The EU’s role in global health and the WHO reform; between health and foreign policy

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Abstract

It has been suggested that in many international institutions, including in the World Health Organisation, struggles over ‘the implementation of the Lisbon Treaty’ undermine the EU’s ability to speak with one voice and thus its effectiveness. However, the EU’s performance in international organisations, regimes and conventions is influenced by not only the extent to which it has clear policy objectives and speaks with a single voice, but also other factors such as its legal competence on matters and the rules and procedures of international organisations it engages with (Jorgensen et al 2011). This paper firstly explores the EU’s growing role and position on health and global health matters, how this role has emerged and the implications of the Lisbon Treaty for the EU’s role in global health. Specifically the EU’s competences in health, the EU’s status within the United Nations and World Health Organisation and the development of its role in global health is considered. Secondly, this paper turns to the EU position on the WHO reform debate and the extent to which the EU represents a single voice in discussions. It concludes that the EU is emerging as a significant player in global health policy and initiatives, for example being pro-active in leading up to the recent UN High level meeting on non-communicable diseases (NCDs). Throughout the WHO reform debate, the EU has presented common positions on the reform, bringing the experience of EU internal governance practices to the table, especially on matters such as stakeholder engagement and transparency. However, as health is increasingly acknowledged as a cross-border, foreign policy issue involving a number of ‘determinants’ and requiring cross-sectoral action, the potential for ‘horizontal’ tensions and ‘turf wars’ between EU actors is evident (e.g. between health, development and foreign policy). The paper concludes by considering a number of questions for future research relevant to the EU’s role in global health and foreign policy.

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Part 1 The EU on health and global health and its status in the UN and WHO

EU on Health and Global Health

According to Article 6 of the Treaty on the Functioning of the European Union (TFEU), ‘the protection and improvement of human health’ is one area where the EU has only the competence ‘to support, coordinate or supplement the actions of the Member States (Council of the European Union 2008).’ Whilst public health policy and service provision is primarily seen as the role of MS, ‘shared sovereignty’ has emerged over public health issues that cut across borders (Mamudu & Studlar 2009). The White Paper: Together for Health, a Strategic Approach for the EU 2008-2013 outlines the EU’s role on cross border issues (pandemics, bioterrorism) and the ‘free movement of goods, services and people’ (EC 2007) and includes overseeing areas such as pharmaceutical regulation and health and safety standards.

It has been claimed by Mamudu & Studlar (2009) that the EU has developed greater authority in public health in an ‘evolutionary manner.’ Emmerling and Heydemann (2012) also discuss the way in which health related legislation has emerged on the basis of Treaty articles other than public health (e.g. agriculture, environmental). The European Parliament has also been instrumental in strengthening EU health actions, both before and in response to crises such as the BSE crisis, crises which have led to legislative reform (Emmerling & Heydemann 2012). The EP has recently been involved in ‘a high number of discussion dedicated to health related topics’ (e.g. E.Coli outbreak, Alzheimers, antibiotic resistance, tuberculosis vaccine, EU global response to HIV/AIDS) (EC 2012a).

One area in which the EU has played a role in multilevel governance along with Member States (and substate entities) and ‘shared sovereignty’ was in the negotiation over regulations: the World Health Assembly invited the EU to negotiate the WHO Framework Convention on Tobacco Control (FCTC) and the International Health Regulations (IHR), and was a party to these alongside MS (Hoffmeister 2007). According to Mamudu & Studlar (2009), shared sovereignty in the area of tobacco control has occurred partly due to the cross-border nature of tobacco control (e.g. in dealing with advertising and marketing), and tobacco control becoming an ‘EU competence,’ following the Maastricht and Amsterdam Treaties which emphasised the role of the EU in health protection (Mamudu & Studlar 2009, see also Emmerling & Heydemann 2012). The Maastricht Treaty specifically included an article on public health which focused on disease prevention (Emmerling & Heydemann 2012). European Union tobacco policies have been promoted through such avenues as

accession policies (with EU MS requiring to adhere to existing EU policy) and its financial support for NGOs. Also contributing to increased EU authority in the area of tobacco control have been factors such as: tobacco company lobbying against EU sharing sovereignty with MS (throughout the development of the FCTC); the subsequent decision of the EU Council to grant authority to the EU to negotiate the FCTC; the EU being a signatory to the FCTC; and, EU involvement in follow up protocols and guidelines (Mamudu & Studlar 2009). This role the EU played in tobacco control arguably led to its greater role in public health more generally (Mamudu & Studlar 2009). Over time, disease specific approaches to programmes and activities were replaced by more horizontal approaches (Emmerling & Heydemann 2012) and the EU policy on global health now recommends ‘systems based’ rather than ‘disease specific’ solutions to global health (EU 2010).

