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The politics and policies of global health in the EU: A historical analysis

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The politics and policies of global health in the EU: A historical analysis

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Abstract

Global health is a broad area that spans across many fields. Political science is questioning why global health policies come to be, yet no definitive answer has been found. This research conducts a historical analysis of the EU global health policy to recast the wider question of which structural factors drive policies of global health. It does so through the application of middle range theories of policymaking. Political attention and policy formulation are the main factors that influenced the policy output of the EU global health policy.

Acknowledgments

I express my deepest thanks to my family, to my friends, to all the people who I met, and to those who are not here anymore. I am how I am today thanks to all of you.

Table of Contents

1 Introduction 5
2 Literature review 7
2.1 Theories of global health 7
2.2 Empirical findings 8
2.3 Modern global health 9
3 Theoretical Framework 10
3.1 Frameworks, not theories 10
3.1.1 Policy cycle 10
3.2 2004-2010: Kingdon Multiple Streams Framework (MSF) 11
3.2.1 MSF Critiques 12
3.3 2010-2019: Policy network theory 12
3.4 2019-2022: Punctuated equilibrium theory (PET) 13
3.5 Conceptualisation 13
3.5.1 EU Global health policy 13
3.5.2 Policy output 14
5 Methodology 15
5.1 Methodological approach 15
5.2 Data selection 15
6 Analysis 17
6.1 2004-2010: Emergence 18
6.1.1 Policy, politics and problems 18
6.1.2 The policy window 19
6.1.3 The entrepreneur 19
6.2 2010-2019: Colliding priorities 21
6.2.1 The EC's tools 21
6.2.2 The Council's tools 22
6.3 2019-2024: Prioritisation of global health? 23
6.3.1 The global health policy goes global 24
6.3.2 A change in formulation 25
6.3.3 Future political directions 26
7 Conclusion 28
8 Bibliography 31
Secondary sources 31
Primary sources 38

Committee of the regions......38
European Commission......38
European Economic and Social Committee......43
European Parliament......43
G7......43
G20......44
The Council of the European Union......44

1 Introduction

Health in foreign policy has its roots in bilateral medical aid, directed by Western donors toward strategically important partners. In short, health was initially used as means to realise foreign policy and to foster development (Feldbaum et al., 2010). These approaches shifted in recent decades; as globalisation ramped up, so did the spread of diseases worldwide. SARS, anti-microbial resistance, HIV, Ebola, and COVID-19 forced states to re-evaluate their approach to global health (Kickbusch & Liu, 2022). Shifting away from bilateralism became an imperative to accommodate coordinated policy responses to global diseases. (Michaud & Kates, 2013; Ruckert et al., 2016). Nowadays the need for a multilateral approach to health is felt, and most major powers have formulated global policies for health (Ministers of Foreign Affairs of Brazil, 2007; Ruckert et al., 2016).

While policies have been adopted, the concept of global health remains under-theorised. Global health can be conceptualised as a term, a concept, a zone, an area of research, a goal, an approach, a principle, a framework, a collection of problems, or a policy process (Salm et al., 2021, p. 6; Smith et al. 2010). Overall, global health as a term lacks theoretical and definitional clarity (Michaud & Kates, 2013; Ruckert et al., 2016).

One of the major actors that has first recognised and developed a policy of global health has been the European Union (EU) (Gil, 2012, p. 4). The EU's global health policy was first proposed in 2010, to promote equitable, universal access to quality healthcare worldwide (9505/10, 2010[1]; Chang & Rollet, 2013; COM(2010)128 final, 2010[2]). The literature agrees the EU could become a significant player in global health, yet it is failing to take the lead due to inconsistencies in its policies (Battams et al., 2012). Research has yet to provide theoretical justifications as to why this is. Determining the reasons for the inconsistent output of the global health policy can produce expectations for its future developments informing all the health actors whose work relies on the aid of the EU. To mention one, the Global Fund receives 50% of its donations from the EU (Kickbush & Franz, 2020). The question guiding the research is the following:

How can we explain fluctuations in policy output of the European Union's global health policy?

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[1] The unique EU ID number was used to cite official documents.

[2] The EU utilises differing citation reporting styles, at times / is used, at others () are used. This is solely a difference in style.

To answer the question, this research presents a review of the literature on global health. Subsequently, the theoretical framework guiding the research is presented. Following, the methodology justifies the employment of historical analysis. The succeeding section provides a historical narrative of the EU's global health policy development and discusses major drivers and hindering factors. A conclusion is provided, including the limitations of the research and suggestions for further research avenues.

2 Literature review

The following section provides an overview of the literature on global health. Global health is a young field that is developing along the paradigms of geopolitics and development. The first section will explore how global health has been engaged with, from an IR perspective. The second section, following a strong development practice, presents empirical research on the effects of global health policies.

2.1 Theories of global health

Global health has always been conceived as a tool of foreign policy. In this realm, the big unresolved question asks why states would engage with global health policies. Seeking an answer, scholars have convened around three concepts; power, altruism and soft power. In turn, these align with three grand theories of IR.

The first branch of the literature focuses on the concept of power. These scholars posit that in almost all cases policies of global health have been driven by pursuance of power (Feldbaum et al., 2010; Ruckert et al., 2016). Non-industrialised countries' health arises as a problem only when it poses a security threat to industrialised nations; nation-states must use health as a strategic tool to pursue national goals (Kickbusch & Liu, 2022, p. 2163; McInnes & Lee, 2006). These works follow the IR theory of realism, where global health is used only to gain power and dominate the international system (Mearsheimer, 1995).

