Advisory Council
on International Affairs

Foundation for a Dutch Global Health Strategy

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Advisory Council on International Affairs

The Advisory Council on International Affairs (AIV) is an independent body which advises the Dutch government and parliament on foreign policy. The Advisory Council produces advisory reports about international affairs both on its own initiative and on request. Its main areas of expertise are European cooperation, human rights, development cooperation and security policy. The AIV focuses on strategic dilemmas and draws attention to new policy matters with a view to the longer term. It produces independent, carefully argued advisory reports that provide analysis and interpretation of current international developments and recommendations for Dutch foreign policy, and in this way contributes to political and public debate on matters of international significance.

The AIV adopted the report 'Foundation for a Dutch Global Health Strategy' (AIV advisory report 121) on 6 April 2022.

Contents

Summary

The House of Representatives has asked the AIV to produce a report on the 'framework for a Dutch global health strategy'[1] which would 'lay the foundation for the development of coherent policy regarding global health issues, which the Netherlands can use to implement its strategic agenda and, leading by example, participate in international forums addressing global health issues and developing multilateral strategies'.[2]

The COVID-19 pandemic has clearly highlighted the need for a global health strategy, and has acted as a catalyst, drawing more political attention to this field. Attention is not enough, however; decisive action is required to make progress on this multidimensional issue. One reason for urgency is that it is highly likely that more health crises will emerge in the near future, in the form of pandemics or epidemics, some of them caused by diseases that are transferred from animals to humans (zoonoses). Chronic, noncommunicable diseases, antimicrobial resistance (AMR), widespread psychological disorders, the persistence of poverty-related diseases, and the simultaneous rise in diseases of affluence in several parts of the world are additional factors that make effective health policy a necessity. Steps must be taken to avoid letting of the focus on and thus the momentum for drafting of a global health strategy weakening once the current pandemic threat recedes somewhat. This would constitute a missed opportunity.

In this advisory report the AIV discusses the five motivating factors underlying the great need for a global health strategy:

1) Under major international agreements and treaties such as the International Covenant on Economic, Social and Cultural Rights and the Sustainable Development Goals, almost all countries – the Netherlands included – have committed to making the right to health a reality, everywhere in the world.

2) Global health is a global public good that requires proper joint stewardship. There is a growing awareness that the way we currently produce and consume, the way the food chain is organised and the use of resources (particularly fossil fuels) all pose risks to health.

3) COVID-19 soon highlighted the relationship between safety and security and health, though it manifests itself in many different areas. Pandemics, health emergencies, weak healthcare systems and the search for safer places to live not only cost lives, they present some of the greatest threats to safety and security. Efforts to tackle these issues that do not look beyond national borders are simply not enough.

4) Health is vital for sustainable growth, socioeconomic and cultural development, justice and stability.

5) More than ever before, this pandemic made it painfully clear that there is great inequality between (and within) countries in terms of access to healthcare. In many cases, the health gap correlates with socioeconomic disparities. Lack of water and food, violence and conflict, and the migration prompted by these factors jeopardise the physical and mental health of countless individuals in many places around the world.

International cooperation and coordination are needed for an adequate response to current and future health issues. Though many global health strategies already exist at various levels and in various forums, no jointly authorised global health strategy has ever been adopted.

This advisory report provides a rough overview of existing global health initiatives. The number of initiatives is impressive, and some positive results have been achieved. The EU, for example, despite initial difficulties in cooperation between member states, has proposed that WHO negotiations on an international pandemic treaty be launched. Individual countries have developed their own global health strategy. There is however no coherence and coordination in this area, leading to a confusing patchwork of national and multilateral initiatives. This is caused, among other things, by the lack of international cooperation, which in itself is due in part to the fact that health policy is generally a national affair, and often the exclusive responsibility of a single government ministry. Unlike national policy on public health, global health policy is not clearly embedded in any institution, and responsibility has not been clearly assigned.

Apart from a lack of coordination between ministries, there is also no cohesive framework to optimise the efforts and interventions of other actors, such as industry, civil society organisations, financial institutions and knowledge institutions. The pharmaceutical industry and other private parties are motivated to contribute to a Dutch global health strategy, as are NGOs and knowledge institutions, but they need government to define a framework.

Over the past decade a great deal of knowledge has been accumulated and many initiatives have been launched, but there is no formal platform or process for the further development of a Dutch or global health strategy. Global health must be more than the sum of the efforts of individual health ministries. Other ministries, such as agriculture, environment, trade, security and science, must also be involved. Though this is something each country must do, the poorest countries in particular will need support if they are to achieve the desired result. Since the situation differs from country to country, support will have to be demand-driven and context-specific.