The Lisbon Treaty (Council of the EU 2007 - in force from 2009)\(^5\) determined that the EU ‘shares competence with the Members States on common safety concerns in public health matters’, whilst health protection is a ‘coordinating competence’ (Emmerling & Heydemann 2012). Article 168 of the Treaty outlines the EU’s role in public health, and states that ‘the Union and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.’ The recent EC communication on ‘EU’s role in global health’ (EC 2010) recognises challenges in global health governance, the importance of strong leadership and the need to coordinate the broad range of global health actors. It recommends a unified position for the EU on global health when dealing with UN agencies and promotes the participation of a range of stakeholders within governance processes (EC 2010).

The EC is still working out its plan of action following the Communication on global health, including how its various different directorates (e.g. health, development) will work together on global health. Health has been a feature of EU development policy; the recent *Increasing the impact of EU Development Policy* (EC 2011) declares that the EU should have a role in health systems strengthening, reducing inequalities in access to health services, promoting policy coherence and protecting against global health threats. The EU is also committed to and has promoted access to essential medicines, following the Doha Declaration on the TRIPS agreement (Emmerling & Heydemann 2012). The Social Determinants of Health have been acknowledged through WHO Comission on the Social Determinants of Health (CSDH 2008), follow up forums such as the World Conference on the Social Determinants of Health (2011) and EU policy (EC 2010). In addition, the EU has a Council conclusion from the time of the Finnish Presidency on Health in All Policies (Council of the EU 2006)\(^6\) and HiAP and Equity (Council of the EU 2010)\(^7\) and requirements for Health Impact Assessments within the


European Commission (EC 2012b). These policies necessitate “health working with other sectors”, the WHO working with other intergovernmental agencies, and better coordination within the EU on global health governance and strategy.

The EU’s status at the UN and WHO

Following the Lisbon Treaty’s establishment of the High Representative of the Union for Foreign Affairs and Security Policy, assisted by the newly created European External Action Service (EEAS), the EU is developing stronger representation and coordinated action in external affairs. Through the EEAS, a new foreign policy service has been created which, according to HR Ashton (2012) ‘brings together economics and politics and creates a new capacity for the European Union to add value to what the Member States do on the ground.’ Through a resolution adopted in May 2011 the EU obtained speaking rights at the United Nations General Assembly (UNGA) (United Nations 2011, A/RES/65/276). This gives the EU (foreign policy actors) the right to speak and participate in debates at the UNGA on behalf of its MS and to make proposals, amendments and interventions (orally), to have its documents circulated as part of the meeting and to have the right of reply (Grevi 2011).

With these new speaking rights, the EU’s role in the UNGA may become more prominent for global health governance, as the ‘social determinants’ are recognised and health becomes more of a foreign policy issue. The EU has already recently played a more prominent role in the UN High Level Meeting on the Prevention and Control of Non-communicable Diseases. Prior to the High-level meeting, the European Parliament passed a resolution affirming its commitment to the meeting (European Parliament 2011, P7_TA (2011) 0390). This recognised NCDs as the major cause of death in Europe, along with major NCD risk factors, the low level of health expenditure on prevention, and the role of social determinants on health inequalities. It called for the EC and EU Member States to have a strong political commitment to address the NCD epidemic, to endorse five key commitments on NCDs and ensure that they were in the Political Declaration on NCDs arising from the High-level meeting (UNGA 2011) and develop national NCD plans by 2013. Commissioner for Health and Consumer Policy, John Dalli, was representing the EU at the meeting.

When it comes to the World Health Organisation, the EU currently has only observer status, whilst EU Member States are members of the organisation. Nevertheless, the EU represents a unified voice and has an EU Member State on the EB representing the EU position in WHO forums. This is a strong voice, given that over 30% of the WHO budget comes from EU Member States. Emerson et al (2011, p.84) point out that that ‘while the EU’s status as observer is reasonable, the arrangements for it to represent its views in plenary WHO

8 http://ec.europa.eu/health/health_policies/impact/index_en.htm
meetings is not yet in line with the Lisbon Treaty provisions.’ The EU does not yet have similar rights with regard to holding statements, bringing in amendments, etc. as it has in the UNGA. Van Schaik (2011) also found the expanded role of the EU in the WHO to be contested immediately after the entry into force of the Lisbon Treaty, both by representatives of the EU Member States and by third countries.

