

# Global health, foreign policy, and agenda setting processes : the European Union as a global health actor

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# **Global health, foreign policy and agenda setting processes**

**The European Union as a global health actor**

**Christoph Alexander Aluttis**

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# **Global health, foreign policy and agenda setting processes**

The European Union as a global health actor

DISSERTATION

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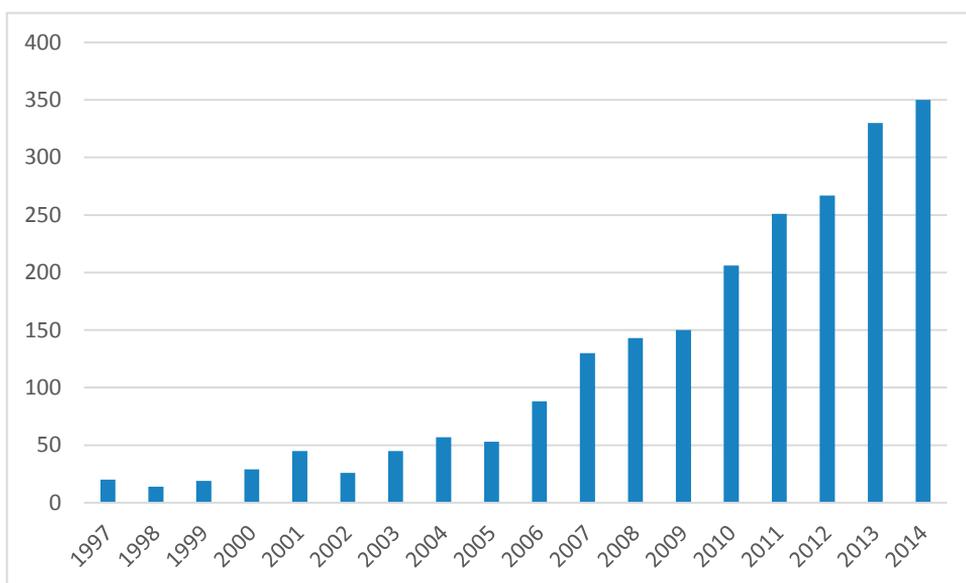


# **CHAPTER 1**

**General introduction and objective of  
this dissertation**

## General Introduction and objectives of this dissertation

During the past decade 'global health' has become a buzzword in both policy and practice, and an increasing number of European organizations and institutions are scaling up their activities under the umbrella of a 'global health' terminology. Also from an academic perspective, there has been a substantial increase in publications that are making use of this term. Figure 1.1 shows that the incidence of new publications referring to 'global health' in the title has continuously risen during the past years.



**Figure 1.1: Number of new publications with 'Global Health' in title (in PubMed)**

The emergence of a 'global health' terminology is accompanied by a discourse about its concrete meaning, its scope, the health issues covered by it and its added value compared to established research areas such as 'public health' or 'international health'. The debate is further mirrored by a plethora of definitions for global health, which have been appraised, discussed and compared extensively (for comparative reviews of definitions, see Beaglehole et al. (2010) and Campbell, Pleic and Connolly (2012)).

### ***What is global health?***

The discourse on the conceptualization, scope and goals of 'global health' is far from having reached consensus. Particularly in Europe, a clear vision for global health has been strikingly absent (The Lancet, 2012). This unclarity among European actors

has often been attributed to the inherently multidimensional nature of global health, the perspectives of those framing the concept and the contexts in which it is applied (Haines, Flahault & Horten, 2011).

In an attempt to distinguish global health from other fields of research, Koplan et al. (2009) justify a co-existence of global health next to established areas such as 'public health' or 'international health' by highlighting differences in geographical reach, level of cooperation, target groups, access to health and differences in the included disciplines. This argument however, has not been uncontested. Fried, Bentley et al. (2010) argue that '*global health is public health*', only with an international dimension to it. Adding to this debate, Bozorgmehr (2010) claims that global health issues do not only refer to the worldwide- or transnational characteristics of health determinants, but more explicitly to a supraterritorial perspective on health. According to the author, international health and public health should focus on transnational health issues, whereas a 'global health' focus should target the global social space in which health related decisions are taken - and less on the collection and interaction of smaller geographical units (Bozorgmehr, 2010). While each of these perspectives accentuates different characteristics of global health, they commonly share a recognition that in today's world, the health of populations is impacted by transcending national boundaries, the influence of globally emerging forces, and a sense of globally shared responsibilities in solving these issues.

#### *The global health understanding of this dissertation*

In order to clarify the global health understanding of this dissertation a working definition for 'global health' is essential. In this regard, this dissertation will build on a framework developed by Frenk, Gómez-Dantés & Moon (2014) who identify three 'strands of action' that are currently performed under a 'global health' terminology.

Accordingly, global health should be concerned with:

1. Activities *within the health sectors*, including global disease outbreaks and pandemics as well as international agreements and cooperation in health;
2. Health in the context of development and poverty reduction;
3. Policy initiatives in other sectors with cross border implications that are of high relevance to health (Frenk, Gómez-Dantés & Moon, 2014).

The first area of global health assumes that contemporary public health action has to incorporate a global perspective in order to protect and improve population health. The most prevalent example here is the control of disease outbreaks across borders. Outbreaks such as HIV/AIDS, SARS, or the 2014 Ebola outbreak in West Africa are typical examples that illustrate the need for a new approach to public health that incorporates a global view and global solutions. Additionally, newly emerging health challenges such as Antimicrobial Resistance (AMR) or the ongoing

global migration of health workers also fall into this category. The second strand can be described as a perspective which is concerned with describing new ways of thinking with regards to development cooperation and health outcomes. The term 'international health' is still associated strongly with this perspective, which focuses much on the health needs of economically poor countries (Frenk, Gómez-Dantés & Moon, 2014). This strand of action therefore focuses on issues such as decreasing health inequities on a global scale, reaching the Millennium Development Goals (MDG), enhancing the effectiveness of health aid, and working towards reaching Universal Health Coverage (UHC). The third strand calls for incorporating health thinking into the agendas of sectors that have a cross-border component at their core. This includes sectors such as for instance trade, migration, environment, or finance, which, in a globalized world, have substantial implications for the health of populations. Accordingly it also deals with questions on how the public health community should engage with other sectors in order to tackle newly arising challenges for health stemming from outside the traditional health sectors.

This conceptualization constitutes the main understanding of 'global health' throughout this dissertation as it strikes an adequate balance between, on the one hand, recognizing global health as a newly emerging field and, on the other hand, viewing it in view of contemporary public health and international health paradigms and debates. A concrete definition that seems to concur with this global health understanding, can be found in the definition by Kickbusch (2006), who states that that global health refers to *'those health issues which transcend national boundaries and governments and call for actions on the global forces and global flows that determine the health of people'* (p.561). This definition will therefore act as the guiding working definition for this dissertation, keeping in mind the three strands of action identified by Frenk, Gómez-Dantés & Moon (2014).

### ***What is 'health and foreign policy'?***

The global health understanding of this dissertation is intrinsically tied to another concept which requires clarification: *health and foreign policy*. Over the past decade foreign policy actors have been increasingly concerned with health issues. One of the most noted developments in this respect occurred in 2007, when Foreign Ministers from seven countries<sup>1</sup> came together and called for applying a health lens to all aspects of their respective countries' foreign policies. The Ministers emphasized through the so called Oslo Declaration, that good health outcomes are *'fundamental prerequisites for other foreign policy objectives such as economic growth & development, political stability and security'* (Amorim et al., 2007). This perspective has

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<sup>1</sup> Countries included: Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand

been supported by a United Nations (UN) report (2009), which provides a series of examples where a strong health perspective would benefit foreign policy objectives - and vice versa. Accordingly, examples where foreign policy issues would benefit from a more pronounced health perspective include the global economic and financial crisis, climate change, food insecurity, migration and trade. In turn, established health issues that would benefit from a more responsive and inclusive foreign policy perspective include infectious disease control, meeting the health-related Millennium Development Goals, access to- and affordability of medicines, health systems strengthening, and also tackling non-communicable diseases (UN, 2009). Accordingly, the United Nations General Assembly (UNGA) as well as the World Health Assembly (WHA) have adopted various resolutions which accentuate the need for strengthening the health in foreign policy nexus and calling on governments to strengthening their respective coordination mechanisms. In addition, a series of annual UNGA resolutions identify health and foreign policy topics that need to be considered from a health and foreign policy perspective. Throughout the years, this included reaching the MDGs, health systems strengthening, infectious diseases and human resources for health<sup>2</sup>.

According to Kickbusch (2011), there are various considerations for governments to engage in health and foreign policy deliberations. These include: 1) security interests (e.g. protection from infectious diseases and bioterrorism), 2) economic concerns (e.g. economic effects of poor health and growing health markets) and 3) social justice deliberations (e.g. reinforcing health as a social value and human right). Similarly, Labonté & Gagnon (2010) refer to various motivations of why governments engage in GHD processes. They propose a list of five motivations for governments to engage health in their foreign policies, including motivations driven by (1) security, (2) trade, (3) development, (4) 'Global Public Goods' and (5) Human Rights interests (Labonte & Gagnon, 2010). The frameworks by Kickbusch (2011) and Labonte & Gagnon (2010) form the guiding theoretical background for this dissertation in the context of health and foreign policy.

### ***The European role in global health***

On July 1st 2015, Luxembourg assumed the Presidency of the Council of the European Union (EU). During a corresponding meeting in Brussels, a civil servant from Luxembourg's Ministry of Foreign Affairs outlined the country's 'global health' priorities for the duration of the Presidency (European Commission, 2015a). Accordingly, she stated that dealing with the afterpains from the West-African Ebola outbreak

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<sup>2</sup> A full overview of UN resolutions on health and foreign policy can be found here: <http://www.who.int/un-collaboration/health/unga-foreign-policy/en/>

was an issue on the Presidency's agenda. While such an announcement is not surprising in its own right, it shows that health issues beyond Europe's borders nowadays have the potential to be considered a significant item of an EU Presidency programme. The announcement of the Luxembourg Presidency is the latest pointer in a series of instances that indicate an evolving acknowledgement in Brussels of a global dimension to health. In 2010, global health had already been featured prominently at the EU level through a European Commission (EC) Communication which described a need for European engagement in global health, and which outlined four respective challenges (2010). Accordingly, these challenges included: 1) a challenge of governance – how to coordinate global health actors; 2) challenges of universal health coverage – how to ensure access to health services for all; 3) challenges of policy coherence – how to break down policy silos; and 4) the challenge of knowledge – how to invest in research that benefits all (European Commission, 2010). This policy framework was subsequently supported politically through corresponding Council Conclusions, in which the Foreign Ministers of the member states also acknowledged a need for more European involvement in 'global health' affairs (Council of the European Union, 2010).

Also at the national levels, the past decade has shown an increased engagement in discussing and developing national policy frameworks to tackle health issues of global concern. On the European continent global health concepts have, for instance, emerged in Switzerland in 2006 (and updated in 2012), the United Kingdom (UK) (2008), and Germany (2013). As stated earlier, also France and Norway engaged with a group of countries to create the Global Health and Foreign Policy Initiative (2007), which called for applying a health lens to the future foreign policies of the countries involved (Amorim et al., 2007).

### ***This dissertation***

Early considerations to engage in a dissertation research on Europe and global health were triggered in 2010 by the aforementioned EC Communication entitled "The EU role in Global Health". The fact that the EC presented a policy framework for the EU to act in matters of global health concern pointed to a newly emerging policy field at European level. Furthermore, with the Lisbon Treaty entering into force in 2009 and the subsequent creation of a European 'Foreign Office' (i.e. the European External Action Service), it seemed as if European foreign policy perspectives would also be elevated high on the EU's agenda. In parallel, the scientific discourse on 'global health' was gaining traction. This combination of an increasing scientific discourse on the global dimensions of public health and the EU's self-proclaimed role as a global (health) actor created a need for a new perspective for European Public Health research, namely a perspective that would be concerned with investigating and linking the scientific global health agenda with a European Public Health perspective. Under the label of 'Global Health Europe', questions were

raised by the research group in relation to this emerging field: Why did global health become a new area of concern for the EU? How can an EU perspective on global health contribute to shaping the global health governance agenda? And how can this new global health perspective actually contribute to strengthening health, both in the EU- as well as in third countries?

### ***Research aim and objective of this dissertation***

This dissertation provides a series of separate scholarly papers that all address different facets of global health in a European context. The overarching goal and objective of this dissertation is twofold:

1. to identify and appraise global health agenda setting processes at both national- and EU-levels. Questions with regards to ‘how’ and ‘why’ global health has made it on the agendas of an EU member state and the EU itself can reveal important insights for current and future policy processes related to global health and health and foreign policy;
2. to explore how health is *de facto* incorporated into the foreign policy of the EU. As empiric knowledge on the factual integration of health into foreign policy is scarce, this dissertation aims to make a contribution to filling this knowledge gap.

Currently, the European Union has been described as an ‘emerging significant player’ (Battams & van Schaik, 2013), and an ‘actor in construction’ for global health (Rollet & Chang, 2013). As this dissertation is therefore concerned with a ‘moving target’, its main goal is to explore the aforementioned questions in more detail and to accompany the dynamically developing global health agenda at the European level in an empiric way. It thereby intends to provide some groundwork for European academics who have an interest in understanding the dynamics of the continuously evolving European global health agenda.

### ***Content of this dissertation***

The chapters in this dissertation present the result from a series of independent studies performed in view of the previously described research objectives. Accordingly, the methodology that was applied to perform each of these studies has been addressed in each chapter separately. **CHAPTER 2** answers the question of ‘why global health was initially identified as a relevant agenda item at EU-level, and why it has, in recent years, lost some of its momentum’. It will do so by reviewing key documents in light of Kingdon’s Multiple Streams Theory on agenda setting (2003). **CHAPTER 3** answers the question of ‘why Germany, the largest member state of the EU, has decided to establish a national policy framework for global

health at this point in time, and how the development process has taken place. It does so by reporting on an interview study performed with German civil servants responsible for drafting and publishing the German Global Health Strategy in 2013. **CHAPTER 4** investigates ‘to what extent health is de facto included in EU foreign policies’, by reviewing the EU’s foreign policy relations with the BRICS countries (i.e. Brazil, Russia, India, China and South Africa) on their health content. **CHAPTER 5** will use the current TTIP discourse as a case study to highlight two main issues in the health and foreign policy debate: Firstly, it shows that health issues are being used as an argument in the public domain to prevent EU foreign policy. Secondly, it will review these popular arguments in view of their validity. Chapters 6 and 7 complement the core content of this dissertation by making contributions to contemporary global health debates. **CHAPTER 6** elaborates on health workforce migration and illustrates an unresolved global health problem, which resonates well with our global health definition of interdependencies and the subsequent need for national, international and intersectorial action. Discussions related to **CHAPTER 7** originated from an event in Brussels in 2012, convened by the EU, to address the problem of assessing and measuring the effectiveness of health aid. Accordingly, the chapter comprises a study that makes suggestions on how to improve the assessment and attribution of effects of development assistance for health. **CHAPTER 8** provides a general integration and discussion of the findings from the previous chapters. It then moves on to provide some relevant implications for both research and practice.

# CHAPTER 2

## Global Health in the European Union – a review from an agenda setting perspective

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## **Abstract**

This review attempts to analyse the global health agenda-setting process in the European Union (EU). We give an overview of the European perspective on global health, making reference to the developments that led to the EU acknowledging its role as a global health actor. The article thereby focusses in particular on the European interpretation of its role in global health from 2010, which was formalised through, respectively, a European Commission Communication and Council of the European Union Conclusions. Departing from there, and based on Kingdon's multiple streams theory on agenda setting, we identify some barriers that seem to hinder the further establishment and promotion of a solid global health agenda in the EU. The main barriers for creating a strong European global health agenda are the fragmentation of the policy community and the lack of a common definition for global health in Europe. Forwarding the agenda in Europe for global health requires more clarification of the common goals and perspectives of the policy community and the use of arising windows of opportunity.

## Introduction

Our health is increasingly shaped by various social, economic and environmental factors that are in turn influenced by globalization (Dollar, 2001; Woodward, Drager, Beaglehole & Lipson, 2001; Huynen, Martens & Hilderink, 2005). In a globalized and increasingly interdependent world, various European Union (EU) policies are also likely to have implications for health and well-being in other parts of the world (Kickbusch, 2006; European Commission, 2007). However, establishing links between the EU's policies and their health impacts at global scale is a fairly complex task, which has not been consistently taken into consideration in the EU's policies and actions with the third countries (Kickbusch, 2006).

In acknowledgement to such claims, more than 300 people came together in Brussels in 2010 to attend a high-level conference under an EU-led initiative entitled 'Global health – together we can make it happen' (Health and Consumer Voice, 2010). The conference aimed at discussing the key challenges for achieving good health in a globalised world and sought to develop and refine the European role in this endeavour. The high-level event was organised and hosted by three EU General Directorates (DGs), including the DGs for Research, Development and for Health and Consumers. Participation of these three DGs was attributed to the EU's recognition of global health as a multidisciplinary issue and the EU's commitment to a consolidated approach towards it. During the conference, the central office of the European Commission (EC), the Berlaymont building, was decorated with a banner promoting the EU's commitment to global health. Commentators interpreted this as a strong EU pledge to acting on global health matters, a commitment that had never been '*so boldly displayed before*' (Global Health Europe, 2010). For two days, a wide range of high-level representatives from the EU, the Member States, the World Health Organization (WHO) and other UN organisations, the private sector, academia, and civil society discussed the European role and approach to global health. The conference included the EU's presentation of its communication on 'The EU role in global health', which provided a policy framework for the EU's future actions in this field. According to the document, the EU's global health commitment was to focus on four thematic challenges: global health governance, achieving universal health coverage, creating policy coherence, and ensuring that knowledge creation benefits all (European Commission, 2010). In his closing speech, former Commissioner for Health and Consumer Policy John Dalli emphasised the willingness to establish European action on global health matters, by stating: 'We are committed to change gear, adjust direction and increase the speed as much as we can to contribute to better health globally. And I can ensure you that the EU will spare no efforts in this quest' (Health and Consumer Voice, 2010). During the conference, it seemed as if a wide range of stakeholders were prepared and willing to enter a policy process, which would contribute to a stronger representation of the EU in a global health context. The EC's communication

on the EU role in global health (2010), and the corresponding Council Conclusions (2010) supported this view. Furthermore, the EC foresaw to publish a European 'Programme for action' on global health, which was to define more precisely the activities and actions to be undertaken.

But since then, the initiative seems to have lost momentum, which was indicated inter alia by the indefinite postponement of the 'Programme for action', as announced during the European Global Health Policy Forum in July 2013 (personal communication, 11 July 2013). This, despite the fact that a global health perspective as a guiding principle for policy has been debated by various national governments across Europe (e.g. in Germany, the United Kingdom, and Switzerland) as well as in other regions of the world (e.g. Japan and the United States). Also, in academia the discussion on global health and Europe's role in this endeavour is in full swing (see: Haines, Flahault & Horton, 2011; The Lancet, 2012; Battams & van Schaik, 2013). We therefore raise the question of why the global health policy framework has not yet progressed further. More specifically, the article has two objectives. In the first part, we will provide an overview of the global health discourse in Europe, highlighting milestones and reflecting on the EU's legitimacy as a global health actor. In the second part, we will build on this review and critically appraise the European global health process after 2010, making use of John W. Kingdon's multiple streams theory (2003) to identify issues that influence the agenda-setting processes for global health in the EU.

### ***The development of a European perspective on global health***

While the year 2010 marked an important milestone in the EU's global health commitment, the foundation was laid already in the previous decade. The outbreak of severe acute respiratory syndrome (SARS) in 2003 formed the first global health threat in the new millennium. It forced policy makers in Europe to look beyond their borders in order to protect the health and wellbeing of their citizen. SARS very vividly illustrated global interdependencies, as the disease spread rapidly via international traffic routes (Ruan, Wang & Levin, 2006). Similarly, the global dimension for health received prominent recognition through the global deliberations that led to the WHO's Framework Convention on Tobacco Control, an international treaty set up in response to the increasingly global character of the tobacco industry. This internationally binding treaty represented a novel approach to the global governance of health issues, in which countries showed a willingness to cooperate at a global level in order to effectively address domestic health issues. The increasing recognition of this global dimension for health and the health effects of globalisation also brought the EU to the table. In 2004, former Commissioner for Health and Consumer Protection, David Byrne, expressed the need to link the development of Europe's foreign policy and security identity with health. Byrne (2004) believed that health could play a vital role in establishing good relationships between Europe and

its global partners. The EU's first health strategy, entitled 'Together for Health', was adopted in 2007, and it took up the vision expressed by Byrne. The strategy gave direction for the EU's health policy for the period 2008-2013 and included global health as one of four key principles. It stated that *'in a globalised 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'* (European Commission, 2007, p. 6). The strategy highlighted in particular the need for more policy coherence across the EU, coordination with international organisations, and the need to increase the EU's influence and visibility on health matters to *'match its economic and political weight'* (European Commission, 2007, p.7). However, these global health priorities were not explicitly included in the European Health Programme 2008-2013, the main instrument of the EC to implement the health strategy. The EC however, did follow up on the global health principles laid out in the health strategy through different channels. In 2009, the EC's DGs for international development (DG DEV), research (DG RTD), and health and consumers (DG SANCO) joined forces and set out to draft the aforementioned communication entitled 'The EU role in Global Health'. After a formal consultative process with European stakeholders and civil society, the policy framework came to life in 2010. Based on this framework, the Commission defined global health to be about *'worldwide improvement of health, reduction of disparities, and protection against global health threats.'* (European Commission, 2010, p.2). Furthermore, the EC reiterated that *'addressing global health requires coherence of all internal and external policies and actions based on agreed principles'* (2010, p.2). The EU's formal acknowledgement that its external policies were not always concerted towards good health outcomes played an important role in this policy framework, as it explicitly acknowledged the need to extend the EU's 'health in all policies' commitment to all its external actions. The EC Communication on its role in global health was further taken up by the Foreign Affairs Council of the EU, which issued their Council Conclusions in response to the EC Communication (Council of the European Union, 2010). By this, the Commission Communication received formal support of the Member States, who reaffirmed the need to act in a consolidated manner on global health issues.

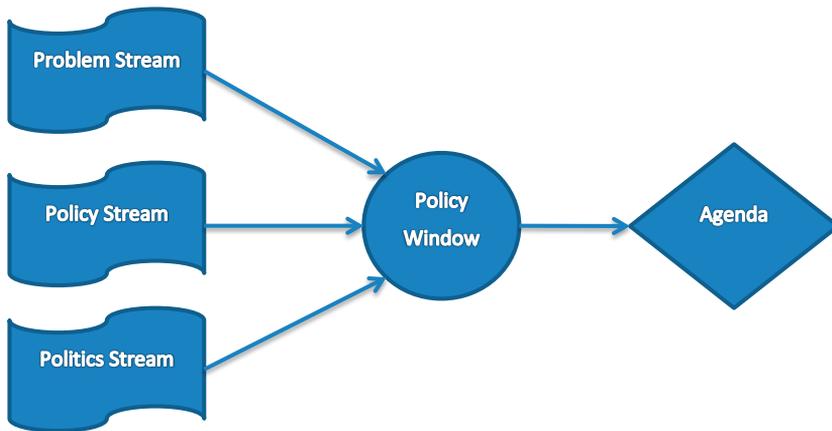
### ***From policy framework to implementation***

In the light of the creation of a policy framework for global health, the EU has been considered to be in a much stronger position to influence related global developments than it was a decade ago. As such, it has been described as an 'emerging significant player' (Battams & van Schaik, 2013) and an 'actor in construction' (Rollet & Chang, 2013). However, three years after the high-level event and the publication of the EC Communication and Council Conclusion, the European debate seems to have fallen silent. Only occasional mentioning of global health can be found in recent EU policy frameworks such as the 3rd European Health Programme 2014-2020,

which minimises the global health agenda to the control of cross-border health threats and in particular infectious diseases. The new European research agenda for 2014-2020, entitled 'Horizon 2020', also does not give reference to global health as a priority. More generally, EU-funded research focussing on the consequences of globalisation on health is likely to be marginalised in Horizon 2020 (Walshe, McKee, McCarthy et al., 2013). Notably, it does acknowledge the need for research partnerships with developing countries and the need for research to achieve the Millennium Development Goals (MDGs), the promotion of HIV/AIDS research and the continuation of the European and Developing Countries Clinical Trial Partnership (EDCTP). However, the European global health agenda initially set out in the EC Communication is much broader than the perspective taken by Horizon 2020. The absence of a comprehensive global health focus in forward-looking European strategies and actions leads to the conclusion that the EU's global health initiative has lost some of its appeal and is currently not prominently represented on the agenda of the EU. This raises the question of why this is the case.

### ***Kingdon's multiple streams theory in a European global health context***

An important question in European policy making is how and why certain issues make it on the agenda of the EC and how they remain in a prominent position. In our context, the question is why global health was identified as a relevant agenda item that led to the high-level event in 2010, and why it has apparently lost some of its momentum since. To answer this, we will apply Kingdon's theory of multiple streams, which provides a theoretical framework on the question of why certain issues make it on the agenda and others fade. Accordingly, an agenda is defined as *'the list of subjects to which government officials and those around them are paying serious attention at any given time'* (Kingdon, 2003). During agenda-setting processes, policy makers narrow down a bulk of possible items to a list that actually becomes the focus of attention. Narrowing down the list of items is of particular relevance to EU policy formulation, because contrary to the popular perception of the EU as an omnipresent bureaucracy, the EU's activities, especially in health, are strictly limited by its mandate and capacity. At the core of Kingdon's theory is the assumption that there are three relevant 'streams' for agenda setting: problems, policies, and politics (Figure 2.1).



**Figure 2.1: From streams to agenda (based on Kingdon, 2003)**

A policy environment (e.g. Brussels) can be viewed as an arena through which these three streams separately and simultaneously flow. The ‘problem’ stream describes *‘those conditions or issues that present themselves as problems, and which require serious attention by policy makers’* (Kingdon, 2003). It seems logical that if a problem is identified as such -and communicated effectively- to policy makers, its chances to make it on the agenda are significantly enhanced. The ‘policy stream’, in turn, describes the existence of feasible and acceptable solutions to those problems, developed by specialists in the policy communities in and around Brussels. If feasible and politically acceptable solutions to a problem already exist, the odds for this problem to make it on the agenda of decision makers improve substantially (Kingdon, 2003). The third stream, entitled ‘politics’ includes the macropolitical conditions in a policy environment such as public mood, ideologies of the current leadership, and existence and activities of interest groups and the media (Kingdon, 2003). All these issues form important promoters or inhibitors for an issue to make it on the agenda. Accordingly, an issue is most likely to make it on an agenda when these three streams come together. Such ‘stream convergence’ therefore occurs when a problem is clearly defined, a solution has been developed and is waiting to be implemented, and the macro-conditions for both problems and solutions are favourable. With all three streams aligned, policy makers then need to anticipate the opening of a ‘policy window’, which creates the opportunity to push the item on the agenda (s. Figure 2.1). These windows can open due to both ‘predictable’ and ‘unpredictable’ events. Very predictable events include elections and the related changes of personnel at the decision-making level. Turnover of key personnel produces new agenda items as the new people in charge are open to ideas that help them give direction to their leadership. Other policy windows, in turn, are fairly unpredictable. These include the appearance of ‘focussing events’ (usually disasters

or crises) that bring everyone's attention to the issue and that can't be ignored (Kingdon, 2003). A recent example of this includes the Fukushima nuclear disaster, which moved the Japanese and some European administrations to consider (at least temporarily) abandoning their nuclear energy programmes. A further example that illustrates these policy windows was the development of the UK Strategy on Global Health 2008-2013. Problems and solutions for global health had been discussed for several years in the UK policy domain, but only when the SARS crisis hit in 2003, a policy window opened and the UK government took concrete action towards formulating and implementing the UK Strategy on Global Health (Gagnon & Labonte, 2013).