The AIV believes it is necessary that a Dutch global health strategy be drawn up in order to guide international efforts in this field on the basis of coherent policy at home. Responding to the request for advice, the AIV would note that the idea that the Netherlands could be a global leader may be a little overambitious at the moment. Not only is the Netherlands far from the first country to present a global health strategy; also – and above all –it has not yet developed a comprehensive national strategy itself. Nevertheless, the Netherlands could play a leading role on certain issues, using its own position, influence and expertise as part of existing strategies and international partnerships.

Recommendations

The alarming situations experienced during the COVID-19 pandemic, and global inequality in access to healthcare and services, highlight the fact that current global health policy is not fit for purpose. The AIV therefore wholeheartedly supports the announcement of a Dutch global health strategy in the coalition agreement, 'Looking out for Each Other, Looking Ahead to the Future' (2021).

It is important that the Netherlands clearly adopts and states its position, and sets out its intended contribution to a global health strategy, including priorities and prospects for action. The recommendations below are the building blocks of the 'foundation for the development of coherent policy regarding global health issues'.[3] In accordance with the request from the House of Representatives, these building blocks offer starting points for a process leading to a comprehensive and coherent strategy 'which the Netherlands can use to roll out its own strategic agenda'.[4]

Many actors work in the field of health in the Netherlands, both public and private, subsidised and non-subsidised, focusing on general health issues, on single diseases or conditions or on humanitarian crises. Setting priorities for government support (in whatever form) requires careful consideration of different policy and funding options. Cooperation, including international cooperation, is preferable to competition, and it only makes sense to offer a service if there is a demand for it. With this in mind, the AIV would make the following recommendations to achieve in general terms the ambition set out in the coalition agreement:

► Recommendation 1

Specify the goal of the Dutch global health strategy within existing international frameworks

The Dutch global health strategy should contribute to the achievement of global health, and give substance to the right to health as described in SDG 3 and previously endorsed in several international agreements based on the Universal Declaration of Human Rights. SDG 2 (End hunger, achieve food security and promote sustainable agriculture), SDG 6 (Clean water and sanitation for all), SDG 13 (Climate action), SDG 14 (Life below water) and SDG 15 (Life on land) also contribute to global health. Within these broad international frameworks, it is important that good use is made of the Netherlands' strengths. The AIV is thinking here of the promotion of coherent policy based on collaboration between different disciplines and actors, to capitalise on the links between the SDGs. The Netherlands also has specific, high-quality knowledge at its disposal, on antimicrobial resistance and microbiology for example. It can moreover build on past work on sexual and reproductive health and rights (SRHR), HIV/AIDS and mental health, and continue to help strengthen international institutions working in the field of global health.

► Recommendation 2

Guarantee international institutional embedding and a long-term focus

EA Dutch global health strategy must be aligned with and strengthen existing international institutions and frameworks. The Netherlands must therefore step up its input to the WHO and the EU in matters of health. This can be achieved through substantive and diplomatic activities, with a broader focus than simply a few specific diseases or humanitarian emergencies. By supporting WHO as a standard-setting and, in some cases, implementing organisation (politically, financially and in terms of policy), and by collaborating within the EU, the Netherlands can help bring about a coherent global health strategy.

► Recommendation 3

Choose strategic priorities

By stepping up international cooperation, the Netherlands can set out strategic priorities that are aligned with those of WHO.

a. **From emergency aid to health infrastructure:** To cope with current and future health issues, it is important that the focus is not only on responding to acute need, but also working towards a strengthened health infrastructure. This broadening of focus is needed even in the provision of emergency aid. A stronger health infrastructure puts countries in a better position to respond to health threats themselves. This priority is a programmatic tool for the WHO's three strategic priorities (Universal Health Coverage (UHC), health emergencies and promoting health & wellbeing).

b. **Prepare for future pandemics:** A powerful and effective plan to improve pandemic preparedness is needed to improve the response to infectious diseases and pandemics. This requires investment, in laboratory capacity for example, which requires exchange of knowledge and thorough fleshing out of the European Commission's proposal for a European Health Union.

c. **Coherence:** Health is the result not merely of individual factors (such as age, gender, lifestyle and genetic predisposition), but also of socioeconomic circumstances and the broader environment in which a person lives. Health should therefore be a key focus not only of health ministries but also of other ministries. Better coordination of government action is needed in virtually all areas, as well as a guiding agenda. This could for example be achieved by re-examining existing policy and current practice. In every new policy memorandum or piece of draft legislation, the government should explicitly state whether and how health has been considered (see also recommendation 4b).