The second branch of the literature focuses on altruism as a driver of global health. States introduce health within a foreign policy domain to drive more attention and resources to it, in the name of altruistic principles and enhancement of global living standards (Katz and Singer, 2007; Møgedal & Alveberg, 2010; Youde, 2018). These follow a constructivist perspective where reality is subjective to the observer (Wendt, 1995).

Lastly, the third branch of the literature states that countries enact policies of global health to gain soft power. The approach emphasises how altruistic support for health programmes can help achieve foreign policy goals through the application of soft power and the practice of 'enlightened self-interest' (Lee et al., 2010; Lee & Gómez, 2011; Michaud & Kates, 2013;

Youde, 2010). This approach is rooted in liberal theory, in the belief that mutual gains can be achieved through cooperation (Keohane, 2012).

2.2 Empirical findings

The field of global health stems from the field of developmental aid and thus shares the same empirical tradition (Feldbaum et al., 2010). Global health has been studied in the BRICS countries, but as their global health policies are not yet affirmed, data and research are scarce. (Gomez, 2012, p. 20; Lee et al., 2010; Watt et al., 2014; Youde, 2010). Instead, researchers have focused on the EU, as its global health policy has been in place for two decades. These findings can be grouped into three categories: international fora, Member States disagreements and policy coherence.

The European Commission (EC) is very active in international fora. It engages in and finances the World Health Organisation (WHO), the UN, and 50% of the Global Fund. (Kickbush & Franz, 2020). Further, the EC plays a leading role in global initiatives (Battams et al., 2014; Bergner, 2023, p. 4; Kickbush & Franz, 2020). Cooperation in the WHO fosters the idea of a united EU (Kickbush & Franz, 2020).

Member States's disagreements have hindered the implementation of the global health policy (Bergner, 2023, p. 9). The Treaty on the Functioning of the European Union introduced shared competence in health which led to contestation, occasionally taking the form of parallel national global strategies (Steurs et al., 2018; Strunz et al., 2021; Van Schaik, 2011; Wu, 2012; Battams et al., 2012). The consequence has been a low prioritisation of the matter on the EEAS agenda, leading to a slow response to the Ebola crisis (Battams et al., 2012; Speakman et al., 2017).

Lastly, policy coherence has proven to be difficult to maintain (Chang & Rollet, 2013). The enforcement of intellectual property protection laws prevented many non-EU countries from vaccinating their population against COVID-19 (Bergner et al., 2020). The attraction of highly skilled medical personnel to the EU clashes with the EU's efforts to strengthen health systems in third countries (Wu, 2010). Public pledges to strengthen the health systems of low to middle-income countries (LMICs) were never followed with the funding needed to execute it (Berner-Rodoreda et al., 2019; DG RTD, 2021; EC 2016).

Taking into account all of the research that has been presented, the EU global health policy results inconsistent, yet no research has explained these inconsistencies.

2.3 Modern global health

The literature is built on a dichotomy, geopolitics and grand theories against development and empirical works. This narrow division is problematic because the concept of global health has evolved. Nowadays global health is a geopolitical tool, a developmental strategy, but also a multi-actor policy-shaping process (Smith et al., 2010). Global health is intrinsically multicausal, and although it is tempting to apply macro-sociological theories to the study of health, these cannot provide fully satisfying explanations as to why global health is embraced (Gil, 2012; Greer et al., 2018; Kickbusch, 2011). Middle-range theories can bridge this divide, connecting empirical results and broader theoretical perspectives, they can account for more context (Ruckert et al., 2016).

The middle-range theories employed in the global health literature focus on policymaking. So far, policy making theories have been mainly applied to the cases of Brazil and South Africa. The theories accounted for many nuances of their global health policies (Gomez, 2012; Modisenyane et al., 2017). In light of the positive results, this research will also engage with policy-making theories to resolve the gap earlier identified, explaining the fluctuating output of the EU global health policy. Exploring this gap through a middle-range theory will account for specific contextualities which are unique to the historical and institutional context. The findings will not establish a universal recipe for good policymaking on global health but will provide a starting point for discussions, direct further case studies, and stimulate comparative research on what shapes global health.

The study of the EU's global health policy has direct policy implications for actors working in the domestic and international health arena. While the EU argues for shared global burdens it blocks access to COVID-19 vaccines to millions of people worldwide. Conducting research to determine what factors influence the EU to privilege (or not) global health, would inform and increase the resilience of actors that depend on its actions. To close this gap the following question will be investigated: *How can we explain fluctuations in policy output of the European Union's global health policy?*

3 Theoretical Framework

3.1 Frameworks, not theories

As established in the literature review, this research will employ middle-range theories of policy-making to explain the drivers of the EU global health policy. However, theories use the relationship between two variables to explain and predict processes and outcomes. This approach is not well suited to study policymaking, as it is often a disordered process that tends to break the rules imposed by theories (Ostrom et al., 2014, 269). Rather, the use of eclectic frameworks will be preferred, as these do not provide strict boundaries but a general orientation to explain a phenomenon (Buonanno & Nugent, 2020, p. 93).

3.1.1 Policy cycle

The policy cycle is an influential concept that seeks to capture the life cycle of a policy. Its five stages typically include agenda-setting, policy formulation, decision-making, implementation and evaluation (Wu et al., 2017). However, in line with EU public administration scholars, rather than utilising these steps as strict boundaries, they will be used as a heuristic representation of the different characteristics of a policy (Buonanno & Nugent, 2020, p. 94). Utilising the cycle in this manner can highlight essential concepts, produce generalisable findings, and accommodate the widespread informality characterising the EU policy process (Buonanno & Nugent, 2020, p. 94; Weible, 2023).