### ***The problem stream for global health in Europe***

The problem stream includes the identification and definition of certain issues or conditions as actual problems. Kingdon's theory states that only when there is a clearly identifiable problem, the issue will be taken up on the policy agenda (2003). Subsequent problems can be identified via different pathways. Most importantly, the definition and understanding of the actual problem at hand must be clear to all stakeholders. The way that a problem is defined and perceived plays a crucial role in agenda-setting processes as, depending on the description of the problem, different solutions will be developed. In a European global health context, this means that the respective issue must be perceived by all stakeholders in the same manner in order to be recognised as a problem. In the European context, however, the policy community working under 'global health' terminology is very diverse, and is thereby working according to different problem definitions and interpretations. The discourse on the conceptualisation, scope, and goals of global health is a continuous discussion item among scholars and policy makers, and a clear vision for global health in Europe has been 'strikingly absent' (Haines, Flahault & Horton, 2011). Across Europe, a multitude of different issues labelled as important 'global health' problems are put forward. This has been exemplified during the public consultation process that led to the development of the EU Communication on its role in global health (European Commission 2009). Accordingly a majority of European actors interpreted global health as being closely linked to topics of international health and development policy, thereby interpreting it as a normative approach to helping others. In this context, important issues labelled as relevant to global health include the needs to combat HIV/AIDS; ensure food security, adequate sanitation and water supply in third world countries; or reaching the MDGs in general. Other stakeholders, however, interpreted increasing interdependencies and common vulnerabilities that arise due to globalisation as the central theme of global health. Issues identified under this interpretation include inter alia the health effects of climate change, global lifestyle changes, and the impact of global trade on health (European Commission, 2009). According to Kingdon's theory, such, differences in problem formu-

lation create a massive barrier for accurate problem definition and recognition, as different parties have different conceptions of what the global health agenda should consist of. The Commission Communication ultimately tried to short-circuit this debate by setting out in its first paragraph that global health *'is a term without one single definition'* (2010). The decision not to define global health in much detail made its approach acceptable to all stakeholders in Europe. However, this came at the expense of not identifying one, but multiple problems that would need to be tackled. The Communication therefore diluted its own focus and made it extremely difficult for policy makers to recognise and define precisely what the 'problem' actually is.

### ***The policy stream for global health in Europe***

The lack of a concise and workable definition of global health also affects the policy stream. The policy stream refers to the various 'solutions' that have been developed by policy communities in response to certain issues (Kingdon, 2013). The quality of a particular solution depends on a variety of factors. One key factor is the strength or fragmentation of the policy community that proposes a particular solution. If stakeholders behind a certain issue are very diverse and fragmented in opinion and understanding, the solutions also become fragmented and thereby lose their stability and structure. More closely knit communities, on the other hand, develop common outlooks, orientations, and ways of thinking (Kingdon, 2003). When policy communities have developed a common language, they can communicate better with each other, and, more importantly, they can communicate more effectively to others. This stability allows a solution to be more consistently advocated for. However, in more fragmented communities, instability of issues creates barriers for pressing for the same issue over and over. This seems to be exactly the situation for the European global health community. It appears to be very fragmented in opinion on what solutions should be a priority on the EU's global health agenda. Kingdon however notes that policy makers often search for exactly this degree of consensus among organised political forces before deciding to act on an issue (Kingdon, 2003). This means that if an entire policy community provides policy makers with a powerful impetus to move in a certain direction, policy makers are actually likely to move. But if there is some conflict or disagreement among organised forces, then political leaders implicitly arrive at an image of the issue that depicts it as too difficult to deal with at this particular point in time.

### ***The political stream and policy windows***

Flowing independently of the problem- and policy stream is the 'political' stream, which is composed of such things as public mood, ideology, interest group pressure, the media, and other influential actors (Kingdon, 2003). Accordingly, policy makers usually judge whether the public would tolerate any directions pursued at the polit-

ical levels. Kingdon (2003) further claims that shifts in the political stream can also be triggered by focussing events. In a global health context, the SARS pandemic in 2003 can be interpreted as such a focussing event because it changed the public and political understanding of global interdependencies, with a sense of urgency. SARS not only provided an impetus to further coordinate national efforts in cross-border infectious disease control, it also heightened the understanding of a common vulnerability in the face of global health threats (Liverani & Coker, 2012). Ultimately, SARS acted as a focussing event which not only led to the creation of the European Centre for Disease Control (Greer, 2012) and the revision and update of the International Health Regulations (WHO, 2005), but also led former Commissioner Byrne to push globalisation and health on the EU's agenda. His emphasis on strengthening Europe's role in global health was announced not only shortly after the time of SARS, but also in the aftermath of the Iraq war, which had led to substantial global divisions politically. In this political mood, Byrne's rationale for a European global health approach would, on the one hand, protect European citizens from infectious diseases, while at the same time act as a driver for peace and stability worldwide (Byrne, 2004). His notion to emphasise the benefits to both EU citizens as well as people in third countries likely allowed for broad stakeholder support. This approach also worked well in the United Kingdom when the government pushed its strategy for global health. Combining domestic health protection with UK leadership in global health governance fell well with both policy makers and the public (Gagnon & Labonte, 2013).

However, the awareness for global health and the enthusiasm that led to the EU conference on global health in 2010 have not been preserved since. The European agenda seemed to have quickly given way to other items which were perceived as more pressing. The financial crisis appears to have turned the EU's attention towards economic recovery and enhancing global competitiveness, thereby potentially side-lining the agendas of less influential DGs, such as DG SANCO or DG DEVCO. However, this does not mean that global health is gone for good. According to Kingdon, it is normal that ideas, proposals, or issues rise and fall in favour from time to time. As such, they fade in and fade out, but they never go away (2003). The fact that global health is currently not very prominently represented within the EU policy community does therefore not mean that the issue is completely off the European agenda. It merely lies quiet in the community and is being developed further by stakeholders and in academia. Ideas are being sharpened and changed and the longer this process takes, the more people become accustomed to thinking along a global health paradigm. Notably, this so-called 'preconditioning' (Kingdon, 2003) for global health in Europe is currently taking place and is likely to continue over the coming years, waiting around for additional policy windows to open.

### ***Summary and Conclusion***

One of the main insights of the application of Kingdon's theory to global health in a European context is that the large fragmentation of the European global health community is not supportive to pushing global health on the EU agenda. A more coherent understanding and a straightforward conceptualisation of Europe's role in global health would enhance the chances of global health becoming an important agenda item at the European level. Stakeholders for global health need to engage in much more intensive dialogue on the definition and priority areas of a European approach to global health to align their position and to appear to the policy makers as speaking with one voice. In addition, stakeholders and advocates for global health need to continuously work the three streams for global health, so that when a policy window opens, action is more likely to be taken. Early initiatives and think tanks on developing a European perspective on global health have already been established across Europe. Together with research institutions, they need to work on a European conceptualisation of global health. The elections to the European Parliament and the change of high-level positions within the EC in 2014 formed another policy window to push global health on the agenda again. However, this requires that problems are defined, solutions are available and feasible, and the community has undergone a process of discussion and revision in order to soften up the issue for policy makers and the public. The timely definition of global health and the alignment of the problem, policy, and politics streams are critical to pushing global health back on the agenda of the EC. It should not be forgotten that even in times of economic austerity with its setbacks and hardships, the EU remains a forceful actor in the world which can speak with a strong voice on health matters of global concern.



## **CHAPTER 3**

### **Global health and domestic policy - what motivated the development of the German Global Health Strategy?**

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## **Abstract**

In 2013, the German government published its national Global Health Strategy, outlining principles and focal topics for German engagement in global health. We asked the question of why Germany has decided to establish a national policy framework for global health at this point in time, and how the development process has taken place. The ultimate goal of this study was to achieve better insights into the respective health and foreign policy processes at the national level. This article reports on the results of semi-structured interviews with those actors that were responsible for initiating and drafting the German Global Health Strategy (GGHS). Our study shows that a series of external developments, stakeholders, and advocacy efforts created an environment conducive to the creation of the strategic document. In addition, a number of internal considerations, struggles, and capacities played a decisive role during the development phase of the GGHS. Understanding these factors better can not only provide substantial insights into global health related policy processes in Germany, but also contribute to the general discourse on the role of the nation state in global health governance.

## Introduction

In 2013, the Federal Government of Germany issued a strategic document entitled *Shaping Global Health, Taking Joint Action, Embracing Responsibility* (The German Federal Government, 2013). The public presentation of this German Global Health Strategy (GGHS) was jointly made by both Ministers of Foreign Affairs and of Health, to 'send a clear message that global health is high on the German agenda' (Federal Foreign Office, 2013). The development of the GGHS is in line with a general trend towards the formulation of national standpoints on global health. Health and foreign policy concepts have emerged over the past years across Europe, including Switzerland in 2006 (updated in 2012), the United Kingdom (UK) (2008), Norway (2012), and the European Union (EU) (2010). In addition, Norway and Sweden have also developed specific World Health Organization (WHO)-collaboration strategies in 2010 and 2011, respectively. The emergence of such strategies can be attributed to the increased frequency and severity with which global developments have impacted on public health. The spread of communicable diseases (e.g. HIV/AIDS, SARS), cross-border environmental impacts (e.g. climate change), and the acknowledgment of complex global health interdependencies with other sectors (e.g. trade and migration) have transformed health from being a 'specialized and technical' field into an area of global political discussion and concern (United Nations General Assembly, 2009). Given these dynamics, nations are re-evaluating their activities in order to better navigate the global health domain and to increase coherency across their governmental departments. Kickbusch and Szabo (2014) explain that 'governance for global health' refers to 'the institutions and mechanisms established at the national and regional level to contribute to global health governance' (p. 3). Accordingly, national global health strategies can provide an effective mechanism for governments to align their domestic political interests with the global health agenda (Kickbusch & Szabo, 2014).

The GGHS elaborates more specifically on Germany's activities in the international health realm and it describes a series of principles and focal topics on which German activities in global health should concentrate (Box 3.1).<sup>3</sup>

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<sup>3</sup> It should be noted that while the GGHS had initially been developed under the former coalition government of Conservatives and Liberals, the current coalition of Conservatives and Social Democrats has stated that the strategy is still in effect (see Deutscher Bundestag, 2014a).

### Box 3.1. Principles and focal topics of the GGHS

#### **Principles of the GGHS:**

- (a) Protect and improve the health of the population in Germany through global action
- (b) Embrace global responsibility by providing German experience, expertise and funds
- (c) Strengthen international institutions for global health

#### **Focal topics:**

- Providing effective protection against cross border threats
- Strengthening health systems throughout the world
- Increasing intersectoral cooperation
- Promoting health research and the health care industry
- Strengthening the global health architecture

Source: The German Federal Government (2013, pp. 2-3)

While the GGHS claims that ‘Germany’s contribution to solving global health problems will take on a new quality’ (The German Federal Government, 2013, p. 3), initial reactions to the German concept have been mixed. The strategy’s strengths were seen in particular in its firm commitment towards universal health coverage (UHC), the support of a strengthened role for WHO, and its emphasis on intersectoral cooperation in global health affairs (Bozorgmehr et al., 2014). The strategy was also met with criticism, particularly due to its ambiguity in taking action, its non-comprehensiveness, its neglect of ‘truly global’ problems and determinants, and its focus on domestic economic interests through the ‘promotion’ of German pharmaceutical and technological products, without considering global debates on intellectual property rights and access to medicines (Bozorgmehr et al., 2014, 2013).

While the content of the strategy is being debated, no research has yet been done on the corresponding considerations and processes that have led to its creation. We are thus particularly interested in questions of how and why the German Federal Government has decided on developing a global health strategy at this point in time. Analogous to a study performed by Gagnon and Labonte (2013), who, in the context of the UK, applied a similar methodology, our research questions can provide not only substantial insights into the characteristics of global health related policy processes in Germany, but also crucial information to stakeholders wishing to pursue similar objectives in their own national settings.

## **Methods**

We performed a series of semi-structured interviews with key actors in the development process of the GGHS.

### ***Study participants***

We intended to interview those actors who played a substantial role in the initiation and drafting of the GGHS. Predefined selection criteria required the interviewees to be (1) civil servants or staff members in a Ministry or a governmental agency, and to be (2) substantially involved in the development process of the German global health strategy. By means of purposive sampling and snowballing, a total of six participants were identified. All of those experts were affiliated with a Federal Ministry or a respective Federal Agency during the development of the strategy. All contacted civil servants agreed to participate in the study and provided informed consent. None of the interviewed participants identified additional actors that would have been relevant for our study.

### ***Qualitative interviews***

Interviews were held during the period between June and August 2014. Interviews were held face-to-face and via telephone, each lasting between 30 and 65 minutes. All interviews were held in German and were recorded, transcribed, and anonymised accordingly. Transcripts were sent back to the participants for validation. The interviews were performed by applying a semi-structured questionnaire, which built on the study and methodology by Gagnon and Labonte (2013), who investigated the UK's global health strategy in a similar fashion. The semi-structured questionnaire was subsequently based on an adapted version of Walt and Gilson's (1994) policy analysis triangle that was also used in the UK study by Gagnon and Labonte (2013). The policy triangle by Walt and Gilson (1994) is a well-established framework to systematically analyse the question of how health policies are developed, focussing in particular on a policy's 'context', 'process', and 'actors'. Accordingly, questions for this interview study were constructed along the areas of (1) context, (2) processes, (3) content, (4) actors, and (5) effects (see Box 3.2 for an overview of questions). Questions on the GGHS's content and effects were also included in our questionnaire in order to further explore the currently debated perceived weaknesses of the strategy in terms of content and effectiveness.

### Box 3.2. Interview questions

- (1) Could you walk us through the major steps of the development process of the strategy? (*process*)
- (2) Which reasons and developments do you consider important drivers for the *decision* to develop a global health strategy? (*context*)
- (3) Which reasons and developments do you consider important drivers for the *development* of the strategy? (*process*)
- (4) Which actors do you consider to have made a relevant impact on the initiation and the development of the global health strategy? (*actors*)
- (5) How were the objectives of the strategy selected? (*context / content*)
- (6) Have there been consultation processes? If so, what did they look like? (*process / content*)
- (7) What have been the effects of the strategy? (*effects*)
- (8) Has the development process of the strategy changed existing processes and structures? (*effects*)

### **Analysis**

A directed content analysis approach as explained in Hsieh and Shannon (2005) was taken as the point of departure for the analysis. Each of the investigators independently read all data repeatedly to 'achieve immersion' and to gain 'a sense of the whole' (Hsieh & Shannon, 2005, p. 1279). Transcripts were then read word by word to identify and code statements according to the five categories. Topics that could not be placed within any of the five categories were allowed to be included as new codes and categories. During a series of meetings researchers presented their findings and compared their individual categorizations with each other. Accordingly, codes were reduced, combined, and reformulated to be more specific in their meaning and a set of core findings identified and agreed upon by the research team. Interpretations of these findings were discussed until a joint understanding was achieved.

### **Results**

Understanding the context and the processes of the GGHS's development were the central elements for our analysis. Subsequently, a number of actors and factors could be identified that played a significant role in the development of the GGHS. These include external developments, stakeholders, and advocacy efforts as well as internal considerations, struggles, and capacities. They will be elaborated more in detail in the following sections. From the collected interview response, we were

also able to reconstruct an overview of actors (Box 3.3) and a timeline that describes the various developments (Box 3.4).

**Box 3.3. Actors involved in the development process of the GGHS**

**Key actors throughout the whole process**

- Ministry of Health (Bundesministerium für Gesundheit) (BMG) – Key player in charge of coordinating the process and member of the core team
- Ministry of Foreign Affairs (Auswärtiges Amt) (AA) – Intellectual initiator of idea and member of the core team
- Ministry for Economic Cooperation and Development (Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung) (BMZ) – Member of the core team
- German Federal Enterprise for International Cooperation (Gesellschaft für Internationale Zusammenarbeit) (GIZ) – Member of the core team

**Actors involved at some stage of the process**

- Civil society – involvement of civil society actors through two workshops and the possibility for written feedback
- Academia – involvement through workshops
- All other Ministries – involvement to give input about reception of such a strategy and additional items to be included
- Other countries – meeting on the issue with other OECD countries during World Health Assembly
- Parliamentary sub-working group on health in developing countries – requested information once about the process
- Cabinet – Approved the strategy

### Box 3.4. Chronology of events

<p><b>Pre-2009</b></p>	<ul style="list-style-type: none"> <li>- Initial ideas for a strategic document on global health emerged in planning staff of the AA. The ‘environment and health’ nexus had been established earlier and from there it was a small intellectual step towards global health.</li> </ul>
<p><b>2009</b></p>	<ul style="list-style-type: none"> <li>- Idea did not materialize further in the planning staff due to other priorities at the time.</li> <li>- Civil servants took the idea from the planning staff to the liaison office in Geneva, where Germany was at the same time in the process of taking up a seat in the Executive Board of WHO.</li> <li>- AA held its 23rd Forum on Global Questions (translated: 23. Forum Globale Fragen), in which it highlighted health as an increasing issue of international concern.</li> <li>- Together with the AA, civil servants in Geneva developed a short concept note on the issue and contacted the BMG.</li> </ul>
<p><b>2010</b></p>	<ul style="list-style-type: none"> <li>- Process taken up by the BMG. After internal considerations on the risks and opportunities to developing such a strategy, the political ‘go’ was given by the Minister.</li> <li>- BMG contacted the BMZ, AA, and GIZ with the intention to form a core competency team to draft a global health strategy.</li> <li>- Internal discussion of main ideas and core-topics; circulation of ideas and call for input among these four key stakeholders.</li> </ul>
<p><b>2011</b></p>	<ul style="list-style-type: none"> <li>- BMG contacted all other Federal Departments to enquire about their position and potential opposition of such a strategy – no major concerns from other departments were received.</li> <li>- Before a ‘draft zero’ was written, a stakeholder consultation was held with civil society to introduce the intention to draft a strategy and to receive written feedback and further comments.</li> <li>- Development of an internal first draft.</li> <li>- Second workshop was held with civil society to receive feedback on the first draft.</li> </ul>

<p><b>2012</b></p>	<ul style="list-style-type: none"> <li>- Independent expert opinion published on the potential for a GGHS, including experiences from other processes (Kickbusch, 2012).</li> <li>- Preparations of World Health Assembly (WHA) in May 2012 delayed writing process.</li> <li>- Informal exchange on the issue with other OECD countries during WHA.</li> <li>- Drafting of the strategy in the second half of 2012 under the auspices of the BMG.</li> <li>- Consultation process with all Federal Ministries on the strategy's content.</li> <li>- Completion of draft and agreement among three core Ministries and their Ministers for the final version.</li> </ul>
<p><b>2013</b></p>	<ul style="list-style-type: none"> <li>- Cabinet decision to accept document, unanimous acceptance among cabinet members.</li> <li>- Publication and presentation of document during the 5th World Health Summit in Berlin.</li> </ul>

***Appraisal of the context***

*External developments*

As outlined in Box 3.4, early considerations to develop a strategy can be traced back to the time before 2009. All interview respondents explained that during the first years of the new millennium, a trend could be observed where health issues were increasingly entering the foreign policy discourse, changing the national perception of the role for health in an international context. Examples given during the interviews included the emergence of new global actors (e.g. The GAVI Alliance, The Global Fund to fight Aids, Tuberculosis and Malaria) and the respective need in the German government to find appropriate pathways for dealing with these new institutions. Other global developments at the institutional level were also recognized by civil servants in the Ministries, including early signs of a WHO reform, the publication of a UN resolution on 'global health and foreign policy', and the first debates on a post 2015 agenda. The experiences reported by the interviewees are congruent to the theoretical elaborations by Kickbusch & Szabo (2014), who state that the emergence and interplay of actors and interests in global health requires national and international actors to re-appraise interests and processes relevant to global health. The German response to these new developments (i.e. through developing a Global Health Strategy) is therefore a logical consequence of the global developments. In addition to the institutional developments at the global governance level, the potential impact of cross border health threats became more evident. In partic-

ular the global spread of communicable diseases and the perceived threat to the German population put pressure on Ministries to create a better understanding of the linkages between foreign policy and public health. Especially the AIDS pandemic, but also other outbreaks such as SARS and swine flu, reportedly sensitized the Ministry's perception of global health threats and their impacts at the national level. According to the interviewees, these global developments naturally affected the daily work of civil servants at the Ministerial levels, whose portfolios and responsibilities shifted accordingly. As one interviewee stated:

*“Of course we always had health in our foreign policies – but all these changing constellations just increased our awareness and really put Global Health in Foreign Policy to the fore.”*

#### *External stakeholders and advocacy*

Civil servants interviewed also reported that they were increasingly pushed by stakeholders from outside the German government to create a stronger German voice in global health. One interviewee referred to a series of scientific publications that called for a need for Germany to enhance its voice and reputation in global health matters. In addition, German staff at international organizations as well as individuals from academia and civil society reportedly approached civil servants directly with questions on why Germany does not have a clearly outlined framework for its global health activities, as the following interview excerpt illustrates:

*“And then you have people in other institutions - usually Germans - that think that Germany has more to offer and should act more strategically. And these people try to push this of course. Our unit has a lot of contact to Germans in UN organizations and in Geneva. And they also see that other countries are doing something. And they keep asking us questions: ‘What is Germany doing? Do we have something like that? It would be great if we did’.”*

Furthermore, interviewees stressed that according to the German self-perception as a relevant global actor, it does not want to fall behind other countries and their activities. Accordingly, the mere development of global health strategies in other countries created some reason for German stakeholders to also move forward, as the following quote suggests:

*“And in parallel, there were a few countries, Switzerland, UK, and USA, that had begun adopting respective strategies. And of course we don’t act in a vacuum, we do realize that. [...]. And it is our self-conception that we do not want to fall behind.”*

#### *Internal considerations, struggles, and capacities*

Initial internal scuffle over competencies and the division of tasks across Ministerial departments also seems to have fueled a successful initiation of the GGHS. The traditional, well-established ‘departmental principle’ in Germany outlines precisely the competencies and responsibilities across German Ministries (Eberlei & Weller, 2001). Newly emerging issues need to be integrated into these existing structures and need to be aligned with the competencies of respective departments. From the interviews it became clear that it was a challenge to place the emerging global health challenges into the existing Ministerial structures. In this context, the AA claimed responsibilities, as it experienced an increased involvement due to the emergence of health issues in their international diplomacy activities. However, this pushed the BMG and in particular the BMZ to become more active in this field, as they saw their competencies and responsibilities affected. As one interviewee discussed:

*“The idea then was that the AA would take up this topic. And of course, this gives an incentive for other departments to do something. Because they say: ‘This is actually our topic, the AA should not act on its own. So let’s do a bit more.’”*

In parallel to these developments, staff positions for global health policy were created both in Geneva and in Berlin in relation to Germany’s nomination to the WHO Executive Board for the period of 2009-2012. Respondents saw the creation of additional capacities as an important factor that enhanced the drafting process for writing such a strategy. However, at the same time, respondents also attributed insufficient capacities to the long duration of the development process:

*“I think the biggest problem was the lack of personnel across three departments. If we had had more personnel resources, then it definitely would have gone much faster. We never had the chance to work on this uninterrupted. There is a World Health Assembly, then something else. Other things have priority, and they need to be done first.”*

### ***Appraisal of the process***

Interviewees furthermore provided more detailed insights into particular aspects of the development process in Germany.

#### *Proactivity and collaboration*

Before the decision was made to develop a strategy, the BMG expressed some practical concerns in their internal considerations on whether they should spearhead this endeavour. These included questions on feasibility, usefulness, and the risks involved in putting itself in a tenuous position with such a strategy. Answering these questions in favour of developing a strategy was crucial in kicking-off its development. Interviewees here reported that the proactive attitude of key stakeholders were decisive in the strategy's coming to life. If the idea had not been championed by an individual in the planning staff of the AA, and subsequently by individuals in the BMG, this may have been the end of the development process.

As one respondent noted:

*“And then you have people that follow a more proactive approach. People that see something like this as an opportunity – as opposed to some who may see mainly the risks involved.”*

An additional point recounted by all interviewees was the smooth collaboration among the core team, under the guidance of the BMG. The subsequent efficient collaboration between the BMG, BMZ, AA, and the GIZ was considered to be an important success factor for the development of such a strategy. However, regarding consultation processes within Ministries, a different picture emerged. While the BMZ and the AA seemingly had no struggle receiving information and input from its colleagues from other divisions, civil servants in the BMG needed to clarify and convince 'in-house' why Germany would need a global health strategy. The quote below illustrates the issue:

*“And I have to say that our Ministry [BMG] is not so well positioned in terms of providing input to a foreign policy concept. That was relatively difficult. Actually it was the biggest difficulty. That was not across Ministries, but within the Ministry. Other divisions asked: ‘For what is this exactly? What is its objective?’”*

#### *Development of the content*

The five focal topics outlined in the GGHS represent a departmental consensus to which every Federal Ministry signed up to. The interviews showed that these five goals were initially defined by the core team and were little subject to change af-

terwards. The discussion among the members of the core team was characterized as being relatively 'consensual' and 'efficient.' Active engagement from political stakeholders in developing these objectives were reported as non-existent, but civil servants from different governmental departments did have different priorities among the objectives. In addition to the core team, all other Federal Ministries were contacted with requests for commentary and input to the Strategy. Respondents to this request included the Ministries for Food and Agriculture, Environment, Internal Affairs, and Research. While none of these Ministries had objections regarding the strategy, they still provided input on their specific activities which they considered relevant for a German approach to global health. Despite the fact that all departments had to come to a consensus about the paper, this process was reported to have been 'without problems.' Notably, the five priorities were not contested or requested to be revised by any other Ministry.

### ***Effects of the strategy***

Respondents acknowledged that the success of this document could hardly be measured by a set of indicators or outcome measures. Interviewees did not expect an immediate observable and causal effect on global public indicators from this document. Reportedly, this was also not the intention of this document. Interviewees emphasised that they did not envision the GGHS to be an action plan that would set out concrete steps to be taken. They rather saw it as a framework that would make a first step in a more coherent German global health approach. In this respect, interviewees pointed out that the Strategy had already led to better cooperation and coordination among the key Ministries involved:

*"It is a concept - and not an action plan. It does not say: 'Tomorrow, we use 50.000 EUROS for A, and the day after 2.5 Million Euros for B.' this document gives us a red thread regarding Germany's position and what it wants to achieve."*

Various respondents emphasized that this strategy provided a viable mechanism that could strengthen the position of global health policy proponents in intra-governmental discussions and deliberations with other Ministries and governmental actors. One respondent noted:

*"A strategy could generally help our daily work immensely. We also have to lobby internally that the policy domain is being perceived in its importance".*

Furthermore, one respondent explained that while this document does not provide an action-plan for the different Ministries, it does give affiliated agencies (such as

GIZ, but also the German Development Bank, Kreditanstalt für Wiederaufbau or KfW) a framework and a supporting argument for their work and their future engagements in the identified focal areas. Finally, respondents also emphasized that the GGHS created a better understanding in the international realm about where Germany actually stands on certain global issues. Subsequently, the national global health strategy also created a better representation of Germany's position in respective global governance settings, including activities at the WHO. According to one interviewee, the strategy also provided a frame of reference for German-EU collaboration through respective Ministries (Health and Development) and their EU counterparts (DG DEVCO and DG SANCO).

