

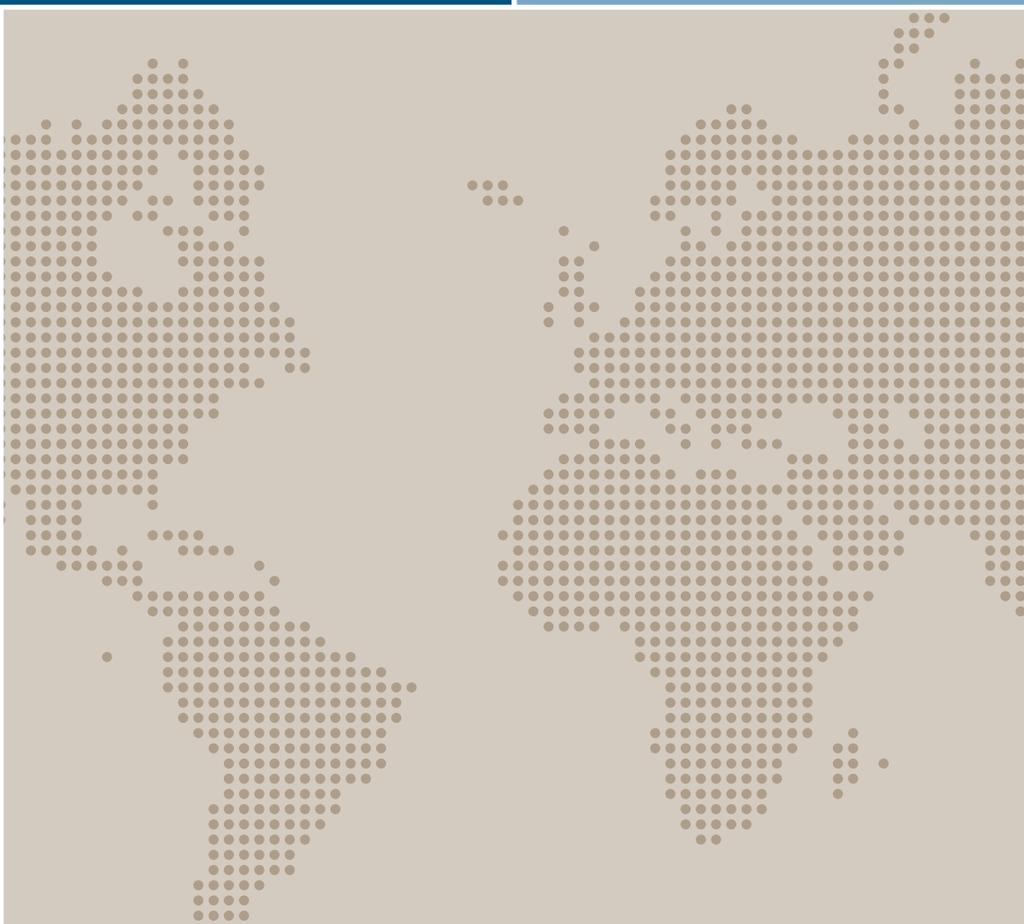
The European Approach to Global Health

Identifying Common Ground for a U.S.-EU Agenda

A Report of the CSIS Global Health Policy Center

AUTHOR
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THE EUROPEAN APPROACH TO GLOBAL HEALTH: IDENTIFYING COMMON GROUND FOR A U.S.–EU AGENDA

*Gaudenz Silberschmidt*¹

Overview

The advent of the Obama administration offers an important opportunity to launch a serious dialogue on strengthening transatlantic collaboration on global health issues. This dialogue will require high-level commitment and engagement from both Europe and the United States. And it will naturally emanate from each side's internal processes and strategic approach to global health.

There is ample reason for stronger, more effective collaboration. The United States and the European Union are arguably the two most-powerful international players on global health. They share a long history of scientific and technical cooperation on health issues, and both have a well-articulated interest both in building capacity in the developing world for health and economic opportunity and in countering transnational health threats.

Previous efforts at collaboration have been hampered by different perspectives on what particular issues fall within the sphere of global health and by different approaches to linking health, international relations, and development. The internal structures and processes that affect global health decisions within the European Union are complex and often difficult for the United States and other external partners to understand or navigate. Europeans and others have similar difficulties understanding U.S. structures and processes affecting global health policies. In several areas, in fact, recent U.S. global health policies have generated considerable criticism and resentment among European partners.

This paper, based on a series of interviews with senior European health leaders, seeks to shed light on European approaches to global health; the interactions among the European Union (EU),

1. Gaudenz Silberschmidt has been head of the Division of International Affairs, Federal Office of Public Health, Switzerland, since 2003.

