 3), following the global economic crisis. Accordingly, the outcomes framework is narrower in scope than the original Health is Global Strategy.

Although **Germany** has a long tradition in international cooperation for health, e.g. via bilateral development aid, industrial, and (to a lesser extent) multilateral policies, the governmental institutions had paid little attention to the concept of global health. Health policy at the European level, in contrast, has been mainly embraced via legal frameworks within the EU. Over the last years the German government however has put itself forward as a leader in global health cooperation and global health diplomacy. It hosted in 2010 the

ministerial conference “Health systems financing - Key to Universal coverage”. The World Health Report 2010 was launched at this event, and was basically the starting point of getting policy and political support for the ‘Universal Health Coverage’ concept. Together with France, Switzerland, the US and Spain, it is a leading force in P4H- The Social Health Protection Network, which originated from the G8 summit in Heiligendamm in 2007 and has since then evolved in an “innovative support network for UHC/SHP”. German global health diplomats are very committed to the ongoing reform of the World Health Organization and a driving factor for institutional and management change at WHO. They do this via the coordinating EU mechanism as well as directly within WHO’s governing bodies (Battams, van Schaik, & Van de Pas, 2014).

The federal government policy note **Shaping global health - Taking Joint action - Embracing Responsibility** (The Federal Government of Germany, 2013) is the first national concept document for global health (Bozorgmehr et al., 2014). The strategy focuses on five areas; effectively combating cross-border health threats; health systems strengthening; expanding intersectoral cooperation- interaction with other policy areas; strengthening health research and health industry; strengthening the global health architecture.

Most recently, the German Presidency of the G7 has taken on global health as a major issue, and puts forward “fighting infectious diseases (especially considering the ongoing Ebola outbreak), improving child and maternal health and strengthening healthcare systems” as main issues.

Health has always been a key theme in **France’s** technical cooperation with ex-colonies, with a special role for the Pasteur institutes and several medical NGOs (Kerouedan, Balique, Gonzalez-Canali, & Flourey, 2011). Since the 2000s, France has been on the forefront to support the global initiatives, such as the Global Fund and GAVI. France was also behind the creation of the UNITAID International drug purchasing facility, which is financed by a solidarity levy on airline tickets. Together with Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand, France is part of the global health and foreign policy initiative, which was created in 2006. In March 2007, the foreign ministers of the 7 countries released the Oslo declaration, which claimed that *“health is one of the most important, yet still broadly neglected, long-term foreign policy issues of our time”* (Pibulsonggram, 2007). France is also a pioneer on Universal Health Coverage, as it has brought the theme of universal health coverage to the international policy agenda via the global health and foreign policy initiative.

Although not entitled a ‘global health strategy’, France launched a **strategy for international health cooperation** in 2012 (Directorate-General of Global Affairs Development and Partnerships of the French Ministry of Foreign and European Affairs, 2012). The Strategy mentions three main challenges, namely the achievement of the MDGs, international health security and coordinating health governance actors. Next to these challenges, the five priorities of the strategy are the strengthening of health systems; the health of women and

children; communicable diseases; (re)emerging diseases and the “one”health-approach and non-communicable diseases.

The Netherlands has considerably reduced its investments in Global Health over the years. About 10 years ago Dutch ODA was about 0.8% of GDP and it made considerable investments in WHO and multilateral funds like GFATM and UNFPA, coordination mechanisms like the IHP+ and bilateral funding via Sector Wide Approaches. A considerable amount of health funds was channeled via Dutch NGOs that then distributed further to local NGOs in the partner countries of the Netherlands. In 2007 the Government initiated a multisectoral platform on Global Health Policy and Health systems Research, which included participation by several ministries, NGOs and academic institutions (Netherlands Global Health platform, 2007). However, with government changes since 2010, the Dutch government has decided to reduce ODA and make health a posteriority, and rather prioritized its development cooperation on global public goods like trade, water governance, food security, and climate change. In the field of health and development cooperation, the Dutch downsized their areas of work on health systems and bilateral health programs. It mainly focuses on Sexual and Reproductive Health and Rights (SRHR), including HIV/AIDS. (Dutch ministry of foreign affairs, 2011).

The Netherlands does not have a specific global health strategic document, but the recent policy note **“What the World Deserves”** (2013) reveals its vision regarding external health policy. Health is in this strategy not part of the global public goods approach, but remains via a SRHR approach part of an aid strategy, that will be implemented mainly in low-income countries, fragile states and post-conflict settings. However, it must be noted that the Netherlands has much interest in trans-border health threats like re-emerging infectious diseases and antimicrobial resistance (Dutch Ministry of Health, 2014). It is an active member of the International Global Health Security initiative. It is the International department of the Ministry of Health that is involved in these policies. The health security involvement has no formal role in the policies of the ministry of foreign affairs and development cooperation.