## **Discussion**

Adding to previous work on global health strategies, and in particular to the work of Gagnon and Labonte (2013) for the UK, this study elaborates on how and why Germany positioned itself in the field of global health. We identified a series of factors that have contributed to developing a first governmental strategy. Our findings showed that a series of external developments, stakeholders, and advocacy efforts created an environment conducive to the formulation of the the GGHS. In addition, a number of internal considerations, struggles, and capacities played a relevant role during the development phase.

### ***The future for German global health policy***

With regards to global health, Kickbusch and Szabo (2014) identify three distinct 'political spaces for governance': (1) global health governance, (2) global governance for health, and (3) governance for global health. Accordingly, 'global health governance' refers to institutions and processes of governance which are related to an explicit health mandate, such as the WHO; 'global governance for health' refers to institutions and policies of global governance which have an impact on health such as, such as trade policies; and 'governance for global health' refers to the governance mechanisms established at national to contribute to global health (Kickbusch and Szabo, 2014). While the development of the strategy clearly refers to the third perspective on governance and global health, we also found that the authors of the GGHS implicitly acknowledged and included each of these three spaces. However, while Kickbusch and Szabo (2014) also call for the active management of those spaces to support the progress of public health in a global environment, concerns have been voiced that the GGHS will have limited effect on such global public health improvements (Bozorgmehr et al., 2014). Compared to approaches in Switzerland or the UK, the German concept indeed remains relatively ambiguous with few mechanisms for implementation and no tangible measurable objectives. This

does lead to the question to what extent a strategy can reach its desired effect when only limited instruments are available to bring it to life. However, as the interviewees explained, it was a conscious choice to develop a mere framework on which a German global health policy could build on. By establishing a set of visible priority areas in a sometimes ambiguous policy domain, the strategy's intention therefore was to create a reference point for stakeholders both inside and outside government to promote global health priorities on the German political agenda and to create a policy space for global health debates. First indications for the start of such a global health discourse in Germany can be found in the early responses from academia and civil society (Bozorgmehr et al., 2014; Bozorgmehr et al., 2013) and in the recent inquiry of the Green party about the implementation of the strategy (Deutscher Bundestag, 2014b).

In their study on the processes in the UK, Gagnon and Labonte (2013) reported that high level political support was crucial in advancing the Global Health Strategy. Notably, we found that in the German case, political engagement was not essential during the formulation process. While initial approval from Ministers was obtained, political action only became relevant during the final cabinet meeting, in which the strategy was ultimately adopted with no further debate. Interviewees attributed this to their observation that the five chosen global health objectives were not 'particularly controversial' across Ministries. However, another explanation for this can also be found in the absence of any formal commitments in the document. The strategy does not outline specific actions and extra commitments from Federal Ministries, which makes the document more acceptable and likely to be approved quicker by the political stakeholders involved. The UK strategy on the contrary outlined a series of objectives and responsibilities for governmental departments, thereby increasing the political stakes in the formulation process and causing the process to be 'difficult, complex and fraught' (Gagnon & Labonte, 2013, p.17). From this observation we assert that additional coordination, leadership, and high-level political support will also be necessary in Germany if the government wishes to really create impact through a set of concrete and tangible measures and actions. However, the current German coalition government has not included the advancement of its global health policy in its current coalition agreement. Furthermore, the government has stated that it regards the current strategy as 'sufficiently concrete' with 'no requirement for an additional action plan' (Deutscher Bundestag, 2014a, p.2). This begs the question of why there is no strong political motivation for driving the strategy forward.

One might argue that political actors within the BMG should be inclined to take a lead in further promoting a strong global health strategy implementation, given its mandate for health and its responsibility for coordinating the government's actions with WHO. However, the BMG in Germany has a traditionally strong focus on domestic health concerns, with only a few links to the European and international

level (Eberlei & Weller, 2001). Its main focus lies on setting boundaries for a largely decentralized and self-administered domestic health system. Subsequently, its institutional capacity for dealing with the rising number of global developments is constrained (Eberlei & Weller, 2001). As a result, global health constitutes a side-lined issue in the Minister of Health's portfolio. The AA and the BMZ could also emerge as champions for global health, as both institutions have a comparatively strong resource base and an international outlook at the core of their activities. However, in these Ministries, it is the 'health' portfolio that remains a peripheral topic, with little political leverage compared to other foreign policy issues (Hein, 2007). Given these structural challenges in each of the Ministries, political support for moving global health policy forward will be difficult to gather in Germany. As Gagnon and Labonte (2013) point out, the UK strategy was largely driven by national security considerations, economic interests and concerns over the UK's international reputation. The agenda was subsequently strongly supported by actors at the highest political levels. The passiveness of political actors in the German context points to a different focus of the German strategy in which it seems that the strategy fulfilled mainly the purpose of strengthening the internal understanding and cooperation on global health issues before venturing out on taking a concrete and ambitious approach at tackling the outlined focal topics. In this context, better cooperation and a better understanding across Ministries seems to have been improving already through the joint development of the strategy. Such a further institutionalization of cooperation at the working level could thus already be an important step towards more coherence in German global health action.

In her expert opinion on the German positioning in global health, Kickbusch (2012) provides a series of suggestions for action, which could help advancing the global health agenda in Germany. She calls for the establishment of an independent expert advisory commission for global health, the creation of an inter-ministerial committee to support and coordinate cross-departmental action, enhancing a systematic dialogue with civil society, increasing global health research and education capacities, and increasing the number of German health attachés in the world (Kickbusch, 2012). Achieving these issues should be on the agenda of global health advocates within and outside the government in order to strengthening the global health discourse in Germany.

### ***Limitations***

This study has made an empirical contribution to the current literature on national global health strategies, shedding light on the particular developments in Germany. However, there are a few limitations to this study. First of all, the relatively low number of six interviews could raise concerns about data saturation and the respective possibility to draw definite conclusions from the data. In our case, however, the interviewed experts could not identify additional participants that would have been

required to be interviewed. We therefore achieved saturation in terms of informants. Furthermore, a methodological study by Guest, Bunce, and Johnson (2006) showed that six interviews are generally sufficient to determine main themes and phenomena in qualitative interview research.

## **Conclusion**

This study has led to insights into the rationale for Germany to engage in developing a national global health strategy. As Germany is increasingly taking up leadership positions in the EU and on the world stage, it can be of much value for the general global health governance discourse to gain a better understanding of the German policy processes for global health.

The current German strategy intentionally did not provide an action plan that would outline a set of objectives to be reached in a given time frame, as the main goal was to provide an initial framework which would outline Germany's position in a complex and sometimes ambiguous global health landscape. In this context, the strategy makes, albeit unintentionally, a contribution to the general discourse on 'global health' as a concept for research, policy, education and practice. By outlining its 'global health' priorities, the German government defines its perspective on the concept and sets boundaries on what it perceives to be global health issues. As Germany is a substantial European and global actor, particularly through its financial contributions, its perspectives and decisions are likely to influence the general discourse regarding global health terminology, priorities and practices.

In conclusion, while the formulation of a strategy has been an achievement by itself, impact can only be created through additional coordination, leadership and high-level political support. While the German policy space on global health before the publication of the strategy has been described as being in 'its infancy' (The Lancet, 2013), the development of the strategy can be seen as its first step in growing up.



## **CHAPTER 4**

### **Health in foreign policy - an explorative study of the inclusion of health issues in the Strategic Partnerships between the European Union and the BRICS countries**

Aluttis, C.A. Hees, J., Pilot, E., Brand, H. & Krafft, T. (2015). Health in foreign policy - An explorative study of the application of health issues in the Strategic Partnerships between the European Union and the BRICS countries. (under review).

## **Abstract**

While the association between foreign policy and health has been intensely discussed among scholars, only little empirical research has been performed on the actual integration of health issues into current foreign policy deliberations. This study therefore reviews the European Union's (EU) Strategic Partnerships with the emerging powers of Brazil, Russia, India, China and South-Africa (BRICS) to explore the health and foreign policy discussions between these major global actors. By performing a quantitative and qualitative content analysis of key documents, we find that health plays a small, albeit consistent role in the relations, predominantly addressed in contexts of 'health security' and 'health in development'. While our findings confirm the assumption that these drivers are particularly dominant in health and foreign policy discourses, we also identified additional motivations for health and foreign policy engagement, which suggests the need for a more nuanced view on the health and foreign policy nexus. While the current approach to health in foreign policy seems encouraging, there is room for further cooperation that would be to the benefit for both sides of the partnerships. Building stronger alliances on between the EU and the collective BRICS coalition could yield a good opportunity for achieving common global health priorities.

## Introduction

Over the past decade, the link between foreign policy and health has been intensely discussed among scholars (Feldbaum & Michaud, 2010; Fidler & Drager, 2006; Katz & Singer, 2007; Kickbusch, 2011; Labonté, 2010; Møgedal & Alveberg, 2010; Owen & Roberts, 2005). Accordingly, health issues have escaped from the ranks of ‘really low politics’ into a more prominent position on foreign policy agendas (Kickbusch, 2011). This perspective was also stressed by the Oslo Declaration in 2007, in which Foreign Ministers from seven countries called for applying a health lens to all aspects of their respective countries’ foreign policies. The Ministers emphasized that good health outcomes are ‘fundamental prerequisites for other foreign policy objectives such as economic growth & development, political stability and security’ (Amorim et al., 2007). Despite an ambiguous impact of the Oslo Declaration (Fidler, 2011a), it resonated well with scholars, who stressed that a more systematic approach to health in foreign policy would not only be a suitable mechanism for achieving high-level foreign objectives of stability, security and wealth, but that it would also be a strong lever for achieving matters of social justice and the protection of human dignity (Kickbusch, 2011).

### ***This paper***

While there is an ongoing scholarly debate on the question of why governments engage in health and foreign policy processes, only a few studies have actually examined the *de facto* integration of health issues into foreign policies. Our analysis intends to contribute to filling this knowledge gap by investigating the role of health in the foreign relations between the European Union (EU) and the BRICS countries (i.e. Brazil, Russia, India, China and South-Africa). Accordingly, this paper intends to answer the question of how health is reflected in the current foreign policy relations between these distinguished global powers. To our knowledge, no primary research has yet reviewed the role of health in these bilateral relations, despite the fact that any agreement made in such a context could have significant impact on both regional and global affairs.

### *Case selection*

The EU formally represents 28 of the wealthiest countries in the world, whose priorities and objectives are mirrored by EU foreign policy and expressed through its External Action Service (EEAS). In recent years the EU has been acknowledged to be an increasingly relevant international actor which contributes to today's world order through its policies and actions (Keukeleire & Bruyninckx, 2011). In this context, it has been studied as an independent actor for international relations analysis (Keukeleire & Delreux, 2014).

The counterparts to the EU in this analysis constitute the so called BRICS countries. While the countries of Brazil, Russia, India and China and South Africa differ considerably geographically, economically, politically and culturally, they share a common goal for a more influential role in the world (Oehler-Sincai, 2011; Sridhar et al., 2013) and have decided to translate their collective economic weight into global political leverage (Keukeleire & Bruyninckx, 2011; Keukeleire & Hooijmaaijers, 2014). Kickbusch (2014) believes that in the near future, BRICS will evolve from being 'policy takers' in global governance to 'policy shapers' on their own terms. Over the recent years, the BRICS group has hosted annual summits to align and strengthen their collaboration, through meetings of Heads of State, their Ministers as well as experts and specialized agencies (Da Silva et al. (2014); Keukeleire & Bruyninckx, 2011)). Recent agreements from these summits demonstrate the BRICS coalition's desire to push for changes in existing global governance models by, for instance, supporting reforms of the UN system or the international financial institutions (Keukeleire & Hooijmaaijers, 2014).

### *Global health priorities of the EU and BRICS*

In 2011, the BRICS countries issued the Beijing Declaration, which states that the collective advancement of particular health issues is 'essential' for progressing BRICS cooperation in general (BRICS, 2011). The Declaration furthermore highlights the common global health priorities of the BRICS countries. A comparison of this statement with the EU's global health priorities<sup>4</sup> shows that both blocs seem to have common priorities regarding the importance for health system strengthening and Universal Health Coverage (UHC). Both blocs also support currently ongoing WHO reform processes, including a call for more flexible funding for WHO. There are however, also notable differences between these two powers. BRICS strongly emphasize the need for technology transfer & access to medicines as key priorities

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<sup>4</sup> EU Priorities for global health here are based on the Conclusions of the Council of the European Union (2010) and the EC Communication on the EU's role in Global Health (2010)

in global health, whereas these issues are not prominently represented in the EU documents.

#### *Current EU-BRICS collaboration*

Despite the emergence of the BRICS coalition on the international sphere, the EU does not have a genuine 'BRICS' policy in place (Keukeleire & Hooijmaaijers, 2014). This approach can be partly attributed to the EU's foreign policy doctrine of 'rules-based' multilateralism, which is based on a preference for binding commitments and agreements with legally recognized international actors. The BRICS model of cooperation however operates mainly on a 'relation-based' model, and as such does not constitute a legal entity by itself. It furthermore promotes national sovereignty, absence of treaty obligations and voluntary commitments. The differences in approaches to multilateralism could be a factor that hampers the creation of formal relations from the EU perspective (Keukeleire & Hooijmaaijers, 2014). The second reason for the lack of a coherent EU approach towards BRICS is that these countries are still very different in their political, economic, demographic and social structures, thereby complicating a general policy targeted at BRICS as a whole (European Parliament, 2011).

#### **Framework of analysis**

Given that the EU does not have a comprehensive BRICS strategy in place, we examined the EU's relation with each member of the BRICS coalition independently on their health content. The main conceptual framework used for our analysis was developed by Labonte (2008), who provides different rationales for the question of why governments embrace health in their foreign policies (s. Box 4.1). Based on this framework, we hypothesized that the health and foreign policy discourse between the EU and the BRICS countries was largely determined by two main motivations, namely 'Health as Security' and 'Health as Development'. Both rationales have continuously been viewed as the most dominant rationales for action in the health and foreign policy debate (Labonté, 2008; Labonte & Gagnon, 2010) and have furthermore been strongly echoed by EU guiding principles in the realm of global health (Council of the European Union, 2010; European Commission, 2010). Furthermore, health security concerns have been for long a well-established perspective in health and foreign policy deliberations, receiving a new impetus through the occurrence of HIV/AIDS but also through more recent pandemics such as SARS, H1N1 and H5N1 (Feldbaum & Michaud, 2010). With regards to the 'health as development' perspective, four of the BRICS countries are formally still considered developing countries by the EU (with the exception of Russia) (European Parliament, 2011), which leads us to the postulation that the development perspective will also play a key role in health and foreign policy deliberations. While our assumption that 'health security' and 'health as development' perspectives will prevail in the relations, our study

investigated the occurrence of all five dimensions identified in the Labonte framework.

**Box 4.1: Why governments engage health in foreign policy (based on: Labonte, 2008)**

- 1) **Health as Security:** A country's duty to protect ones citizen from foreign risks; e.g. infectious diseases and other cross-border threats
- 2) **Health as Development:** Improving health through effective development policy; e.g. a country's engagement in reaching the MDGs
- 3) **Health and Trade:** Supporting an increased flow of goods and services, impacting on health through economic well-being and enhanced access to goods and medicines
- 4) **Health as a Global Public Good:** Seeing health as a global public good that requires shared global provision, responsibility and regulation.
- 5) **Health as a Human Right:** Acknowledging the Human Right to Health and using this as a guiding principle for foreign policy

## Methods

The main mechanism for EU engagement with other leading- and emerging powers in the world are so called Strategic Partnerships (Grevi & Khandekar, 2011). While no clear reference of this Partnerships instrument can be found in any of the EU treaties, they can be described as the EU's diplomatic framework of engagement with a series of selected countries that are considered to be of strategic relevance. We used these Strategic Partnerships as the point of departure for our analysis by reviewing the Joint Statements published in the context of partnership meetings and summits. According to Holslag (2011), Joint Statements can be seen as a reliable source of information for identifying the content and scope of the Strategic Partnerships, as they highlight the key deliberations during the summits. As Joint Statements tend to be only 1-3 pages long and only highlight key points, we assumed that any mentioning of health issues in those statements indicated a certain relevance of the issue at hand.

We limited our time-frame of analysis to those Joint Statements that were drafted between 2000 and 2014. The choice for this time-frame was a balancing act between getting insights into the consistency of health being applied as a foreign policy agenda item over time and the risk of appraising outdated information with little relevance for today.

The majority of Joint Statements were openly accessible through searches on related EU websites. In total, 59 official documents were included for the five different Partnerships between the EU and the BRICS countries (see Annex 3.1 for an overview). The analysis and subsequent interpretation of documents was guided by a thematic analysis perspective, as outlined in detail by Dixon-Woods et al. (2005). We thereby applied an aggregating and interpreting analytical approach. Firstly, we performed a quantitative content analysis of the Joint Statements to appraise the prevalence of health issues in these documents. By counting and categorizing the sections that were concerned with health issues we could describe in quantitative terms how often health topics occurred in the deliberations. Accordingly we calculated the share of those paragraphs in relation to the whole document to investigate the percentage of the documents devoted to health issues.

For the qualitative content analysis, each document was read and re-read independently by different researchers, with notes made concerning the health content and the context in which it was addressed. Accordingly, we appraised and refined the individual findings in a series of meetings until a consensus was reached about the specific context in which health issues played a role in each of the Partnerships. In addition, for our content analysis, we also cross-checked the analysis of Joint Statements with other publicly available documents that related to each Strategic Partnerships meeting, including meeting and progress reports, press releases, Memoranda of Understanding as well as Common Road Maps and Action Plans to gain better insights into the deliberations and to subsequently strengthen our analysis.

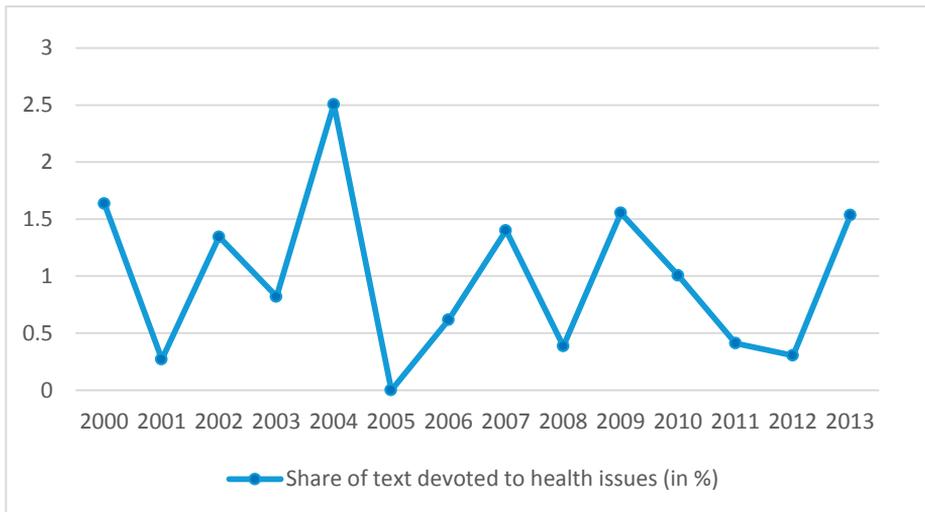
## **Results**

Our quantitative analysis of the 59 Joint Statements revealed how often health has been mentioned in the Joint Statements, including the percentages of text allocated to health issues. Across the EU's relations with the five countries, health issues accounted for 0.13-1.25% of text in the Joint Statements (Table 4.1). Health was featured most prominently in the deliberations with South-Africa, while in the Partnership with Russia, health was mentioned only three times over a time span of 13 years.

**Table 4.1 – Quantitative analysis of Joint Statement (JS) texts**

	EU-Brazil (since 2007)	EU-Russia (since 2001)	EU-India (since 2000)	EU-China (since 2000)	EU-South Africa (since 2008)
Nr. of times 'health' is mentioned	8	3	8	14	6
Percentage of JS text concerned with health issues	0.78%	0.13%	1.08%	1.19%	1.25%

Across all EU-BRICS relations combined, there is also no observable trend with regards to the amount of text dedicated to health issues. The spike in 2004 in the words dedicated to health can be traced back to EU-China Joint Statements in which increased attention was given to infectious disease control, likely due to the outbreak of Severe Acute Respiratory Syndrome (SARS) in China.



**Graph 4.1 - Average percentage of text in Joint Statements concerned with health issues (across all EU-BRICS relations)**

Nevertheless, the abovementioned numbers show that health has occasionally been mentioned in the EU-BRICS Joint Statements during the period studied. Table 4.2 provides an overview of the context in which health issues were addressed. The fact that such health issues were mentioned in the Joint Statements is noteworthy by itself, as it indicates that they have been an issue of deliberation at the highest political levels.

**Table 4.2 – Contexts in which health is mentioned in high-level Joint Statements**

<b>EU-Brazil</b>	<ul style="list-style-type: none"> <li>- Cooperation on global universal health coverage and access to health care</li> <li>- Promoting health in developing cooperation in third countries</li> <li>- Research cooperation in new therapeutics, nanotechnologies and public health</li> <li>- Cooperation on global health agreements</li> <li>- Cooperation in the sanitary and phytosanitary fields</li> </ul>
<b>EU-Russia</b>	<ul style="list-style-type: none"> <li>- Health protection in the cross-border trade of goods</li> </ul>
<b>EU-India</b>	<ul style="list-style-type: none"> <li>- Research cooperation in genomics and biotechnology for health</li> <li>- Cooperation in health and development and particular cooperation on meeting the health related MDGs and on achieving Universal Health Coverage in India</li> <li>- Co-operation to combat drug trafficking and drug abuse</li> </ul>
<b>EU-China</b>	<ul style="list-style-type: none"> <li>- Cooperation in the prevention and control of infectious diseases (i.e. avian influenza, SARS, HIV) and the implementation of the international Health Regulations</li> <li>- Cooperation on enhanced industrial product safety, consumer product safety, and food safety, so as to protect public health</li> <li>- Collaboration on occupational health, including health and safety at work</li> <li>- Support of China's introduction of the 'Euro' emission standards</li> </ul>
<b>EU-South-Africa</b>	<ul style="list-style-type: none"> <li>- Health as an important sector for (sustainable) development cooperation in South-Africa</li> <li>- Collaboration on Primary Health Care Programmes in South-Africa aimed at increasing life expectancy, reducing maternal and child mortality and supporting the fight against HIV/AIDS and Tuberculosis</li> </ul>

### ***Analysis of documents***

As outlined in the methodology, the analysis of Joint Statements was further complemented by a more in depth reading of supplementary documents, including the more detailed action plans, working group reports and roadmaps for collaboration. Accordingly, we found that although health only takes up a small share in the Joint Statements, they did regularly make it on the agendas of corresponding bilateral action plans, working groups, progress reports and roadmaps. These findings are further presented and elaborated upon in the following sections and framed according to Labonte's (2008) classification of prevailing motivations for health engagement. Tables 4.3 – 4.7 summarize these findings according to each categorization.

In this context, it should be acknowledged that the categorization of issues under the predetermined framework by Labonte does not come without challenges. Many of the issues identified could not be strictly placed in one category or the other. Issues such as for instance the International Health Regulations (IHR) clearly followed a health security- as well as a global public good mindset. Accordingly, if issues were identified to fit into multiple categories, they were mentioned as such in each respective category. An additional Table 4.8 further addressed those issues that could not be clearly placed into any of Labonte's categories.

#### *Health as security*

Cross border protection and the subsequent securitization from health threats has been for long considered the most dominant motivation for engaging health in foreign policy (Feldbaum & Michaud, 2010; Labonte & Gagnon, 2010). This mind frame was found to be present across the EU's activities with each of the BRICS countries (s. table 4.3 for an overview of issues identified). Particularly in the relations with China, Brazil, and Russia, we found regular deliberations aiming to ensuring the safety of food-, consumer- and industrial goods in the context of globalization and an increased cross-border trade. Through dialogues on sanitary and phytosanitary standards and on agreements on standard setting for industrial products, the deliberations focus largely on the need for health protection of European consumers. Given that the EU has a mandate on engaging with other countries on trade issues and given that these countries represent significant trade partners to the EU, this perspective on the safety of tradable goods is not surprising.

In addition, in each of the EU-BRICS relations we found an emphasis on the protection of health from specific communicable diseases. Especially in the EU-China high-level summits, a strong focus has been put on reinforced cooperation on the implementation of the International Health Regulations (IHR) and on more technical cooperation on health protection from communicable diseases, like SARS and Avian Influenza. Stumbaum (2007) states that the security perspective in the EU-China relation perspective has unsurprisingly been driven by the fact that some of the

more recent pandemics with global repercussions originated in China. However, deliberations on communicable diseases are also strongly prevalent in all other EU-BRICS relations, with the EU offering cooperation and its support to combatting a wide range of current and newly emerging health threats.

Table 4.3 - Summary of health issues under the 'Health as Security' mindframe

Item in Labonte's framework	Health topics addressed
<p><b>Health as Security</b></p>	<p><b>EU-Brazil</b></p> <ul style="list-style-type: none"> <li>- Creation of a consultation mechanism on sanitary and phytosanitary issues</li> <li>- Share relevant best practices for fighting diseases, particularly HIV/AIDS</li> </ul> <p><b>EU-Russia</b></p> <ul style="list-style-type: none"> <li>- Protection of human health in the context of cross border trade of goods</li> <li>- Dialogues on communicable diseases, food standards and food safety</li> <li>- Dialogue on health, safety and protection requirements for electrical equipment and machinery</li> <li>- Increase preparedness to confront pathogenic diseases and pandemics (surveillance, monitoring and data exchange)</li> </ul> <p><b>EU-India</b></p> <ul style="list-style-type: none"> <li>- Cooperate in combatting drug traffic</li> <li>- Collaborate on food safety</li> </ul> <p><b>EU-China</b></p> <ul style="list-style-type: none"> <li>- Cooperation on infectious disease prevention and control, including scientific exchange on diseases (i.e. avian influenza, SARS, HIV/AIDS and new epidemics)</li> <li>- Co-operation on sanitary and phytosanitary issues</li> <li>- Cooperation on strengthening industrial product and consumer goods safety</li> </ul> <p><b>EU-South-Africa</b></p> <ul style="list-style-type: none"> <li>- Dialogues on health information systems and epidemiological surveillance</li> <li>- Combatting HIV/AIDS and other pandemics</li> </ul>

### *Health and Trade*

The 'health and trade' discourse encompasses a variety of intersections between trade, health and foreign policy. The linkages vary widely, from the health effects of trade liberalization, viewing health services and products as tradable commodities, or controversies over intellectual property rights and access to medicines (Labonte & Gagnon, 2010). Our review found that these motivations were partially represented in the EU-BRICS relations, most prominently in the EU's dialogues with India and Brazil (Table 4.4). Economic collaboration and joint research in areas such as pharmaceuticals, genomics, biotechnology and e-health was debated in the EU-Brazilian relationship in view of a desire to advance innovation and economic development in the health sectors. Similarly, the EU also seeks collaboration with India on innovative areas, including biotechnology research, bio-informatics and the development of pharmaceuticals. In this context, debates on the sharing of benefits arising from the utilization of genetic resources and technologies seem to have occurred in both relations. The wish for greater interaction between the EU- and Indian and Brazilian administrations on pharmaceutical research could point to a change in thinking towards the recognition of interdependencies, rather than representing EU pharmaceutical companies' interests through insisting on intellectual property protection on the expenses of access to medicines. Such a move towards more cooperation may grow out of necessity to preserve European access to genetic resources in an environment where countries of the South (including Brazil and India) increasingly claim a need for benefit-sharing of their domestic resources (Kamau, Fedder, & Winter, 2010).