This text offers a personal view on what Europe is doing and thinking about global health and where there might be further opportunity for transatlantic collaboration. It is based mainly on my experience as vice director and head of international affairs of the Swiss Federal Office of Public Health (corresponding to an assistant secretary for international affairs of the ministry of health) and my two-month sabbatical as a visiting fellow with the CSIS Global Health Policy Center in November / December 2008. I have conducted 13 telephone interviews with senior-level colleagues in various departments in eight key countries, the European Commission, the World Health Organization, and academia. The interviews were explicitly conducted under Chatham House rules, meaning that answers would not be attributed to individuals. They have strongly inspired my writing and provided many useful ideas. I would like to thank all these colleagues for their help.

This document was written as a background paper for the CSIS Commission for Smart Global Health Policy. It reflects the state of affairs in early 2009.

the European Commission (EC), and member states; and, finally, European perceptions of U.S. global health policies. All of those interviewed strongly support the need for a more consistent and reciprocal dialogue between the United States and Europe, although there were varying opinions on what the initial focus of such a dialogue should be. The paper concludes with suggestions for enhancing U.S.-EU engagement to better identify partnership opportunities in improving global public health in the long term.

Defining Global Health

The United States and European nations often have differing understandings of what is meant by the term “global health,” and these differences can complicate cooperation within international forums as well as in harmonizing policy and program outreach to other countries. (See Appendix A, What Is Global Health?)

The Bush administration largely kept U.S. national health policy distinct from its global health policy, the latter being focused on the least-developed and a few geopolitically strategic countries. European actors taking a strategic approach to their own policy on global health generally work on the basis of a continuum that embraces domestic policy, neighborhood policy, continental policy, health as a global public good, and health development policy, where all except their own domestic health policy are considered part of global health and where global health has clear links to their own national health policy.

In 2006, the European Foundation Center published “European Perspectives on Global Health: A Policy Glossary,”² which provides a strategic overview of global health and where Europe should be going. The report describes global health this way:

Global health refers to those health issues which transcend national boundaries and governments and calls for actions to influence the global forces that determine the health of people.

The multitude of policy fields influencing global health poses a particular challenge for the formulation and implementation of a consistent global health policy. Often the position on a particular topic depends as much on which specific ministry representative is asked as it does on which country is asked. When dealing with different international organizations, two or more ministries of the same government may take conflicting positions on the same issue. Access to medicines is an example. This issue involves core responsibilities and authorities of various ministries, including but not limited to those responsible for health, development cooperation, foreign affairs, trade, intellectual property, research, drug regulations, finance, and customs. In this and other areas, a sound global health policy needs to include balanced and well-functioning mechanisms to improve policy coherence in such a way that no one of the legitimate concerns of the various government entities at the table consistently dominates.

European Global Health Activities

The European Union has become the major player on the European continent in many policy fields. The EU has developed a remarkable system of shared sovereignty between its 27 member

2. http://www.efc.be/ftp/public/ic/Health/EFC_EPGH_GlobalHealthGlossary.pdf.

states and the Union, where policy is increasingly decided in common and forms part of the joint legislation called *acquis communautaire*. The EU is based on the four freedoms of movement—of persons, goods, services, and capital. The EU's GDP is slightly larger than that of the United States, and its population of 500 million is slightly larger as well.

Until a few years ago, national fiscal, social, and health policies were largely exempt from EU integration. However, the national-level prerogative on health policy has changed over recent years. At first, health integration focused solely on public health issues, beginning with health protection measures, such as blood safety, and initiatives such as the creation of the European Centre for Disease Prevention and Control (ECDC) in Stockholm in 2005. Integration now includes a proposed directive on cross-border patient mobility, which could be a test case for a major future challenge (i.e., how to guide the interoperability of health systems globally, when not only the goods and labor markets but also the health service market is becoming globalized).

In international health forums such as the World Health Organization (WHO), the EU speaks increasingly with one voice (although it retains 27 votes). The complex internal structure and need to bring member states to a common position often lead to a complex interplay of interventions by the European Commission—for example, in trade-related issues, intervention by the rotating presidency³ and interventions by individual EU member states. While this development has made the EU into one of the world's largest powers, the details of its functioning are sometimes difficult for outsiders to understand. Moreover, the need for internal coordination (i.e., *within* the EU) can hinder the progress of multilateral negotiations and even weaken the EU's influence on such negotiations. There is an interesting parallel here between the EU and the United States: The two most important players in the global health arena each have such complex internal decision-making processes and involve such a multiplicity of players that, once they have struggled to find a common internal position, they often have difficulty compromising on those well-discussed positions in order to reach a global consensus.

The most active players within the EU are the United Kingdom, France, and the Nordic countries of Sweden, Finland, and Denmark, together with the European Commission. Germany and the Netherlands are becoming more active, while many of the other countries are heard on individual topics but rarely in overall strategic global health discussions. Outside the EU, Norway and Switzerland are smaller but well-positioned players on global health. Switzerland and the UK are the only two European countries with a global health strategy agreed upon at cabinet level. (See Appendix B, *The European Dramatis Personae*.)