Parallel Developments: The EEAS, ‘One Health’ strategy and global health security

Since 2008, the ‘One Health’ strategy has been introduced by the EU, which is an integrated approach to health risks and considers interactions between animals, humans and their environment (the focus is on zoonotic infections, Avian and human influenza). The ‘One Health’ strategy is defined as:

‘an integrated approach to health that focuses on the interactions between animals, humans and their diverse environments. It encourages collaborations, synergies and cross-fertilisation of all professional sectors and actors in general whose activities may have an impact on health.’

(EEAS 2012)

The Manhattan Principles of ‘One World, One Health’ (simply known as ‘One Health’) developed in 2004 at a conference hosted by the Wildlife Conservation Society. This was followed by a ‘One World, One Health’ strategic framework for reducing risks of infectious diseases, developed by the Food and Agriculture Organisation (FAO), World Organisation for Animal Health (OIE), World Health Organisation (WHO), United Nations Children’s Fund (UNICEF), the World Bank and the UN System Influenza Coordinator, following a recommendation from the 2007 International Ministerial Conference in New Delhi on Avian and Pandemic Influenza (FAO et al 2008).

The ‘One Health’ global health security strategy is currently the main focus of the EEAS when it engages within global health matters. It is notable that within this strategy, the World Health Organisation was ‘one of the actors’ on the Expert Group (it was represented on this group by the Director of Food Safety, Zoonoses and Foodborne Diseases) at the recent meeting on ‘One Health Governance and Global Network’ (Oct-Nov 2011), together with other intergovernmental agencies, the UN Food and Agriculture Organisation (FAO) and the

World Organisation for Animal Health (OIE). The 'One Health' strategy would like to set up a separate network governance framework that liaises with the tripartite WHO/FAO/OIE. Following the recent Expert Group meeting, a Task Group has been set up to progress a 'non-governmental, non-multi-lateral organisation' (the EEAS is involved in this Task Group, but not the WHO or NGOs/private stakeholders). It was previously established by the One Health global network that:

‘One Health should not be ‘possessed’ or ‘mastered’ by any one organisation or institution; that One Health should remain flexible and comprehensive; and that One Health can be promoted by various institutions, but it should not be institutionalised. There also was consensus that a One Health Global Network should be developed to improve coordination and collaboration.’

(Expert Meeting on One Health Governance and Global Network November 2011, p.4)

Currently the EU and the US are the main actors endorsing this strategy.

The current controversy on the need to develop further H5N1 (Avian Flu) research and the biosecurity concerns around it, and the differences of opinion between public health and biosecurity communities, demonstrates the importance of the WHO being integral to the “One Health” governance framework and future strategy (see WHO 2012).\(^\text{12}\) However, Fidler and Calamaris (2012) argue that this controversy has highlighted governance problems on research involving H5N1 following a recent WHO meeting to discuss the problem:

‘we have triage without agreement on what rules should guide the triage process at the WHO meeting, which is itself ad hoc, restricted in participation, not open to the public, and thus, of questioned legitimacy...even given the ad-hoc nature of the WHO meeting, a good precedent would help because the H5N1 controversy has demonstrated that neither existing governance principles nor processes handle this global health problem – and this problem is not going away.’

**A more prominent role for the EU, but coherence challenges are increasing too**

It has been suggested that ‘today, the EU is an important partner in nearly all global health topics: politically, economically and financially – and the implementation of the Lisbon Treaty is expected to strengthen this role’ (Emmerling & Heydemann 2012). However, as Van Schaik (2011) points out there is a coherence challenge between 1) MS and the EU on the one hand on (initially) health matters where the EU has competence and, 2) as health becomes more of a foreign policy (i.e. responding to external threats and trade issues), policy coherence between ‘health’ policy experts and the new positions of the High

\(^{12}\)http://www.who.int/mediacentre/news/releases/2012/h5n1_research_20120217/en/index.html
Representative and the European External Action Service. In addition, policy coherence across various parts of the EU (including parts of the EC such as health and development) is another potential challenge.

Part 2 EU positions on the Reform of the WHO

This section provides a brief background to key issues in the WHO reform before considering various EU positions on the reform of the organisation. This is based on document research as well as observations at the recent WHO 130th EB meeting (January 2011).