In **summary**, the UK, Germany, France and the European Commission opted in their strategic documents for a comprehensive global health agenda. Despite differences in emphasis and specific interpretation, recurring themes in all four strategies are the following:

- health system strengthening
- the health MDGs: fighting infectious diseases, mother health and child health.
- strengthening global health governance
- supporting global health research
- interaction with other policy areas

The Netherlands opted for a thematic focus on sexual and reproductive health and rights. While this theme is touched upon in all other strategies as well, the Netherlands takes it as its main focus.

4.2. Institutional set-up

The institutional set-up among the five donors differs significantly. Both the UK and the German strategy are presented as whole-of-the-government strategies.

Within the UK, the department of Health led an inter-ministerial working group for Global Health, which coordinated the development of the 2008 strategy and would oversee its implementation (Primarolo, Malloch-Brown, & Lewis, 2009). The group included representatives of a wide range of departments³, with the department of Health, the Ministry of Defense, Department for International Development and the Foreign and Commonwealth Office being the most important.

In case of the development of the German strategy, several ministries were involved as well, claiming that *“the federal ministries involved already regularly share their information and experience on current and planned activities in the field of global health when needed, this instrument will be expanded”* (The Federal Government of Germany, 2013, p. 41). However, it is unclear from the Strategy which ministries are actually involved. Bozorgmehr et al (2014) also criticized the lack of clarity on how the inter-ministerial collaboration would be effectively arranged.

The Communication of the European Commission (2010a) was launched by three directorates-general, namely DG Devco, DG Sanco and DG Research. These three directorates-general are also taking the lead in the further development of global health action of the EU. It is unclear however, to what extent other related DGs were involved in the development of the strategy, and –even more importantly- to what extent they are involved in the implementation of the strategy. Policy coherence is a big priority within the Commission communication, with a specific focus on five areas, namely (a) trade and access to medicines, (b) migration and the availability of health professionals, (c) security and health, including health in situations of fragility and the prediction, detection and response to global health threats, (d) food security, food assistance and nutrition and (e) the health aspects of climate change. Consequently, it remains the question to what extent departments such as DG trade, DG ECHO and DG climate are involved in the Commission’s action on global health.

³ The working group includes Ministers from the Department for Business, Enterprise & Regulatory Reform, Department for Children, Schools and Families, Department for Environment, Food and Rural Affairs, Ministry of Defense, Department of Health, Department for Innovation, Universities & Skills, Department for International Development, Foreign and Commonwealth Office, Home Office, HM Treasury, and the Northern Ireland Government.

In France, the strategy has been published by the Directorate-General of Global Affairs, Development and Partnerships of the French Ministry of Foreign and European Affairs. While the strategy was launched by this department only, Shridar and Smolina (2012) state that there has been increasing collaboration between the Ministry of Foreign and European Affairs and the Ministry of Health, and that coordination mechanisms exist across these and other relevant ministries. In January 2013, a round table was organized on how to increase the effectiveness of France's contribution to global health (French Ministry of Foreign Affairs and International Development, 2013). The scattering of actors and lack of coordination between them was mentioned as one of the challenges. Therefore, it was suggested to form a platform which would bring all actors together to reflect jointly on an overall strategic framework.

In the Netherlands, formal cooperation between the different ministries has rather decreased than increased. An interdepartmental, multi-actor platform on global health policy and health systems strengthening has stopped its formal functioning at the end of 2013. The different ministries work together in a more informal 'networked' approach on certain themes, including the involvement of relevant private (biomedical) companies and NGOs. As part of a larger austerity agenda, the Netherlands has reduced its ODA from 0,8 % to 0,5%, and seeks for a more active multi-stakeholder cooperation based on Corporate Social Responsibility and civil society involvement. The Ministry of Foreign Affairs (via its *minister for aid and trade*) focuses on SRHR, and indirectly tries to leverage the involvement of biomedical companies in the development of vaccines, medicines etc. The Ministry of Health is mainly involved in global health security initiatives and multilateral representation in the EU and WHO. Interestingly, the Ministry of Health (and not the Ministry of Foreign Affairs) takes the lead in diplomatic trade missions related to health care, e.g. to India, Russia and China (Dutch Government, 2013).