Since this research investigates policy output, it will focus on the first three stages, excluding policy implementation and evaluation. In order to select the appropriate frameworks, we must consider the temporality of the policy; Figure 1.

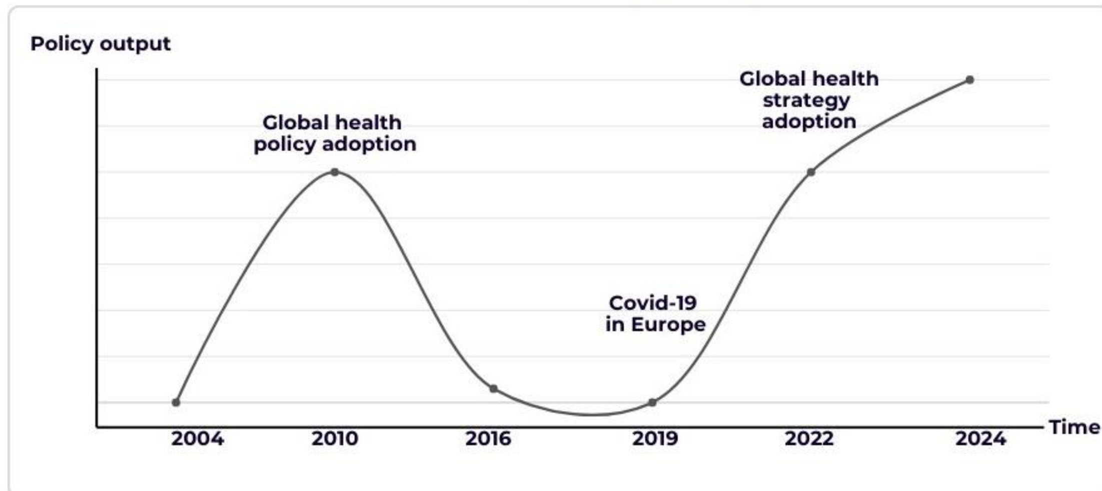

Figure 1; Global health policy, policy output from 2004 to 2024 (Leclerc, 2023).

Three key moments can be recognised, the first adoption in 2010, the COVID-19 pandemic, and the second adoption in 2022.

3.2 2004-2010: Kingdon Multiple Streams Framework (MSF)

Kingdon's MSF model will be used to analyse the 2004-2010 period. It is a framework that explains agenda-setting and is suited for policy formulation (Weible, 2023). It is a well-regarded framework, applied across the literature to examine policy processes in many fields. The conditions that support the MSF, federalism and multiple centres of power, are also applicable to EU governance (Ackrill et al., 2013; Buonanno & Nugent, 2020, p. 96; Herweg, 2017, p. 24; Weible, 2023, p. 47).

The MSF is based on five pillars. The problem, policy, politics, windows of opportunity and policy entrepreneurs. Problems are situations (healthcare funding) which can be framed as a problem by some actors (health spending is too high) to other actors, mainly ones that can impose a change. Policies are technical solutions to the problem (liberalisation). While many policies options are available, policy entrepreneurs (senators) will push for their preferred policy to be adopted. The political stream describes if there is a political will to approve a

policy as a solution to a problem. This cannot happen anytime, but only during windows of opportunity (Weible, 2023, p. 32), which can only be opened in the problem and politics streams. Windows appear when there is a focusing event (economic crisis), when an indicator drops dramatically (employment), or when members of government change (elections) (Weible, 2023, p. 37). The rationale of the theory goes as follows: when a window of opportunity opens, a policy entrepreneur will push forward a policy that is supported by politics and addresses a problem, ideally leading to the policy being accepted.

For extensive explanations and modern reviews of the MSF see Weible (2023) and Herweg (2017).

3.2.1 MSF Critiques

Critiques of the framework sustain that its use in an EU context requires adjustment (Ackrill & Kay, 2011). However, these critiques address smaller attributes of the policy, like the independence of the policy streams and the influence of mess media (Buonanno & Nugent, 2020, p. 98; Weible, 2023, p. 51). Other critiques point to the 'abstractness' of the streams which hinders the formulation of effective hypothesis (Herweg, 2017, pp. 40-51; Weible, 2023, p. 51). However, as this research does not utilise the MSF as a rigid theory but rather as a framework to approach the sources, these critiques are beyond the scope of this research.

3.3 2010-2019: Policy network theory

Policy network theory is fitting to explain the 2010-2019 period because it explores how the interaction of actors in a network affects a policy in the decision-making stage. The theory is appropriate as the EU is heavily characterised by reliance on different institutions to upkeep legislation (Buonanno & Nugent, 2020, p. 100). Furthermore, network theory has successfully been applied to many EU policy studies; compliance with internal market directives, financial regulations, telecommunication, and security cooperation are among some (Christopoulos & Quaglia, 2009; Hobolth & Sindbjerg Martinsen, 2013; Kelemen & Tarrant, 2011; Zwolski, 2015).

Policy networks are structures of independence involving multiple organisations where units are not merely formal subordinates in a hierarchical sense, but mutually dependent (Klijn &

Koppenjan, 2000). Therefore, for a policy to be successful, cooperation must be present between these units. However, as coordination of goals does not result naturally the network must be steered towards that goal (O'Toole, 1997). In the network approach, actors depend on each other's resources; resource distribution and rules are gradually shaped, solidified and altered in these interactions between entities of the network (Klijn & Koppenjan, 2000; O'Toole, 1997). Differences and disagreements between actors may cause conflicts (O'Toole, 1997).