The WHO reform: background

The debate on the WHO reform began as a discussion concerning WHO financing, commencing with the financial crisis in 2009 and leading to consultations on broader reform in January 2010. Along with financing, discussions soon turned to the role and core business of the WHO, along with the governance and management of the organisation (WHO 2010). Non-government organisations were particularly concerned about the governance of the WHO and the way in which the organisations was managing conflicts of interest to protect the public interest (HAI Europe 2011).

Key issues in the reform debate now include:

- **Leadership and core business of the WHO** - including global health priorities
- **Management** - efficiency, accountability and transparency
- **Financing** - specifically its predictability, sustainability and flexibility
- **Stakeholders and Partnerships** - better coordination of the large array of stakeholders contributing to global health (i.e. public and private organisations, CSOs/NGOs, etc.) and the management of conflicts of interest (see A64/INF.DOC/5 2011).

The 64th World Health Assembly (May 2011) endorsed a reform agenda and urged WHO Member States to supports its implementation (WHA64.2). The expected outcomes of these reforms are; ‘greater coherence in public health...improved health outcomes [aligned with] agreed global health priorities... [and a more] effective, efficient, responsive, objective, transparent and accountable’ organisation (A64/4 2011).

Subsequently, at the 129th Executive Board meeting (May 2011), WHO MS asserted their control over the reform process and called for the reform to be a transparent, MS driven process. Three concept papers were requested, on the topics of 1) evaluation of the WHO, 2) a World Health Forum and 3) WHO governance. In June 2011, the WHO produced these three concept papers on the reform (WHO 2011, a,b,c). WHO Regional committees were also requested to engage on the reform process, through consultations at regional
committee level (held Aug-Oct 11), reporting back to a special session of the WHO EB in November 2011. The WHO reform was most recently discussed at the 130th EB meeting (January 2012), where the focus was WHO programmes and priorities, management, governance and financing of the organisation.

**EU positions on the Reform**

It has been suggested previously that Member States have divergent views of health issues and have been reluctant to cede competence/authority to the EU on these matters (Van Schaik 2011). However, in response to the WHO concept papers, and for the WHO EB Jan 2012 meeting, the EU generally had a unified position on the WHO reform debate. It presented statements on 1) the concept papers (EU 2011) and 2) priority setting, governance and management reforms (EU 2012 a,b,c).

**Leadership and core business of the WHO**

The EU argued that the concept papers on evaluation of the WHO, a World Health Forum and WHO governance should be better linked and include options for action and their consequences/impact and financial implications (EU 2011). The EU suggested a procedure as is undertaken in the EU whereby the EC prepares papers for EU Member States with options. It appears that representatives of the EC and EU MS compare the secretariat of the WHO to the EC and would like to see similar procedures adopted to the ones internally used in the EC. Also recommended was aligning resources with priorities and exploring options for flexible funding. In terms of priority setting, the EU suggested a drafting group to develop a process and timeline for the reform (EU 2012a). The EU also cautioned against setting targets for country level expenditure prior to the establishment of WHO priorities (EU 2012a). The EU recommended that the WHO focus on its WHO’s normative and global mandate, and that a balance must be developed between national level needs and priorities and the normative /standards setting role of the WHO. Conversely, at the 130th EB meeting other countries such as India emphasized that priority setting began with country requirements, whilst Canada spoke about a ‘country driven’ approach at the same time as maintaining that the WHO should set priorities on a global level, and the US discussed the WHO’s comparative advantages for priority setting.

In regards to the proposed independent formative evaluation of the WHO (WHO 2011a), the EU, whilst supporting a focus on health system strengthening, called for ‘a special focus also on primary health care, disease prevention and health promotion’ along with accountability of the WHO leadership in strengthening health systems and of the WHO itself in terms of finances/budget and performance (EU 2011). The need for timely evaluation was raised, along with questions about the costs and composition of the proposed oversight committee for evaluation and processes for selecting an evaluation consortium (EU 2011).
The relationship between the independent evaluation and the reform process is unclear. There is also some tension in the fact that 1) there have been widespread criticisms of the governance and management of the organisation (including management of conflicts of interest) leading to the call for a broad reform process (including the independent evaluation), whilst 2) WHO Member States and the WHO Secretariat are playing a key role in the reform of the organisation. Member States have emphasised the need for the reform to be a MS driven process at the May 2011 EB session, following concerns about the speed and direction of the reform expressed at the January session (Third World Network 2011).