Another important aspect regarding the actors influencing global health policy, is the significant role of European non-state actors such as academics, private companies and civil society organizations. As mentioned above, there is active cooperation between these actors in thematic global health fields in the Netherlands. This is rather on technical cooperation, than on developing policies (Wemos, 2013). In the UK, a huge role was played by the Nuffield Trust, which is an organization that provides evidence-based research and policy analysis for improving health care in the UK (Gagnon & Labonté, 2013). Furthermore, a wide range of stakeholders from private, public and civil sectors were involved in the development of the UK strategy via workshop discussions and written consultation. In Germany, the federal government supports since 2009 the Annual World Health Summit at the Charite university in Berlin. This summit is one of the main international academic conferences where relevant global health issues are discussed. With regards to the EU, the European Partnership on Global Health -which was later renamed European Council on Global Health and is now called Global Health Europe- has played a big role in mapping the different dimensions of global health and urging for the development of a European

approach towards global health (Kickbusch & Lister, 2006; Kickbusch & Matlin, 2008). Together with the Swedish presidency of the EU and the Karolinska Institute, this platform also organized the Nobel forum seminar: The European Union as a Global Health Actor, which provided a lot of input for the EC communication. Non-state actors are currently still involved in EU action on global health via the Global Health Policy Forum.

Developing an intersectoral strategy provides the opportunity to sit together and ensure a consistent approach across all government departments. Nevertheless, the differences and interests across the many players involved can also create significant debates on conflicting goals or priorities. In the UK, there was a lack of consensus on the interpretation of global health during the process of developing the strategy (Gagnon & Labonté, 2013). While actors such as the Health Protection Agency linked global health mainly with diseases that cross borders, the Department of Health International Unit, DFID and NGOs focused more on issues such as social determinants of health. Furthermore, severe debates took place on conflicting priorities, including a debate on trade in conventional arms and a debate on intellectual property and access to medicines (Gagnon & Labonté, 2013). The lack of consensus on the interpretation of global health also surfaced during the public consultation process that led to the Commission Communication. Discussions revealed three main interpretations (Karolinska Institutet, Swedish Presidency, & Global Health Europe, 2009). While the first interpretation focused mainly on health needs in developing countries and the health inequalities between countries, the second interpretation considered global health to be about the health threats for all countries, including the European ones. A third interpretation focused on the cross-cutting nature of global health and the health impacts of globalization, referring to issues such as climate change, unfair trade policies, spread of unhealthy lifestyles, water and food security etc. Trying to balance these different perspectives, the Commission communication stated that no single definition for global health exists:

“Global health is a term for which no single definition exists. It is about worldwide improvement of health, reduction of disparities, and protection against global health threats. Addressing global health requires coherence of all internal and external policies and actions based on agreed principles.” (European Commission, 2010a, p. 2)

4.3. A common vision?

As already expressed by Stuckler & McKee (2008), policy-making rarely follows just one frame. Policy documents are typically a “mush” of several frames, as different actors push for different goals. Given the variety of actors influencing global policy making in the EU and the member-states (infra), this was also the case in the strategic documents we analyzed.

All strategies involved in this analysis refer to human rights, values or solidarity within their policy documents. The Commission communication states that *“the EU should apply the common values and principles of solidarity towards equitable and universal coverage of*

quality health services in all external and internal policies and actions”(European Commission, p.5). The UK strategy is meant to “*help to build a better, fairer world*” (UK Government, 2008, p.3). France mentions solidarity, human rights and aid effectiveness as the central values of their strategy (Directorate-General of Global Affairs Development and Partnerships of the French Ministry of Foreign and European Affairs, 2012, p. 5). Germany’s strategy states that “the German contribution to global health is guided by universal values. German policy is committed to human rights as the basis of every community, of peace and of justice in the world” (p 14. German Federal Government 2013). In its approach on SRHR the Dutch government also focuses a lot on human rights elements, stating that “*Netherlands remains in solidarity with the extreme poor [...] Annually, 300,000 women die during childbirth. Women- and labor rights remain under heavy pressure.*” (Dutch Ministry of foreign affairs, 2013. P.4).

These references relate to the social justice paradigm. In line with this paradigm, a focus on horizontal funding approaches would be supported. In the report of the Public Consultation on the Commission Communication, it is mentioned that “the [EU] focus would need to be distanced from the more disease-driven North American based approach to Global health, which follows a line of specific campaign issues and the MDGs, rather than health-systems based” (European Commission, 2010b, p. 9). Based on the Commission communication, the European Commission clearly supports this horizontal approach, by stating that “The EU should concentrate its support on strengthening of health systems to ensure that their main components – health workforce, access to medicines, infrastructure and logistics and decentralized management – are effective enough to deliver basic equitable and quality healthcare for all [...]. A comprehensive approach including all priorities is the only efficient one” (European Commission, 2010a, p. 6). The Commission furthermore states that the IHP+ framework (assessing comprehensive national health plans through joint assessment, funding one national health budget and one monitoring process) should be the preferred framework for providing EU support. Furthermore, it is also stated that the EU should support the health system approach in global financing initiatives such as the GFATM and the GAVI.