3.4 2019-2022: Punctuated equilibrium theory (PET)

PET will be employed in the 2019-2022 period because it accounts for the effects of shocks in agenda setting and policy re-formulation. In these years COVID heavily affected the EU and must be accounted for. Further, PET identifies systemic attributes contributing to the policy change to be federalism, separation of power and jurisdictional overlap, which are three key pillars of the EU policymaking structure (Weible, 2023).

PET is based on the assumption that national political systems are by nature conservative, favouring the status quo. The system is built on a pattern of stability, with dramatic shifts occurring when eruptive forces break this equilibrium. These shifts can be exogenous or endogenous, and when these changes settle into place, institutional reforms and new actors may come into play. When an issue is placed on the macro-political agenda, small changes in circumstances can cause large policy changes; and the system is undergoing a positive feedback process (Baumgartner & Jones, 2009).

3.5 Conceptualisation

3.5.1 EU Global health policy

With global health policy, this research comprehends both the EU 2010 global health policy and 2022 global health strategy, as well as any other EU independent policies that directly imply an effect on matters of global health.

3.5.2 Policy output

Policy output is defined by three factors: the regularity at which documents are produced, the relevance of the content of the policies, and their impact on the global health policy.

5 Methodology

5.1 Methodological approach

To dissect a complicated phenomenon such as global health within a complex institution such as the EU, an appropriate methodology must account for multicausality and must cover multiple years. Process tracing would qualify; however, the literature does not offer the solid empirical foundations required by this methodology. Therefore, historical analysis is preferred.

Historical analysis adds to the study of global health from a political science perspective because it analyses primary and secondary sources to present the 'temporal structuration of social actions and processes' (Hall, 2007, p. 82; Roberts, 2006). A historical analysis situates events in historical and cultural contexts, considering the timing and sequence of events (Halperin & Heath, 2020, p. 261). Given the number of sources available, a researcher must perform a selection, where minimising bias must be at the centre (Thies, 2002; Trachtenberg, 2009). Finally, the researcher must approach the sources with a method, to select the main drivers of an event. Some historians critique the use of theory in historical analysis, but even these historians engage in comparisons that implicitly rely on theory (Hall, 2007). As Trachtenberg says:

""the facts never really just "speak for themselves." The historian thus has to make them "speak" by drawing on a kind of theory" Trachtenberg (2009, p. 30).

Thus, in this research, the sources have been approached through a policy cycle framework. Finally, the analysis will present a narrative that is sequenced chronologically, highlighting the key moments and behaviours that affect the policy output of the global health policy (Hall, 2007, p. 91; Schrag, 2021).

5.2 Data selection

To observe how the global health policy evolved, policy documents from core policy actors in EU governance have been analysed. In the field of health, the EC is by far the most

important of these policy actors (Buonanno & Nugent, 2020, p. 98). Concurrently, the Council is another key player to observe as it has jurisdiction over foreign policy (p. 98). Policy documents from these two institutions were the majority of the primary sources analysed. Further documents with direct implications to the global health policy published by the Committee of the Regions, the European Court of Auditors, the Economic and Social Committee and the European Parliament have also been used. These sources were gathered utilising the health-related search engine of EC's website, and the search engine of the Council's website. The following keywords have been used: 'global health' and 'global health policy'. The type of documents consists of legislation, agendas, communications, reports, legislative proposals, consultation rounds, and the EC multi-annual work programme. As these documents were used to communicate between the institutions, they contain fingerprints of what changes have been made over time (p. 98). All relevant documents were available online in the databases of the European institutions.

Archival research would bring added value in the form of access to information internal to the meetings. However, with the time and financial constraints of this research, it could be completed only partially, introducing bias in the research. Therefore, no archival research will be undertaken.

The objective of the study is to observe change over time; the timeframe will span from 2004, when the idea of the policy was first introduced, up to the present day, 2024.

6 Analysis

The analysis is divided into three sections. The 2004-2010 period covers the agenda-setting and policy formulation stages; the MSF guides the analysis. The second section, 2010-2019 begins with the adoption of the global health policy and analyses the policy making until 2019; network theory will direct this analysis. The last period, from 2019 to 2024, begins with the formulation of the second global health strategy, up to current days. This analysis will be directed by PET.

Policies often fall prey to the policy cycle theory, which states that policies are boosted before an election to realise electoral gains (Ackrill et al., 2013; Bailey, 2022; Bartolini, 1999). However, global health does not bring any quick visible benefit to the population. Secondly, EU elections have been held in 2019, 2014, and 2009. As the two global health policies were proposed in 2010 and 2022, the temporality does not match with the theory.

6.1 2004-2010: Emergence

6.1.1 Policy, politics and problems

The emergence of the global health policy on the EU's agenda was connected to the international political climate. In fact, the 2000s had been particularly productive in terms of political agreements on global health. Health was a central component of the United Nations Millennium Declaration Resolution (SEC/2007/ 1374, 2007). At the WHO two binding health regulations were adopted; the Framework Convention on Tobacco Control in 2003 and the International Health Regulations in 2005 (SEC/2007/ 1374, 2007). The 2005 Paris Declaration marked the transition from health as development, to global health, based on solidarity (SEC/2007/ 1374, 2007). As the international arena became more accustomed to global health, policies begun to proliferate. It is likely that the EU adopted a policy of global health to match these new international standards.

However, the world became interested in global health not just because of its intrinsic value. The threats of viruses crossing borders, and the risk of bioterror heightened securitisation around health, which prompted action from the international community (McInnes & Lee, 2006). The 2001 anthrax attacks led to the establishment of the Global Health Security Initiative (15789, 2007). After the N1H1 pandemic, the EU and the US agreed to deepen cooperation in global health. (General Secretariat of the Council, 2009). Overall, attention to health also meant that health became one of the largest global markets (Nobel Forum Seminar, 2009, p. 10).