► Recommendation 4

Set out guiding principles for a global health strategy

Assuming a rights-based approach, and thus the right to healthcare and protection of health, the AIV recommends that the following principles be incorporated into the Dutch global health strategy.

a. ***One Health:*** This approach is based on the understanding that humans, animals, ecosystems and the natural environment are connected. Several sectors and disciplines are involved in One Health. The goal is to identify, prevent and – if prevention does not work – respond to emerging and endemic threats to health.

b. ***Health in all policies:*** This approach encourages the inclusion of health considerations in policymaking in all sectors that impact on health, such as macroeconomics, transport, agriculture, land use, housing, social security, public safety and education. This constitutes an important step towards preventing health problems.

c. ***Do no harm:*** This principle from medical ethics can also be applied to general human health. The introduction of a do no harm principle for governments, civil society organisations and the private sector can promote the development and enforcement of legally enforceable codes of conduct to prevent damage to health caused by air pollution, working conditions or chemical substances, for example. Applied to interventions in the health sector in the Global South, this means for example that a brain drain must be prevented.

d. ***Context-specific approach:*** A focus on specific elements of the health issue (such as sexual and reproductive rights or mental health) should be positioned in the broader framework of efforts to strengthen countries' capacity to improve the health of their population on an independent basis. These efforts should be demand-driven, not supply-driven.

► Recommendation 5

Put one's own house in order

To make a useful contribution to global health, the Netherlands will have to put its own house in order. Currently, no ministry is mandated to develop and implement global health policy.

a. Give the Ministry of Health, Welfare and Sport a clear mandate to take ultimate responsibility for coordination on matters of health.

b. Give the Ministry of Foreign Affairs responsibility for coordinating diplomatic aspects of health and efforts to strengthen joint political and institutional ability to achieve results.

c. The following ministries should at any rate be involved (in alphabetical order): Agriculture, Nature & Food Quality, Defence, Economic Affairs & Climate Policy (including Climate & Energy Policy), Education, Culture & Science, and Infrastructure & Water Management. Making this interministerial process work will require sufficient support and, above all, collaboration. The key concern is to translate the One Health and do no harm principles into policy, and to make health a part of all relevant policy considerations.

d. Draw up a joint annual progress report ('The State of Global Health Policy'), with the Ministry of Health, Welfare and Sport as publication coordinator.

► Recommendation 6

Provide a framework for multisectoral collaboration

There is no coherent framework at national level to integrate and optimise the input of actors other than ministries – such as industry, civil society, financial institutions and knowledge institutions – into a global health strategy. In AIV advisory report 99, *'The Dutch Diamond Dynamic'*, the AIV indicated the desirability and likely benefits of collaboration between all sectors in the Netherlands. The facets (actors) of the Dutch Diamond (authorities, industry, knowledge institutions, civil society and financiers, including the health sector) can all help provide a Dutch contribution to global health. There should be a platform where all relevant actors in the Netherlands could work together to tackle global health challenges, with the same goal, the same strategic priorities and guiding principles. Given the complexity of global health, a multisectoral approach is needed. With such a comprehensive approach, the Netherlands can seek to become a lead nation on certain carefully selected focal points.

► Recommendation 7

Focus on affordability and accessibility of healthcare

Change the way essential medicines, vaccines and medical devices are regulated to improve affordability and accessibility. The current system protects the patents and data of innovative manufacturers. This is necessary in many cases so that they can recoup research and development costs. Excessive profits are not justified, however, particularly because publicly-funded research is often the basis for the development of new active ingredients. Patents must not be abused to create monopolies. Mission-oriented innovation policy is needed, in line with the ideas of Mariana Mazzucato.[5] Innovation must not only focus on development of drug treatments for the market in prosperous countries, but also on the population, conditions and infrastructure of the Global South. The prices of medicines and vaccines must reflect the contribution from the public purse. Digitalisation (telehealth) can also help make care more accessible. The ownership of data must be properly considered, as must ways of preventing new monopolies from emerging. Sharing knowledge is important, but not enough in itself. What matters is making knowledge accessible in a range of local or regional situations. The learning process must be mutual, and new knowledge should be developed on this basis.

► Recommendation 8

Do not wait for the next health crisis

Global health is currently the focus of a great deal of attention. It is important that this focus not weaken. This can be prevented by setting out a step-by-step roadmap towards health as a global public good. It is important to do this in a way that does justice to the complexity of the global health issue, and this will require collaboration at national and international level. Start, for example, with a launch conference involving the appropriate ministries, with partners from the Global South and the Dutch players concerned: companies, knowledge institutions and NGOs. Learn from the COVID-19 pandemic. Ask participants what they can contribute, what they can do to prevent zoonotic disease, for example, to apply the do no harm principle, or to make healthcare accessible and affordable for all. Ask experts how concretely to assess the health impact of legislation and policy. Ask companies how they can monitor and report. See whether the responses are enough to flesh out the Dutch global health strategy. Identify missing elements of the roadmap as quickly as possible, and seek a path that will bring results in the short term, without losing sight of the long-term problems.