In addition to this discussion, a health and trade perspective could also be observed in the EU's relations with Russia. Cooperation was announced in the harmonization of standards regarding medical devices and pharmaceuticals and the intensification of the cooperation in the field of quality control and pharmaceutical inspections. Ultimately, the goal of this is the further facilitation of market access between the EU and Russia.

Table 4.4 - Summary of health issues under the 'Health and Trade' mindframe

Item in Labonte's framework	Health topics addressed
<p><b>Health and Trade</b></p>	<p><b>EU-Brazil</b></p> <ul style="list-style-type: none"> <li>- Health as an area for scientific and technological cooperation</li> <li>- Coordinated research in new therapeutics, nanotechnologies and public health</li> <li>- Finding consensus on access to genetic resources and the fair and equitable sharing of benefits</li> </ul> <p><b>EU-Russia</b></p> <ul style="list-style-type: none"> <li>- Harmonization of standards regarding medical devices and pharmaceuticals</li> <li>- Intensification of the cooperation in the field of quality control and arrangement of pharmaceutical inspections</li> <li>- Facilitation of market access for medical products</li> </ul> <p><b>EU-India</b></p> <ul style="list-style-type: none"> <li>- Collaboration in health technology and ICT- research</li> <li>- Enhanced economic cooperation and research on pharmaceuticals, genomics, biotechnology, e-health and Ayurveda products</li> <li>- Collaborate towards access to genetic resources and the fair and equitable sharing of benefits arising from their utilisation</li> </ul> <p><b>EU-China</b></p> <ul style="list-style-type: none"> <li>- Joint research and innovation initiatives in health (not further specified)</li> </ul> <p><b>EU-South-Africa</b></p> <ul style="list-style-type: none"> <li>- N/A</li> </ul>

### *Health as Development*

Health as Development played a noteworthy motivation across the EU-BRICS relations (s. Table 4.5 for a summary). Especially the EU's relations with India and South-Africa address health issues in the context of poverty alleviation and development. While the ulterior motive here also could be security and global stability through 'soft-power' diplomacy efforts, motivations brought forward are explicitly labeled as development driven, viewing health as an end in itself and a determinant for well-being and prosperity.

Besides direct financial support, the EU maintains regular dialogues with South-Africa on human resources for health, health economics and financing, health information systems strengthening and epidemiological surveillance, as well as HIV/AIDS and gender issues in health. In the context of these priority areas, health is seen as a crucial component of development cooperation, focusing largely on capacity building in the health sector. Especially HIV/AIDS takes up a prominent position in the relation, reportedly due to its negative impact on infrastructures and services, on human resources and on the economy in South-Africa.

Also in the EU-India Partnership, health has been reaffirmed as an important outcome for development cooperation, and strong emphasis has been given in the documents on achieving the different health related MDGs. Both parties furthermore agreed to collaborate more closely on strengthening India's health system, in particular by collaborating on communicable and non-communicable disease control as well as on the prevention and treatment of addictions.

In the case of the EU's Partnership with Brazil, we found that both sides agreed to engage in trilateral development cooperation to improve the health of people in deprived parts of the world. In this context, Brazil and the EU agreed to cooperate on health system strengthening projects in other developing countries and by sharing relevant best practices on fighting diseases, with a special focus on HIV/AIDS, health and safety in the workplace, and on the protection of human health in the context of agricultural practices

Table 4.5 - Summary of health issues under the 'Health as Development' mindframe

Item in Labonte's framework	Health topics addressed
<p><b>Health as Development</b></p>	<p><b>EU-Brazil</b></p> <ul style="list-style-type: none"> <li>- Health as an outcome for triangular development cooperation projects between the EU, Brazil and other developing countries, with a view on achieving health related MDGs.</li> <li>- Explore opportunities regarding the enhanced local generic production of essential medicines</li> </ul> <p><b>EU-Russia</b></p> <ul style="list-style-type: none"> <li>- Common studies on the contribution of health to economic development</li> </ul> <p><b>EU-India</b></p> <ul style="list-style-type: none"> <li>- Shared research efforts on diseases such as HIV, malaria or tuberculosis</li> <li>- Improving health of the poor in India, in line with MDGs</li> <li>- Strengthening Indian health sector financially</li> <li>- Strengthening standards of literacy and health in India</li> </ul> <p><b>EU-China</b></p> <ul style="list-style-type: none"> <li>- Cooperation on advancing social challenges including achieving universal health care</li> </ul> <p><b>EU-South-Africa</b></p> <ul style="list-style-type: none"> <li>- Health as a priority area for bilateral EU development support to South-Africa; with a specific focus on HIV/AIDS, Tuberculosis and child mortality</li> <li>- Dialogues on HIV/AIDS and gender issues</li> <li>- Dialogues on human resources for health,</li> <li>- Dialogues on health economics and financing</li> </ul>

### *Health as a Global Public Good*

Another discourse refers to the perspective that health can be viewed as a global public good, shared among the global populace and requiring shared global responsibility (Labonte & Gagnon, 2010). Placing issues under this mindframe during this review was particularly complicated, as it was not always clear from the documents whether a global public good understanding was a key driver for action. Nevertheless, a few areas were identified where a global public good perspective could have played a relevant role (Table 4.6). For instance, the focus between the EU and China on reinforced cooperation on the implementation of the International Health Regulations (IHR) could be interpreted as reflecting such a global public good understanding, as it requires a global collective to prevent diseases to spread globally. Similarly, the EU and Russia mentioned mutual support in implementing the WHO Framework Convention on Tobacco Control and to cooperate on international health issues through the respective fora.

Beyond these deliberations, various references were made to the need to combat diseases on a global scale. Whether the need for global control of infectious diseases originates in a global public goods understanding or has its roots in health security deliberations remains debatable. Nevertheless, each of the five EU-BRICS deliberations made multiple references to the need for global collective action. Other topics identified to require a global perspective included a wide range of issues, including tackling the global economic and financial crisis, climate change, food insecurity, and energy scarcity. While these factors ultimately will have an effect on health through multiple pathways, they were not addressed in the partnerships from a health perspective. Only in some discussions on climate change, the health effects were particularly addressed. In each relation, statements were made that such global challenges needed to be addressed collectively through the UN system.

Table 4.6 - Summary of health issues under the ‘Health as a Global Public Good’ mindframe

Item in Labonte’s frame-work	Health topics addressed
<p><b>Health as a Global Public Good</b></p>	<ul style="list-style-type: none"> <li><b>EU-Brazil</b></li> <li>- Cooperation on a global response to climate change mitigation</li> <li><b>EU-Russia</b></li> <li>- Enhanced cooperation on health in the framework of international organizations</li> <li>- Cooperation on implementing the WHO Framework Convention on Tobacco Control (FCTC)</li> <li>- Cooperation on dealing with the effects of climate change on health</li> <li><b>EU-India</b></li> <li>- Collaboration on climate change adaptation and health</li> <li>- Combatting pandemics and health challenges at the global level</li> <li>- Cooperation globally on challenges posed by diseases such as HIV/AIDS, tuberculosis and malaria</li> <li><b>EU-China</b></li> <li>- Collaboration on the implementation of the IHR</li> <li>- Co-operation to combatting HIV/AIDS as well as other newly emerging infectious diseases through UN mechanisms</li> <li>- Cooperation in international health</li> <li><b>EU-South-Africa</b></li> <li>- Collaboration in dealing with the health effects of climate change</li> </ul>

### *Health as a Human Right*

The Health as a Human Right approach to health and foreign policy has been described by Labonte as the legal acknowledgement of the Human Right to Health and its practical utilization as a starting point for foreign policy (2010). The importance of recognizing and basing their partnerships on human rights was proclaimed in each of the EU-BRICS partnerships. Subsequent human rights dialogues have been established between the EU and each of the BRICS with the goal of the continuous debate on Human Rights issues. However, explicit references to specific 'Human Rights to Health', as outlined in various International Human Rights Framework covenants (e.g. Article 25 of the Universal Declaration of Human Rights, Article 12 of the International Covenant on Economic, Social and Cultural Rights), were scarce. The only reference could be found in the EU's relations with Brazil and India, in which the parties agreed to collaborate on Universal Health Coverage, arguing from a human rights-, and a human right to health perspective. Beyond this, little specific reference is made to health related international human rights frameworks and resulting obligations. The human right to health therefore does not constitute an explicit topic for EU-BRICS deliberations on health (Table 4.7).

Table 4.7 - Summary of health issues under the 'Health as a Human Right' mindframe

Item in Labonte's frame-work	Health topics addressed
<p><b>Health as a Human Right</b></p>	<p><b>EU-Brazil</b></p> <ul style="list-style-type: none"> <li>- Promoting the human right to access to health care</li> </ul> <p><b>EU-Russia</b></p> <ul style="list-style-type: none"> <li>- N/A</li> </ul> <p><b>EU-India</b></p> <ul style="list-style-type: none"> <li>- Achieving universal health coverage in India through lending financial support for expanding coverage of health services</li> </ul> <p><b>EU-China</b></p> <ul style="list-style-type: none"> <li>- N/A</li> </ul> <p><b>EU-South-Africa</b></p> <ul style="list-style-type: none"> <li>- Support universal provision of basic health services to the poor, including primary health care</li> </ul>

Table 4.8 - Summary of health issues under not classified under and specific mindframe

Unspecified	Health topics addressed
	<p><b>EU-Brazil</b></p> <ul style="list-style-type: none"> <li>- Cooperate on- and strengthen health and safety in the workplace</li> </ul> <p><b>EU-Russia</b></p> <ul style="list-style-type: none"> <li>- Dialogue on alcohol consumption and addiction incl. information sharing</li> <li>- Cooperation between the European Medicines Agency and the Russian authorities on orphan medicinal products and rare diseases</li> <li>- Cooperation in medical and public health education</li> </ul> <p><b>EU-India</b></p> <ul style="list-style-type: none"> <li>- N/A</li> </ul> <p><b>EU-China</b></p> <ul style="list-style-type: none"> <li>- Cooperation on enhancing occupational safety</li> <li>- Cooperation on noncommunicable diseases</li> <li>- Health personnel training</li> <li>- Introducing European emission standards for better health in China</li> </ul> <p><b>EU-South-Africa</b></p> <ul style="list-style-type: none"> <li>- N/A</li> </ul>

## Discussion

During our review of the bilateral EU-BRICS deliberations, we found that health issues made it on the agendas continuously, however, with a proportionally very small share of attention allocated to it compared to other issues. In terms of health related content, our findings seem to support existing assumptions that the health and foreign policy agenda is predominantly influenced by cross-border security interests and health in development perspectives. However, arguments originating from a 'trade', 'human rights' or 'health as a global public good' perspective were also present in the talks, but not as prominently. While our findings therefore confirm the assumption that security and development motivations are particularly dominant in the health and foreign policy discourses, we also identified additional motivations for health and foreign policy engagement, which suggest a need for a more nuanced view on the health and foreign policy nexus.

In this context, it should be noted that the classification of health issues into distinct motivations for foreign policy engagement may be an oversimplification of reality. Watt, Gomez and McKee (2013) point out that using a straightforward and clear-cut policy framework for analysis can overlook the fact that international relations are usually 'complex and nuanced', and that the field of global health is 'difficult to untangle'. Our framework-based review therefore may have not considered a variety of contextual and procedural factors that may have influenced the EU-BRICS health and foreign policy discourses. Furthermore, the question remains as to how big the gap is between rhetoric and the real state of affairs. Despite the fact that we also reviewed common plans and roadmaps, more insights into the actual actions and implementations following from these deliberations would be helpful to actually identify the impact that the incorporation of health issues has in these partnerships. For instance, the actual implications for the health of the populations on both sides of the partnership can hardly be assessed by such a document review. Despite these limitations, this explorative review does provide a starting point for unraveling the intricate and multifaceted field of health and foreign policy, based on a clear and straightforward framework.

### ***Policy implications from this review***

While there is already little bilateral collaboration between the EU and the BRICS countries, we argue that even stronger agreements on health issues could be valuable to both sides of the partnership. There are various opportunities for broadening the scope for bilateral action. For example, relatively costly European health systems could benefit by learning about cost-effective healthcare innovations designed in the BRICS countries. Following 'reverse innovations' thinking, there has been a growing realization that high income countries can learn from health related innovations that emerge in less well equipped settings elsewhere (Syed, Dadwal, & Mar-

tin, 2013). The EU and its member states' health systems could therefore learn from health technology innovations that occur in the emerging economies. Further opportunities for health service collaboration between EU member states and for instance India have been identified in the areas of telemedicine; clinical trials and research, medical transcriptions and back office support, medical value travel, and more (Chanda, 2011). BRICS countries in turn, could gain much knowledge from the experience of 28 different EU member states on achieving universal health coverage at the national level in a sustainable way. Overcoming issues of universal access and coverage have been persisting challenges for the BRICS countries (Rao, Petrosyan, Araujo & McIntyre, 2014). Such collaboration could establish a pragmatic perspective of health and foreign policy engagement on the basis of mutual health benefits. Furthermore, and following Kickbusch's (2011) 'soft power' argument for health and foreign policy, pragmatic collaboration between the EU and the BRICS countries could contribute to strengthening cooperation mechanisms and institutional arrangements and could ultimately improve bilateral relations in general. It has even been argued, that cooperation on technical areas can transform the interaction between international actors 'from one of competition for power to one of cooperation' (Fidler, 2005).

### ***Towards a cohesive EU-BRICS policy?***

The rise of the BRICS as a political group has led the European Parliament to review and debate the EU's foreign policy approach to this grouping of countries. While the EU Parliament does recognize the potential power of a cohesive BRICS approach to global governance, it continues to recommend to engage with the countries of Brazil, Russia, India, China and South Africa on a bilateral basis (European Parliament, 2011). While the current impact of the BRICS collective seems to be limited in the sphere of global health governance (Harmer, Xiao, Missoni, & Tediosi, 2013), many believe that future collective BRICS action will have substantial impact on global health agendas and governance processes. Given the fact that BRICS are likely to align and increase their political leverage in global health deliberations, the EU should therefore consider the implications of such a scenario and should discuss the possibility for a solid common BRICS policy. Intra BRICS agreements on global health priorities made in Beijing in 2011 already point to diverging viewpoints and interests to those of the EU. If the EU therefore wants to maintain its current positions on global health (e.g. positions on intellectual property provisions, or on strengthening effective multilateralism) it should proactively enter a discussion with this emerging bloc of global players, and should take into account their common views, interests and approaches. Given that the future direction of the health and foreign policy debate might be determined by the question of how foreign policies of BRICS will adjust in the light of global challenges and changes (Kickbusch, 2014), cooperation also with the collective BRICS countries could thus be paramount for maintaining a

future EU voice in global health affairs. The currently experienced shift in global power relations towards BRICS should therefore not be regarded as a challenge, but rather as a distinctive opportunity for an effective EU-BRICS interaction and cooperation.

## **Conclusion**

By reviewing the deliberations between the EU and the BRICS countries on its health content, we got a better understanding of how health is featured in the foreign policies between some global economic and political powers. We found that although health only takes up a small share in high level Joint Statements, a number of health issues regularly made it on the respective agendas of action plans, working groups and roadmaps. By using Labonte's different frames for health and foreign policy engagement, we found commonalities as well as differences in motivations between each of the BRICS countries. While security- and development perspectives have been prevalent drivers in each of the Strategic Partnership, we further found a variety of motivations from the spheres of trade, 'global public goods' and human rights that drove health to be an issue at the bilateral talks. Supporters for a stronger health and foreign policy link could argue that there is still more room for further cooperation that could be to the mutual benefit for both sides of the partnerships. Furthermore, the overly bilateral engagements limit the EU to reach its full potential in shaping the global health governance agenda together with the political BRICS entity. Building stronger alliances for global health between the EU and the collective BRICS coalition could yield an opportunity for achieving common global health priorities in the future.

## **CHAPTER 5**

### **Getting rid of the noise – a review of popular claims and concerns in the debate on the health sector impacts of TTIP**

Aluttis, C.A., Brand, H. & Krafft, T. (2015). Getting rid of the noise – A review of popular claims and concerns in the debate on the health sector impacts of TTIP. (under review).

## **Abstract**

The currently ongoing negotiations between the European Union (EU) and the United States (US) on a Trans-Atlantic Trade and Investment Partnership (TTIP) have sparked a vivid debate on the costs and benefits of such an agreement for citizens on both sides of the Atlantic. Much of the public concern revolves around the impacts of the agreement on national public health- and health care sectors. With this paper we address some key concerns that have been voiced in the public debate and discuss them in the light of available information to better appraise their substance and validity. To achieve this, we compare the public arguments with available TTIP documents and with the published final text of the Canada-EU Comprehensive Economic and Trade Agreement (CETA), which has been viewed as a forerunner and model treaty for TTIP. Through our review we find that some of the popular claims are unsupported at face value. However, a more in depth elaboration on the issues reveals that the devil is in the details and that the TTIP agreement does in fact comprise a series of issues that could have a negative effect on future health care and public health related policy processes.

## Introduction

In 2013, the United States and the European Union began talks on a bilateral Trans-Atlantic Trade and Investment Partnership (TTIP). This Free Trade Agreement (FTA) foresees the liberalization of trade in goods and services and the elimination of 'behind the border barriers', by reducing regulatory burdens. Despite the fact that such international trade agreements are extremely complex in nature and not easy to digest for non-experts, TTIP has sparked an unprecedented interest (and opposition) by citizen across Europe. While the European Commission, many national governments and the large majority of the private sector voice their support for TTIP, public opposition is mounting. A large public initiative, the 'STOP TTIP' campaign, has already received more than 3.2<sup>5</sup> million signatures of European citizen demanding to not only stop the EU-US negotiations, but also to stop the already finalized Canada-EU Comprehensive Economic and Trade Agreement (CETA) from being signed and ratified by the Parliaments across Europe. The initiative has evolved into a pan-European network of more than 400 civil society organizations, contesting TTIP at national- and European level, including a lawsuit brought forward to the European Court of Justice to allow the campaign to be turned into a formal European Citizen Initiative (Stop TTIP Campaign, 2014).

In an attempt to gain the high ground over the debate, supporters and opponents of the agreement lead a variety of arguments into the field. While proponents largely project significant economic benefit and welfare gains to both sides of the Atlantic (European Commission, 2013), its critics have raised a broad range of concerns about its negative implications, including fears about the inherent risk that such an agreement can bring for the maintenance of high European social protection standards. As Karlsson (2015) points out, the rhetoric used by both supporters and critics in this context is often 'simplistic', with portrayed TTIP outcomes ranging between 'heaven' and 'hell' scenarios.

The validity and predictability of TTIP's economic benefits have already been discussed extensively, with different outcomes reported.<sup>6</sup> In this respect, it is also crucial to subject some of the publicly made arguments on TTIP's non-economic impacts to a more detailed appraisal and analysis. With this paper we discuss some of the different arguments related to health care and public health impacts, by reviewing the public debate and by comparing the concerns with documents about the negotiations that have been leaked or made available by the European Commis-

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<sup>5</sup> Numbers are as of 06-10-2015. See the Stop TTIP Campaign campaign's website for the most recent numbers: <https://stop-ttip.org/>.

<sup>6</sup> For examples of economic analyses, see: Fontagné, Gourdon & Jean (2014) and Pelkmans et al. (2014).

sion. Furthermore, we chose also to utilize the final text of the CETA agreement as a source of information in order to complement the analysis. The CETA agreement has been referred to as being a 'role model' for the TTIP negotiations (Rostowska, 2013), with similar technical outcomes expected for both agreements. Given that the CETA talks have already been successfully concluded, with 1600 pages of results being published, it can provide valuable and much-needed insights into what TTIP will bring to the European continent. In addition, we believe that by reviewing CETA on a variety of crucial points we can not only give better insights to the current debate on TTIP, but we can also provide information for decision makers and national parliaments, who have been asked to review, sign and ratify CETA in the months to come.

### ***Outline and direction of this paper***

Issues concerning the health and well-being of citizen have been at the center of the TTIP debate since the beginning of the negotiations in October 2013. Many of the agreement's critics state that the TTIP is likely to have a negative effect on the public's health through various channels. Imported chlorinated chicken, hormone treated beef and genetically modified organisms (GMOs) have become vivid symbols for the agreement's opposition. However, the discussion is more multifaceted, with many more issues addressed in the debate<sup>7</sup>. Instead of addressing each of these issues individually, we identified three cross-cutting issues for our analysis that have particular relevance to the health sector, and that seem to be dominating the debate (see box 5.1). Accordingly, we focused on providing an in-depth appraisal of these concerns. Furthermore, understanding these three horizontal issues will provide insights to the mechanisms and issues at play that are the root for concerns over the popular concerns regarding chlorinated chicken, pesticides and hormone treated beef.

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<sup>7</sup> Annex 5.1 provides a non-exhaustive overview of health related concerns that have been voiced in the public debate through various media outlets.

**Box 5.1: Key arguments regarding the health sector brought forward against TTIP in the debate**

1. TTIP will create regulatory convergence and a subsequent ‘race to the bottom’ in health- and environmental protection
2. TTIP enhances the privatization of public sectors and allows US market access to crucial areas, including the health care sector
3. Investor to State Settlement Disputes (ISDS) mechanisms hinder the formulation of public health policies, and lead to ‘regulatory chill’ in important regulatory areas

The following sections will each appraise one of the statements outlined in Box 5.1 in more detail. It should be reiterated that the ultimate aim of this paper is not to provide a case for or against TTIP, it is rather to provide a more in depth analysis of these key concerns and thereby to create a better basis for discussion and debate.

***Claim 1: TTIP will create regulatory convergence and a subsequent ‘race to the bottom’ in health- and environmental protection***

The current public discourse about TTIP implies that the negotiations between the EU and the US will lead to a harmonization and a lowering of European standards and regulations, especially in areas such as food safety or the environment. A report by the TTIP critical NGO Corporate Europe Observatory (CEO) claims that *‘EU and US corporations have joined forces to remove as many labor, health and environmental standards as possible in a devastating race to the bottom* (CEO, 2013). Similarly, on its website, Campact (2015), one of the biggest German NGOs working on TTIP states that *‘with the TTIP agreement in force, practices that are allowed in the U.S. would also be permitted in the EU. This clears the way for fracking, genetically-modified food production, and hormone-treated cattle’*. In a more nuanced editorial on the issue, Jarman (2014) also states that it will be *‘a difficult promise for the EU to keep, when it states that its standards of protection will not be diluted by TTIP’*. While these issues are certainly not in the interest of any citizen, the question is whether they are actually substantiated.

Before engaging in a more in depth analysis of these popular claims, it should be noted that achieving regulatory cooperation and coherence is indeed one of the core aims of the TTIP agreement (s. European Commission, 2014). Furthermore, Vogel (2012) has pointed out in much detail that European standards on food and environment have often been stricter in the past than their North American counterparts. As he explains, the EU frequently applies an assessment approach based on *perceived* risks and follows a ‘precautionary principle’ approach, whereas the US bases its regulations on *actual* and *proven* risks (Vogel, 2012). Such differences in

approaches to risk assessments notably can lead to different outcomes in regulatory behavior on the same issue. For example, there are 82 pesticides currently in use in the US, which are formally banned in the EU on the grounds of health and environmental concerns (Center for Environmental Law, 2014). Furthermore, in the past the US has filed complaints against the EU at the World Trade Organization (WTO) on the grounds that the EU's regulatory actions regarding GMOs and hormone treated meat products form an effective trade barrier for unjustified reasons<sup>8</sup>. In addition, some of the position papers of American and European industries on TTIP call for lower regulatory regimes in a variety of areas<sup>9</sup>. There is therefore a well-documented desire from the industry sectors as well as by the American government to reduce the stringency of EU regulations in favor of enhanced American market access. But the central question here is: will this ultimately be achieved under TTIP, and will future regulatory action in the EU be lower when TTIP is in place? Or can we take the EU negotiators word for it, when they state that regulatory standards will not be compromised under any circumstances?

Regulatory cooperation between the EU and the US has already been going on for more than a decade and informal consultations between regulators have already promoted a high degree of regulatory convergence across the Atlantic in many areas. However, even with such cooperation in place, there are still areas where EU- and US- regulators do not manage to agree on a common perspective due to diverging preferences or differences in ambition on achieving certain standards (Gerstetter, 2014).

With regards to the question whether TTIP will change current practices, it is important to note that the setting of standards and the development of regulations in Europe are legal competencies of the EU, the member states and their respective regulatory agencies. An international agreement such as TTIP cannot touch upon the regulators' right to independently review the risks of certain products and compounds, and to set corresponding standards. Harmonizing current product standards across the Atlantic, and (potentially) 'racing to the bottom' would therefore only be possible, if subsequent laws and regulations were changed by the respective legislative branches. For example, in order to reach a potential harmonization of standards in the area of chemicals, the subsequent EU regulation on Registration, Evaluation, Authorization and Restriction of Chemicals (REACH) and the American Toxic Substances Control Act would need to be legally amended, which can only

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<sup>8</sup> See: US complaint against EU: WT/DS291 - Measures affecting the approval and marketing of biotech products (GMOs) & US complaint against EU: WT/DS26 - Measures affecting meat and meat products (Hormones)

<sup>9</sup> See for example: Crop Life America & The European Crop Protection Association. Position paper: Proposal on US-EU Regulatory Cooperation; March 7, 2014. 2014.

occur through formal legislative procedures by the respective constituencies (Karlsson, 2015). As Gerstetter (2014) further points out, full autonomy remains with these regulatory actors, even if TTIP comes into place. But what will TTIP then effectively achieve when it talks about regulatory convergence? From the current negotiation texts we can see that a series of objectives are pursued in the negotiations (Box 5.2).

**Box 5.2: Promoting regulatory convergence under TTIP**

With regards to regulatory convergence, the EU and the US currently negotiate to :

- Publish regularly a list of planned regulatory acts – providing information on their objectives and scope; provide details of the planning of the legislative process, including information on any planned stakeholders’ consultations
- Allowing for feedback from the other side of the Atlantic, including stakeholders’ input regarding planned and foreseen regulations; Considering that feedback in decision making
- Exchanging data and information and cooperating in collecting evidence and data for subsequent standard setting
- Looking at existing regulations with a view to examining where there is scope for more compatibility and coherence towards international standards/regulations
- Eliminating double testing procedures and mutual recognition of conformity assessments.
- Assessing the impact of upcoming regulations on trade and investment flows
- Creation of a common Regulatory Cooperation Council (RCC) to prepare and publish an annual regulatory cooperation programme; to monitor the implementation of the provisions in the overall regulatory cooperation chapter, and to prepare joint initiatives or proposals for international regulatory instruments.

Source: European Commission (2015b)

While a closer and more structured cooperation as outlined in Box 5.2 is not inherently negative, there are three aspects that require further thought and debate from a public health perspective.

First of all, the establishment of a Regulatory Cooperation Council (RCC) intends to influence and shape regulators’ future decision making processes on both sides of the Atlantic. While the exact composition and methods of work of the proposed RCC are not yet entirely clear, its objective is to promote the reduction of regulatory differences and to achieve more coherent regulatory practices across the Atlantic.

Accordingly, more convergence of regulation between the EU- and US is likely to be achieved through such RCC, as the institutionalized cooperation between agencies on both sides of the Atlantic will lead to more exchange of ideas and viewpoints on the regulation of substances. By demanding regulators to cooperate in such an RCC, the ability of EU regulators to take independent decisions is not formally affected, but the additional obligations to cooperate and exchange may actually hinder or stall autonomous EU action on the implementation of regulations.

In many areas, such an RCC could certainly be helpful in reducing unnecessary regulatory burdens – but it is uncertain if European regulators will also be able to maintain their strict positions on environmental- or food standards when there is a constant inducement from the RCC to find common regulatory solutions with their American counterparts. It is furthermore questionable whether future European regulation, for instance in fields such as nano-materials or endocrine disruptors, will likely be less independent and less stringent if European regulators are asked to develop such standards in regular consultation with their US colleagues.