As international action on health became more frequent, so did the involvement of the EU, making effective EU action in global health a political priority. While in 2006 global health was not listed as a priority in the EU (11635/06, 2006), this changed and by 2009, Canice Colan, Senior Coordinator for global health at DG SANCO, expressed the following:

> *The UNGA, the World Health Assembly, ECOSOC, the Human Rights Council – the EU is very active at the international level, but not always seen as being active, or as effective as we should or could be. Actors who have a global health strategy across government show us what, at the EU level, we are*

sometimes missing: consistency of action, across the board, consistency of messaging (Nobel Forum Seminar, 2009, p. 5).

As the world's largest free market and a power in the international arena, the EU had many incentives to develop a structured global health policy. As predicted by the MSF, the combination of the policy, politics and problem stream, were instrumental to push global health on the EU's agenda.

6.1.2 The policy window

Evolutions of the MSF in the EU context found that policy windows in the EU tend to be open for long periods of time (Ackrill & Kay, 2011, p. 86, Huisman & de Jong, 2014; Saurugger & Terpan, 2016). In accordance with their findings, the EU global health policy also enjoyed a long policy window. Its opening was marked by the 2004-2006 consultations, alongside talks at international meetings (DG SANCO, 2007, p. 8). However, the three policy streams only merged in 2009 at the Nobel Forum (Nobel Forum Seminar, 2009). The window would close shortly after the seminar, as the EC and the Council would adopt the 'EU global health policy' (9644/10, 2010; COM(2010)128 final, 2010). The policy focused on globalisation, the importance of research, and health as a means to development (SEC(2010) 380 final, 2010; SEC(2010) 381 final, 2010; SEC(2010) 382 final, 2010).

6.1.3 The entrepreneur

To understand the developments of the policy between the early formulation of the global health policy and its adoption, one must first identify which institution was responsible for the policy. It can be argued that entrepreneurship was bound to belong to the Council because it holds jurisdiction over foreign policy matters, of which global health is part. However, responsibilities are not as clear-cut. The EC has an obligation to help Member States cooperate, and cooperative community action is indispensable to improve and protect health (COM/2007/0630 final, 2007). Although the Council will have a prominent role in the policy, the EC has space to participate in the promotion of the global health policy through the principle of subsidiarity.

The idea of a health policy with a global outlook was first mentioned in 2004 when Commissioner Byrne called for a reform of the EU's strategy for health (Byrne, 2004, p. 9). This initial formulation of global health was limited to gaining a leadership position in international fora; it did not establish any programme with tangible results. In response, stakeholders called for structural global health actions, financed by the EU health strategy; the main financial instrument of the EC for health policy (DG SANCO, 2007, p. 8). However, the EC excluded global health from the official 2008-2013 health strategy, and only inserted a generic aim to improve health beyond the EU borders (COM/2007/0630 final, 2007; SEC/2007/ 1374, 2007; SEC/2007/ 1375 final, 2007; SEC/2007/ 1376, 2007). This meant that the global health policy could not access finances for structured programmes, making it hard to create consistency, activity, and finance programmes. Further, no one between the Committee of the Regions, the European Economic and Social Committee, and the European Parliament made any relevant mention of global health when reviewing the strategy (2008/C 172/08, 2008; 2009/C 77/23, 2009; P6_TA(2008)0477, 2008).

Beyond making weak drafts, the EC also lacked leadership. When the 2009 N1H1 epidemic, erupted, the EC placed itself as a facilitator between Member States, and as an independent scientific body, clearly signalling the lack of intent to gain a central position in the response to the epidemic (COM(2009) 481 final, 2009, pp. 4, 10; SEC/2007/ 1374, 2007).

As interest was absent from other institutions the Council asserted itself as the leader. The N1H1 epidemic called for global cooperation in the short term and for a long-term strategy to strengthen public health systems in developing countries (14338/09, 2009, p. 5). After the EC unveiled the 2010 global health policy (COM(2010)128 final, 2010), the Council did not retain it sufficient and stressed the need to strengthen the health perspectives in EU external policies, placing itself as the first and only EU organ to actively seek after a stronger global health proposal (9505/10, 2010, p. 5). However, without the support from other institutions the Council imprinted change only insofar as it had full powers. This explains the strong and united action in international organisations, as documented by Kickbush & Franz (2020), and the lack of initiatives in other areas (Battams et al., 2012).

These findings also bring evidence against the hypothesis made by Aluttis et al. (2014) and Veron et al. (2022), who posit that these inconsistencies in the 2010 policy were caused by decreasing political attention. As just showed, beyond the Council, political attention was never there in the first place, causing policy incoherence. While the Council was constructing

a global health policy, the EC was not offering the support needed to make the policy stand. Thus, it becomes clearer why free trade agreements were upheld at the cost of medicinal shortages, (Chang & Rollet, 2013; Wu, 2010) or why the EU advocated for global access to vaccines while at the same time safeguarding its own access to them (Bergner et al., 2020).

6.2 2010-2019: Colliding priorities

As established in the previous section, the EC and the Council regarded the global health policy with different political priorities. Nonetheless, both established groups to work on the topic. Using network theory, the following section will analyse how the policymaking of the global health policy was carried out.

6.2.1 The EC's tools

The EC could influence policymaking on global health through financing and policy proposals. In regard to financing, like its 2008-2013 predecessor, the 2014-2020 financial strategy only generically mentions global health policy in brief and vague statements (282/2014, 2014). This implied that the lack of financial support to build structured programmes would be renewed for the next six years.