**Management and Financing**

The EU supported the four main areas of governance reform as outlined in the concept paper, but suggested that the paper needed to propose problems and challenges (as previously discussed through WHO processes), along with suggested solutions (EU 2011). Other suggestions included agendas linked to objectives and priorities of the WHO, single resolutions tied to the strategic goals of the WHO, distinguishing the roles of governance bodies, using the Joint Inspection Unit for policy advice on the decentralisation of WHO, creating alignment between agendas across regional, EB and WHA levels, and analysis of partnerships to determine their alignment with WHO strategies (EU 2011). The EU did not support a separate body dealing with reform. The EU also called for a greater focus on organisational effectiveness, and processes for ‘accountability, transparency and results-based management at country level’ (EU 2012c). At the 130th EB meeting, the EU highlighted managerial reform as being of great importance in the reform process.

Also at the 130th WHO EB meeting, the EU supported the 3 cycle financing mechanisms proposed by the WHO (EB 130/5), which was also widely supported by other MS. This would involve 1) a priority setting process led by Member States, 2) Member States being brought together with non-state financiers of the WHO in a ‘pledging process’ to link priorities with funding, and 3) monitoring and reporting on funding and resource gaps and results (WHO EB 130/5). There were mixed views across EU MS about the value of a ‘pledging conference’ as proposed by the WHO in stage 2. This is a plan to involve WHO’s state and non-state financial supporters in a transparent process where funds are openly pledged. According to the DG, this ‘dialogue’ would have the advantage of making clear to MS what different areas of their countries governments are contributing, whilst enabling countries to know what each other is contributing, so that better targeting of funds may occur (130th WHO EB meeting Jan 2012). In its statement at the 130th EB meeting, the EU expressed interest in alternatives to the pledging conference (as some MS may be prevented from participating in it due to country legislation) and asked about its role in increasing predictability of funds, and suggested other mechanisms such as collecting voluntary contributions and promoting them online. France raised questions about the dialogue’s potential visibility, legitimacy and effectiveness and the UK underscored EU concerns that distinctions be made about different types of contributions being made. Conversely, Germany supported the pledging conference
as a move towards greater transparency, and emphasised that agendas should not be set by big private donors but by WHO Member States in a democratic manner. Countries such as China and Switzerland also supported the pledging conference. The appropriateness of the name ‘pledging conference’ was called into question by a number of States, including China, Canada, Sweden and the UK – this was latterly referred to as ‘financing dialogue’ by the DG.

Stakeholders and Partnerships

One of the most difficult issues in the reform debate is that of involving non-state stakeholders. The position of the EU on this matter is related to its position on other issues, such as the role of private sector actors in financing the WHO, and the resulting priorities and possible conflicts of interest that may emerge from this. It is also based on its extensive experience with stakeholder engagement.

The status of the EU within WHO global health governance processes is a very salient question but has not been prominent with the WHO reform. In any discussion on non-state actors, a distinction must be made between the EU as non-state entity (but with supranational elements in its governance structure) and non-state actors such as NGO and private industry alliances. At the same time as supporting a larger role for NGO stakeholders in WHO governance (along the lines of what already occurs within the EC), and whilst expressing concern about potential conflicts of interest, the EU underlines the importance of the WHO remaining a state-based organization and has emphasised the need for the WHO reform to be a MS driven process. France emphasised that MS should be the only actors in terms of decision making, whilst Germany discussed MS role in the agenda for financial reform. This proposed ‘Member State’ driven relationship is similar to that between the EC and EU Member States.

Involving stakeholders such as NGOs and alliances within governance/policy is consistent with the EC’s health strategy (EC 2007) which affirmed the Citizens’ Agenda, promoting citizen empowerment in relation to health care. EU processes for engagement with stakeholders are well-established, and the EU has brought to the WHO reform debate its experience in the area. The EU has developed a number of discussion papers and guidelines on the way in which it works with NGOs and in public consultation (e.g. EC 2000, EC 2002\(^\text{13}\)). For instance, the EC DG for Health and Consumers has established stakeholder dialogue groups and action platforms with the aim to diligently contribute to policy shaping and consensus (EC 2012c).\(^\text{14}\) The ‘Citizens’ Initiative’ was also enabled through the Lisbon Treaty, whereby citizens across MS have the capacity to invite the EC to submit a legislative