Secondly, it is foreseen that under the RCC, stakeholder consultation will be considered a more important element in future regulatory procedures. Regulatory processes will thus be more transparent and open to interested stakeholders who are willing to contribute and to provide feedback to the planned actions. While such an approach enhances transparency and principles of participatory governance, there is an inherent risk that such stakeholder consultation will be skewed towards the interests of the affected industries. The private sector commonly has a higher level of human- and financial resources available to participate in such consultations, compared to, for instance, associations that put the health and safety of the consumer to the fore. Such a skewedness of representation can already be documented in currently ongoing discourse around the TTIP debate. For instance, more than 90% of the European Commission's consultation meetings with stakeholders were held with industry representatives.<sup>10</sup> While the interests of the private sector naturally play a central role in trade agreements, consultations on regulatory measures under a RCC should not be subjected to such skewed information flows, as it should first and foremost have consumer protection motives in mind when debating the stringency of regulations and standards. Allowing for an overly amplified industry involvement in such consultations could create a stronger incentive for the regulators to approve regulations that are more industry friendly and less stringent in terms of consumer safety.

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<sup>10</sup> The full list of stakeholder consultations can be found here:  
<http://www.asktheeu.org/en/request/473/response/2049/attach/4/List%20of%20meetings%20with%20stakeholders.pdf>

A third argument that requires caution and alertness regarding regulatory convergence under TTIP concerns the foreseen introduction of an impact-assessment of future regulations on trade and investment flows. Currently, EU policies and regulations often need to undergo social, environmental and economic impact assessments to estimate their prospective effects on European society. If a fourth dimension on 'trade and investment flows' is to be introduced to European impact assessment mechanisms (see Box 5.2), international trade would de facto constitute a factor for policy makers to be considered in their actions. It is not difficult to imagine that a strict regulation on toxic chemicals would receive a negative assessment score on its impacts on international trade. And since the enhancement of trade is a key objective on both sides of the Atlantic, measures to constrain trade in favor of consumer protection would likely receive a negative scoring during the impact assessment, thereby providing an argument against it.

### ***In summary***

Our analysis of the documents notes that regulatory independence and autonomy between the EU and the US will legally remain - even after TTIP's implementation. Former EU Commissioner for Trade de Gucht was therefore not wrong when he stated that 'existing regulations and standards will under no circumstances be sacrificed' (de Gucht, 2014). Nevertheless, there are still inherent risks when regulatory convergence is to be accomplished in TTIP. The implementation of an RCC creates a mechanism that could shift the balance of interests and actors in EU regulatory action towards the benefit of trade and economic interests – and subsequently to the detriment of other policy goals, such as environmental health or consumer protection. In addition, the foreseen systematic and formalized collaboration on future regulation is also very likely to lead to a subtle convergence of philosophies and practices across the Atlantic, with the possibility for a discursive shift away from maintaining high European regulatory precaution standards towards enhancing economic and trade interests.

***Claim 2: TTIP enhances the privatization of public sectors and allows US market access to health care systems***

One of the core features of modern FTAs is that they are not only concerned with enhancing trade in goods, but also with promoting transatlantic trade in services. It is therefore the pronounced goal of TTIP to give American and European companies the right to enter each other's markets and to allow for companies to offer their products and services under the same conditions as domestic businesses. In the course of the debate, media outlets have stated that once TTIP has been successfully concluded, European public service sectors will have to undergo privatization and allow for market access for American companies and service providers (s. Huffington Post, 2014). As public service sectors such as health care, social services or education are held in very high esteem by European societies and are seen as a distinct feature of European identity, there has been strong resentment and opposition to any announcements that these sectors will be opened up to trans-Atlantic competition as a result of TTIP. Especially in the UK, a fierce discussion is ongoing about the consequences that TTIP would bring to its National Health Service (NHS).

Looking more in detail at the currently available documents and the CETA text, we can make a more substantiated appraisal of these claims. Firstly, it is accurate that the agreement between the EU and the US aims at providing enhanced market access to sectors currently not open to parties from the other side of the Atlantic. It is therefore the pronounced objective of TTIP to create the space which allows European firms to offer their services in the US and vice versa. As the specific negotiations on TTIP are still ongoing, it is not yet entirely clear what the outcome of the negotiations will be and which sectors will definitely be subject to the opening to the other side of the Atlantic - but if TTIP will be any similar to the publicly available CETA agreement, we can already gain some insights about the impacts on European service sectors, including its health care systems. Our review of the CETA text (2014) shows that there is no reference in the agreement that will force European countries to privatize their public sectors. This also applies for the health care sectors. Even with a trade agreement as CETA in place, the decision to privatize a sector still remains with the member states and their respective governments. Given the high degree of comparability between the CETA and TTIP, we can assume a similar position to be taken by the European Commission in the EU-US agreement.

However, if a European national government decides to privatize certain areas, then CETA can go into effect and subsequently permit Canadian companies access to those services. Figure 5.1 summarizes these complex processes under CETA.

While CETA (and TTIP) by no means force the privatization of public sectors, they still contain substantial implications for those sectors that are already privatized. Most notably, as described in Figure 5.1, the CETA agreement works with a so-called 'negative listing' approach, which means that every private service sector will be

opened for competition to the respective other side of the Atlantic, unless it is otherwise specified. CETA therefore requires both the EU and the member states to actively exclude a private sector from the agreement if it does not want it to be opened up for competitors from North America. As the CETA agreement is already in the public domain, we reviewed the negative listing approach and looked at those sectors that European governments wished to exclude from the agreement. Annex 5.2 provides an overview of countries and the sectors they decided to exclude from the CETA agreement. The review revealed notable differences between European countries with regards to the number and kind of private sectors that they would like to see omitted from the agreement. Austria for instance mentions 16 specific sectors to be excluded from the agreement, including the provision of healthcare services. Other European countries took similar approaches and opted for putting their healthcare services on this negative list, thereby effectively excluding them from the agreement. However, in the context of the UK, only four sectors are mentioned to be excluded from CETA, namely 1) Legal services, 2) Extraction of petroleum and gas, 3) marine activities and 4) veterinary services. The fact that health services are not one of these four shows that the British NHS is not entirely 'off the table' for Canadian market access. An important lesson to learn from the review of the CETA negative list therefore is that interested stakeholders and citizen should look very closely at the CETA agreement and the respective TTIP outcomes to investigate which political choices their national constituencies make with regards to allowing market access to their trans-Atlantic counterparts - and which areas they decide to actively exclude from such agreements.

The 'negative listing' approach taken in CETA and TTIP can be subjected to some further criticism. Contrary to a positive listing approach, negative listing aims at reaching a maximum degree of liberalization in service sectors, as it includes every sector unless it is otherwise specified. This is a new playing field for the EU and its member states, who have never previously signed an FTA that follows such a liberalization approach. Following this approach, countries have to be very proactive in putting sectors on the list that they want to see excluded from the agreement. Neglecting or failing to do for whatever reasons opens up the sector to the other side of the Atlantic – with all positive and negative consequences attached to it. Administrations in small member states such as Malta, Cyprus or Luxembourg are particularly vulnerable in this context, as they may not have sufficient administrative and expert capacities to complete a thorough review of their preferences for a negative listing. The demand to analyze and appraise each sector in the light of whether it should be excluded by a free trade agreement requires a substantial amount of human and legal resources, which may not be available in the responsible institutions in the small member states.

Besides the struggles for small European member states, a negative listing approach also implies that all future service sectors will be covered by the agreement because they were not explicitly excluded. Thinking about future services such as gene banking or elaborate data sharing services, these sectors would automatically be put up for transatlantic competition, with potentially significant implications for public health sectors. Despite the possibility that there may be a desire to protect such services from foreign market access, legislators may be in conflict with the CETA or TTIP agreements when they want to prevent Canadian or American companies to enter those markets. However, it should be noted that CETA does acknowledge these risks and includes a firewall that *'reserves the EU's and the member states' right to limit market access to public services such as education, health, social services and water supply'* (CETA, 2014). Future market access in these sectors can thus still be regulated and North-American companies can still be prevented access from these sectors, if a government decides to do so. But questions should be asked as to how this firewall will function in practice, and how this would conflict with arbitration claims under Investor To State Settlement Dispute (ISDS) mechanisms<sup>11</sup>.

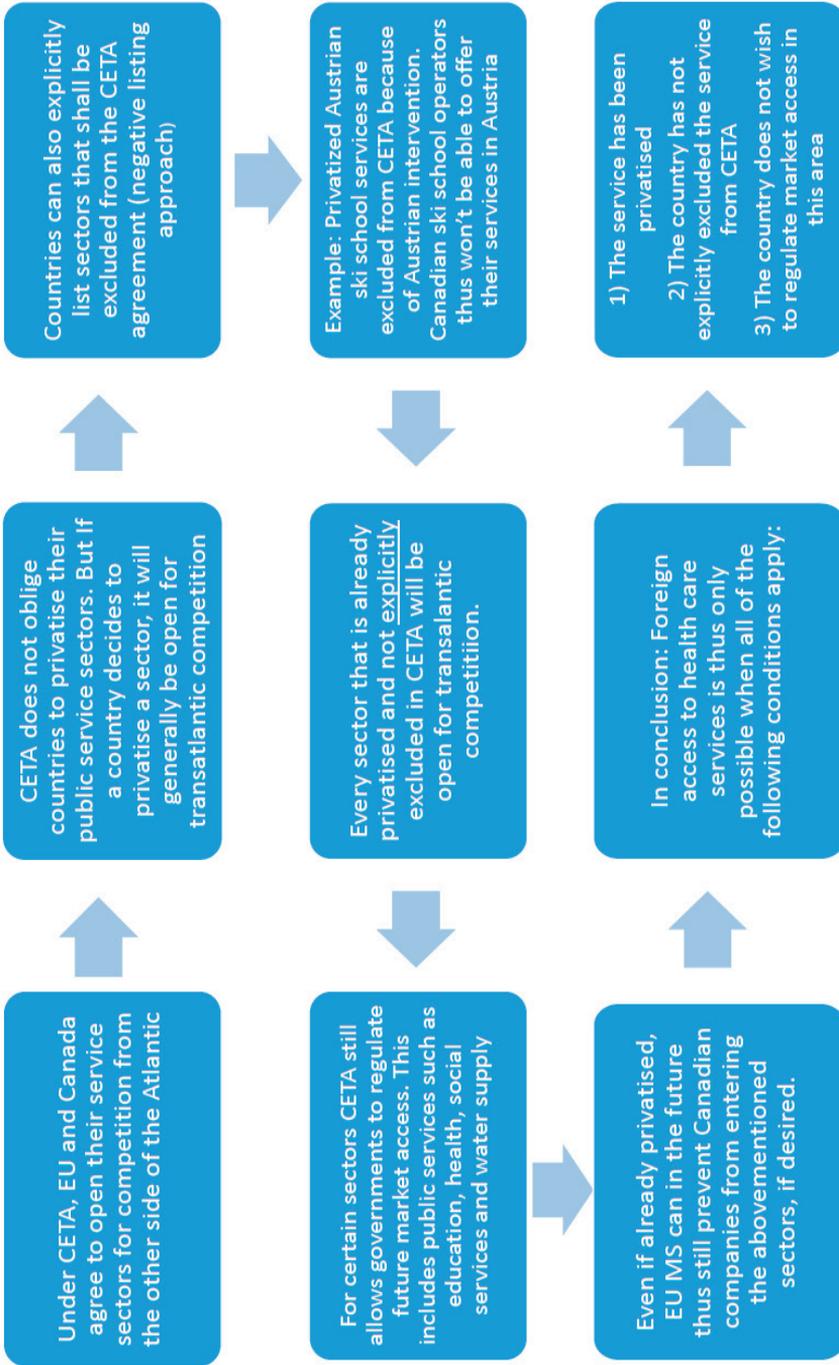
### ***In summary***

Our findings show that CETA (and most likely TTIP) will not oblige member states to engage in the privatization of sensitive sectors, such as for example health care. Countries will remain in the driver's seat over those decisions and it will be member state governments that can make the decision to privatize certain sectors, to set up a monopoly or to limit market access to sensitive sectors. However, if these countries wish to privatize certain sectors, then TTIP and CETA facilitate the opening of these sectors to businesses and investors across the Atlantic. While the current CETA agreement has a series of safeguards in place that also allow for future regulation, the question is to what extent these are sufficient, especially in the light of a negative listing approach, which tends to be more intrusive and risky than a positive listing one, for various reasons.

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<sup>11</sup> As discussed in the following section of this paper.

Figure 5.1 - The CETA agreement and market access to health care services



***Claim 3: Investor to State Settlement Disputes (ISDS) mechanisms hinder the formulation of policies, and lead to regulatory chill in important regulatory areas***

Possibly the most contentious and heated issue in the public debate on modern trade and investment treaties refers to those chapters of the agreement concerned with investment protection. Both CETA and TTIP foresee the implementation of an Investor to State Settlement Dispute (ISDS) mechanism. ISDS is an instrument designed to secure the rights of a foreign investor by allowing it to file a claim against a government if it sees its rights violated. Box 5.3 provides an overview of the investor's rights that are likely to be safeguarded by the TTIP agreement.

**Box 5.3 - Investor's rights granted under TTIP**

1. Protection against discrimination based on nationality
2. The right to 'fair and equitable treatment'
3. The right not to be directly or indirectly expropriated without full compensation
4. The right to the free transfer of means (e.g. capital)

Source: European Commission, 2013a

The European Commission (2014) states that such protection provisions have been common standard for modern bilateral investment treaties, with EU member states collectively having signed more than 1400 agreements featuring these kinds of investment protection measures. However, the ISDS mechanism only made it into the public spotlight with the emergence of the general debate on TTIP. Public protest against the mechanism has been fierce and has led the European Commission to carry out a public consultation on the matter on how to improve it. The public consultation resulted in an unprecedentedly high number of responses, with the large majority of answers rejecting ISDS as a whole. In total, the Commission received 140.000 responses, of which 88% were categorically rejecting an ISDS mechanism. (European Commission, 2015c) Due to this polarized discussion, the EC decided to postpone this chapter of the negotiations until the very end of the negotiations.

The inherent risks of ISDS for autonomous regulation have been discussed at length in various position papers and articles. Some of the risks stemming from ISDS for public health have been addressed by Gleeson and Friel (2013) as well as specifically for environmental regulation under TTIP by Gerstetter and Meyer-Ohlendorf (2013). One of the main concerns is that ISDS could be used as a mechanism by companies to file complaints against governmental regulation set up in the interest of public health or well-being, if they violate the investor's rights outlined in Box 5.3. In re-

cent years, such conflicts could indeed be observed. ISDS provisions under the North American Free Trade Agreement (NAFTA) already resulted in challenges to Mexican, Canadian and US governmental measures in areas such as health, safety and environmental regulation (Côté, 2015). Another famous and currently still ongoing case from the public health sector relates to Philip Morris's utilization of ISDS provisions in 2011 to sue the Australian government for compensation for its law that all cigarettes must be sold in plain paper packaging (Australian Government, 2011). Also in Europe, the Slovak Republic has lost a case to the Dutch insurance company Achmea for reversing its privatization of the health insurance sector. Slovakia was forced by the arbitration committee to pay 25 million EURO in damages to Achmea for this policy change (Eureka B.V vs. Slovak Republic, 2010). Similarly, Swedish energy producer Vattenfall took Germany to an arbitration court over €700 million in compensation in response to the the decision of the government to shut down German nuclear power plants because of health protection concerns. (Bernasconi-Osterwalder & Hoffmann, 2012). While each individual arbitration case requires a thorough individual review, it seems plausible that losing such a multi-million dollar arbitration case would not only result in additional public expenses for a government – but it would also influence the future decision making processes of governments, disinclining them to implement certain re-nationalization measures or other regulatory action. This phenomenon is commonly referred to as 'regulatory chill' (Côté, 2015). The critics of such mechanisms claim that it does not matter who will legally win such a long lasting arbitration battle - but that the mere existence of an ISDS mechanism in place constitutes a sword of Damocles hanging over the heads of decisions makers, who may have to fear multi-million- or even billion dollar arbitration cases to be brought forward against their decisions.

Notably, while such developments seem logical, recent research by Côté (2015) could not yet find consistent scientific evidence for the claim that ISDS actually have caused such regulatory chill in the past. Accordingly, she suggests that 'the impact of private actors in the policy making process is perhaps less pronounced than many fear' (Côté, 2015). However, empiric evidence on this subject is scarce and remains claims remain that some form of interference exists between the political decisions of governments- and the ability of companies to file claims against such decisions.

In a response to these risks, EU and Canadian negotiators have built in a series of firewalls in CETA to improve the ISDS mechanism and to provide regulatory security to governments, by trying to reduce the possibilities for abuse of the ISDS mechanism and to make it more robust against frivolous claims. Box 5.4 lists the new firewalls in place.

#### Box 5.4: ISDS improvements under CETA and future FTAs

##### ISDS improvements include:

- A preamble confirming the right to regulate in the context of public health, safety, environment, public morals and the promotion and protection of cultural diversity
- Precise definition of key words such as 'fair and equitable treatment' and 'indirect expropriation', thereby limiting room for interpretation of such terminology.
- Introduction of a fast track system to quickly reject unfounded or frivolous claims
- Introduction of a binding code of conduct for arbitrators
- Pre-agreement on a list of arbitrators between the EU and Canada
- Enhanced transparency in ISDS disputes

Source: European Commission, 2013a

Notably, such measures clearly would improve the current ISDS mechanisms compared to their predecessors in earlier FTAs. However, the question is whether these firewalls will be enough to protect national governments from claims and potential abuse of ISDS provisions. Even with an improved system in place, arbitration cases will ultimately boil down to a legal interpretation of wordings by those committees that will decide over the matter. For example, ambulance services in some countries are considered 'hybrid services', legally belonging either to the health- or to the transportation sector. The legal interpretation by a judiciary regarding the legal positioning of ambulance services would determine whether the preamble in Box 5.4 would uphold the right of governments to regulate in this matter. Accordingly, governmental regulation may still be subject to legal challenges under ISDS, if the arbitration committee decides to interpret a certain investment in a way that is not covered by the preamble.

Besides this, the debate can also be placed in the context of current discourses in Europe on the role and functioning of the European social welfare state. Currently, we see that a number of governments in Europe are moving towards the privatization of services, including their health care sectors. In England for instance, the 2012 Health and Social Care Act 2012 has promoted the privatization of large parts of the National Health Service (NHS) (Reynolds & McKee, 2012). Countries such as Greece, Spain, Portugal and Italy have also been pushed strongly towards the liberalization of professional services and the withdrawal of the state from the direct provision of such services under EU Country Specific Recommendations and Economic Adjustment Programmes (Busch, 2012). In Greece for instance, the former government followed external pressures and agreed to put in place a series of privatization

schemes and the deregulation of private health services (Kondilis, Gavana, Ierodiakonou et al., 2013). The rise to power of a left-wing government in Greece in 2015 however provides a good case in point on how a democratically legitimized change of political preferences can interfere with agreements made under TTIP. Once a sector has been privatized and opened up for foreign investors, reversing this privatization and re-nationalizing it at a later stage will be made much more difficult with an ISDS mechanism in place, as foreign investors may be able to file claims against this re-nationalization under ISDS.

### ***In summary***

The original goal of dispute mechanisms such as ISDS was to give foreign investors security and a stable investment environment despite legal uncertainty in the target country. Recent years however have shown that ISDS mechanisms have effectively challenged some governmental decisions to regulate in favor of the general health and well-being of its people. Whether these challenges are justified or not, they instill a sense of regulatory insecurity into the minds of the decision makers. While the mechanisms are being improved under CETA, the question remains whether these firewalls will be sufficiently effective in preventing the abuse of ISDS.

## **Discussion and Conclusion**

This paper provided some more clarity and some new aspects on three prominent points of health concern that are continuously voiced in the discussion around TTIP. Our review showed that with complex trade agreements, the devil is in the details. While some of the publicly voiced arguments are often not entirely correct, they still point to issues that require at least more attention and in-depth discussions. By reviewing some of the proposed mechanisms by TTIP, we were therefore able to clear up some of the commotion around the agreement and to fine-tune some of the arguments made.

On another note, the TTIP discussion features an interesting development with regards to civil society involvement in the EU. In the past, such agreements have commonly been negotiated without public involvement, and have not garnered much public interest even when they were concluded. In recent years, this seems to have changed. Public interest in bilateral agreements has increased dramatically, and public opinion can function as a powerful factor deciding over their successful conclusion. Already in 2012, the Anti-Counterfeiting Trade Agreement (ACTA) was rejected by the European Parliament (2012), due to a mounting public opposition against this agreement. Similar opposition is currently mounting against the TTIP and CETA agreements, and it will be interesting to see to what extent this public opinion will have an influence over the outcome of these agreements. Notably, TTIP

also marks an interesting case in point for the health and foreign policy discourse, as the major public arguments brought forward against the agreement strongly relate to concerns over population health and well being. It seems as if public health concerns can be considered a powerful argument around which a large number of people are willing to rally to influence the outcome of the high-level EU-US deliberations. We believe that if TTIP is to be brought to a successful conclusion, EU and US negotiators need to take these public sentiments more into consideration and should ideally address them in their negotiations in order to garner public support. Therefore there could be a distinct opportunity to use TTIP to fully promote and endorse high protection standards rather than putting them at risk through some of the measures outlined in this paper. Taking such a focus in TTIP negotiations would constitute a trade agreement which would quickly gain the public support from Europe's civil society. Given the new realization that such mammoth projects can nowadays hardly go unnoticed and against public opinion, it may be wise to ask the question of how TTIP can be turned into an agreement that does not include potential risks to our society, but that produces gains that go beyond a mere economic growth perspective. The successive conclusion of TTIP negotiations should therefore not only be measured in potential economic welfare gains, but should also be tested on the extent to which it promotes European values in public health as well as in social, environmental and labour matters.

However, we reiterate that this paper is not a statement for- or against TTIP, and that we should be careful not to instantly demonize trade and subsequent agreements such as TTIP or CETA. Strong trade ties between the EU and the US generally have brought welfare to both American and European companies and citizens. And despite various differences, both regions have well-developed legal and regulatory regimes designed to protect the environment and their citizens' health. In comparison to other regions of the world, European and American standards provide high levels of protection, and, if implemented with due diligence, a TTIP agreement could function as a benchmark for the whole world in setting high standards and norms.

# CHAPTER 6

## The workforce for health in a globalized context – global shortages and international migration

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## **Abstract**

The 'crisis in human resources' in the health sector has been described as one of the most pressing global health issues of our time. The World Health Organization (WHO) estimates that the world faces a global shortage of almost 4.3 million doctors, midwives, nurses, and other healthcare professionals. A global undersupply of these threatens the quality and sustainability of health systems worldwide. This undersupply is concurrent with globalization and the resulting liberalization of markets, which allow health workers to offer their services in countries other than those of their origin. The opportunities of health workers to seek employment abroad has led to a complex migration pattern, characterized by a flow of health professionals from low- to high-income countries. This global migration pattern has sparked a broad international debate about the consequences for health systems worldwide, including questions about sustainability, justice, and global social accountabilities. This article provides a review of this phenomenon and gives an overview of the current scope of health workforce migration patterns. It further focuses on the scientific discourse regarding health workforce migration and its effects on both high- and low-income countries in an interdependent world. The article also reviews the internal and external factors that fuel health worker migration and illustrates how health workforce migration is a classic global health issue of our time. Accordingly, it elaborates on the international community's approach to solving the workforce crisis, focusing in particular on the WHO Code of Practice, established in 2010.

## Introduction

Healthcare services are a rapidly growing sector of the world economy. Globalization processes and the worldwide increase in demand for healthcare have not only fueled the trade in healthcare technologies but also opened domestic borders for foreign labor in the health sector, resulting in cross-border migration of health workers<sup>12</sup>. While the phenomenon of international health workforce migration was discussed as early as 1974 (s. Bhagwati & Hamada, 1974), it has dramatically increased in scale due to the liberalization of markets and changes in population dynamics over the past two decades (Clark, Stewart & Clark, 2006). While it is difficult to provide a precise picture of global migratory flows, various studies indicate a pattern that is characterized by migration from low- and middle-income countries (LMICs) to high-income countries (HICs) in North America and Western Europe (WHO, 2006; Clemens & Pettersson, 2008; Gathercole, 2003; Kirigia, Gbary, Muthuri et al., 2006).

The freedom of health workers to offer their services in a globalized employment market must be seen within the context of a global undersupply of human resources for health. The World Health Organization (WHO) stated in 2006 that globally there was a shortage of almost 4.3 million doctors, midwives, nurses, and other health workers. It further estimated that globally 75 countries had fewer than 2.5 health workers per 1000 population, which is the 'minimum number necessary to deliver basic health services' (WHO, 2006). According to the same report, the large majority of countries with a serious shortage of health workers are located on the African continent (WHO, 2006). Already stressed health systems in countries such as Zimbabwe, Nigeria, Ghana, Zambia, and South Africa experience a net outflow of health workers, while HICs in North America, Europe, the Middle East, and Oceania actively 'import' health service labor in order to sustain their healthcare systems in the light of existing or anticipated shortages (Clemens & Petersson, 2008). The HICs' reliance on health workers from overseas contributes to the so-called brain drain phenomenon in LMICs, in which highly skilled personnel leave a particular country in order to offer their services else-where. This shift in resources is believed to play out particularly intensely in Africa. According to WHO, Africa has only 10% of the world's population, yet they bear 25% of the global disease burden.

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<sup>12</sup> A health worker is defined as 'anyone engaged in actions whose primary intent is to enhance health' (3). In this article, however, we limit our analysis to doctors and nurses, as data are mainly available for these two professions (3). When we refer to health workers, we therefore address doctors and nurses - unless otherwise specified.

This disease burden in turn is confronted by only 3% of the whole global health workforce (WHO, 2006). While the African continent already is a particular hotspot when it comes to shortages in health service delivery, health workforce migration is likely to exacerbate the situation. Depending on the particular profession and country, African countries are estimated to lose up to 70% of their health workforces to HICs. In 2008, approximately 65,000 African-born physicians and 70,000 African-born professional nurses were estimated to be currently working overseas in HICs (Clemens & Petersson, 2008). This lack of health workers on the African continent can literally create life endangering situations for communities where the health services simply vanish due to the emigration of qualified personnel. Especially in sub-Saharan countries, health worker migration is believed to have serious negative effects on the availability and quality of health services (Kirigia, Gbary, Muthuri et al. 2006; Mills, Kanters, Hagopian et al., 2011). Furthermore, it has been claimed that LMICs not only lose manpower in the health sector, but also effectively lose out on their financial investments into training and education (Kirigia, Gbary, Muthuri et al., 2006).