But by large, the EC's activities in regard to the global health policy will be expressed through the global health forum, a conference to decide what policies to actuate, established in 2010. Overall, the activity of the forum will vary extensively over the decade. At first, when the momentum from the approval of the policy was still high, the forum was characterised by political clout and multi-stakeholder presence, and a discussion of many facets of the global health policy. During 2011-2012, the forum was led by DG SANCO and DG DEVCO regularly hosting multiple rounds of conferences each year (DG DEVCO, 2011; DG DEVCO, 2012a; DG SANCO, 2010a; DG SANCO, 2010b; DG SANCO, 2011a; DG SANCO, 2011b; DG SANCO, 2011c; DG SANCO, 2011d;). Likewise, the topics discussed were wide-ranging at every meeting. Multiple actors and multiple topics ensured the global focus was kept in place, maintaining the policymaking and policy output relevant and up to date.

However, the intersectional nature of the forum started to shift in 2012 (DG DEVCO, 2012b). In the following years, while a multistakeholder presence was maintained, the agenda became monothematic, solely focused on 'temporary' events. Securing Horizon programme financing in 2012 (DG DEVCO, 2012b), addressing the role of private health in developing countries in 2014 (DG DEVCO, 2012c; DG SANCO, 2014; DG SANCO, 2014a; DG SANCO, 2014b). Then the Ebola outbreak of 2014-2015 captured the full attention of the forum (DG ECHO, 2014; DG DEVCO, 2014; DG SANCO, 2014c). By 2015; the EU 'Year of Development', the focus had been ultimately monopolised, and the forum, chaired by DG Intpa, neglected all other aspects beyond development (DG Intpa, 2015a; DG Intpa, 2015b; DG Intpa, 2015c; DG Intpa, 2015d; DG RTD, 2016). Focus on single events led to a division of global health into its single components. This segmentation resulted in a loss of meaning and political interest. Overall policy output decreased steadily over the years and came to a stop. The year of development signalled the death of the forum, as no meeting took place between 2016 and 2022.

6.2.2 The Council's tools

Like the EC, the Council also suffered from internal issues which harmed the global health policy. Upon the approval of the 2008-2013 health strategy, the Council created the working party on public health at the senior level (WPPHSL), which in the Council's words, was meant to be the main forum for discussion on strategic health issues, among which global health was present (ST 9462/09, 2009). In parallel, the Council also established the Chief Medical Officer meeting, where experts would meet to untangle the technical questions (17922/10, 2010). Although in principle the WPPHSL and the global health policy forum were intended to have two different aims, in practice this was a thin division, and the two fora likely overlapped each other, creating confusion. They did not share economic and human capital resources, thus not being able to propose effective policies. WPPHSL meetings followed the agenda of international health meetings, and when the world agenda did not feature any high-level health meetings, the WPPHSL also did not meet (14112/11, 2011, p. 3; 14116/11, 2011, p.2). This created very irregular schedules and little strategic reflection on the long-term goals of the policy. Furthermore, rather than discussing global health issues, the forum was misused to debate what the EU position in the WHO should be, being treated like an official ambassadorial setting rather than a policy making forum (14112/11, 2011, p. 2;

14116/11, 2011, p. 4). Furthermore, the Council also privileged medical industrial research over global health research (11635/06, 2006).

As predicted by network theory, a lack of coordination and guidance between the EC and Council groups lead to fragmentation, and lack of communication. Economical and human resources were kept separate, thus little policy output was produced, and the policy was soon forgotten. Concurrently to these practical challenges, global health was never set as a political priority. Battams et al. (2012) and Van Schaik, (2011) explain this lack as inter-institutional contestation. As a consequence of poor policy formulation and lack of political attention, no meaningful policy would be produced by the EU in this decade.

6.3 2019-2024: Prioritisation of global health?

After years of inactivity, 2019 marks the first small revival of the global health policy. The EC published brief documents restating its commitment to global health (COM(2021) 252 final/2, 2021; COM(2021) 380 final, 2021; COM(2021) 764 final, 2021). A working party within the Council would criticise the state of the policy (5093/20, 2020; 11412/19, 2019), and a year later, the Council issued a paper with suggestions on how to improve the global health policy (5093/20, 2020). However, the efforts were still limited to vague statements and reaffirming the centrality of the WHO in global health (12276/20, 2020). A pandemic roadmap was drawn by the EC to be abandoned two years later (Ares(2018)1651235, 2018). Furthermore, neither the EC, the European Parliament, nor the Council mentioned global health as a priority in the drafting of the 2020 health strategy (COM(2020) 405 final, 2020; The Council, 2020). Thus, no funds were allocated to global health in the 2021-2028 period, and no concrete financing plans were drawn (2021/522, 2021; COM(2020) 405 final, 2020). In doing so, the European institutions tragically ignored a wake-up call from the European Court of Auditors, which was calling for increased funding and measures in light of EU unpreparedness in case of pandemics (European Court of Auditors, 2016, p. 11). The consequences will be harshly felt by Europeans, as from 2020, the COVID-19 pandemic will claim thousands of lives.

Before moving to the effects of COVID-19, a small reflection is appropriate. Over two decades, the EC has always refused to include a budget for policies on global health. While at first, this might seem like a budgeting issue, it is not, as the EU already spends billions every

year on the Global Fund and the WHO, which are global health-related. Thus, the exclusion of global health from the budget seems more a political choice, rather than a financial one. While the Van Schaik (2011) and Bergner (2023) have tried to explain irregular policy output through Member States disputes, these findings highlight that many issues were instead caused by inter-institutional disagreement.