The UK, Germany and France also try to balance disease control and health systems strengthening. Germany and the UK do not explicitly reflect on the vertical vs. horizontal approach, but their objectives balance both approaches. The French policy document states that “beyond the vertical approach by pathology or population, the strategy aims to strengthen approaches that are cross-cutting, so as to address the structural challenges which put pressure on health systems” (Directorate-General of Global Affairs Development and Partnerships of the French Ministry of Foreign and European Affairs, 2012, p. 6). The Netherlands however, is an outlier. In essence they moved away from a more horizontal approach to health systems about a decade ago, to a focus on SRHR programs, both via its bilateral cooperation and via multilateral channels (such as UNFPA and GFATM). There are four objectives within the Dutch SRHR strategy, of which one is improving quality and access

to public and private sexual and reproductive health services. In the 2013 strategy there is no elaboration how to improve the health systems building blocks (*Dutch ministry of foreign affairs, 2011 & 2013, p. 13*).

The references to values and the support for health system strengthening (except for the Netherlands) links clearly with the social justice frame. Nevertheless, this frame is not dominant in all documents, since the British, Dutch and German strategy are largely influenced by the self-centered paradigms of security and investment.

As Labonté and Gagnon (2013) already pointed out, the most prevalent objective of the UK strategy is to benefit the UK. One of the criteria used to determine the areas covered in the strategy was “whether the UK stands to benefit directly from engaging in the issue, for example, where there are clear links to the health of the UK population” (p.18). This self-interested approach results in a dominant focus on security and investment within the strategy. As mentioned in the foreword of Gordon Brown “the first duty of any government must be to ensure the safety of its people, but this can no longer be achieved in isolation”(p.3). The investment frame is also dominant in the strategy, with one of the objectives being “the enhancement of the UK as a market leader in well-being, health services and medical products”(p.10). The dominance of the security and investment paradigms was even more apparent in the 2011 framework, which aimed to “reassure the UK’s security and prosperity at home, and UK citizens’ interests overseas” (p. 2). Furthermore, the brief reference to human rights which was present in the 2008 strategy disappeared.

Also the Netherlands took a straightforward approach and mentions the self-centered paradigm as a clear value in its development cooperation framework.

“In our international contacts we have three important ambitions. Firstly: the eradication of extreme poverty in one generation (getting to zero), Secondly: inclusive and sustainable growth worldwide. Thirdly: Prosperous Dutch companies abroad” (Dutch Ministry of foreign affairs, 2013. P.5)”.

The German Global health strategy is also clear about its self-centered security and economic interest. *“It is our goal to ensure the sustainable protection and improvement of the health of the German Population” and “German health research and the health care industry, alongside the establishment of local pharmaceutical production in developing countries, can make an essential contribution to improving the global health situation” (German Federal Government 2013, p.2 & p.33).*

Although the UK global health strategy might have been used as a blueprint for developing the Commission communication (as stated in the UK outcomes framework), the Commission communication is far less peppered by self-interest. However, while the Commission’s global health communication itself makes no references to the security and investment perspectives, this does not mean that these perspectives are not at play within the European

Union. Health security in the EU and internationally is dealt with via the Health Security Committee and the Global Health security initiative, both launched in 2001. The Health Security Committee is chaired by the Commission and is made up of officials from national governments. Together with the G7 countries, the European Commission is also part of the Global Health Security Initiative, which aims for better preparedness and responses to the potential health threats, including the spread of infectious diseases as well as bioterrorism. Apparently, the European Commission considers its global health security agenda and its general global health agenda as two separate policy domains. With regards to the investment frame, the stance of the EU regarding the debate on the protection of intellectual property in Trade Agreements and its impact on access to medicines remains a highly debated issue, especially given the current negotiations on the Transatlantic Trade and Investment Partnership.