### ***Health workforce flow in a globalized context***

Adequately quantifying the flows and stocks of health workers in a globalized world is a very difficult endeavor, as reliable information is nearly impossible to obtain, and is generally described as of 'poor quality' (Mills, Kanters, Hagopian et al., 2011) or even 'anecdotal' (OECD, 2007). The difficulties in establishing accurate data on global workforce flows stem from, among other factors, a lack of registration data in both sending and receiving countries, the complexities of migration pathways, and the definition of a migrating health worker's status in the receiving country (i.e. whether the migration is temporary or permanent) (Kirigia, Gbary, Muthuri et al. 2006; Mills, Kanters, Hagopian et al., 2011, OECD, 2007). The lack of reliable data therefore makes it very difficult to sketch an accurate picture of workforce migration patterns. One sophisticated attempt to map and quantify health workforce flows was conducted in 2007 by the Organisation for Economic Co-operation and Development (OECD), which reviewed the in- and outflow of doctors and nurses for OECD countries based on the best available data. Regarding OECD members which are also members of the European Union (EU), the authors estimated that the percentage of foreign-born nurses ranged from 0.4% in Finland to 25.8% in Luxembourg. In Switzerland, which is not a member of the EU-28, this number rises to 28.6%. For doctors, the percentages ranged from 3.2% in Poland to 35.3% in Ireland (OECD, 2007). A full overview of selected countries from Europe that are included in the OECD study can be found in Table 6.1. In addition, the study showed that over

the past 25 years, the number and the percentage of foreign-trained<sup>13</sup> nurses and doctors increased significantly in European countries (OECD, 2007). The OECD study showed that nearly all European OECD countries increasingly rely on recruiting health workers from abroad to fill their shortages. In addition, the Health Professional Mobility in the European Union Study (PROMeTHEUS) points in the same direction as the OECD findings and estimates that countries such as Estonia, Slovakia, and Poland have little reliance on foreign medical doctors, with a demand ranging from 0.02 to 0.7% of the total workforce. On the contrary, countries like Switzerland, Slovenia, Ireland, and the United Kingdom were found to be among the European countries with very high reliance on foreign medical doctors, with 22.5 to 36.8% of their current workforce having been trained abroad (Wismar, Maier, Glinos et al., 2011). Both OECD and PROMeTHEUS studies express that migration also occurs heavily between European countries. For example, most of Ireland's foreign-trained nurses were trained in the United Kingdom. In Norway, the large majority of migrant nurses come from other Scandinavian countries. Unfortunately, the immigration of doctors and nurses from non-European countries can hardly be assessed systematically, as data on the exact flows of personnel are very limited and difficult to obtain. This therefore does not make it possible to establish a clear picture of the flow of health workers between European countries and the rest of the world. Nevertheless, in a study of 10 EU member states, Dussault, Fronteira, and Cabral (2009) estimate that, on average, one-third of migrant doctors came from outside the EU. This figure rises to 60% in France and Italy, and even to 80% in both Ireland and the United Kingdom.

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<sup>13</sup> Making a distinction between *foreign-born* and *foreign-trained* health professionals in this context is important, as it is the *foreign-trained* health workers that are of relevance in the discussion on migration and the related shortages of health workers - and not the *foreign-born* professionals, who may have gotten their degree in the country of their current residence.

**Table 6.1 - Number of foreign born nurses and doctors in European OECD countries**

Country of residence	Nurses			Doctors		
	Total	Foreign born	% of total	Total	Foreign born	% of total
Austria	56 797	8 217	14.5	30.068	4.400	14.6
Belgium	127.384	8.409	6,6	39.133	4.629	11,8
Denmark	57.047	2.320	4,1	14.977	1.629	10,9
Finland	56.365	470	0.8	14.560	575	4.0
France	421.602	23.308	5.5	200.358	33.879	16.9
Germany	781.300	74.990	10,4	282.124	28.494	11,1
Greece	39.952	3.883	9.7	13.744	1.181	8.6
Hungary	49.738	1.538	3.1	24.671	2.724	11.0
Ireland	43.320	6.204	14.3	8.208	2.895	35.3
Luxembourg	2.551	658	25.8	882	266	30.2
Netherlands	259.569	17.780	6.9	42.313	7.032	16.7
Norway	70.698	4.281	6.1	12.761	2.117	16.6
Poland	243.225	1.074	0.4	99.687	3.144	3.2
Portugal	36.595	5.077	13.9	23.131	4.552	19.7
Spain	167.498	5.638	3,4	126.248	9.433	7.5
Sweden	98.505	8.710	8.9	26.983	6.148	22.9
Switzerland	62.194	17.636	28,6	23.039	6.431	28,1
United Kingdom	538.647	81.623	15.2	147.677	49.780	33.7

Source: OECD, 2008

### ***Push and Pull factors***

A wealth of contemporary literature is concerned with reviewing the so-called push and pull factors that determine whether a person will remain in their country of training or work elsewhere. ‘Push’ factors refers to those conditions that exist in the country of origin and drive a health worker away from the health system in which they were trained. ‘Pull’ factors in turn are external, because they describe those circumstances in the destination countries which provide an incentive for health workers to immigrate. Recent literature reviews highlighted that various financial, professional, political, social, and personal factors can act as both push and pull factors that contribute to health workers’ decisions to migrate (Dywili, Bonner & O’Brien, 2013). These factors include better remuneration in other countries, professional advancement and better career opportunities, a safer and better working environment, and a better quality of life (de Mesquita & Gordon, 2013). Also political factors, such as getting away from unstable regions, can act as push factors and play a major role in decisions to leave the country (Oosthuizen, 2005). Clemens (2008) found that there is a positive correlation between greater political stability

and prosperity, on one hand, and health worker retention, on the other. Alternatively, civil war and economic stagnation were strong predictors for health worker emigration (Dussault, Fonteira & Cabral, 2009). Additional push factors can include extremely unsatisfactory working conditions in the country of origin, lack of medicine and inadequate supplies and equipment, a large nurse-to-patient ratio, and epidemics of HIV/AIDS and other serious illnesses, which contribute to making work stressful in developing countries (Dywili, Bonner & O'Brien, 2013 ; Oosthuizen, 2005).

Furthermore, a variety of employment organizations exist in HICs which pursue active recruitment strategies in LMICs. It has been estimated that in the United States alone, 270 companies were engaged in international nurse recruitment, a sharp increase from approximately 40 companies that existed in the late 1990s (Eckenwiler, 2009). This, despite the fact that overseas recruitment has been widely described as 'unjust' and 'unethical' (Hooper, 2008) and even 'criminal' by some (Mills, Schabas, Volming et al., 2008).

### ***Cost and benefits of workforce migration***

There is a broad discussion in the scientific literature on the question whether health worker migration has negative effects on the sending country and its people, while the receiving country and the health worker will benefit. Notably, the picture is somewhat complex, and any review should include all possible factors that can be considered beneficial or detrimental. A comprehensive overview of the costs and benefits of health worker migration can be found in Table 6.2, which complements a previous review of Stewart, Clark and Clark (2007) and provides an overview of the relevant claims in the current discussion. The authors suggest that in principle there are two groups who benefit most from health workforce migration: the migrants themselves and the residents of the recipient country (Stewart, Clark & Clark, 2007). At first, health workers themselves clearly benefit due to usually better working conditions, better career opportunities, and higher salaries. In addition, the residents of the recipient country benefit from an adequate supply of healthcare services and a savings of tax moneys through training fewer healthcare professionals than they would otherwise need (Ahmad, 2005). Some argue that the sending countries benefit to some extent as well from receiving financial remittances from the health workers living in developed countries (Adams, 2003; Hooper, 2013). However, this view has not been uncontested, as remittances throughout the whole life course can hardly match the training and education costs invested in the migrant (Gathercole, 2003; Brock, 2012). Furthermore, doctors and nurses receive publicly financed education, whereas remittances are usually sent back to families in private. Brock (2012) argues that remittances may even have a negative effect of exacerbating inequalities by increasing the wealth of the privileged while impoverishing the poor. Others argue that in the case of circular migration patterns, countries can

gain significant skills and knowledge if the emigrant worker returns home after a few years abroad. One survey found that 50% of physicians in the United Kingdom who emigrated from an LIC had the intention to return to their home countries at some point (Kangasniemi, 2007). The underlying assumption here is that these individuals will have enhanced knowledge and skills that they can put to use once they return to their home country. Another article further points to the complex pathways involved in calculating financial costs and benefits of migration and states that migration could -under certain circumstances - have a positive effect on the welfare of the country of origin (Clemens, 2011). Contrary to this, a study by Mills et al. of nine sub-Saharan countries asserts that the collective investment loss for training those doctors who are currently working abroad approaches \$2.17 billion (Mills et al., 2011). Reportedly, Kenya alone loses an investment of about US\$500,000 for every doctor who migrates. For each emigrating nurse, Kenya loses investments worth US\$300,000 (Kirigia et al., 2006).

Accordingly, the gains of these investments shift to the receiving countries, who can save on their training investments. It has been estimated that the total financial savings of recruiting doctors from abroad amounted to up to \$2.7 billion for the United Kingdom and \$846 million for the United States, thereby effectively acting as a subsidy for HIC health systems (Mills, Kanters, Hagopian, 2011).

In addition to the economic dimensions, the sustainability of healthcare systems in developing countries increasingly comes under pressure as facilities become understaffed, the quality of care decreases, and the morale among the remaining staff deteriorates. With regard to the effect of migration on direct health outcomes, only a few studies exist that try to link health outcomes with migration, as it is very difficult to establish a causal relationship. One notable study showed that in countries in which the HIV prevalence rate exceeds 3%, a doubling of the medical brain drain rate was associated with a 20% increase in adult deaths from HIV/AIDS (Bhargava, Docquier, 2008). However, the currently existing scientific evidence is insufficient to make any sound statements on the direct health effects of health worker migration. However, it seems common sense that losing health workers will lead to a deterioration of quality of health services, which will ultimately lead to more negative health outcomes (Hooper, 2013).

**Table 2 - Costs and Benefits in sending and receiving countries:**

<b>Effects of health worker migration</b>	<b>Sending countries</b>	<b>Receiving countries</b>
<b>Costs</b>	<ul style="list-style-type: none"> <li>- Shortages in domestic health care service capacity</li> <li>- Financial loss in investment of training and educating the workforce</li> <li>- Financial loss of consumption and tax receipts</li> <li>- Decline in morale and commitment among remaining workers</li> <li>- Loss of social and human capital</li> <li>- Knowledge spillover losses</li> <li>- Undermining institution building and development as a whole</li> <li>- Loss of expert knowledge in academia and education centers</li> <li>- Loss of role models for young students</li> </ul>	<ul style="list-style-type: none"> <li>- Some administrative costs involved</li> <li>- Enhanced local competitiveness</li> </ul>
<b>Benefits</b>	<ul style="list-style-type: none"> <li>- Remittances received from people working abroad</li> <li>- Improvements in skills of returnees</li> <li>- Collaborative partnership between diaspora and local professionals</li> </ul>	<ul style="list-style-type: none"> <li>- Relief of supply shortages</li> <li>- Improved quality of health care</li> <li>- Tax receipts from foreign workers</li> </ul>

*Source: Adopted from Stewart, Clark and Clark (2007) and further developed*

### ***WHO's Code of Practice***

This review has shown that migration of health workers is a phenomenon in which decisions and actions taken in one country can have substantial and direct effects on another country. Recruiting doctors and nurses from a LMIC to serve the demand in HICs effectively creates a shortage in the country of origin, and hence contributes to worse health outcomes. Finding solutions to this problem therefore can occur only at the international level, as the problem's determinants often cross borders and governments.

From a global health governance perspective, one of the most notable actions to tackle the health workforce crisis was formulated in 2010 during WHO's 63rd World Health Assembly. The 'Global Code of Practice on the International Recruitment of Health Personnel' intends to serve as a policy framework for addressing the health workforce crisis at a global scale. It establishes a framework for the ethical recruitment of health personnel and guides its member states in the development of national frameworks for ethical recruiting (WHO, 2010). The Code of Practice proposes that conditions for the recruitment of health personnel should be set out in bilateral agreements between source and destination countries, thereby creating win-win situations in the context of health workforce migration. These bilateral agreements could, for instance, foresee a reimbursement of the source country for every migrating doctor. But yet again, this would require systematic and effective monitoring of migratory flows.

The Code further stresses that it respects the rights of individual health workers to migrate and therefore asks source countries to address the factors that drive the health worker's emigration. This is an important point, as the individual right of a migrant to seek opportunities elsewhere can conflict with the country's goals to secure the provision of health services of its people. Improving health worker retention while at the same time respecting their individual rights can be achieved by improving working conditions in the donor country itself. In return, the destination countries are particularly asked by the Code to ensure adequate and context-specific long-term health workforce planning, focusing on capacity building of local professionals in order to decrease the pressure to 'import' health workers from elsewhere. Furthermore, destination countries are asked to support sending countries technically and financially to mitigate the current effects of migration of health personnel (WHO, 2010). Such solutions to the workforce crisis have been widely discussed and considered effective in tackling the shortages of health workers (Buchan, 2006).

The Code of Practice can be viewed as a laudable initiative, as it identifies a global understanding of the problem at hand, and functions as an early attempt to coordinate international cooperation across health systems. Fidler (2011) even describes the Code as part of a series of 'groundbreaking governance regimes' for the global health problems of our time. However, as with many international agreements, one

of the Code's major weaknesses is that it is non-binding in nature to its signatories. Member states and other stakeholders are therefore merely encouraged to apply the Code to their national practices, and compliance to the Code is hardly monitored or enforced. This raises the question of whether the current Code is sufficiently powerful to change countries' behavior toward more ethical recruitment guidelines. In this regard, some notable suggestions have been made to improve its effectiveness and to alleviate the health workforce crisis. First of all, as the lack of data substantially hampers the effective implementation of any workforce policies, Glinos et al. call for a systematic monitoring of migratory flows in order to understand whether policies and strategies suggested by the Code are being respected and effective. Even HICs across Europe struggle in monitoring the in- and outflow of migrant health workers (Glinos, Wismar, Maier et al., 2011). Addressing this issue is key to successfully developing policies and interventions to meet the problems caused by health workforce migration. Secondly, Glinos et al. suggest the introduction of national accountability frameworks that ensure compliance with the Code, including compliance from public administration and healthcare providers. Such accountability frameworks could ensure compliance at the national level, as they could include sanctions or fines for non-compliance (Glinos, Wismar, Maier et al., 2011). Despite these certainly useful recommendations, it remains questionable whether HICs will move toward this direction.

Currently, it is simply too easy (and financially lucrative) for HICs to secure their undersupply of health professionals by importing foreign staff. Incentives to change the current policies under the Code of Practice are therefore relatively small, and the current global power relations seem to be skewed in such a way that many HICs benefit from the current practice, which makes them likely to resist any actions that put restrictions on them.

## **Summary and conclusion**

The phenomenon of health workforce migration can be labeled a classic global health issue of our time. Globalization fuels migration, and health workers worldwide are becoming increasingly mobile, connected, and aware of the opportunities in other, more affluent countries. While there is still a lack of systematic monitoring of migratory flows, existing studies show that a global market for health professionals has developed, leading to a global increase of doctors and nurses migrating to other countries.

However, from a health needs perspective, this global market for doctors, nurses, and other health professionals appears to be distorted. In a globalized market, HICs can address their shortages in health personnel by recruiting and importing quali-

fied health workers from elsewhere. Shortages thereby are shifted from HICs to LMICs, thereby increasing global inequities. Because many of the so-called pull factors are external in nature (i.e. outside a country's regulatory boundaries), a LMIC can do little to influence these factors in order to prevent the emigration of its qualified health workforce.

This article has discussed several issues around this problem. It showed how the shift of labor can have both positive and negative implications, depending on the country's role in the migratory scheme. While the migrating health workers and the receiving countries benefit in general, it is the donor countries and its citizens who suffer most from the brain drain.

While health worker migration is not desirable in terms of healthcare service quality and equity, it also reveals a structural problem of healthcare systems worldwide. The chronic global undersupply of health workers points to the fact that many HIC healthcare systems are unsustainable, as they rely on foreign labor in order to provide their services. In many EU countries, sufficient provision of health workers already depends on immigration. In the light of aging societies and projected future increases in the demand for health workers, this current status seems unsustainable. Even worse, in times of economic crisis, countries less affected by recession could attract even more health professionals from countries where salaries in the medical sector are being cut and the health workforce is being downsized. The current practice by many HICs to fill their staff needs by recruiting therefore merely serves as a 'quick fix' and cloaks unsustainable practices, as the underlying problems of undersupply are not tackled effectively. For European countries, it should be apparent that recruiting health workers from overseas does not solve the global workforce crisis; it only shifts shortages to a country that is even less well situated to cope with the shortages, potentially inducing life-threatening situations in those countries. But as long as the international demand outweighs its supply, training more health workers in low-income countries will not be an effective solution, as this simply serves to further fuel the export market.

The WHO Code of Practice has been a small step in the right direction. However, the only realistic and sustainable policy option can be to simply create a greater supply of health workers in HICs by means of increasing the training capacities, improving overall working conditions, and making the jobs of nursing and other healthcare professionals more attractive to the domestic workforce. While this is not the easiest and cheapest solution, it is the only one that can effectively tackle the global undersupply while also being fair and sustainable to LMICs.

# CHAPTER 7

## Improving the assessment and attribution of effects of development assistance for health

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### **Contributions**

Nour Ataya and Christoph Aluttis undertook the analysis of approaches to assess and attribute the effect of DAH on health outcomes. Andy Haines and Antoine Flahault provided oversight and advice. Rifat Atun made substantial contributions to the drafting of the Viewpoint.

## Improving the assessment and attribution of effects of development assistance for health

Overseas development assistance for health (DAH) increased substantially from 2000, but has plateaued since 2010 because of the global economic crisis, (Institute for Health Metrics and Evaluation, 2012) with growing public demands for funders and beneficiary countries to show the effect of investments (Victoria et al., 2011; EAGHA, 2014). When showing effect, donor agencies and countries need to address two challenges: first, accurate estimation of the effects of investments in different areas (eg, vaccines or health systems) on health outcomes; and second, attribution of the effects to specific investments.

There are methodological challenges in establishing a relation between DAH and health outcomes (appendix p. 1)<sup>14</sup> (de Jongh et al., 2013; Department of International Development, 2012). The validity of the results presented by major funding agencies has been questioned because of weaknesses in models used to estimate outcomes, in appropriate counterfactuals, and overgenerous assumptions of investment effects (McCoy et al., 2013). Attribution of health outcomes to external investments by specific agencies has also proved to be challenging because of the multiplicity of funding sources (Car et al., 2012). Further, methods that attribute health effects to single interventions or specific funds do not reflect the vital contribution of health systems to health outcomes (Baeza, Lim, Lakshminarayanan, 2012; EAGHA, 2014; Atun, et al., 2010; Atun et al., 2013)

Most donors have committed to aid effectiveness principles underpinned by the Paris Declaration (2005) and the Accra Agenda for Action (2008), which stress national ownership and leadership, as well as harmonisation and alignment by donor agencies to national systems (OECD, 2005; OECD, 2008). Increasingly DAH is channeled through national delivery systems, making it difficult to attribute results to a specific funder. Yet most donor agencies continue to report 'their' results. (EAGHA, 2014). The appendix<sup>15</sup> pp. 2–8 provides an overview of current approaches used in assessment and reporting of the effect of DAH.

The most commonly used approaches to assess and report the effect of DAH on health outcomes are tracking of trends in mortality, morbidity, and coverage indicators (appendix pp. 4, 9)<sup>15</sup>; and estimation of lives saved and deaths averted (appendix pp. 4, 10)<sup>15</sup>. Methodological challenges include insufficient reliable data, and poor disaggregation by age, sex, socioeconomic groups, and geographical location (Martinez et al. 2009). Assessment of the health effect of health systems strengthening (HSS) interventions with use of these measures is particularly challenging, because of the complex causal pathways through which these interventions are likely

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<sup>14</sup> The appendix has been published online on the website of [www.thelancet.com](http://www.thelancet.com).

to have an effect (Martinez et al., 2009). Furthermore, gaps in tracking input (eg, HSS expenditures) and output indicators (e.g. measures of service availability, accessibility, and quality) limit the ability of studies to fully describe the sequence of inputs, activities, outputs, and outcomes, leading to an effect (appendix pp 4, 9)<sup>16</sup>. (Martinez et al., 2009).

Donor agencies also use lives saved or deaths averted metrics to quantify the effect of DAH targeting disease specific interventions by comparison of health outcomes after the implementation of an intervention with the outcomes in similar geographical areas that did not receive the intervention during the same period; with outcomes in the same area(s) before the intervention was implemented; and with a hypothetical counterfactual scenario for the same area during the same period (WHO, 2009). Peer-reviewed models are used to estimate outcomes with these measures on the basis of estimated population coverage of interventions with well documented health outcomes (appendix p. 11)<sup>16</sup>. For example, the Global Fund has estimated lives saved by disease-specific interventions such as antiretroviral therapy for AIDS (Stover et al., 2011) and by insecticide-treated nets that reduce mortality (The Global Fund, 2011), whereas GAVI has used several peer-reviewed models to estimate deaths averted by immunisation of children (appendix pp. 10–11)<sup>16</sup>.

Six points of interaction of DAH with national health systems have been identified: governance, finance, health workforce, health information systems, supply management systems, and delivery of health services (appendix p. 5)<sup>15</sup> (Shorten et al., 2012; WHO Maximizing Positive Synergies Group, 2009). However, there is no single framework to classify these interactions, and research has identified several challenges - e.g. insufficient data including for contextual factors that might have affected health effects and both the complexity of health system interventions and of the causal pathways leading to health effects (appendix<sup>16</sup> pp 6–8, OECD, 2005; OECD, 2008; Car et al., 2009; Atun et al., 2011).

Two main approaches used by donor agencies when attributing health effects to their funding are determination of plausible counterfactuals and establishment of exclusive attribution. When determining plausible counterfactuals, no intervention has frequently been used to attribute a health effect that could be linked to a specific source of funding, but determination of counterfactuals has been challenging, especially since an ideal control group was difficult to identify (appendix p. 13)<sup>16</sup>. The result attributed to a funder is sometimes assumed to be a proportion commensurate with the donor agency's contribution to the overall investment for the intervention or country in question (Glaziou et al., 2011; Akachi & Atun, 2011; Korenromp et al., 2012), although funding is often pooled at country level (appendix p.

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<sup>15</sup> The appendix has been published online on the website of [www.thelancet.com](http://www.thelancet.com).

13)<sup>16</sup>. There is as yet no consensus between key stakeholders on the strategies to improve and harmonise measurement approaches (Victoria et al., 2011; Chan et al., 2010; EAGHA, 2014; Shorten et al., 2012), but they could benefit from refinement and wider application of several promising approaches used by donors (s. panel 7.1).

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<sup>16</sup> The appendix has been published online on the website of [www.thelancet.com](http://www.thelancet.com).

### Panel 7.1 - Promising initiatives on impact assessment

Recently, there has been an increase in calls for testing of a broader range of study designs including theory-based, case-based studies, and participatory approaches in international development settings (Department for International Development, 2012). Beyond health, the Network of Networks for Impact Evaluation (NONIE) and the International Initiative for Impact Evaluation (3ie) support the use of study designs that enable analysis of interventions across the whole causal chain, from input to effects, and advocate the use of mixed methods for impact assessment to provide a more complete picture of effect (International Initiative for Impact Evaluation, 2010; Leeuw & Vaessen, 2009).

In an attempt to strengthen country monitoring and evaluation platforms, the UN interagency groups (eg, UN Evaluation Group, Inter-agency Group for Child Mortality Estimation, and Maternal Mortality Estimation Inter-agency Group) aim to develop new indicators, enhance capacity at country level to improve monitoring systems and strengthen data use, and harmonise work across partners on assessment and reporting of progress towards the Millennium Development Goals (MDGs). (UNICEF, 2008). Additionally, the Development Impact Evaluation Initiative by the World Bank provides technical assistance to projects and partners throughout the project cycle to ensure high-quality monitoring and effect evaluation (DIME, 2010).

One proposed approach, Health Impact Accounts (HIAs), aims to identify crucial value chains (such as infrastructure, transportation, procurement systems, etc) required for effective implementation of interventions (whether disease-specific or HSS interventions) at country-level, then apportions credit for effect to all investors, according to their relative contribution to different components of the value chain (Baeza et al., 2011).

Recent efforts, including those by International Health Partnership Plus (IHP+), have tried to improve and harmonise approaches used by donor agencies and partner countries to assess the effectiveness of development assistance for health (DAH) to: reduce demands on weak health systems for donor-specific information; strengthen transparency and enhance comparability across different donor agencies; show the contribution of health systems to improvement of health; and increase the efficiency of resource use and provide reliable estimates of benefits of DAH (Victoria et al., 2011; Baeza et al., 2011; Shorten et al., 2012; Buse, & Tanaka, 2011; Shakaishvili et al., 2011). IHP+ encourages the documentation of results and of health aid effectiveness through in-depth individual country case studies. It also advocates joint annual reviews of country health strategies, including monitoring, evaluation, and review mechanisms, based on country monitoring platforms (IHP

Plus, 2011). However, the extent to which the IHP+ support to improved monitoring of national health strategies produces improved output information that could serve as a basis for further health impact assessment remains to be established (EAGHA, 2014). Joint annual reviews by several donors would improve harmonisation and mutual accountability by aligning donor assessment and reporting with national assessment and reporting mechanisms, thereby avoiding parallel donor-specific systems (EAGHA, 2014).

We provide four suggestions to encourage agreement between donors on the principles underpinning assessment and reporting of the effect of DAH. First, approaches to assessment and reporting should mainly respond to country needs (including national governments and end beneficiaries) and emphasise mutual accountability (OECD, 2005; OECD, 2008). Country-owned monitoring and evaluation platforms need to be strengthened by external and domestic investments, and include robust additional studies. For example, a national evaluation platform that uses the district as the unit of design for natural, quasi experimental or experimental studies and is based on continuous monitoring of core indicators can provide a rigorous comparison of effectiveness of interventions and different scale-up approaches (Victoria et al., 2011; WHO Health Metrics Network, 2008). Strengthening of monitoring and evaluation platforms should include a careful appraisal of potential incentives towards biased reporting, which exist in the relationship between partner countries and donors, especially in performance oriented initiatives such as GAVI's immunization services support (ISS) (Lim et al., 2008). Such perverse incentives might affect the accuracy of the data used to assess the effect of DAH, which in turn misinforms donors and their constituencies about their progress and might counteract efforts to strengthen country monitoring and evaluation platforms. Validated and standardised instruments and sampling frames, establishing systems for quality control and periodic surveys on a range of health topics that benchmark country-reported data, could help to address biases arising from perverse incentives (Lim et al., 2008). Second, approaches to assess and report the health effects of DAH should identify the contextual factors both within and outside the health system that contribute to the observed results and might affect their wider applicability. Third, there should be greater consistency and transparency in the selection of counterfactual scenarios, taking into account potential confounding by factors such as economic growth or conversely economic shocks that can affect the determinants of health (Chee, His, Carlson, Chankova, & Taylor,, 2007). Fourth, approaches to assess and report the health effects of DAH should be adapted to different settings and needs. They should draw on a range of methods and designs dependent on what inference is likely to be made from them. They should be tested in both stable and fragile states, with coordinated approaches to monitoring sector performance that foster country ownership (e.g. the International Health Partnership Plus [IHP+] monitoring and

evaluation framework) and reduce uncoordinated multiple donor programmes (Shorten et al., 2012).

Substantial knowledge gaps in assessment of the effect of DAH exist, especially for investments in health systems. These knowledge gaps are accentuated by the absence of consensus about the definition of what constitutes HSS activities and expenditures (Shakarishvili, et al., 2011).

Methodological challenges include double counting, underestimation of the contribution of health systems to health effect, and overlooking of system-wide effects of DAH (Baeza et al., 2011; EAGHA, 2014; WHO, 2009). These challenges could undermine public confidence on the fidelity of the figures presented on the effectiveness of DAH (Baea et al., 2011). Exclusively attributing effect to disease-specific interventions supported by donor agencies could lead to channelling of greater financial support to disease-focused interventions than to HSS interventions (Baeza et al., 2011; EAGHA, 2014), which could be particularly damaging in view of the plateauing in DAH since 2010 (Shakarishvili et al., 2011; ONE, 2013; Institute for Health Metrics and Evaluation, 2012). Some studies have suggested that disease-specific interventions have potential adverse effects on the health system – e.g. distorting national health priorities and diverting health workers from other responsibilities (WHO Maximizing Positive Synergies Group, 2009; UNICEF, 2008; Rabkin, El-Sadr & De Cock, 2009; Biesma et al., 2009). However, there is paucity of empirical evidence to convincingly conclude whether the effects of disease-specific interventions on health systems have been negative or positive (Car et al., 2012). Rigorous methods are needed to assess whether negative systemwide effects of DAH, including fungibility, are a substantial problem (Korenromp et al., 2012; Lu et al., 2010). Donor agencies need to develop their own skills and competencies and work with the research community to further address the methodological challenges inherent in assessment approaches.