Returning to COVID-19; in line with punctuated equilibrium theory, the COVID-19 crisis functioned as a puncture. After a substantial period of equilibrium, where the policy was substantially ignored between 2016 and 2019, COVID-19 brought an exogenous shock which broke the equilibrium and substantially changed the perception of global health. COVID-19 highlighted the global interconnection of health and underscored the health difficulties of many countries outside of the EU. This wake-up call fostered reforms (8417/23, 2023; EC, 2022), which revived the global health policy forum, and replaced the global health policy on the agenda (Kyriakides, 2023; von der Leyen, 2021).

6.3.1 The global health policy goes global

COVID-19 was a global pandemic, and it required a global response. The idea of global health was obviously central in the pandemic, and while COVID-19 was still at large, the EU adopted its second and reinvigorated global health strategy. However, the process that brought the adoption of the 2022 strategy was very different than what characterised the 2004-2010 period.

The first change brought by the COVID-19 shock has been a greater emphasis on the 'global' approach of the policy. The EU extended its works on global health beyond the WHO to collaborate with other important organisations, such as the G20. This represents a break with the past as the EU has always been an invitee at the G20, yet the EU and the G20 countries only quickly discussed global health over the years (G20 Antalya, 2015; G20 Brussels, 2014; G20 Germany, 2015; G20 Germany, 2017, G20 Taormina, 2017). In the pandemic period, this changed, and global health became the centre of attention at the 2021 global health summit (EC & Italy, 2021), co-hosted by the G20 presidency and the EC. At the summit, the EU and the G20 countries, alongside academia and civil society (EC, 2021; EC et al., 2021b), adopted the Rome declaration, focusing on prevention and emergency response to health threats (EC et al., 2021a). It must be noted that it is not yet possible to speak of a truly global approach, as the Rome Declaration is heavily focused on the interests of industrialised

countries. Nonetheless, opening to collaboration with the G20 is a step forward towards a more ‘global’ health policy.

This shift is decisive because, until this moment, the only international expression of global health from the EU had been engagement with the WHO. Although important, this engagement always remained limited to abstract goals, lacking concrete objectives. Instead, by initiating collaboration with other major powers, the EU realised the first concrete, solid and global partnership, coordinating the mobilisation of trillions of resources aimed at addressing issues of global health (G20 Saudi Arabia, 2020).

The symbol of the internationalisation of global health policy is perhaps best seen at the 2022 conference to introduce the strategy to the world. In contrast with the 2010 conference where only DGs and WHO were present, the EU included a very large and diverse set of actors; like the WHO director, DG climate and health, the private sector, the Gavi fund, the Caribbean public health agency, the World Bank, and the G20 presidency (EC, 2022). Certainly, the rank of officers at a conference does not assure the quality of the policy, but it transmits a message. Diversity of partnerships, international coordination, and consultations with actors globally will be at the centre of the EU’s global health policy.

6.3.2 A change in formulation

Beyond causing a sharp turn in the EU’s international approach to global health, the pandemic also marked a widening in the EU’s conceptualisation of global health, leading to a better-formulated policy, reflected in the new 2022 EU global health strategy (COM(2022) 675 final, 2022).

Instead of focusing on a narrow implementation of global health like in 2010, the new policy included a larger set of actions to implement the policy. The first evidence of a change of pace is found at the Riyadh G20, where the EU expressed the need to coordinate global finance, climate change, and trade to face the pandemic (Charles Michel, 2020; G20 Saudi Arabia, 2020). When the works for the second global health policy began, the EC incorporated the content of the public consultations, (Ares(2022)4697731, 2022; Ares(2022)7906176, 2022), and the criticalities highlighted by the WPPHSL were addressed (9623/21, 2021), leading to a more structured formulation of the policy. The final text introduces greater accountability, partner research with the global south, operationalised in 20

principles, which are accompanied by monitoring frameworks to assess the effectiveness of the policies and monitor funding, long-term financial mechanisms, coherence of policies, collaboration with G7 and the G20, alongside support for the WHO, and a long-term goal up to 2030. Finally, the global health policy forum was also re-established (EC, 2022; EC, 2023a)

These changes are fundamental since they address one of the two structural deficiencies of the 2010 policy, lack of structure; the other being a lack of political commitment. Providing structure will allow working parties to follow a schedule, instead of following international health crises. Having benchmarks can delineate quantifiable results to more easily assess impact and address deficiencies. In short, what the old policy lacked in terms of organisation, the new one possessed.

This is not just an evolution in methods, but it also represents an evolution in the understanding of global health. The concept of global health enlarged, from the narrow focus on health threats and health as development to a wider understanding that emphasises interconnection between global health, the climate, the economy, trade and many other fields (G7, 2021). In fact, the 2022 strategy notes for the first time the necessity to include other fundamental areas, like climate neutrality, biodiversity loss, air and water pollution, safety standards, humanitarian assistance, education, and finance as complementary topics to the 'classical health' in order to effectively address global health (COM(2022) 675 final, 2022). The EU's policy finally reflects the modern theoretical and practical complexities of global health.

6.3.3 Future political directions

While changes in the formulation of the policy are necessary to ensure a better implementation, these require political backing to be implemented. PET theory predicted that after the COVID-19 shock political attention would return and a cycle of positive feedback would start. However, evidence is mixed.

On the one hand, the EU-Africa pact on health (EC, n.d.a), the implementation of DG HERA (EC, n.d.b), the health emergency preparedness response, the establishment of the European and Developing Countries Clinical Trials Partnership (EDCTP) (EC, 2023b), are all positive signs. These are the first large-scale, structured, and international efforts that the EU has put

in place with other partners to address global health, signalling that, at least for now, political investments are being made by the EU (14599/21, 2021).