The overall role of global health in European policy is characterized by growing interest in defining security more broadly. Over the last five years, foreign policy circles in Europe have become increasingly interested in global health, although that interest has not yet been articulated in a structured form. Although many foreign-policy makers and diplomats traditionally have had little interest in health issues, a number of current policy leaders became involved in global health issues when they were exposed to them earlier in their careers. Norway's foreign affairs minister Jonas Store and France's recent foreign minister Philippe Douste-Blazy, for example, were the principal drivers of the Oslo Ministerial Declaration "Global Health: A Pressing Foreign Policy

3. The presidency of the EU rotates among member states every six months; in 2009, Czech Republic and, beginning July 1, Sweden; in 2010, Spain and Belgium; in 2011, Hungary and Poland.

Issue of Our Time,”⁴ which was signed by the ministers of foreign affairs of Norway, France, Brazil, Indonesia, Senegal, South Africa, and Thailand. Store was head of the cabinet of then director-general of the World Health Organization Gro Harlem Brundtland, and Douste-Blazy is a physician and former health minister, as is Bernard Kouchner, Douste-Blazy’s successor as French foreign minister.

Prior to the advent of the United States’ President’s Emergency Plan for AIDS Relief (PEPFAR), the EU’s Official Development Assistance (ODA) for health was roughly 50 percent larger than that of the United States.⁵ This fact is often overlooked because the United States is one government (with multiple agencies), while the EU has 27 national governments and the Commission. PEPFAR has shifted the global health spending balance in favor of the United States.⁶

Although the bilateral donors and the support for multilateral institutions such as the WHO seem to be stronger and more consistent in Europe than in the United States, foundations in Europe are smaller and less innovative than are their U.S. counterparts. Some European foundations have made significant philanthropic contributions both domestically and internationally, but none has engaged in global health as significantly as the Bill and Melinda Gates Foundation, the Bloomberg Foundation, the Rockefeller Foundations, and several other major U.S. philanthropies. Europe also has less of a think-tank tradition than does the United States. However, a few programs aside from the classical European academic actors in global health (such as the London School of Hygiene and Tropical Medicine and similar schools in Liverpool, Antwerp, and Basel) have started to work on global health and global health diplomacy, most notably the Graduate Institute of International and Development Studies in Geneva and a new global health program at Chatham House in London.

4. [http://www.norvege.no/policy/peace/peace/helse+og+utenrikspolitkk+-+Agenda+for+Action.htm](http://www.norvege.no/policy/peace/peace/helse+og+utenrikspolitikk+-+Agenda+for+Action.htm)

5. OECD DAC database, retrieved from <http://stats.oecd.org/qwids/> (in current prices, USD millions):

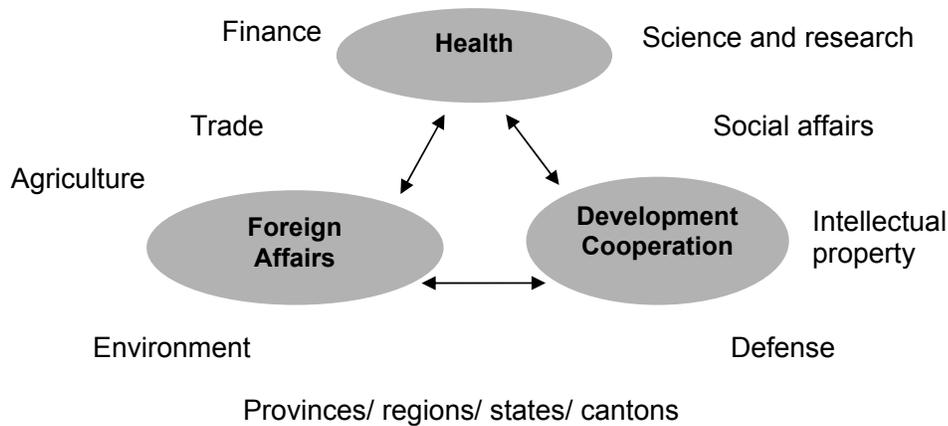
Time Period	Health ODA 2002	2003	2004	2005	2006	2007
All Donors, Total	2,914.17	3,369.14	4,095.05	4,487.49	5,398.84	5,199.1
EU Members, Total	1,203.72	1,297.52	1,461.37	1,543.08	2,239.17	2,030.91
United States	677.91	698.46	1,026.52	1,114.26	1,349.25	1,135.03

6. <http://www.pepfar.gov/press/80064.htm> (accessed in December 2008).