Improved measurement, enhanced comparability across different agencies, and strengthened transparency in assessment of the effect of DAH should give credence to the results reported by funding agencies. To advance this agenda and appraise these new approaches in more depth is crucial, in view of the large amounts of funds spent, the growing recognition of the importance of HSS interventions to achieve global health goals, and the political pressures on aid budgets at a time of economic austerity.



# **CHAPTER 8**

## **Discussion and Conclusion**

## Discussion and Conclusion

The objective of this dissertation was to gain a better understanding of the emerging European global health agenda and the *de facto* utilization of health in foreign policies. Getting better insights into the engagements of the EU and its member states in health and foreign policy has become a relevant area for public- and global health research in the 21st century.

Research performed in the context of this dissertation was therefore concerned with exploring two main issues: a) agenda setting at national and EU-level, and b) the actual health and foreign policy application in Europe. This discussion section subsequently elaborates in particular on those two aspects. While these two contexts constituted the main focus of this dissertation, it additionally investigated two particular global health issues more in detail. This included elaborations on the health workforce in a globalized world, and on improving the effectiveness of development assistance for health. Both issues are currently more topical than ever, given the observed lack of doctors during the Ebola outbreak in West-Africa, and the discussions on health financing for development in the 2030 Agenda for Sustainable Development.

### ***Agenda setting at national and EU-level***

This dissertation research approached the question pertaining to how and why global health is on the agendas in Europe on two levels, namely a review of the agenda setting processes at the EU level and a designated in depth appraisal of agenda setting processes at the national level (i.e. in the case of this dissertation, an appraisal of the agenda setting processes in Germany).

A key result from the review of the EU's agenda in view of Kingdon's theory on agenda setting was that differences in definitions and applications of global health across stakeholders, and the lack of a scientific consensus regarding scope, boundaries and areas of concern can constitute a barrier for advancing a global health agenda at the European level (Aluttis, Krafft, Brand, 2014). While a multicontextual approach to global health has been described as 'inevitable', it is exactly this multicontextuality and the broad interpretation of the term that creates difficulties for shaping effective global health policies and for gaining subsequent support from politicians. According to Kingdon (2003), a precondition for an issue to make it on an agenda (and to stay there) is that there is a general consensus among affected policy communities on the general direction that should be pursued. As Kingdon (2003) explains, policy makers often search for exactly this degree of consensus among organized political forces before deciding to act on an issue. This means that if an entire policy community provides policy makers with a convincing impetus to move in a certain direction, policy makers are actually likely to act. But if there is some conflict or disagreement among a policy community on the desired direction or

outcomes, then political leaders implicitly arrive at the conclusion that the issue at hand may be too difficult to deal with at this particular point in time. This could be the case in the European context, where stakeholders in Brussels apply different understandings of what constitutes 'global health', with some emphasizing the developmental dimensions of global health, and others focusing on interdependencies and transnational implications. On another note, Kingdon (2003) explains that for a policy to be moved forward, it must be actually feasible to reach the desired goals with the resources available. With regards to the EU Communication on Global Health, reaching the outlined objectives can be considered a very ambitious objective. Each of the four global health challenges outlined by the European Commission represents an enormous undertaking, which would require substantial efforts to be addressed successfully. The extreme complexities involved in solving one of the global health challenges, let alone all four challenges, could make policy makers and politicians very reluctant to champion the European global health agenda and to push it forward, as their successful conclusion will likely not be possible in the near future.

With regards to global health agenda setting processes at the national level, our interview study with civil servants in Germany revealed that a series of *external* developments, stakeholders and advocacy efforts created a conducive environment for the creation of the German Global Health Strategy (GGHS). The subsequent *internal processes* were characterized by a series of internal considerations struggles and capacities across the Ministries of Health, Development and Foreign Affairs, that played a decisive role during the development phase of the German Global Health Strategy (Aluttis, Clemens, Krafft, 2015). Especially the creation of additional capacities in respective departments and individual leadership were paramount for the successful development of the strategy development. Understanding these national processes and consideration that lead to the formulation of national global health frameworks is an important factor for advancing the health and foreign policy debate. However, the interview study also raised some questions regarding which national actor should take forward the implementation of the strategy. As Ministries of Foreign Affairs and Development are often endowed with more financial means than Ministries of Health, they may be more suited to follow through with implementation. However, priorities in those Ministries may not be focused so much on advancing this agenda due to a focus on health that is rather peripheral.

On a final note, while the GGHS does not have any tangible impacts on global population health outcomes, it does constitute a major step in terms of establishing visibility for Germany's priorities in a global context, and it raises Germany's profile and moral accountability as an international actor. This can ultimately contribute to good global health governance.

### ***Health and foreign policy application in Europe***

The second part of this dissertation aimed at investigating the actual incorporation of health into foreign policy at the EU level. After the Conclusions of the Council of the European Union, which stated that ‘the EU should become a relevant health and foreign policy actor’ (2010), this dissertation asked the question to what extent health actually was incorporated in the EU’s current foreign policies. This dissertation therefore reviewed the European Union’s (EU) Strategic Partnerships with the emerging powers of Brazil, Russia, India, China and South-Africa (BRICS) to explore the health and foreign policy discussions between these major global actors. The explorative character of the document review provided a starting point for appraising the complex field of health and foreign policy in a real-world setting, based on actual policy agreements between two major global players.

Following the classification by Labonte and Gagnon (2010), this dissertation found that the EU’s foreign policy with the BRICS countries addresses health predominantly in ‘health security’ and ‘health in development’ contexts (Aluttis, Hees, Pilot, Brand, and Krafft, *forthcoming*). However, this dissertation also identified additional motivations for health and foreign policy engagement, which go beyond the security and development paradigms, thereby suggesting a more nuanced EU view on health in foreign policy, including “health and trade” “global public goods”, “health as a human right” perspectives. The fact that the EU’s view on health in foreign policy at times also follows global public goods and human rights perspectives is encouraging from a health equity perspective.

The study suggests that there may be more room for further pragmatic bilateral cooperation on health issues that would be beneficial to both sides in each of the EU-BRICS partnerships. As high income countries can learn from health related innovations that emerge in less well equipped settings elsewhere (Syed, Dadwal, & Martin, 2013), the EU and its member states with its costly health systems could learn from health innovations that occur in the emerging economies. BRICS countries in turn, could gain much knowledge from the experience of 28 EU different member states health systems on ways to achieve universal health coverage in a sustainable way. Furthermore, following Kickbusch’s (2011) ‘soft power’ argument for health and foreign policy, closer collaboration between the EU and the BRICS countries on for achieving Universal Health Coverage in the BRICS countries could also contribute to strengthening cooperation mechanisms and institutional arrangements, and could ultimately improve bilateral relations in general.

This thesis also reviewed the application of health in a foreign policy context from a somewhat different angle. Accordingly, it reviewed a case where health concerns have been used as an argument to campaign *against* EU foreign policy. The EU negotiations with the United States on the Trans-Atlantic Trade and Investment partnership (TTIP) have come under a lot of pressure by civil society groups across Europe, with health and well-being concerns being central arguments of the opposi-

tion since the beginning. Accordingly, this dissertation discussed the key health arguments brought forward in the light of available information to better appraise their substance and validity. It found that the health related arguments in the discussion have a certain amount of populist tenor. However, at the core of each argument, they do carry potential implications that could have negative effects on future health care and public health related policies and processes. (Aluttis, Brand, Krafft, *forthcoming*). The review of arguments showed that EU foreign policy can nowadays be heavily scrutinized by civil society, and that health concerns can constitute a substantial argument around which large numbers of opponents can rally to advocate for policy change. The TTIP case furthermore shows that EU trade policy can nowadays be hardly made in isolation and in disregard of social or health concerns. When European health issues are seemingly at stake, it becomes very complicated for European Commission Directorates such as DG Trade to advance their agenda independently. In the light of this, it would be wise for TTIP negotiations and any future free trade discussions to not only consider potential welfare gains, but also to put European social values into the equation. Prioritizing health and social values alongside, or even above purely economic outcome measures would quickly transform public opposition to such an agreement into public support.

### ***Further global health debates***

The chapters six and seven of this dissertation were concerned with more specific health topics that are part of the broad contemporary global health discourse. Including a review of those issues in this dissertation emphasizes the fact that under the global health umbrella, research on particular public health subjects also needs to be continuously advanced from a European perspective.

Chapter six of this dissertation provided a narrative review of the literature on health workforce migration in a globalized world and emphasized that a global undersupply of health workers continues to threaten the quality and sustainability of health systems worldwide. In this context, it also shows to what extent European health systems are currently employing foreign trained doctors and nurses, pointing to underlying mechanisms that are potentially unsustainable. Given the background of the recent Ebola virus disease outbreak in West Africa, this discussion is more relevant than ever. Unsurprisingly, the countries most affected by Ebola lacked essential health worker capacities to tackle the diseases effectively from the onset. When the Ebola outbreak struck, Sierra Leone for instance only had an estimated total of 120 medical doctors in the whole country (Gostin, 2014), serving a population of six million. Additionally, its health care system had already been damaged by a decade long civil war, providing heavy incentives for doctors to leave the country in search for safety and opportunity. Concurrent with globalization and the liberalization of markets, which enable health workers to offer their services in countries elsewhere, it is possible that the Ebola crisis will also act as another 'push' factor in

its aftermath, thereby continuing to weakening health systems. This despite the fact that Sierra Leone would actually need to increase its workforce 20 times to meet a minimum threshold for an adequate health workforce (Gostin, 2014).

Existing 'push' and 'pull' factors need to be thoroughly addressed by European policy makers, including a better understanding of those 'pull' factors created at the member state level. Subsequently, this understanding needs to be incorporated into coherent policy making when trying to prevent future crises such as Ebola from occurring. A first step for policy makers at national level would be the full implementation and adherence to WHO's Code of Practice, which provides a framework for ethical workforce recruitment that does not harm the health system of the sending country. The current practice by many high income countries to fill their staff needs by recruiting from elsewhere constitutes an unsustainable, unjust, and in the case of Ebola, deadly, practice.

With regards to the aid effectiveness debate in chapter seven, this dissertation suggests that there are methodological challenges in establishing a relation between development assistance for health (DAH) and actual health outcomes. The validity of the results presented by major funding agencies can be questioned because of weaknesses in models used to estimate outcomes, in appropriate counterfactuals, and overgenerous assumptions of investment effects. Especially assessing the health effects of health systems strengthening (HSS) interventions is particularly challenging, because of the complex causal pathways through which these interventions are likely to have an effect on health systems. The subsequent recommendations and discussion on using appropriate methods to measure the effectiveness of health aid is more relevant than ever, given current discussions and processes towards the implementation of the Sustainable Development Goals (SDG) and the outcomes of the 3rd Financing for Development Conference held in Addis Ababa in June 2015. Major players such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the Gavi vaccine alliance (Gavi) are continuously in need to reassess their funding principles and methodologies in order to justify towards their constituents that their financial contributions are spent in the most effective and efficient way. Both organizations also acknowledged that measuring the effects of aid for health system strengthening remains a grand challenge and that more work needs to be performed in order to improve effective policies and practices.

## ***Implications from this dissertation for research and practice***

### *Implications for research*

While ‘global health’ related research and education seems to be on the rise in Europe, only a small number of academics are actually concerned with the European dimension of it, and empiric studies with a ‘Global Health Europe’ focus are sparse. This dissertation provided some groundwork for the field by describing the agendas of the EU and its largest member state, and by appraising and pointing to various health and foreign policy linkages. But this dissertation can only be a starting point. Linking global health to EU policies, objectives and actions, and understanding the contributions that Europe makes (and can make) requires much more empiric work and analysis. Academics and organizations interested in the European role for global health therefore should set up corresponding research activities and should engage in a more intensive dialogue among each other, as well as with civil society and decision makers on this issue.

Accordingly, a large number of follow-up research questions could be derived from the studies performed in this dissertation. Table 8.1 provides a non-exhaustive overview of both descriptive and normative questions that could be investigated. Such questions are not exclusive to public health researchers, but could be addressed by researchers from all relevant disciplines, including development-, environment-, European studies, law, and economics. A larger and multifaceted research community could create a stronger research base on which a coherent European approach to the global health issues of our time could be created.

**Table 8.1 - Suggestions for further research**

Potential questions for further research:

- Can the current understanding of Global Health terminology in Europe be mapped? Is there a need for a more distinct European understanding of 'Global Health'? If so, what should it look like?
- What are the global health priorities of the member states? How do member states align their current foreign policy priorities with health?
- How- and on which specific (global) health issues should the EU seek to cooperate with BRICS countries more strongly?
- How could a European trade policy be created that is coherent in its approach towards positive social- and health promoting outcomes? How can bilateral trade agreements make a positive contribution to global population health?
- In the wake of the Ebola crisis, what can Europe learn from the crisis, and how can European policies actively contribute to preventing such crises in the future?
- How do European countries perform with regards to the implementation of the WHO Code of Conduct on Workforce Recruitment?
- How can the EU as one of the largest global donors contribute to achieving better health aid-effectiveness?

*Implications for policy and practice*

One of the main foci of this dissertation was to review various policy documents and governmental activities in global health. Corresponding results from such a research approach should ideally provide some implications for policy and practice. Accordingly, a number of implications can be derived from the research performed for this dissertation. The following section addresses three points which should be addressed in particular. Firstly, one of the main insights of the application of Kingdon's theory to global health in a European context was that the large fragmentation of the European global health community is not supportive to pushing global health on the EU agenda. The dissertation argued that a more coherent understanding and a more straightforward conceptualization of what Europe's role in global health should be would enhance the chances of global health issues becoming more important agenda items at the EU level. The creation of the European Academic Global Health Alliance (EAGHA) in 2011 has already been a good first step in strengthening a coherent European research perspective in this respect. The alliance was formed by universities to bring together International Health/Tropical Medicine and Public Health institutions and 'to develop a European voice on Global Health issues', and, more importantly, 'to influence relevant policies' (EAGHA, 2012). Such systematic

collaboration among European research groups can be considered a good start for advancing the European global health agenda in a coherent way and to subsequently advocate for evidence based policies at the European level.

Secondly, global health capacity building at the national level for both research and policy should remain of high priority. This dissertation has shown in chapter three that in the case of Germany, additional capacities and proactive engagement in the respective Ministries were crucial for advancing the global health agenda. Hence, capacity building at member state level should be an important entry point for strengthening national global health agendas. Currently, there seems to be momentum to advocate to governments to move towards strengthening their institutional capacities for health and foreign policy. Events such as the West-African Ebola outbreak, which to this date concerns politicians at the highest political levels, the 2015 Middle East respiratory syndrome (MERS) outbreak in South Korea, or the increasing realization (including by the G7) that antimicrobial resistance poses a risk to European member states have the potential to elevate health higher on the agenda of foreign policy makers and to provide an impetus for governments to act. In line with recommendations given by Kickbusch in the context of Germany (2012), potential action at for governments in Europe could include: increasing the global health capacities in their respective Ministries, increasing global health research and education finances, engaging in a systematic dialogue with civil society and creating inter-ministerial committees to coordinate health actions across governmental departments to strengthen coherent approaches to global health. Achieving these issues should be on the agenda of global health advocates both within and outside governments to strengthen national global health discourses.

Thirdly, the European Parliament (2011) stressed that „the EU and its Member States need to act more strategically so as to bring Europe’s true weight to bear internationally”. In relation to the research performed in chapter four of this dissertation, the EU could consider reevaluating its current bilateral engagement with the BRICS countries. The rise of the BRICS as a political group could have substantial implications for global health governance. Some experts, including WHO’s Director Margaret Chan, believe that future collective BRICS action can have substantial impact on global health processes (WHO, 2011). Given the fact that BRICS are possibly further aligning and increasing their political leverage in global health deliberations, the EU should consider the implications of such a scenario and should at least consider complementing its current approach of bilateral engagement through a solid common BRICS policy. As current BRICS agreements on global health priorities already point to diverging viewpoints and interests to those of the EU, it would be advisable to proactively enter a discussion with this emerging bloc of global players, and to take into consideration their common views and interests. The currently experienced shift in global power relations towards BRICS should therefore not be

regarded as a challenge, but rather as a distinctive opportunity for an effective EU-BRICS interaction and cooperation.

### ***Final remarks***

It is evident that one PhD dissertation cannot provide a comprehensive and all-encompassing answer to the question of '*what Europe should be doing in the field global health*'. The difficulty in answering this question lies not only in the normative nature of this question, but is also due to the fact that both the EU as an actor, and global health as a research field are extremely complex and multifaceted. This dissertation therefore does not (and cannot) provide a conclusive answer to what the EU and its External Action Service should be doing with regards to their global health activities. Instead, it makes some relevant fundamental contributions that bring us closer to answering the above question. By answering various sub-questions pertaining to the EU's role in global health, it contributes to the still relatively scarce knowledge base in this field and gives some insights into the health and foreign policy linkages at the EU- and national level.

# **VALORIZATION ADDENDUM**

## VALORIZATION ADDENDUM

The ‘valorization’ of research findings has been considered an increasingly important element for all research activities at Maastricht University. Essentially, valorization refers to increasing the impact of research findings and enhancing their benefit to society. Accordingly, thinking about the benefits of scientific activity in economic, social or environmental terms can create more legitimacy and added value to academic research. According to the understanding of this doctoral research, valorization can thus be defined as: “a process that can support the utilization of scientific knowledge in practice”. This valorization addendum is therefore first and foremost a thinking exercise on the question of how the research results generated by this dissertation can yield benefits to society beyond its value to the scientific community.

### ***Suggested approach for the valorization of this dissertation’s research findings:***

This thesis provides some valuable insights into global health issues from a European perspective. Due to the fact that the definition and understanding of Europe as a global health actor is currently only emerging, this has been one of the first PhD dissertations on this subject. The research activities and outcomes that have contributed to this PhD dissertation are thus unique and provide a few possibilities for valorization. In the following paragraphs we outline two pathways through which it is possible to use this dissertation for more societal impact.

#### *1 Providing courses and lectures to global health curricula in Europe and beyond.*

Academic global health programs around the world are growing rapidly in scale and number. Also in Europe, various academic institutions in Europe have started offering curricula with global health concepts at the core of their teachings. Within those curricula, the role of EU institutions as global health stakeholders is often not taught at all. However, students in Europe nowadays should have a basic understanding of the role of the EU, its institutions, mandate and activities in relation to global health matters. Based on our research, and coupled with our educational competencies, we could set up a flexible 4-8 week module for universities that are teaching global health. This could even be free of service, as part of an online course on global health essentials in Europe. The content for this kind of valorization would not only derive from this dissertation’s research results, but also from the background research that was required to compile it. As our research can be considered an early step in an evolving field it is important to educate further about this field, so that students and future researchers will build on it and take it forward.

## *2 Strengthening the think tank on Global Health Europe.*

During the writing of this dissertation the author has already taken up a role in the valorization of research by getting involved in a think tank for European engagement in global health, entitled „Global Health Europe“. This think tank is a collaborative effort between selected academic institutions in Europe with the aim to ‘promote synergies between the policy spheres of public health, foreign policy, development and research for Europe in a global context’ (Global Health Europe, 2009). Accordingly, this think tank aims at bringing together the leading experts in European engagement on global health and to create and communicate knowledge to policy- and decision makers.

So far, the think tank has mainly been concerned with organizing Global Health Europe related events, and publishing relevant think pieces on the issue. Another central element to this endeavour is the administration of a dedicated website entitled [www.globalhealthurope.org](http://www.globalhealthurope.org), through which the research team communicates developments and important aspects to the public as well as to academics and other stakeholders. Notably, typing the search words “global health” and “Europe” into google yields the abovementioned website as one of the top hits, directing every individual directly to this think tank. This is an easy and cost-effective way to communicate research results to a wider audience and provides an entry point for interested stakeholders.



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# APPENDICES

## APPENDICES

### CHAPTER 3: Annex 3.1 - Overview of Joint Statements consulted on their health content

	Documents consulted during review (in chronological order)	Year
<b>Brazil</b>	1 <sup>st</sup> Brazil-European Union Summit, Lisbon; Joint Statement	2007
	2 <sup>nd</sup> Brazil-European Union Summit, Rio de Janeiro; Joint Statement	2008
	3 <sup>rd</sup> Brazil-European Union Summit, Stockholm; Joint Statement	2009
	4 <sup>th</sup> Brazil-European Union Summit, Brasilia; Joint Statement	2010
	5 <sup>th</sup> Brazil-European Union Summit, Brussels; Joint Statement	2011
	6 <sup>th</sup> Brazil-European Union Summit, Brasilia; Joint Statement	2013
	7 <sup>th</sup> EU-Brazil Summit, Brussels; Joint Statement	2014
<b>Russia<sup>17</sup></b>	5 <sup>th</sup> Russia-European Union Summit, Moscow; Joint Statement	2000
	6 <sup>th</sup> Russia-European Union Summit, Paris; Joint Statement	2000
	7 <sup>th</sup> Russia-European Union Summit, Moscow; Joint Statement	2001
	9 <sup>th</sup> Russia-European Union Summit, Moscow; Joint Statement	2002
	10 <sup>th</sup> Russia-European Union Summit, Brussels; Joint Statement	2002
	11 <sup>th</sup> Russia- European Union Summit, St.-Petersburg; Joint Statement	2003
	12 <sup>th</sup> Russia-European Union Summit, Rome; Joint Statement	2003
	14 <sup>th</sup> Russia- European Union Summit, The Hague; Joint Press Release	2004
	15 <sup>th</sup> Russia- European Union Summit, Moscow; Joint Statement and Road Map	2005
	16 <sup>th</sup> Russia- European Union Summit, London, Joint Statement	2005

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<sup>17</sup>Despite the fact that more than 30 Summits were held between the EU and Russia, Joint Statements were largely not publicly accessible. Our analysis for Russia is therefore limited.

	17 <sup>th</sup> Russia-European Union Summit, Joint Press Conference Sochi	2006
	19 <sup>th</sup> Russia-European Union Summit, Samara, Joint Press Conference	2007
	20 <sup>th</sup> Russia-European Union Summit, Mafra, Joint Press Conference, Mafra	2007
	21 <sup>st</sup> Russia- European Union Summit on cross border cooperation, Khanty-Mansiysk; Joint statement	2008
	22 <sup>nd</sup> Russia-European Union Summit, Nice, Joint Press Release	2008
	25 <sup>th</sup> Russia-European Union Summit, Rostov-on-Don, Joint Statement	2010
	26 <sup>th</sup> Russia-EU Summit, Brussels, Joint Press Statement	2010
	27 <sup>th</sup> Russia-EU Summit, Nizhny Novgorod, Press Statement	2011
	28 <sup>th</sup> Russia-EU Summit, Brussels, Press Release	2011
	30 <sup>th</sup> Russia-EU Summit, Brussels, Common Press conference	2012
	31 <sup>st</sup> Russia-EU Summit, Yekaterinburg, Press conference	2013
<b>India</b>	1 <sup>st</sup> India-European Union Summit, Lisbon; Joint Declaration	2000
	2 <sup>nd</sup> India-European Union Summit, New Delhi; Joint Communiqué	2001
	3 <sup>rd</sup> India-European Union Summit, Copenhagen; Joint Press Statement	2002
	4 <sup>th</sup> India-European Union Summit, New Delhi; Joint Press Statement	2003
	5 <sup>th</sup> India-European Union Summit, The Hague; Joint Press Statement	2004
	6 <sup>th</sup> India-European Union Summit, New Dehli; Joint Action Plan	2005
	7 <sup>th</sup> India-European Union Summit, Helsinki; Joint Statement	2006
	8 <sup>th</sup> India-European Union Summit New Delhi; Joint Statement	2007
	9 <sup>th</sup> India-European Union Summit, Marseille; Joint Statement	2008
	10 <sup>th</sup> India-European Union Summit, New Delhi; Joint Statement	2009
	11 <sup>th</sup> India-European Union Summit, Brussels; Joint Statement	2010
	12 <sup>th</sup> India-European Union Summit, New Delhi; Joint Statement	2012

<b>China</b>	4 <sup>th</sup> China-European Union Summit Brussels; Joint Press Statement	2001	
	5 <sup>th</sup> China-European Union Summit Copenhagen; Joint Press Statement	2002	
	6 <sup>th</sup> China-European Union Summit Beijing; Joint Press Statement	2003	
	7 <sup>th</sup> China-European Union Summit The Hague; Joint Statement	2004	
	8 <sup>th</sup> China-European Union Summit Brussels; Joint Statement	2005	
	9 <sup>th</sup> China-European Union Summit Helsinki; Joint Statement	2006	
	10 <sup>th</sup> China-European Union Summit Beijing; Joint Statement	2007	
	11 <sup>th</sup> China-European Union Summit Prague; Joint Press Statement	2009	
	12 <sup>th</sup> China-European Union Summit Nanjing; Joint Statement	2009	
	13 <sup>th</sup> China-European Union Summit Brussels; Joint Press Communiqué	2010	
	14 <sup>th</sup> China-European Union Summit Beijing; Joint Press Communiqué	2012	
	15 <sup>th</sup> China-European Union Summit Brussels; Joint Press Communiqué	2012	
	16 <sup>th</sup> EU-China Summit Beijing; Joint Press release	2013	
	<b>South-Africa</b>	1 <sup>st</sup> South Africa-European Union Summit Bordeaux; Joint Statement	2008
		2 <sup>nd</sup> South Africa-European Union Summit Kleinmond; Joint Statement	2009
		3 <sup>rd</sup> South Africa-European Union Summit Brussels; Joint Communiqué	2010
4 <sup>th</sup> South Africa-European Union Summit South Africa; Joint Communiqué		2011	
5 <sup>th</sup> South Africa-European Union Summit Brussels; Joint Communiqué		2012	
6 <sup>th</sup> South Africa-European Union PRE-Summit Pretoria; Joint Communiqué		2013	

**CHAPTER 5: Annex 5.1: Non-exhaustive selection of health related headlines & statements in the public debate on TTIP**

**Health related headlines & statements in the public debate around TTIP**

2. *"Could TTIP threaten healthy sustainable diets?"* [Eating Better, 03-03-2015]
3. *"Covert US-EU Trade Deal Could Make NHS Privatization Irreversible – Trade Unions"* [Open Health News, 10.09.2014]
4. *"TTIP must not 'wipe out' social and health rights in Europe"* [The Parliament magazine, 25.06.2014]
5. *"Negotiators struggle to find benefits for public health in TTIP"* [EurActiv, 08.09.2014]
6. *"TTIP: Health sector braced for 'damage control'"* [EurActiv, 07.10.2013]
7. *"TTIP: Healthy profits, but what about people?"* [NewScheintist, 03.11.2014]
8. *"Report: transatlantic trade agreement could increase toxic pesticide use"* [the guardian, 07.01.2015]
9. *"European Activists Say They Don't Want Any U.S. 'Chlorine Chicken'"* [npr, 30.09.2014]
10. *"Europeans Say 'No Thanks' To American Chlorinated Chicken And Hormone Beef"* [mintpressnews 19.02.2014]
11. *"TTIP and Food Safety: Why transatlantic negotiators worry about another chicken war"* [The Gloablist, 02.10.2014]
12. *"NGO alliance warns TTIP regulatory cooperation will lower EU food standards"* [EU food law, 11.02.2015]
13. *"TTIP: A lose-lose deal for food and farming"* [corporate Europe observatory]
14. *"New study: How TTIP brings pesticides into baby food"* [translated from a German website, blog.campact, 15.01.2015]
15. *"TTIP: Free trade for pesticides?"* [Pesticide Action network, 22.01.2015]
16. *"TTIP: turning Bees into has Beens?"* [agricultural and rural convention, 22.01.2015]
17. *"TTIP: already disrupting Europe's precautionary principle?"* [agricultural and rural convention, 10.08.2014]
18. *"NGO says pesticide industry using TTIP to weaken EDC regulation"* [Chemical Watch, 12.01.2015]
19. *"Report Says TTIP Would Undermine Toxic Pesticide Regulations"* [Manufacturing.net, 20.01.2015]
20. *"Trading away access to medicines"* [Oxfam, 29.09.2014]