Global health

1.1 Introduction

The COVID-19 pandemic put human health, the global economy, livelihoods, general wellbeing and safety at grave risk. It exposed a large number of weaknesses in the current situation, thus painfully exposing the need for a global health strategy. In this sense, COVID-19 acted as a wake-up call and accelerator for awareness – already widespread in professional circles – that global health deserves to be a structural political priority. This was also the subject of AIV advisory letter no. 34, *'The Netherlands and the Global Approach to COVID-19'* (May 2020). This pandemic has underlined the urgency and necessity of devising and implementing a global health strategy in time for the next such emergency.

COVID-19 is a zoonotic disease – one that has jumped from animals to humans. Globally, some 75% of all emerging zoonoses originate in wild animals. The global expansion of intensive livestock farming, increasing world trade and the growth in international travel have significantly increased the risk of zoonotic disease (such as avian influenza).[6] Natural phenomena like the migration of birds can also spread infection on a large scale. The Netherlands is vulnerable to zoonoses, due to the high density of livestock farming in certain regions, where the numbers of animals kept on farms are very high. Measures at national level and the regulation of trade in wild animals and intensive livestock farming will not be enough to combat zoonoses. International cooperation is vital, both to prevent epidemics and pandemics, and to tackle any that do occur. A pandemic is not under control anywhere until it is under control everywhere.

It is highly likely that, besides major outbreaks of infectious disease, other health crises will emerge in the near future. Non-communicable diseases (NCDs) like cancer, diabetes and cardiovascular disease are the biggest cause of death globally (accounting for 74% of global mortality).[7] These diseases and the risk factors that contribute to them (alcohol, tobacco, poor diet and lack of exercise) have a major negative impact not only on health, but also on sustainable economic productivity and stability.

In addition, there is great inequality both within and between countries, for example in the quality of and access to healthcare. Around half the world's population has inadequate access to essential healthcare, or none at all. These developments show that a global health policy would be a good thing. However, such a policy cannot be limited to the health sector. Climate change, loss of biodiversity, environmental pollution, degradation of ecosystems, population growth, production and consumption patterns (of food and other goods) all have a demonstrably negative impact on health.

Drawing up a global health strategy that encompasses all relevant aspects of health is a vast challenge, on which several researchers have worked in the past at the Dutch government's request. The Policy and Operations Evaluation Department (IOB) – the independent evaluation service of the Ministry of Foreign Affairs – highlighted the importance of global health in its examination of the relationship between the Netherlands and WHO between 2011 and 2015.[8] Previous reports by the Netherlands Institute of International Relations 'Clingendael' have also called for a more effective global health policy.[9] In 2018 the Ministry of Health, Welfare and Sport commissioned a survey of support for a policy on global health (*Verkenning van het draagvlak voor beleidsformulering* over *Global Health).* In 2021 the expert group on zoonotic disease published a report on zoonoses (*Zoönose in het vizier*) on behalf of the Minister for Medical Care & Sport and the Minister of Agriculture, Nature & Food Quality (LNV). This AIV advisory report builds on these earlier publications.

The growing interest in global health is also apparent from the rising number of 'global health strategies' being published, both by countries and by international organisations. Such strategies often call for coherent policy to eliminate or neutralise factors harmful to health and promote factors with a positive impact on health. The subject is thus much broader than simply healthcare policy, and cannot be viewed exclusively from the perspective of development cooperation or as simply a national or international effort. International cooperation is not easy to achieve, however, because governments tend to prioritise the wellbeing of their own population, and trust their own experts and measures.

The differences between national, international and global require some explanation. Healthcare has always been and still is seen as a national responsibility, albeit that prevention has long been a subject for European or international regulation, on matters of food safety for example. International health policy focuses on cooperation between countries, both bilateral and multilateral, on infectious disease that spreads across borders, through the monitoring and tackling of outbreaks of epidemics and support for low-income countries, for example. The term 'global health' assumes solidarity across the entire planet. Health is not merely an individual good, it is also a public good. Problems of this nature are transnational, and impact countries, communities and individuals in both poorer and wealthier countries. This implies that governments and other actors (such as industry, civil society, knowledge institutions and philanthropists) have a shared responsibility. A shared perspective on priorities and approach is vital.

1.2 Questions and scope

In a letter from its President to the AIV dated 25 February 2021, the House of Representatives requested advice on a framework for a Dutch global health strategy. More specifically, the AIV was asked to draw up an advisory report which would 'lay the foundation for the development of coherent policy regarding global health issues, which the Netherlands can use to implement its strategic agenda and, leading by example, participate in international forums addressing global health issues and developing multilateral strategies.'[10] Further details of the request for advice were given in the letter which the Permanent Parliamentary Committee on Foreign Trade and Development Cooperation sent to the President of the House on 17 February 2021 (see Annexe I). In its coalition agreement, 'Looking out for Each Other, Looking Ahead to the Future' (2021), the government announced that a Dutch global health strategy would be developed.[11]

This advisory report brings together information and insights that can provide the foundation for Dutch policy and a Dutch contribution to a global health strategy. In issuing this report, the AIV intends to outline a potential strategic Dutch effort at global level. It does not therefore provide any specific details of what the Dutch contribution to global health should be, but sets out the context, principles and main outline of a strategy.