Programs	FY 2004 Enacted	FY 2005 Enacted	FY 2006 Enacted	FY 2007 Enacted	FY 2008 Enacted	Cumulative Total*
Focus Countries	845	1,370	1,756	2,849	4,090	10,910
Global Fund	547	347	545	724	840	3,003
Other Bilateral Programs	444	455	426	389	443	2,157
Other Activities (including NIH Research and TB Programs)	475	547	563	561	623	2,769
TOTAL EMERGENCY PLAN (without malaria)	2,311	2,719	3,290	4,523	5,996	18,839

*Includes FY 2004 - FY 2008 enacted. As of January 11, 2008

The key triangle



Intersectoral Coordination: Links between Health, Development, and Foreign Affairs

The main European governmental players in global health can be described as a triangle composed of the ministries responsible for health, development cooperation, and foreign affairs, with many other ministries having authority and interest in particular areas of global health policy. (See figure, above.)

This triangle of responsibilities evolved out of post–World War II realities, in which health became an important pillar of European development policy. The ministries of health were involved mainly in the WHO, which was largely a technical and scientific agency before global health began to be perceived as a pillar of foreign policy. Two consequences of this structure, which is—with some variations—common to most industrialized countries, are worth discussing.

First, this structure creates uncertainty in assigning policy and funding responsibilities. The H₅N₁ bird (avian) influenza epidemic in 2005, which carried the threat of being the origin of the next human flu pandemic, illustrated for an audience well beyond public health experts the potentially dire societal consequences of emerging new infections. A vigorous common effort against H₅N₁ was considered a sound investment in a key global public good. While governments made significant investments to fight bird flu, they faced the challenge of finding a budget line to cover those investments. Ministries of health have billions of dollars, but that money is usually reserved for domestic investments. Ministries or agencies responsible for development cooperation also have billions of dollars but focus on the needs of least-developed countries, while the spread of bird flu was largely occurring in emerging economies such as China, Vietnam, Indonesia, and Egypt. Ministries of foreign affairs often do not have significant budgets outside of their internal spending, while most ministries of defense would not include this aspect of global health security in their security concept and spending priorities. On this type of issue, the U.S. budget appropriations process has greater flexibility than the EU processes in deciding on necessary new investments in global public goods.

Second, the structure does not lend itself to engagement with emerging economies, an increasingly important grouping within global health affairs. The implicit split of health-related responsibilities between ministries of health responsible for contacts with industrialized countries and ministries of development cooperation responsible for contacts with developing countries may have made sense in the latter part of the twentieth century. Today, however, most of the world's poor people live in emerging economies, which are neither classical developing nor industrialized countries. In the field of global health, most governments have difficulty adapting to this new reality; some simply ignore it. International organizations and nongovernmental organizations have not adjusted to this challenge either.

Most health systems are under constant reform and can profit from international comparison and lessons learned. Among industrialized countries this is done through the OECD Health Committee,⁷ the European Observatory of Health Care Systems,⁸ and many academic institutions. For developing countries, the WHO, the World Bank, development agencies, and several academic institutions have profound knowledge of health systems and advise and support their reforms. At present, there is no single institution with sufficient knowledge and analytical capacity to advise on what China, India, Brazil, Indonesia, South Africa, and other emerging economies can learn from one another about reforming their health systems, nor can any organization provide a meaningful platform for peer learning.

Transatlantic Relations on Global Health

As on many issues, there is no monolithic European view on U.S. global health efforts. There were clear trends, however, in how Europeans recently judged the Bush administration in this domain—trends that similarly offer suggestions to the Obama administration. Experts interviewed for this paper were remarkably consistent in their emphasis on the need for greater reciprocity in U.S.-European dialogues. (See Appendix C, European Perspectives on Reciprocity in U.S.-EU Dialogues.) This sentiment was best captured by a senior European health expert, who argued that Europeans were not working with, but rather *around*, the United States in global health. He further stated that there was a permanent caveat on the issue of sexual and reproductive health, which has seriously undermined the reputation of the enormous effort and leadership shown by the United States through the PEPFAR program.

There was a tendency among many European health experts to view the Bush administration as anti-multilateralist, as evinced by the U.S. failure to ratify the WHO Framework Convention on Tobacco Control (FCTC), or to join UNITAID—an international financing mechanism for HIV/AIDS, tuberculosis, and malaria medicines—or join the International Health Partnership (IHP+), the latter two considered important forums by European member states.

Further, the United States has often been seen as taking a patronizing stance in global forums. Last year, when then-Health and Human Services Secretary Michael Leavitt spoke at an informal EU health ministers' meeting, he focused on praising U.S. achievements and did not discuss collaboration but simply invited Europeans to follow the U.S. example. Not surprisingly, this approach did not evoke a positive response from the Europeans present. During a December 2008 event hosted by the Center for Strategic and International Studies (CSIS), Secretary Leavitt gave a one-hour

7. http://www.oecd.org/about/0,3347,en_2649_33929_1_1_1_1_1,00.html.