\(^{13}\) See ‘Towards a Reinforced Culture of Consultation and Dialogue: General principles and minimum standards for consultation of interested parties by the Commission’ COM(2002)704

\(^{14}\)http://ec.europa.eu/dgs/health_consumer/sdg/index_en.htm
proposal, an initiative which could be highly relevant to the health realm (Kaczynski et al 2010). It has recently launched a public consultation on this initiative in 2012 (EC 2012d).\textsuperscript{15}

In its position paper of July 2011, the EU argued that the focus of the WHO reform should be \textbf{managerial reform} of the WHO (i.e. increasing accountability and transparency), \textbf{priority setting} and revising the process of budgeting rather than the proposed World Health Forum (WHF) which would enable stakeholder and partnership engagement (this had moved centre stage as a topic of debate due to NGO opposition to it). However, at that stage the EU generally supported the WHF, and suggested it may assist in helping the WHO to focus on its priorities and prevent overlap. However, it had a number of questions about the WHF, pertaining to its purpose, function, financing, governance, accountability and role in terms of providing policy input into themes/content areas (i.e. NCDs) versus processes (e.g. for working together). Managing conflicts of interests in stakeholder input was considered an important area for further discussion. The EU was concerned that the WHF should not be a decision-making body, and argued that the relationship between discussions at the WHF and EB/WHA and the development of resolutions needed to be clarified. Piloting and review of the forum was suggested, along with using other strategies for stakeholder input, such as using the internet to enable civil society to input into processes. The EC already uses a wide range of strategies for public consultation, including distributing consultation documents, using advisory committees and using the internet (EC 2008).\textsuperscript{16} The WHO could learn from the EC from the way in which it engages with a range of stakeholders.

Concerns about conflicts of interests were raised by the EU during discussions on the WHO reform document \textit{Governance and promoting engagement with other stakeholders and involvement with and oversight of partnerships} (WHO 2011d)\textsuperscript{17} at the 130\textsuperscript{th} EB meeting. It is notable that the EC has already established a ‘transparency register’ of those seeking to influence EU policy. The EU requested more information on mechanisms to involve NGOs and the private and not for profit sectors in the WHO, supported the EB overseeing partnerships and WHO working with NGOs whilst working to high accountability standards. The EU supported a review of principles and a framework for WHO’s relationships with private, for profit and not for profit sectors.

\begin{itemize}
\item \textsuperscript{15} http://ec.europa.eu/dgs/secretariat_general/citizens_initiative/index_en.htm
\item \textsuperscript{16} http://ec.europa.eu/civil_society/apgen_en.htm
\item \textsuperscript{17} http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_5Add4-en.pdf
\end{itemize}
Discussion

EU’s stronger role in global health initiatives and external representation

As discussed, the European Union has now developed its role in global health and is improving its external representation within UN bodies including the WHO. The EU has taken a pro-active role in initiatives such as the UN High-level Meeting on the Prevention and Control of NCDs, it now has a voice in the debate at the UNGA and has established common positions through the WHO reform processes. For example, there is a common position on the importance of the WHO’s normative and global mandate and the need for clear processes on priority setting linked to resources, albeit some divergence from Member States on methods/processes of reform (such as the pleading conference to improve transparency).

Within these positions and statements, the EU is bringing to the table its experience and current practices; e.g. EC methods of stakeholder input and engagement and tools to improve transparency (e.g. ‘transparency registers’), which the WHO could learn much from. The EU’s authority in reform debates appears to partly derive from the experience and practice of the EC. For the future, it would be interesting to look further into the issue of the EU implicitly and explicitly advocating its own governance practices for the WHO, notably with regard to the issue of stakeholder involvement.

The limits of Westphalian solutions

Previously the EU had a largely undetermined role within intergovernmental agencies and in 1985 Delors famously described the EU as an ‘unidentified political object.’ The UN system still has problems with what the EU is as its very nature does not fit the present rules of intergovernmental governance. However, as Zielonka (2006: v-vi) writes, "Westphalian solutions are largely inadequate for coping with an enlarged EU." One could argue that the EU should have an interest in a more network based plurilateral form of governance in order to push its weight. Van Langenhove (2010, p. 25) has argued that the EU ‘could play a central role in transforming the current multilateral system. He describes a future of multi-stakeholder governance which is less about hegemonic power where states are the ‘star players and where ‘one can expect a fluid web of multi-stakeholder partnerships between different types of actors at different levels of governance including the regional level’ (Van Langenhove 2010, p. 24). The proposed ‘One Health’ governance strategy, involving the EEAS, may be a good example of the type of governance which Van Lagenhove describes.