1.3 Structure of the report

Chapter 2 examines why a global health strategy is needed, discussing five motivating factors.

Chapter 3 considers the development of global health as a policy theme. It describes existing international, European and national initiatives on global health.

Chapter 4 presents an analysis of the current situation. It concludes that producing a Dutch global health strategy would be useful, necessary even, to guide efforts in this area in the framework of international cooperation. This could certainly be useful for the Netherlands itself. The report ends with recommendations for a Dutch global health policy.

Annexe II states how and where the questions posed by the House of Representatives are addressed in this advisory report.

Motivating factors

This chapter identifies five motivating factors that underline the need for a global health strategy.

2.1 International agreements

The right to health, as enshrined in several international conventions ratified by the Netherlands, is a major motivating factor for a global health strategy. Article 25 of the Universal Declaration of Human Rights (1948) states that 'everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control' (see also also AIV advisory report no. 110, *'Sustainable Development Goals and Human Rights: An Indivisible Bond'*). The right to health is also laid down in more thematic agreements such as those on the rights of women, children and people with a disability, and in WHO's constitution (1948): 'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.'

The AIV would underline the importance of Article 25 of the Universal Declaration of Human Rights for global health issues. Under this article, the UN member states, including the Netherlands, have made agreements concerning the right to health. One of these is the International Covenant on Economic, Social and Cultural Rights (ICESCR), based on the Universal Declaration, which was adopted on 19 December 1966 and after ratification by 35 member states entered into force on 3 January 1976. The right to health is enshrined in article 12.1 of the ICESCR, which reads: 'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'[12] The Committee that monitors compliance with the convention published an authoritative interpretation of this article (a General Comment) in 2000, emphasising the availability, accessibility (non-discrimination, physical accessibility, economic accessibility and information accessibility), acceptability (in cultural terms) and quality of healthcare.

In 2015, as part of the UN 2030 Agenda, and as a follow-up to the Millennium Development Goals (MDGs), the Sustainable Development Goals (SDGs) were adopted. Alongside the legal bases for global health, the SDGs, particularly SDG 3 (good health and wellbeing for all), are a significant reference point for it. The SDGs take a more collective and goal-oriented approach to health, rather than a purely human rights-based approach. At the same time, the two approaches are inextricably linked, with human dignity as the basis. Sustainable development is a prerequisite for human rights to be achieved, and human rights are needed for sustainable development. It is important to continually and explicitly highlight this link, for example between SDG 3 and the right to healthcare as recognised and elaborated under international law. The AIV issued a report on the relationship between the SDGs and human rights in AIV advisory report no. 110, *'Sustainable Development Goals and Human Rights: An Inseparable Bond'*. When this report was published, then AIV member Ernst Hirsch Ballin stated that 'the Netherlands must continually make it clear that the SDGs entail obligations, and that human rights remain benchmarks of explicit and enforceable obligations'.[13] The right to health requires precisely such an approach.

2.2 Health as a global public good

The second motivating factor regards health as a global public good that requires stewardship. Taking care of health as a global public good is regarded as a primary responsibility of governments, on which international cooperation is vital.[14]

There is a growing realisation that our production processes and consumption of resources (particularly fossil fuels) entail health risks. Zoonoses, infectious diseases (with pandemic potential), production methods, consumption patterns, pollution, loss of biodiversity, degradation of ecosystems and climate change have both direct and indirect effects on health. The current and future effects of climate change include poor harvests, megacities that are becoming unliveable, increased flooding, constant shortages of fresh water, and growing migration between and within countries and continents. People with the lowest incomes will be hardest hit (see also AIV advisory letter 33, *'International Climate Policy'*). It is evident that the health of humans, animals and plants and the health of ecosystems are closely interlinked. Countries, sectors and disciplines will have to work together to get to grips with this complex issue.

The understanding that the health of humans, animals and the environment is linked is often referred to as the One Health approach. The realisation that health is influenced by policy in numerous sectors (including macroeconomics, transport, agriculture, land use, housing, social security, public safety and education) and that an intersectoral approach is therefore required is referred to as the Health in All Policies approach, which comes from ideas about the social determinants of health. This approach is based on the principle that human health is determined not only by individual factors (such as age, gender and genetic predisposition) but also by social conditions (working conditions and the cost of a healthy diet) and the living environment (natural environment and air quality). Recently, the 'planetary health approach' has also emerged as a discipline that specifically considers the limits of the planet, and is now a Royal Netherlands Academy of Arts and Sciences (KNAW) field of research.[15] The One Health and Health in All Policies approaches are both necessary to safeguard health as a global public good.