8. <http://www.euro.who.int/observatory>.

presentation citing examples of U.S programs in 15 different countries around the world without once mentioning the work of any European country, the EU, the WHO, or any other multilateral organization.

The PEPFAR program, one of the single-largest global health initiatives ever, was at first poorly received in Europe. This was due to the tense overall transatlantic relations prevailing in 2004 and to what many in Europe perceived as PEPFAR's moralistic approach to HIV prevention. In addition, PEPFAR was criticized for its unilateralism and a focus on countries of geopolitical interest for the United States. Among those in Europe working directly on HIV/AIDS, this perception has largely abated in recent years, with Europe's own scaling-up of investment in HIV/AIDS and better collaboration with the United States. But many Europeans working in other areas of global health tend to remember the criticism of PEPFAR more than they do its remarkable achievements in AIDS treatment and the better transatlantic collaboration of recent years.

In the view of many Europeans, negative sentiment toward the United States was associated more with the Bush administration and much less with the U.S. Congress. This provides an important window of opportunity for the Obama administration to enter into a new dialogue. Despite European skepticism about U.S. global health policy, important collaborations persisted in the Group of Eight, the Global Fund to Fight AIDS, TB, and Malaria, the Global Health and Security Initiative (GHSI),⁹ the coordination of negotiation positions in the Western Europe and Others Group (WEOG) during WHO negotiations, and many other ties.

Possibilities for a New Transatlantic Dialogue on Global Health

The time is right to begin a serious transatlantic dialogue on global health. This dialogue will require high-level commitment and engagement on both sides and needs to take account of each side's internal strategic processes and global health strategy. It can build on existing dialogues such as with the global health security initiative. The conversation should not start with an agenda preset by either side but, rather, begin with an open forum designed for listening to differing perspectives.

Among those interviewed for this paper, opinions were divided on the main issues to address in a renewed transatlantic global health dialogue. Questions emerged in the following areas:

- Should a dialogue focus predominantly on the least-developed countries or on a continuum of global health issues, including industrialized and emerging economies?
- Should a dialogue focus on specific disease topics or on questions of global health governance?
- Should a transatlantic dialogue focus on a few limited global health issues, to be realistic and results-oriented, or should it try to address the multitude of global health challenges?

To my mind, an effective and sustained transatlantic global health dialogue will need to address the challenges the developing world, the industrialized world, and emerging economies face in common. This dialogue should seek a balance between concrete action-oriented steps on disease and health systems and improving the governance of approaches to global health. It can begin with a clear focus on a few deliverables, but also provide a platform to address other issues as discussion progresses.

9. <http://www.ghsi.org/>.

Initial dialogue could begin around a few discrete key issues that meet the above criteria. Strengthening national surveillance capacity, for example, might offer an appealing starting point. The International Health Regulations¹⁰ (IHR) constitute a legally binding instrument adopted by all 193 WHO member states to protect against the international spread of diseases.

An initial focus on surveillance capacity has a number of advantages:

- It is a common challenge for industrialized countries, emerging economies, and least-developed countries.
- Strengthening surveillance capacity requires a strengthening of national health systems and their interoperability, one of the major global health challenges.
- Surveillance functions properly only with sufficient numbers of trained personnel.
- Surveillance capacity is needed for global health security and for identifying and solving current local health problems (e.g., TB diagnostic and therapeutic capacities).
- Strengthening surveillance capacity requires mechanisms of technology transfer.
- The IHR and its surveillance capacity are based on the principle of universality; no country or region can be left out.

Other global health challenges to be addressed in a transatlantic dialogue could include the following:

- Maintaining global health commitments during and after the current global financial crisis.
- Strengthening the multilateral system and global health governance (although this latter should best include a larger forum that includes emerging economies and developing countries).
- Health security (including pandemic preparedness).
- Efforts to strengthen health systems in the developing world.
- Access to medicines.
- Addressing the critical need for health professionals.
- Better linking of health issues with food security and the alleviation of hunger.

On the U.S. side, the United States could take a number of actions that might facilitate U.S. engagement with international partners on global health issues. For example, the United States could:

- Elevate the director of global health affairs within the Department of Health and Human Services (HHS) to the level of assistant secretary; currently, the director is a special adviser to the HHS secretary. A similar position might be appropriate for the director of global health within the Department of State.
- Establish basic training in global health diplomacy for new Foreign Service officers. While global health has de facto become an integral part of diplomacy, most diplomacy textbooks and training courses still ignore that fact.

10. <http://www.who.int/csr/ihr/en/>.