Despite the rhetorical support towards health system strengthening, there are some signs that these words have not actually turned into action. The focus on health system strengthening contradicts with the large contributions towards multilateral initiatives. According to an overview of 50 years of French cooperation in health, the priority given to global initiatives came at the expense of French bilateral contributions and the focus on infectious diseases at the expense of its support to health systems (Kerouedan et al., 2011). A recent report of the International Development Committee of the British parliament also stated that the good reputation of DFID regarding health systems strengthening is under threat, due to a growing target-driven mentality and reliance on multilaterals (International Development Committee, 2014). While DFID remains reasonably focused on system strengthening in its bilateral programs, an ever greater proportion of UK aid is spent through multilateral agencies, who have not yet sufficiently switched focus to system strengthening. Furthermore, the report elaborates on the relation of the UK with IHP+. While Gordon Brown launched the initiative in 2007, the UK is said to be less active in this forum nowadays. The report concludes that DFID should become a *“vocal champion of system strengthening and seek to influence its international partners to prioritize it in their work”*.

Lastly, the lack of financial commitments does not fit with the social justice frame. Except for the UK strategy - which mentioned the 0,7% target for 2013 and a 50% target of direct support towards improving health, education, water, sanitation and social protection services- there are no commitments regarding the amount of ODA for health. Given the lack of these financial commitments, there is a risk that global health is rather viewed through a charity paradigm. Action for Global Health (2013) has furthermore revealed that -except for the UK- there has been a considerable decrease in funding for health among European donors, due to the financial crisis. The combination of a clearly self-interested global health strategy and steady financial commitments for global health in the UK, might reinforce the statement of Kaul and Gleicher (2011) that *“voluntary cooperation is more likely to happen when it makes sense for all, that is, if it is based on a clear and fair win-win agreement”*.

5. Discussion and conclusion

Global health has become an important item on the policy agenda of the EU and its member states. While the European Commission has been increasingly active, the member states want to keep a grip on this domain as well. Through a comparative analysis of the policy documents of the European Commission, the UK, France, the Netherlands and Germany, we aimed to investigate the existence of a common 'EU' vision in global health.

Our analysis has clearly shown the increased attention for global health within the European Commission and the EU member states. In line with the European Commission, the UK, Germany and France share a broad interpretation of global health, addressing a wide variety of themes. However, the Netherlands stands alone in this analysis with having a specific focus on sexual and reproductive health and rights. Regarding the institutional set-up, there seems to be a general trend towards more inter-ministerial collaboration. A whole-of-a-government approach is used within the UK and Germany. Also in the European Commission, the collaboration between three separate directorates-general was a relatively unique and new approach. In France and the Netherlands however, global health is only dealt with by the Ministry of foreign and European Affairs and the Ministry of Aid and Trade respectively. Nevertheless, the need for more collaboration among other departments is increasingly being recognized.

Despite these common trends, our analysis shows a mixed picture regarding the existence of an 'EU' vision regarding global health. The Commission Communication clearly supports a social justice frame, by stressing values and supporting health system strengthening and the IHP+ principles. While the social justice frame is also apparent to a certain extent in the strategies of the member states, the British, German and Dutch policy documents clearly stress the self-interest of investing in global health. The security and investment frames are thus dominant in these strategies. Furthermore, due to the financial crisis and the increased role of multilateral aid for health, it is likely that the focus on health systems strengthening remain hollow phrases.

Due to this mixed picture, the existence of a common 'EU' vision on global health is questionable. However, supplementary research that investigates the implementation of the global health strategies will be necessary to further elaborate on this. As most global health strategies show a broad agenda and are built on a mix of self-centered and altruistic rationales, the proof will finally be in the eating of the pudding. Empirical studies, that will analyze the European Commission and the members states' operationalization of their global health strategies will thus be needed. Relevant cases could be the Ebola outbreak and the call for strengthening resilient health systems, health in the sustainable development Framework post-2015; the pathway to Universal Health Coverage; global mobility of the health workforce; or an intersectoral domain like climate change and health.

The results of our comparative analysis also raise further questions on the relation between the EU and its member states with regards to global health. While Member States remain important actors in global health, they also refer in their policy documents to the EU as an important actor in global health. With several coordination mechanisms at stake, the EU is more than 'just another donor' in global health. However, it is not clear where these coordination efforts are leading to. One option is that coordination efforts might lead to a convergence of the substance of EU policy on global health, with member states increasingly sharing the same values, focus and approaches regarding global health. However, as the differences in our analysis showed, this convergence is not yet a given. Consequently, if convergence is unlikely to happen, a second option is a procedural coordination, with EU donors complementing each other's actions in global health. Additional research is needed to investigate the coordinating role of the EU in global health. A critical investigation of coordination mechanisms such as the EU Member States Experts Group on Global Health, Population and Development as well as the Global Health Policy Forum might be helpful in this.

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