2.3 Cross-border health threats

The third motivating factor concerns cross-border disruptions to health and the relationship between health and human security (see box). Pandemics, emergency health situations and weak healthcare systems not only cost lives, they are also some of the greatest threats to security.[16] Such global threats are permanent, and cannot easily be brought under control in the event of an outbreak unless there is a global effort to find solutions (see also also AIV advisory letter no. 34, *'The Netherlands and the Global Approach to COVID-19'*).

Infectious diseases like HIV/AIDS, tuberculosis, malaria, hepatitis C, cholera and measles could become a global threat to health without appropriate policies. Zoonotic diseases like SARS, MERS and avian influenza are potentially transmissible and thus constitute cross-border threats to public health. In addition, population growth, rapid urbanisation, environmental degradation and growing antimicrobial resistance (AMR) are also leading to greater and greater health risks and have potentially transnational impacts.[17] New diseases are emerging and have socioeconomic effects. Growing mobility and increased economic interdependence are also causing these global health threats to increase.

Moreover, WHO highlights the use of biological weapons, such as bacteria, viruses, insects, fungi and other toxic substances, as a real and growing threat.[18] Biological weapons are classified as weapons of mass destruction that have cross-border effects, as also observed in the National Security Strategy (2019) and its interim evaluation (2021): 'The impact of an attack or incident involving chemical,

biological, radioactive or nuclear (CBRN) materials is cross-border by definition, in terms not only of security and direct damage but also of politics and diplomacy.'[19] This impacts on physical security and health, as well as on mental health as a result of anxiety, depression or stress.

The concept of human security was introduced in the UNDP *Human Development Report* 1994 with the goal of defining the concept of security more broadly, so that it encompasses more than just the protection of the territory of sovereign states by military means. The *Human Development Report* attempted to draw more attention to the position of individuals than the traditional approach to security. It therefore introduced seven components of human security: economic security, food security, health security, environmental security, personal security, community security and political security (see also AIV advisory report no. 110, *'Sustainable Development Goals and Human Rights: An Indivisible Bond'.*)

2.4 Health as a prerequisite for sustainable growth

The fourth motivating factor concerns health as a prerequisite for growth. Health is vital for achieving sustainable growth, socioeconomic and cultural development, justice and stability, all over the world. For a long time, attention focused mainly on economic growth, fiscal expansion and indicators like GDP. However, sustainable growth must also take account of planetary boundaries (the ecological ceiling) and the social foundation.[20] Good health is an important value for most people. At the same time, avoidable health problems create unnecessary tensions. Staff illness can for example cause loss of productivity and, conversely, better health can improve the productivity of adults, reduce sickness absence and improve children's ability to learn.[21]

The first thousand days of a child's development, from the moment of conception, are vital to good health. The basis of optimum health and development throughout life is laid during this period. A child without a good start in life and a healthy diet has a greater likelihood of experiencing physical and mental problems such as diabetes, cardiovascular disease, overweight and depression later in life. A good start also affects a child's social and emotional development. As such, this period is vital for the health, stability and prosperity of society in the long term.[22]

2.5 Health inequalities

Health inequalities are the fifth motivating factor. The pandemic made it painfully clear, more than ever before, that there is huge inequality in healthcare. Not only is healthcare capacity in Africa, parts of South America and Asia significantly smaller than in the EU, the availability and distribution of vaccines is also highly unequal, as is the availability of medical equipment and trained healthcare workers. This inequality applies not only to curative care, but also to preventive care and early diagnosis. The are major differences between population groups in all countries in terms of health and access to healthcare. This inequality costs lives.[23] Inequality, including health inequality, exists in the EU, too, and even before the COVID pandemic there were major differences between EU member states in terms of access to and the quality of healthcare.[24]

The COVID-19 vaccination rate is low in many relatively poor countries. Oxfam reports (2022) that 80% of vaccines have gone to G20 countries, and only 1% have reached low-income countries.[25] On 29 January 2022 less than 6% of the population of Burundi, Tanzania, the Democratic Republic of the Congo, Yemen and Nigeria had been fully vaccinated against COVID. In Burundi the figure was a mere 0.05%. In Yemen, which has been in the grip of civil war since 2014, only 1.1% of the population had been fully vaccinated on 31 January. Furthermore, distribution of vaccines in poor countries

remains a major challenge. The infrastructure required to store vaccines at very low temperatures – including a reliable electricity supply – is lacking.[26] Supplies like masks and tests and treatments (e.g. oxygen) are also very unequally distributed.[27]

Poorer countries and groups face huge health risks. There are several reasons for this. The health gap runs parallel to socioeconomic differences. Lack of water and food and the presence of violence and conflict threaten the physical and mental health of countless individuals. Vulnerable groups and countries are exposed to greater health risks due to unhygienic living conditions and lack sufficient access to healthcare and social protection. Infectious and poverty-related diseases occur most commonly in tropical and subtropical regions, and they hit the poorest groups disproportionately hard. These inequalities in living conditions, access to health services and to power, money and resources have existed for a long time.[28] Adequate global health policy is needed to close the health gap, with a focus on the accessibility and affordability of healthcare. Health insurance, organised through employers or otherwise, could be an important tool in this effort (see also AIV advisory report no. 118, '*Social Protection in Africa*').