- Establish the position of a U.S. health attaché to the EU in Brussels.
- Revise its position in the OECD to actively support analytic work and cross-country peer learning to help all OECD countries, including the United States, in their ongoing reforms of their own health systems. The Bush administration opposed such work, arguing that the OECD should focus only on collecting health data.
- Encourage the WHO and the World Bank to share their expertise on health systems in emerging economies.
- Elaborate a coherent overall U.S. governmental global health strategy similar to the Swiss and UK models.
- Consider creating a global health interagency coordination platform at the assistant secretary level, where all departments of the U.S. government relevant to global health are represented.
- Strengthen the World Health Organization as the key global health actor.
- Review the Helms-Biden act, which puts UN organizations and particularly the WHO under financial constraints and dependent on voluntary contributions, making it impossible to fulfill its mandate.
- Allow and instruct the U.S. Centers for Disease Control and Prevention (CDC) to work more closely with the WHO, as the CDC has done in the past. Newly created disease control and prevention centers such as the ECDC in Stockholm should be associated as appropriate to such collaboration.

APPENDIXES

APPENDIX A: WHAT IS GLOBAL HEALTH?

There is no single consensus definition of global health. Different actors base their arguments and actions on different implicit or explicit understandings of global health. This is best summarized in the five metaphors about global-health policy by David Stuckler and Martin McKee, amended by two more metaphors by Ilona Kickbusch:

Principle	Selected goals	Priority disease / condition	Key institutions
Global health as foreign policy	Trade, alliances, democracy, economic growth, reputation, stabilize or destabilize countries	Infectious diseases, HIV/AIDS	U.S. State Department, USAID, President's Emergency Fund for AIDS Relief (PEPFAR)
Global health as security	Combat bioterror, infectious diseases, and drug resistance	Avian influenza, severe acute respiratory syndrome (SARS), tuberculosis, AIDS	U.S. Centers for Disease Control and Prevention (CDC)
Global health as charity	Fight absolute poverty	Famine or malnutrition, HIV, AIDS, tuberculosis, malaria, rare diseases	Bill & Melinda Gates Foundation, other philanthropic bodies
Global health as investment	Maximize economic development	HIV/AIDS, malaria	World Bank and International Monetary Fund, International Labor Organization, private sector
Global health as public health	Maximize health effect	Worldwide burden of disease	WHO, vertical disease-specific NGOs
Global health as a market	Health is a future growth market	Profit opportunities in health systems	Private and public competitors
Global health as a human right	Health is a human right	Diseases, such as HIV/AIDS, for which the rich have a treatment that is too expensive for the poor	Access to medicines via NGOs

Source: Five metaphors about global-health policy, from David Stuckler and Martin McKee, *The Lancet* 372 (July 12, 2008): 95–97. Amended according to Ilona Kickbusch, “Identifying Critical Societal Public Health Needs: In Search of the Public Health Paradigm for the 21st Century,” white paper, August 2008, 1–39, available at <http://www.ilonakickbusch.com/public-health/apha-white-paper-2008.pdf>.

An additional dimension, most noticeable among European actors, is the idea of a continuum extending from domestic policy through neighborhood policy, continental policy, health as a

global public good, and health development policy, where all except a country's own domestic health policy are part of global health and where global health has clear links to the country's own national health policy.

APPENDIX B: THE EUROPEAN DRAMATIS PERSONAE

The European Union

According to the concept of shared sovereignty, the EU has to be considered as both a single bloc and as a collection of its individual parts. At present, the EU is clearly the dominant political force in Europe.

The European Commission

The European Commission (EC) is the guardian of the EU treaties, but acts also as the executive branch with its own strategic and operative action. The EC is among the most advanced players in Europe on global health strategy, and its role in this area is likely to grow in the future.

Having worked traditionally with a classical global health approach through its directorates for aid, cooperation, and external affairs, the EC has articulated a new health strategy including global health, led by a health directorate. The EU white paper *Together for Health: A Strategic Approach for the EU 2008-2013*¹¹ defines four fundamental principles for EC action on health:

- a strategy based on shared health values;
- “health is the greatest wealth”;
- health in all policies; and
- strengthening the EU's voice in global health.

The approach the EU intends to take on global health is best reflected by some quotes from this strategy:

- “The EC and its Member States can create better health outcomes for EU citizens and for others through sustained collective leadership in global health.
- “In a globalized world it is hard to separate national or EU-wide actions from global policy, as global health issues have an impact on internal Community health policy and vice versa. The EC can contribute to global health by sharing its values, experience and expertise, as well as by taking concrete steps to improve health. Work can support efforts to ensure coherence between its internal and external health policies in attaining global health goals, to consider health as an important element in the fight against poverty through health-related aspects of external development cooperation with low income countries, to respond to health threats in third countries, and to encourage implementation of international health agreements such as the World Health Organization's Framework Convention on Tobacco Control (FCTC) and International Health Regulations (IHR).
- “The EU's contribution to global health requires interaction of policy areas such as health, development cooperation, external action, research, and trade. Strengthened coordination on

11. http://ec.europa.eu/health/ph_overview/Documents/strategy_wp_en.pdf

health issues with international organizations, such as WHO and other relevant United Nations agencies, World Bank, International Labor Organization, OECD and Council of Europe, as well as other strategic partners and countries, will also enhance the EU's voice in global health and increase its influence and visibility to match its economic and political weight.”