**CHAPTER 5: Annex 5.2: Overview of service sectors to be excluded from CETA (selected countries and the EU)**

Country	Issues	Health Sector related?
Exclusions Mentioned by the EU	<ul style="list-style-type: none"> <li>- Rules remain for current and future EU re-search programmes</li> <li>- For agricultural markets, MS shall buy cereals which have been harvested in the EU</li> <li>- Accounting and Auditing services</li> <li>- Postal services</li> <li>- Supporting services for air transport, Rental of aircraft</li> <li>- Maritime and inland waterway transport</li> <li>- Rail transport</li> <li>- Other transport services (provision of combined transport services)</li> <li>- Customs Clearance Services</li> </ul>	<ul style="list-style-type: none"> <li>- National decision making power over the selling and disposing of health, social and educational services to national providers remains allowed</li> </ul>
Exclusions mentioned by <b>Austria</b>	<ul style="list-style-type: none"> <li>- Acquisition, purchase, rental or leasing of real estate</li> <li>- Executives (e.g. managing directors) responsible for the observance of the Austrian Trade Act (Gewerbeordnung) must be domiciled in Austria for all sectors</li> <li>- Legal services</li> <li>- Accounting and bookkeeping services, Auditing services, Taxation advisory services</li> <li>- Higher education services</li> <li>- Ski School &amp; Mountain guide services</li> <li>- Water Transport, Supporting Services for Water Transport</li> <li>- Road Transport: Passenger Transportation, Freight Transportation, International Truck transport services</li> <li>- Pipeline transport</li> <li>- Transmission and distribution of electricity</li> <li>- Veterinary services</li> </ul>	<ul style="list-style-type: none"> <li>- Medical services</li> <li>- Retail sales of tobacco</li> <li>- Retail sales of pharmaceutical, medical and orthopaedic goods, other services provided by pharmacists</li> <li>- Insurance and insurance related services</li> </ul>
Exclusions mentioned by <b>Belgium</b>	<ul style="list-style-type: none"> <li>- Mining</li> <li>- Legal services</li> <li>- Architectural services and urban planning / landscaping</li> <li>- Placement services of personnel</li> <li>- All sorts of marine activity</li> <li>- Supporting services for air transport, rental of aircraft</li> </ul>	<ul style="list-style-type: none"> <li>- None</li> </ul>
Exclusions mentioned by <b>Croatia</b>	<ul style="list-style-type: none"> <li>- Acquisition of real estate</li> <li>- Legal services</li> <li>- Accounting, auditing and bookkeeping services</li> <li>- Architectural services and engineering services</li> <li>- Real estate services</li> <li>- Veterinary services</li> </ul>	<ul style="list-style-type: none"> <li>- Retail sale of pharmaceuticals and retail sales of medical and orthopaedic goods</li> <li>- Hospital services,</li> <li>- Ambulance services,</li> <li>- Residential health facilities other</li> </ul>

	<ul style="list-style-type: none"> <li>- Related scientific and technical consulting services</li> <li>- Hotels and Restaurants, Travel Agencies and Tour Operators Services (including tour managers), Tourist guides services</li> <li>- Ski school services, Mountain Guide Services</li> <li>- Marine activities</li> <li>- Maritime transport services and Services auxiliary to all modes of supply</li> </ul>	<ul style="list-style-type: none"> <li>- than hospital services</li> <li>- Insurances</li> </ul>
Exclusions mentioned by <b>Cyprus</b>	<ul style="list-style-type: none"> <li>- Acquisition of real estate</li> <li>- Extraction of crude petroleum and natural gas</li> <li>- Legal services</li> <li>- Accounting and bookkeeping services, Auditing services, Taxation advisory services</li> <li>- Technical testing and analyses</li> <li>- Travel Agencies and Tour Operators Services (including tour managers Tourist Guide Services)</li> <li>- Marine activities</li> </ul>	<ul style="list-style-type: none"> <li>- None</li> </ul>
Exclusions mentioned by <b>Finland</b>	<ul style="list-style-type: none"> <li>- Mining, Services incidental to mining, Engineering related scientific and technical consulting services, Ore mining</li> <li>- Reindeer husbandry</li> <li>- Cross-Border Services</li> <li>- Legal services</li> <li>- Auditing Services</li> <li>- Translation Services</li> <li>- Funeral, cremation and undertaking services</li> <li>- Marine activities</li> <li>- Supporting Services for Water Transport</li> </ul>	<ul style="list-style-type: none"> <li>- None</li> </ul>
Exclusions mentioned by <b>Germany</b>	<ul style="list-style-type: none"> <li>- Newspapers, journals: Each publicly distributed and/or printed newspaper, journal, or periodical must clearly indicate a "responsible editor", who may be required to be a permanent resident of Germany, the EU or an EEA country</li> <li>- Legal services</li> <li>- Legal services: Patent lawyers</li> <li>- Accounting services, Auditing services</li> <li>- Supply services of support personnel</li> <li>- Marine activities</li> <li>- Water Transport, Supporting Services for Water Transport, Rental of ships, leasing services of ships without operators</li> <li>- Veterinary services</li> </ul>	<ul style="list-style-type: none"> <li>- Medical Services,</li> <li>- Dental Services,</li> <li>- Midwives services,</li> <li>- Services provided by nurses</li> <li>- Human health and Social Care services, hospitals, ambulance services, rescue services</li> <li>- Retail sales of pharmaceutical, medical and orthopaedic goods</li> </ul>
Exclusions mentioned by <b>Greece</b>	<ul style="list-style-type: none"> <li>- Acquisition of real estate</li> <li>- Legal services</li> <li>- Auditing Services</li> <li>- Primary Education Services, Secondary Educa-</li> </ul>	<ul style="list-style-type: none"> <li>- Services provided by Nurses, Physiotherapists and Paramedical Personnel</li> <li>- Retail sales of pharmaceutical,</li> </ul>

	<ul style="list-style-type: none"> <li>tion Services</li> <li>- Higher Education Services</li> <li>- Tourist Guides Services</li> <li>- Marine activities</li> <li>- Supporting Services for Water Transport</li> <li>- Operators of road freight transport services</li> <li>- Veterinary Services</li> </ul>	<ul style="list-style-type: none"> <li>medical and orthopaedic goods</li> <li>- Insurance and insurance-related services</li> </ul>
Exclusions mentioned by <b>Luxembourg</b>	<ul style="list-style-type: none"> <li>- Legal services</li> <li>- Marine activities</li> </ul>	<ul style="list-style-type: none"> <li>- Retail sales of pharmaceutical, medical and orthopaedic goods</li> </ul>
Exclusions mentioned by <b>Malta</b>	<ul style="list-style-type: none"> <li>- Acquisition of real estate</li> <li>- Legal services</li> <li>- Higher education services, Adult education services</li> <li>- Water Transport, Supporting Services for Water Transport</li> <li>- Other transport services</li> <li>- Electricity</li> </ul>	<ul style="list-style-type: none"> <li>- Retail sales of pharmaceutical, medical and orthopaedic goods</li> </ul>
Exclusions mentioned by <b>the Netherlands</b>	<ul style="list-style-type: none"> <li>- Customs Clearance Services</li> <li>- Legal services</li> <li>- Services by patent agents</li> <li>- Hallmarking services</li> <li>- Marine activities</li> <li>- Electricity Distribution, Transportation of Natural Gas</li> <li>- Extraction of crude petroleum and natural gas</li> <li>- Veterinary Services</li> </ul>	<ul style="list-style-type: none"> <li>- None</li> </ul>
Exclusions mentioned by <b>Poland</b>	<ul style="list-style-type: none"> <li>- Acquisition of real estate</li> <li>- Nationality condition for the editor-in-chief of newspapers and journals</li> <li>- Types of establishment</li> <li>- Legal services</li> <li>- Auditing services</li> <li>- Translation and Interpretation Services</li> <li>- Supporting Services for Air Transport</li> <li>- Production, transmission and distribution of electricity, Bulk storage services of liquids or gases, Services Incidental to Energy Distribution, Wholesale or retail of electricity</li> <li>- Veterinary Services</li> </ul>	<ul style="list-style-type: none"> <li>- Insurance and insurance-related services</li> </ul>
Exclusions mentioned by <b>Spain</b>	<ul style="list-style-type: none"> <li>- Administrative authorisation is required for foreign investment in activities directly related to real estate investments for diplomatic missions by States that are not members of the European Union</li> <li>- Legal services</li> <li>- Auditing Services</li> <li>- Intellectual property attorney</li> <li>- Higher Education Services</li> <li>- Tourist Guides Services</li> </ul>	<ul style="list-style-type: none"> <li>- Retail sales of tobacco</li> <li>- Retail sales of pharmaceutical, medical and orthopaedic goods</li> <li>- Insurance and insurance-related services</li> </ul>

	<ul style="list-style-type: none"> <li>- Marine activities</li> <li>- Veterinary Services</li> </ul>	
<p>Exclusions mentioned <b>by the UK</b></p>	<ul style="list-style-type: none"> <li>- Legal services</li> <li>- Extraction of petroleum and gas, mining</li> <li>- Marine activities</li> <li>- Veterinary services</li> </ul>	- None



# **SUMMARY / SAMENVATTING**

## SUMMARY

During the past decade, 'global health' has become a buzzword in policy, research and practice and an increasing number of European governments and institutions are scaling up their activities under a 'global health' terminology. National global health concepts have for instance emerged in Switzerland in 2006 (updated in 2012), the United Kingdom (2008), and Germany (2013). Global health has also been featured prominently at the European Union (EU) level through a European Commission (EC) Communication in 2010 which provided an initial policy framework for the EU to act on global health matters. The fact that the EC provided a policy framework for the EU to act in matters of global health points to a newly emerging policy field at European level. The concurrent occurrence of a scientific discourse on the global dimensions of public health and the EU's self-proclaimed role as a global (health) actor created a need for a new dimension of European Public Health research, namely one that links the scientific global health agenda with a European perspective. This dissertation therefore is situated between the nexus of global health- and European Public Health research.

This dissertation provides a series of separate scholarly papers that all address different facets of global health in a European context. The overarching goal and objective of this dissertation is twofold:

1. to identify and appraise global health agenda setting processes at both national- and EU-level. Questions with regards to 'how' and 'why' global health has made it on the agendas of an EU member state and the EU itself can reveal important insights for current and future policy processes related to global health and health and foreign policy;
2. to explore how health is de facto incorporated into the foreign policy of the EU. As empiric knowledge on the factual integration of health into foreign policy is scarce, this dissertation aims to make a contribution to filling this knowledge gap.

Accordingly, **CHAPTER 1** gives a general introduction to the topic and clarifies some key concepts relevant for this dissertation. In particular the multifaceted use of 'global health' as a concept is elaborated upon. Also the link between health and foreign policy is discussed and clarified for the context of this dissertation. The chapter furthermore outlines the main objectives of this dissertation.

**CHAPTER 2** answers the question of 'why global health was initially identified as a relevant agenda item at EU-level, and why it has, in recent years, lost some of its momentum'. It does so by reviewing key documents and processes in light of Kingdon's Multiple Streams Theory on agenda setting. The review ultimately gives an overview of the European perspective on global health, starting out by describing

the developments that have led to the EU acknowledging its role as a global health actor. The article then focusses in particular on the European interpretation of its role in global health from 2010, which was formalised through a European Commission Communication and Council of the European Union Conclusions. Departing from there, and based on Kingdon's Multiple Streams Theory on agenda setting, the chapter identifies some barriers that seem to hinder the further establishment and promotion of a solid global health agenda in the EU. The main barriers for creating a strong European global health agenda are the fragmentation of the policy community and the lack of a common definition for global health in Europe. The chapter closes by making some recommendations on how to move the European global health agenda forward.

**CHAPTER 3** answers the question of 'why Germany, the largest member state of the EU, has decided to establish a national policy framework for global health at this point in time, and how the development process has taken place'. Semi-structured interviews were performed, with German civil servants responsible for drafting and publishing the German Global Health Strategy (GGHS) in 2013. This chapter therefore reports on the results of those semi-structured interviews. It shows that a series of external developments, stakeholders, and advocacy efforts created an environment conducive to the creation of the strategic document. In addition, a number of internal considerations, struggles and capacities played a decisive role during the development phase of the GGHS. Understanding these factors better can not only provide substantial insights into global health related policy processes in Germany, but also contribute to the general discourse on the role of the nation state in global health governance.

**CHAPTER 4** investigates 'to what extent health is *de facto* included in EU foreign policies', by reviewing the EU's foreign policy relations with the BRICS countries (i.e. Brazil, Russia, India, China and South Africa). While the association between foreign policy and health has been intensely discussed among scholars, only little empirical research has been performed on the actual integration of health issues into current foreign policy deliberations. By performing a quantitative and qualitative content analysis of key documents, it finds that health plays a small, albeit consistent role in the relations, predominantly addressed in contexts of 'health security' and 'health in development'. While the chapter's findings confirm the assumption that these drivers are particularly dominant in health and foreign policy discourse, it also identifies additional motivations for health and foreign policy engagement, which suggests the need for a more nuanced view on the health and foreign policy nexus.

**CHAPTER 5** uses the current TTIP discourse as a case study to highlight two main issues in the health and foreign policy debate. Firstly, it shows that health issues are being used as an argument in the public domain to prevent EU foreign policy. Secondly, it reviews popular public health arguments against the agreement in view of their validity. To achieve this, it compares the publicly made arguments with availa-

ble TTIP documents and with the published final text of the Canada-EU trade agreement (CETA), which has been viewed as a forerunner and model treaty for TTIP. Accordingly, it finds that some of the popular claims are unsupported at face value. However, a more in depth elaboration on the issues reveals that the devil is in the details and that the TTIP agreement does in fact comprise a series of issues that could have a negative effect on future health care and public health related policy processes.

**CHAPTER 6** illustrates an unresolved global health problem, which resonates well with our global health definition of mutual interdependencies - and the subsequent need for national, international and intersectorial action. It provides a review of the contemporary global health workforce migration phenomenon and tries to establish an overview of the scope of the migration and respective patterns, including the role of European countries in this. It further focuses on both positive and negative effects of all actors involved in both high- and low-income countries. Accordingly, it elaborates on the international community's approach to solving the workforce crisis in an interdependent world, focusing in particular on the WHO Code of Practice, established in 2010.

The idea for **CHAPTER 7** originated during an event in Brussels in 2012, convened by the EU, to address the problem of assessing and measuring the effectiveness of Development Assistance for Health (DAH). The paper subsequently reviews current practices and suggests that there are methodological challenges in establishing a relation between DAH and actual health outcomes. The validity of the results presented by major funding agencies can subsequently be questioned because of weaknesses in models used to estimate outcomes, in appropriate counterfactuals, and overgenerous assumptions of investment effects. Especially assessing the health effects of health systems strengthening interventions is particularly challenging, because of the complex causal pathways through which these interventions are likely to have an effect on health systems. Accordingly, the chapter makes some recommendations on how to improve the assessment and reporting of the effects of development assistance for health.

**CHAPTER 8** provides a general integration and discussion of the findings from the previous chapters. It then moves on to provide some relevant implications for both research and practice.

## SAMENVATTING

### **Mondiale gezondheid, buitenlands beleid, en agendavormingsprocessen: De Europese Unie als een mondiale gezondheidsactor**

Tijdens het afgelopen decennium is 'global health' ('mondiale gezondheid') uitgegroeid tot een modewoord in beleid, onderzoek en praktijk. Bijgevolg werkt een toenemend aantal Europese overheden en instellingen aan schaalvergroting van hun activiteiten in het kader van een 'global health' terminologie. Nationale concepten rond 'global health' zijn bijvoorbeeld ontstaan in Zwitserland in 2006 (bijgewerkt in 2012), het Verenigd Koninkrijk (2008) en Duitsland (2013). 'Global health' is ook prominent op het niveau van de Europese Unie (EU), via een Europese Commissie (EC) Communicatie in 2010, waarin een eerste beleidskader voor de EU werd opgesteld om in kwesties van mondiale gezondheid op te treden. Het feit dat de EC een eerste beleidskader heeft geschetst zodat de EU kan handelen bij mondiale gezondheidsaangelegenheden wijst op een nieuw opkomend beleidsterrein op Europees niveau. Het gelijktijdig plaatsvinden van een wetenschappelijk discours over de mondiale dimensies van volksgezondheid en EU's zelfverkleerde rol als mondiale (gezondheids-) actor creëerde een vraag naar een nieuwe dimensie van 'European Public Health' onderzoek, dat wil zeggen een perspectief dat de wetenschappelijke mondiale gezondheidsagenda verbindt met een Europees perspectief. Dit proefschrift plaatst zich daarom op de nexus tussen onderzoek naar mondiale gezondheid en Europese volksgezondheid. De algemene doelstelling van dit proefschrift is om een meer gedetailleerd inzicht te verschaffen in de Europese mondiale gezondheidsagenda en bij te dragen tot een beter begrip hiervan. Het tracht enkele fundamentele bijdragen te leveren rond de vraag naar wat de rol van de EU is in mondiale gezondheid, zowel als wat deze zou moeten zijn. Meer concreet, kunnen de twee hoofddoelstellingen van dit proefschrift als volgt worden beschreven:

- Het identificeren en evalueren van agendavormingsprocessen voor mondiale gezondheid op zowel nationaal als EU-niveau. Vragen betreffende 'hoe' en 'waarom' mondiale gezondheid tot de agenda van een EU-lidstaat en de EU zelf is doorgedrongen, kunnen belangrijke inzichten verschaffen voor huidige en toekomstige gerelateerde beleidsprocessen;
- Het verkennen hoe gezondheid de facto wordt opgenomen in het buitenlands beleid van de EU. Aangezien empirische kennis over de feitelijke integratie van gezondheid in het buitenlands beleid schaars is, heeft dit proefschrift tot doel een bijdrage te leveren aan het opvullen van deze kennislacune.

Bijgevolg geeft **HOOFDSTUK 1** een algemene introductie van het onderwerp en verduidelijkt een aantal hoofdconcepten die relevant zijn voor dit proefschrift. Voornamelijk wordt het veelzijdige gebruik van 'global health' als concept uitgewerkt. Ook wordt het verband tussen gezondheid en buitenlands beleid besproken en toegelicht in de context van dit proefschrift. Hoofdstuk 1 geeft bovendien de belangrijkste doelstellingen van dit proefschrift weer.

**HOOFDSTUK 2** geeft een studie weer van de mondiale gezondheidsbeleidsprocessen op EU-niveau, waarbij de vraag 'hoe mondiale gezondheid een plek heeft ingenomen op de agenda van de EU' behandeld wordt. Dit gebeurt door het bestuderen van belangrijke documenten en processen in het licht van Kingdon's Multiple Streams Theory over agendavorming. De studie geeft uiteindelijk een overzicht van het Europese perspectief op mondiale gezondheid, beginnend met een beschrijving van de ontwikkelingen die geleid hebben tot het door de EU erkennen van haar rol als mondiale gezondheidsactor. Het artikel richt zich vervolgens in het bijzonder op de Europese interpretatie van haar rol in mondiale gezondheid sinds 2010, die geformaliseerd werd via, respectievelijk, een EC Communicatie en Conclusies van de Europese Raad. Vanuit dit uitgangspunt, en op basis van Kingdon's Multiple Streams Theory over agendavorming, identificeert het hoofdstuk een aantal barrières die de verdere invoering en bevordering van een solide mondiale gezondheidsagenda in de EU lijken te belemmeren. De voornaamste barrières voor het creëren van een sterke Europese mondiale gezondheidsagenda zijn de fragmentatie van de beleidsgemeenschap en het gebrek aan een gemeenschappelijke definitie voor mondiale gezondheid in Europa. Het hoofdstuk sluit af met een aantal aanbevelingen over hoe de Europese mondiale gezondheidsagenda verder kan worden ontwikkeld.

**HOOFDSTUK 3** behandelt de vraag naar 'wat de belangrijkste motivaties en drijvende factoren zijn voor gezondheid en buitenlands beleid op het nationale niveau', en rapporteert over een interview-studie uitgevoerd met Duitse ambtenaren verantwoordelijk voor het opstellen en publiceren van de Duitse Global Health Strategy (DGHS) in 2013. Semi-gestructureerde interviews zijn uitgevoerd rond de vraag waarom Duitsland besloten heeft een nationaal beleidskader voor mondiale gezondheid op dit moment in te voeren, en hoe het ontwikkelingsproces heeft plaatsgevonden. Zodoende beschrijft dit hoofdstuk de resultaten van deze semi-gestructureerde interviews. Hieruit komt naar voren dat een reeks van externe ontwikkelingen, belanghebbenden en 'advocacy' acties een gunstig klimaat creëerde voor de oprichting van dit strategisch document. Daarbij speelde een aantal interne overwegingen, worstelingen en capaciteiten een beslissende rol tijdens de ontwikkelingsfase van het DGHS. Een beter begrip van deze factoren kan niet alleen aanzienlijk meer inzicht verschaffen in de mondiale gezondheidsgerelateerde beleidsprocessen in Duitsland, maar kan ook bijdragen aan de algemene discours over de rol van de nationale staat in mondiale governance voor gezondheid.

**HOOFDSTUK 4** onderzoekt 'in welke mate gezondheid *de facto* in het buitenlands beleid van de EU is opgenomen', door het bestuderen van de internationale betrekkingen van de EU met de BRICS-landen (Brazilië, Rusland, India, China en Zuid-Afrika). Hoewel de associatie tussen buitenlands beleid en gezondheid intensief besproken wordt onder wetenschappers, is er echter weinig empirisch onderzoek verricht naar de daadwerkelijke integratie van gezondheidsaangelegenheden in huidige buitenlandse beleidsoverwegingen. Door het uitvoeren van een kwantitatieve en kwalitatieve content analysis van belangrijke documenten, wordt duidelijk dat gezondheid een kleine, zij het een constante, rol speelt in de relaties, voornamelijk vertegenwoordigd in de context van 'health security' en 'health in development'. Hoewel de bevindingen in dit hoofdstuk de aanname bevestigen dat deze drijvende factoren vooral dominant zijn in de discours over gezondheid en buitenlands beleid, identificeert het ook aanvullende motivaties voor betrokkenheid bij gezondheids- en buitenlands beleid, wat op de noodzaak wijst voor een meer genuanceerde kijk op de nexus tussen gezondheid en buitenlands beleid.

**HOOFDSTUK 5** gebruikt de thans lopende TTIP discussie als een case study aangezien het debat gezondheidsbelangen verbindt met het Europees buitenlands beleid. Gezondheidsbelangen worden in deze context systematisch gebruikt als een argument om het buitenlands beleid van de EU te belemmeren. Dit hoofdstuk bestudeert daarom de geldigheid van de populaire gezondheidsgerelateerde argumenten. Om dit te bereiken, worden de openbaar gemaakte argumenten vergeleken met beschikbare TTIP-documenten en met de gepubliceerde definitieve tekst van de handelsovereenkomst tussen Canada en de EU (Canada-EU Trade Agreement - CETA), die gezien wordt als voorloper en modelverdrag voor TTIP. Hieruit blijkt dat een aantal van de populaire beweringen op het eerste gezicht niet worden bevestigd. Een meer diepgaande uitwerking van deze punten laat echter blijken dat 'de duivel in de details schuilt', en dat de TTIP-overeenkomst in feite een reeks zaken bevat, die een negatief effect zou kunnen hebben op toekomstige gezondheidszorg en volksgezondheidsgerelateerde beleidsprocessen.

**HOOFDSTUK 6** illustreert een onopgelost mondiaal gezondheidsprobleem, dat goed resoneert met onze definitie van mondiale gezondheid als onderlinge afhankelijkheden - en de daaruit voortvloeiende noodzaak voor nationale, internationale en intersectorale actie. Het biedt een beschrijving van het hedendaagse mondiale fenomeen van migratie van gezondheidspersoneel en tracht een overzicht te geven van de omvang van de migratie en de respectievelijke patronen, inclusief de rol van Europese landen hierin. Het richt zich verder op zowel positieve als negatieve effecten van alle actoren die betrokken zijn in zowel hoge als lage inkomenslanden. Bijgevolg, gaat het dieper in op de aanpak van de internationale gemeenschap bij het oplossen van de personeelscrisis in een onderling afhankelijke wereld, met bijzondere aandacht voor de WHO Code of Practice, opgesteld in 2010.

Het idee voor **HOOFDSTUK 7** is ontstaan tijdens een bijeenkomst in Brussel in 2012, georganiseerd door de EU, om het probleem van het beoordelen en meten van de effectiviteit van ontwikkelingshulp voor gezondheid (Development Assistance for Health - DAH) aan de orde te stellen. Hierop volgend beschrijft de studie de huidige gang van zaken en duidt erop dat er methodologische uitdagingen zijn in het vaststellen van een relatie tussen DHA en werkelijke gezondheidsuitkomsten. De geldigheid van de resultaten weergegeven door belangrijke financiers kan daarom in twijfel worden getrokken wegens gebreken in de modellen gebruikt om uitkomsten in te schatten, verkeerde contrafeitelijke aannames en te genereuze aannames over investeringseffecten. Vooral het vaststellen van de gezondheidsuitkomsten van interventies om gezondheidssystemen te versterken is bijzonder moeilijk, vanwege de complexe causale verbanden waarop deze interventies waarschijnlijk een effect op gezondheidssystemen hebben. Bijgevolg maakt dit hoofdstuk een aantal aanbevelingen over hoe het evalueren en rapporteren van de effecten van ontwikkelingshulp voor gezondheid verbeterd kan worden.

**HOOFDSTUK 8** geeft een algemene integratie en discussie van de bevindingen uit de voorgaande hoofdstukken weer. Vervolgens worden enkele relevante implicaties voor zowel onderzoek als praktijk gegeven.

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# **CURRICULUM VITAE & PUBLICATIONS**

## CURRICULUM VITAE

Christoph Alexander Aluttis was born on 29 November 1983 in Duisburg, Germany. Between 2005-2009 he studied at Maastricht University and obtained a BSc. degree in Health Sciences and an MSc. in Public Policy and Human Development. After his studies he obtained a 'Carlo Schmid' scholarship from the German Foreign Exchange Service (DAAD) to work for six months at the World Health Organization Regional Office for Europe in Copenhagen.

Upon completion of the scholarship, Christoph returned to Maastricht University to work as a junior researcher on an EU funded project which mapped the public health capacities across European Union states. After successfully concluding the project on mapping the public health capacities Christoph embarked on a PhD trajectory at the Department of International Health at Maastricht University to investigate the European role in Global Health in more detail. Throughout his PhD track, Christoph has been involved in various teaching activities at the Bachelor and Master level in European Public Health. He also became involved in faculty matters as the official CAPHRI PhD Representative.

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