1 NO POVERTY
2 ZERO HUNGER
3 GOOD HEALTH AND WELL BEING
4 QUALITY EDUCATION
5 GENDER EQUALITY
6 CLEAN WATER AND SANITATION
7 AFFORDABLE AND CLEAN ENERGY
8 DECENT WORK AND ECONOMIC GROWTH
9 INDUSTRY, INNOVATION AND INFRASTRUCTURE
10 REDUCED INEQUALITIES
11 SUSTAINABLE CITIES AND COMMUNITIES
12 RESPONSIBLE CONSUMPTION AND PRODUCTION
13 CLIMATE ACTION
14 LIFE BELOW WATER
15 LIFE ON LAND
16 PEACE, JUSTICE AND STRONG INSTITUTIONS
17 PARTNERSHIPS FOR THE GOALS

Dutch and international health policy

3.1 The rise of global health policy

Professionals had been warning of the potential for pandemics for a long time, but it was not until around the turn of the 21st century that global health policy and the required international cooperation and coordination appeared expressly on the international agenda. Prior to that, public health was regarded mainly as a task for national governments. The need for global policy was linked directly to the growing spread of viral (flu and other) epidemics, which were posing an increasing risk to human health.[29] Around the year 2000 local epidemics of avian influenza occurred in humans (H5N1) in Asia, and in 2003 the SARS virus caused an epidemic that spread from Asia to other continents.

The year 2000 is also crucial because it saw an escalation of the HIV/AIDS pandemic, in Africa in particular,[30] and because the first generation of antiretroviral treatments for AIDS had become available by then. In response, HIV/AIDS and LGBTI activists formed transnational human rights networks and demanded access to drug treatments, which was being impeded by international patent legislation agreed by the World Trade Organization (WTO), among other things. As a result, non-state actors like NGOs began to play a greater role in international activities concerned with health.

The year 2000 was also the year when the leaders of 189 countries signed the MDGs. Three of the eight goals were about health: MDG 4 (Reduce child mortality), MDG 5 (Improve maternal health) and MDG 6 (Combat HIV/AIDS, malaria and other diseases). The same period also saw the launch of some major public-private initiatives like the Global Fund to Fight Aids, Tuberculosis and Malaria (TGF) and Gavi, the Vaccine Alliance. Gavi and the Global Fund are now among the largest health organisations in the world.[31] Philanthropic organisations like the Bill & Melinda Gates Foundation played a big role in funding them, and the US made major investments in the President's Emergency Plan For AIDS Relief (PEPFAR). All these developments were linked not only to the MDGs, but also to the fact that the HIV/AIDS pandemic was seen as a threat to international security and stability, as reflected in UN Security Council resolution 1308 on HIV/AIDS and international peacekeeping operations.[32] The emergence of these major thematic initiatives and international funding to achieve the MDGs and prevent epidemics focused attention on the underlying structural aspects of healthcare, such as socioecological and economic determinants. Concepts like human security (see box in chapter 2) also made healthcare an explicit focus of attention in the field of security and defence.

In 2007 the foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand drafted the Oslo Ministerial Declaration identifying global health as 'a pressing foreign policy issue of our time'.[33] Around that time, health attained a more prominent position on global policy agendas.

In the wake of the financial crisis of 2008, however, countries increasingly turned their attention to other priorities, focusing more on their own economic growth, stability and security. Other major issues like armed conflict in the Middle East, international terrorism, refugee flows and labour

migration drew attention away from global health. One key factor was that the HIV/AIDS pandemic now appeared to be under control, thanks to greater access to antiretroviral drugs around the world. As international public funding shrank, the share of funding provided by philanthropists and industry grew.

An Ebola epidemic broke out in West Africa in 2014 (see box). This led to renewed calls for investment in resilient health systems.[34] After this Ebola outbreak, in December 2015 WHO compiled a list of endemic and pandemic diseases. Coronaviruses were (and still are) in the Top 10 Blueprint priority diseases.[35] Not only did a potential pandemic feature as a major risk on the WHO list, warnings of a pandemic were issued by bodies in the Netherlands, too, like the National Network of Safety and Security Analysts (ANV), the National Institute of Public Health and the Environment (RIVM) and the Netherlands Environmental Assessment Agency (PBL), highlighting the fact that the country was not well prepared for such an event.[36] Although the signals were unmistakable, there was barely any response. The Netherlands was not the only country to ignore the warning signs, incidentally. The warnings of experts elicited little response from politicians more widely in Europe and beyond. This might have been the result of the relatively limited harm to health caused by recent epidemics – like the Mexican flu pandemic (2009) – or the fact that they were limited to a single region (see box: The Ebola epidemic).