Germany

Germany can be described as being in the second tier of European global health actors but with the potential to join the front group. For a long time, through its financial contributions (primarily on HIV/AIDS) and technical support in the field, Germany was an important actor in global health, although its involvement in the health policy debates was less than one would expect from the largest European economy. In the context of its nomination to serve on the WHO Executive Board from 2009 through 2012, Germany currently is working on a more strategic approach to global health regarding its priorities for the WHO. These are likely to focus on health systems, drug quality, and infectious diseases such as TB. Germany's eastern European neighbors are home to a multidrug-resistant TB epidemic, an immediate public health concern. German institutions such as the Robert Koch Institute, a federal institution responsible for disease control and prevention, can make valuable contributions toward global health,

Among the big European players, Germany is perceived as neutral and can therefore facilitate action. Its engagement at the top level was illustrated by the prominent place of health at the 2007 Heiligendamm G-8 Summit and by Chancellor Angela Merkel's opening of the Global Fund replenishment meeting in September 2007.

United Kingdom

The UK is traditionally at the forefront of the global health debate, both for funding and for policy. It was the second country to have a government-wide global health strategy and the first one to do so through a broad participatory process. It was also the first to attach significant new resources to the strategy's implementation. The summary of the strategy, “Health Is Global: A UK Government Strategy 2008-13,”¹² is an interesting model for other countries, including the United States. The five main themes summarize the UK's perspective on current global health challenges:

- better global health security;
- stronger, fairer, and safer systems for delivering health;
- more effective international health organizations;
- stronger, freer, and fairer trade for better health; and
- strengthening the way we use evidence to improve policy and practice.

The UK plans to invest more than \$1 billion annually with different health systems and different government departments involved, most notably the Department for International Development (DFID) and the Department of Health (DH). It remains to be seen if they can deliver fully during the current economic crisis, but the UK will in any case remain a top player in global health.

12. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088702

France

France is the third big player in the EU and on global health. French global health priorities are primarily Millennium Development Goal-based (e.g., HIV, access to medicine), health systems, and health security (including social protection). France's global health activities are more focused around specific initiatives and on the francophone countries, while France is less present on some of the other issues. Like the UK and Russia, France is a semi-permanent member of the WHO Executive Board. It has been the initiator of some innovative financing mechanisms (the airline ticket finance scheme, UNITAID, for the bulk purchase of drugs, for example) and, together with Norway, of the Global Health and Foreign Policy initiative.

Italy

Italy's priorities in global health are health security, financing health systems, and public-private partnerships for health. Italy is perceived as one of the important players in global health funding and, by its role as the host of the 2009 G-8 summit with a component on global health, is active in global policies to fight illicit drugs but is less active in other fields of global health.

Nordic EU members

The three Scandinavian EU members, Sweden, Finland, and Denmark, are traditionally at the forefront of global health policy in terms of development cooperation, and their health ministries are active players. In addition to EU coordination, they work closely together to coordinate in the framework of the Nordic Council, where Norway and Iceland are also members. Currently, Sweden seems the most active of the Nordic countries, focusing its efforts on health systems and health-related Millennium Development Goals (MDGs) and communicable diseases (HIV/AIDS, malaria, TB) in sub-Saharan Africa. Increasingly it also addresses the so-called double burden of disease in which the same countries suffering from these infectious diseases are also affected by chronic non-communicable diseases. Sweden is also active in the areas of health security, sexual and reproductive health and rights, and the social determinants of health. It supports efforts toward universal coverage of health services through a Ministry of Health-led dialogue with China and with India.

Non-EU Countries

Russia

Except for its role in the G-8, Russia seems to be relatively absent from the global health debate, especially noteworthy due to the deepening health crisis in the country. Its OECD membership bid has been made conditional by the OECD Council on an in-depth review of the Russian health system.

Turkey

Turkey is not very active in global health debates, but nonetheless is innovative and active in reforming its own health system. It is currently undergoing a review of its health system jointly performed by the OECD and the World Bank.

Norway

Norway is one of the most active players among the smaller countries on global health. Based on its social tradition and oil-based income, it devotes the highest percentage of GDP to ODA of any country, and it has made health one of its priorities in development cooperation. Together with France, it initiated the Oslo declaration process on Global Health and Foreign Policy. Norway, Australia, Canada, New Zealand, and Switzerland are the independent industrialized countries often called on to chair or mediate delicate global health negotiations.