Health and Global Health as cross-border, cross-disciplinary issues

As recognized by the One Health strategy, many health issues are cross-border and require cross-border solutions. In addition to health being ‘cross-border,’ a new understanding of health has arisen which acknowledges the ‘social determinants’ of health – an approach which has been acknowledged throughout WHO reform debates. These will require more
cross-government, cross-sector, and interagency, intergovernmental strategies. Health has also been increasingly acknowledged as a foreign policy issue, centrally linked to issues like human rights and sustainable development. Many of the important issues recently raised by the High Representative in her discussion with Brazil are within the scope of global health: climate change, sustainable development and human rights (Ashton 2012).

A one-year review of the European External Action Service has recently suggested that there is a lack of ‘integrated vision’ for foreign affairs and a turf war between the EEAS and the EC’s Directorate General for Development and Cooperation.¹⁸ It has also been previously noted that Member States resist ‘centralization’ and cooperation on foreign policy issues, posing problems for a service such as the EEAS (Vanhoonacker & Reslow 2010). As health becomes more of a foreign policy issue, there is not only potential tension in vertical coherence between EU MS and other EU actors (e.g. EC; EEAS), but also in horizontal coherence, between health policy experts and specialists in other areas such as foreign policy and development.

**Future Research**

There are a number of issues which arise from considering the EU’s more prominent role in global health and health becoming more of a foreign policy issue, which lead to questions for further research. Some questions that may be considered include:

- **Horizontal integration:** What is the relationship between health and foreign policy experts across the EC/EEAS? What is the relationship between health and development experts within the EC? How do health/development/foreign policy actors within MS communicate? Has the upgraded role of EU foreign policy actors led to turf wars between the EU and MS? Has this upgraded role led to turf wars between health and foreign policy specialists? Have there been any consequences of this upgraded role for the EU’s ability to speak with a single voice?

- **Vertical integration:** How do EP resolutions on global health issues (e.g. in the case of NCDs) influence EU positions at the WHO?

- **EU representation in UN bodies:** Will the speaking rights of the EU as adopted by the UNGA be extended to other parts of the UN, including the WHO? Does the EU desire membership status at the WHO, in addition to that of EU MS – what are the positions of EU MS and others States on this? How will MS from other regions (e.g. Latin America and South–East Asia) react to a more prominent role being taken by the EU?

- **Global health governance:** Specific questions also arise from the aforementioned One Health strategy, such as: Will the new global health security governance structure be

a parallel structure potentially bypassing WHO's convening and coordinating role? How will citizens groups/NGOs be represented in new governance for global health security? How will multi-stakeholders access new One Health governance and strategies? How will private interest organisations be involved and conflict of interest matters dealt with? How will differences of opinion between public health and biosecurity communities be managed? How will the EEAS will position itself within the International Health Regulations/Pandemic Influenza Preparedness (PIP) frameworks and any future negotiations on their implementation and review?

- **WHO reform**: How will possible divergences between MS and EU on reform issues be dealt with? Will the EU become more dominant in financing the WHO whilst contributions from MS decrease due to financial austerity? To what extent is the EU advocating its own governance practices for the WHO? Can EU/MS health governance/legislation provide examples for the WHO to build on? What can the WHO learn from the way in which the EU manages conflicts of interest?

**Conclusion**

Where the EU once had only a ‘supporting role’ in health, the EU has developed a greater role within global health through its role in negotiating the FCTC and IRH, and more recently via its global health policy, EP statements on NCDs, its common positions on the WHO reform debate and via the One Health Strategy. The new provisions of the Lisbon Treaty, and notably the upgraded tasks of the High Representative, the establishment of the European External Action Service and the changing role of the EU delegations should pave the way for a more coherent, consolidated role for the EU in its external affairs, including health. Whilst there is potential for incoherence between health experts and foreign policy specialists, integration will be necessary for a unified, effective EU voice. Integration between areas such as health, development and foreign policy is likely to become more salient following global health being higher upon the UN agenda (e.g. NCDs), the EU’s new position at the UNGA and the social determinants of health being increasingly acknowledged. A number of research questions arise from the increased prominence of the EU’s role in global health and the upgraded role of EU foreign policy actors, which can be explored in future research.

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