On the other hand, the picture becomes less bright when we look at the Council's statements. In the 2023 Granada declaration, where the Council laid out its main priorities, global health is absent (The Council, 2023c). The global health strategy is only mentioned a few times over a span of two years (6090/23, 2023; 15308/22, 2022), and the Council also waited two years before delivering their conclusions, reiterating their support but without proposing proactive actions (5908/24, 2024). Indeed the impetus of global health appears to be quickly waning, as the Council's priorities involve less and less global health, and return on internal health matters, like rare diseases, cancer policy, data space, and health in employment (The Council, 2021; The Council, 2022a; The Council, 2022b; The Council, 2022c).

However, the EU is also exhibiting self-interested behaviour, in line with the trend of health securitisation found in the literature (Youde, 2022). Since COVID-19, the concept of open strategic autonomy has been introduced in the EU, which has extended into the branch of health. In contrast with previous years, the EU is portraying interdependence as an existential threat. Medical supplies and medicines stocks are being securitised, with the final goal to create an EU that is non-reliant on external actors (The Council, 2020; The Council, 2023a). However, securitisation is likely to increase policy incoherence. Self-sufficiency comes at odds with the EU Africa pact, as sub-Saharan Africa cannot afford to outprice the EU on these supplies and yet is in disproportionate need of doctors and medical equipment (Taylor & Dhillon, 2011). Further, despite the global nature of antimicrobial resistance, and its centrality in global health policy, the EU is creating a path towards antimicrobial resistance that does not contemplate collaboration with others (8417/23, 2023; SWD(2017) 240 final, 2017; The Council, 2023b). It remains to see if these securitising measures are just short term adjustments caused by COVID-19, or if they will become a permanent part of the EU's strategy.

7 Conclusion

This research has explored the question of: *How can we explain fluctuations in policy output of the European Union's global health policy?* This research finds that policy fluctuations in policy output are caused mainly by the changes in the policy formulation and changing political attention. In accordance with the MSF, in the early 2000s, growing political pressure at the international level, as well as global health threats incentivised the EU to propose a global health strategy of its own; the first significant policy output of global health. However, the Council was the only institution promoting the policy. Lack of support from the other actors in the EU network led to a weak formulation of the policy, which caused confusion overlapping authority, and a lack of political guidance. As predicted by network theory, without set goals the responsible actors followed developments of global crises rather than pursuing the promotion of a constructive agenda. Due to this institutional nightmare, little to no policy output was produced, and the global health policy quickly lost relevance. The policy was only re-awakened once COVID-19 punctured the global political arena. As per PET, the shock produced by COVID-19 broke the static equilibrium and brought political attention to global health. The crisis fostered a more comprehensive understanding of global health, leading to a new policy in 2022. The strategy was formulated in a more structured manner, applying roadmaps and accountability. These more rigorous guidelines begun to bear fruits, and since 2022 the proposed policies are aimed to sustain long-term programmes and long-term goals with a global outlook, reflecting modern conceptualisations of global health.

Shortcomings of the research

A shortcoming of the research has been the inability to determine individual entrepreneurship. The analysed documents do not report names of individuals but only of its publishing institution. Conducting archival research could give access to meeting minutes, notes and other written materials that could contextualise better individual responsibilities, if there were any. Doing so would contribute to defining more clearly the role of individual entrepreneurs within the Council, also contributing to the emerging scholarship on policy entrepreneurship and policy change (Mintrom & Norman, 2009).

Theoretical implications

The patterns predicted by MSF, PET and network theories were all confirmed. However, the findings of this research hold further implications for MSF and PET theory.

To begin with, the MSF states that windows of opportunity can only be opened in the problem and politics streams. However, in this case, the window of opportunity was opened in the policy stream, at the 2009 forum. Secondly, the MSF claims independence of the three streams. However, in this case they influenced each other; epidemics and poverty presented global threats (problem stream) that led to global initiatives on health (politics streams), to which the EU has responded with their own global health policy (policy stream). These findings bring further evidence to the current policy debate on the universality of the MSF (Weible, 2023). They indicate that the MSF should be adjusted to account for the different institutional contexts.

Secondly, EU adaptations of PET theory posit that multi-DG-management of a policy could cause shocks that would rupture the policy (Daviter, 2009). However, this case points in the opposite direction. The policy was most successful when managed by multiple DGs, and suffered a decline when the multi-stakeholder format was stopped.

Future research

The application of theories of policymaking explained differing policy output over time; they found that political attention and policy formulation are key. However, middle range theories were not enough to explain why political attention changed over the years. Conducting interviews with policymakers could instead attest to how political attention is allocated. Revealing why political attention shifts would enable the prediction of global health policy changes. Therefore, this research calls for further research to be conducted, to outline what are the political drivers of the global health policy. A suitable path forward would be to analyse these interviews through the lens of grand theories of IR, as these provide justifications for broad political movements.

Beyond calling for further interviews with grand theories, this research also calls for approaching the global health literature with a new mindset. As of now, the three branches of the literature are being developed independently, but as shown from this research, each of them can bring useful contributions to the same case. Grand theories account for political movements, middle range theories account for context and research on policy evaluation

signals inconsistencies. Combining insights from each branch, future studies will be able to bring more comprehensive propositions to explain the current state of global health policies.

Finally, as global health policies are emerging worldwide, more research is needed on them. Conducting comparative research between the policy cycles of global health in different federations, such as the US, Switzerland, and the quasi federation of the EU, could highlight the pitfalls to avoid and best practices of global health. These could inform prescriptive policies towards other federations that are grappling with the formation of global health policies such as Brazil, India and Russia.

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