Norway's health priorities are focused around Millennium Development Goals 4 and 5 (reducing child mortality and improving maternal health), with the strong engagement of Prime Minister Jens Stoltenberg on maternal health. Its other priorities—health system strengthening, gender issues, HIV/AIDS, and the Global Health and Foreign Policy initiative—are meant to support those goals.

Switzerland

Switzerland is, besides Norway, the other relevant non-EU global health player in Europe. Geneva hosts key health organizations and can be called the “global health capital.” The Swiss Development Cooperation has a long tradition of health work, including in health research, tropical disease, and sexual and reproductive health. Unlike many other countries, however, Switzerland has not managed to increase its global health financing over recent years.

Switzerland was the first country to have a global health strategy adopted at cabinet level. The Swiss Health Foreign Policy,¹³ signed by the ministers responsible for health and for foreign affairs, including development cooperation, defines 18 medium-term goals in the following five fields:

- Protect the health interests of the Swiss population
- Harmonise national health policy with international health policy
- Improve the effectiveness of international collaboration on health
- Improve the overall global health situation
- Maintain Switzerland's role as a host country to international organizations and as a base for major companies working in the health sector.

While less elaborate than that of the UK and lacking the necessary increased funding, the Swiss strategy has incorporated a number of features to strengthen policy coherence that could serve as models for other countries, particularly in today's context of limited resources. Among the policy measures are the creation of a coordination office for health in the ministry of foreign affairs; a joint electronic information platform where all government entities working on global health consult one another; strengthening academic capacity, notably through the establishment of the global health program at the Graduate Institute of International and Development Studies in Geneva; and staff exchange whereby a senior position in international affairs in the ministry of health is filled with a career diplomat. A further measure established an inter-ministerial coordination meeting annually at the secretary level and five times a year at the assistant secretary level,

13. <http://www.bag.admin.ch/org/01044/index.html?lang=en&download=M3wBPgDB/8ull6Du36WenojQ1NTTjaXZnqWfVp3Uhmfnapmmc7Zi6rZnqCkkIZ2fHh/bKbXrZ6lhuDZz8mMps2gpKfo>.

in which all government entities working on global health are involved to improve strategic and operative coordination.

Switzerland is also the first country to have had its health system analysed jointly by the OECD and the WHO, clearly linking global health and national health policy.

APPENDIX C: EUROPEAN PERSPECTIVES ON RECIPROCITY IN U.S.-EU DIALOGUES

The need for greater reciprocity in U.S.-EU dialogues came across clearly as a common theme throughout the interviews conducted for this paper. A sampling of quotes from those interviewed is listed below.

Many spoke about the importance of both listening and speaking as the foundation of a dialogue:

- The United States has so much to offer but has to learn that others can also offer something.
- Learn to listen.
- Both sides can learn.
- A real dialogue is needed where the United States is not imposing its wish list.
- Consult other countries before taking your own decisions.
- Both parties should listen to each other rather than talk to each other.
- Carry on discussions rather than negotiations.
- The United States should look not only at self-interest but also at shared interests.
- The United States should review the cases where it has been the blocking party in the last eight years and be prepared to make changes.
- Go in with an open mind, open ears, and open eyes, and listen to what the other has to say.
- Bring Obama's attitude of true dialogue and do not come with a set agenda.
- The agenda is not a unilateral agenda.
- Decrease arrogance.
- Everybody can learn from a dialogue.
- Dialogue does not mean that we agree, but requires listening to maximize synergies.

Others mentioned expectations about greater and more systematic multilateralism from the new U.S. administration:

- Be open to multilateralism.
- Get out of the anti-multilateralism mode.
- Eliminate the caveats on sexual and reproductive health.
- Dialogue is a real process, not a single shot.
- There has been a dialogue, but not robust.

- Give more importance to a more structured dialogue.
- Recognize the role of the EC.
- The United States should send a strong message: We need you, we cannot do this alone.
- The United States and the EU are top powers in the world. This requires common approaches.
- Broaden discussions to a G-20 dialogue.
- Involve all levels in dialogue, including the senior political level as well as the technical level.
- Consider the existing global health dialogues such as the Global Health Security Initiative, which is focused on nuclear, biological, and chemical threats and pandemics. Broaden health security with the inclusion of climate and health.
- The United States should participate in a meaningful way in multilateral processes and ratifying conventions.
- Ratify the WHO Framework Convention on Tobacco Control.
- The United States should take dialogue seriously and involve the right people.
- The United States should be convinced about dialogue.
- U.S. leadership is welcome but as *primus inter pares*—“first among peers.”