At the same time, some action was apparent. Since 2005 the Dutch Ministry of Health, Welfare and Sport has focused more attention on AMR, hosting an international interministerial conference in The Hague in 2014 attended by ministers of health and agriculture, and by the Directors-General of WHO and FAO.[37] The Netherlands also signed up to the Global Health Security Agenda (GHSA, see box).

Global Health Security Agenda

The Global Health Security Agenda (GHSA) was launched in February 2014 in response to the global threat from infectious diseases in an increasingly interconnected world. In the past, outbreaks like SARS (2002), H1N1 influenza (2009), MERS-CoV (2012), H7N9 flu (2013) and Ebola (2014) had had devastating effects on humans, security and the economy of the countries concerned, and at regional and global level.

The GHSA was approved by the G7 in June 2014. More than 60 countries have now signed up to the GHSA, which focuses mainly on infectious diseases and pandemic threats.

The Ebola epidemic (2014-2016)
On 8 August 2014 WHO declared a public health emergency of international concern in response to the Ebola outbreak in West Africa. The outbreak of the highly infectious Ebola virus in three West African countries (Guinea, Sierra Leone and Liberia), plus a number of isolated cases elsewhere, led to 28,650 recorded cases. The official death toll is 11,300, though WHO assumes that the actual number is much higher.

The rapid spread of the disease, including to urban areas, caused great international concern that it would spread beyond the West Africa region. Countries sent medical and military assistance to help tackle the epidemic. At that time, no treatment or vaccine was available to prevent spread of the disease, due in part to a lack of investment in the prevention and treatment of neglected tropical diseases. Furthermore, as WHO revealed, the international community had invested too little in countries' core capacities (such as laboratories, monitoring systems, One Health policy and healthcare workers) in preparation for such epidemics.

In 2014 it was concluded that only 64 of the 196 WHO member states (32.5%) had the core capacities to implement the International Health Regulations (IHR).[38] The late response to the Ebola epidemic in 2014 is therefore no surprise. It is thanks only to the capacity to learn and the good response of a number of African counties (like the DRC and Uganda) that several other Ebola epidemics were nipped in the bud in the years that followed, with the help of a new vaccine that had since become available.[39]

In 2016 IOB concluded that, in view of the lessons learned from the Ebola epidemic, the Netherlands must also contribute to efforts to strengthen basic healthcare systems in other parts of the world. It was stated at the time that more attention needed to be devoted to a Dutch global health strategy, including increased funding for WHO from the EU. IOB wrote that 'there is otherwise a great risk that the problems that arose in association with the Ebola outbreak will be repeated in the future'.[40]

3.2 SDG 3: globally and in the Netherlands

Health is also defined in broad terms in the SDGs, from physical and mental health to access to care and medication, emergency assistance and pandemic preparedness. The subject of health is not addressed only in SDG 3. Other goals, including SDG 2 (End hunger, achieve food security and promote sustainable agriculture) and SDG 6 (Clean water and sanitation for all) are vital for improved health. With the One Health approach in mind, SDG 13 (Climate action), SDG 14 (Life below water) and SDG 15 (Life on land) also contribute to global health. Universal Health Coverage (UHC, see box) was also identified as a goal in the framework of the SDGs in 2015, and reaffirmed in 2019 at a meeting of heads of state and government (High Level Meeting) at the UN General Assembly.

Universal Health Coverage
Universal Health Coverage (UHC) means affordable access to healthcare for all individuals and communities. Health encompasses the entire spectrum of essential, high-quality health services: health promotion, disease prevention, treatment, rehabilitation and palliative care, throughout life. UHC protects people from the risk of incurring high costs for health services. This in turn reduces the risk that they will fall into poverty, which would make their own future and often that of their children uncertain. An overview of progress towards UHC[41] published by WHO in 2021 shows that it had risen from approximately 45% in 2000 to 65% in 2017.[42] In Africa, UHC remains stalled at 46%.

The wording of SDG 3 (see annexe VI) reflects the complexity of the issue. Health is seen as a global public good and a human right, and achieving it makes demands of policy, regulation, implementation and monitoring. It also requires adequate institutions throughout the field of medical research and training, from disease prevention to highly specialised care, from funding to accessibility, and from physical to online care (see also AIV advisory report no. 110, '*Sustainable Development Goals and Human Rights: An Indivisible Bond*)'. As such, SDG 3 is both a global objective and a serious task for the Netherlands itself.

Global

Of efforts to achieve SDG 3 at global level, the UN reported in 2019 that 'major progress has been made in improving the health of millions of people'.[43] 'Maternal and child mortality rates have been reduced, life expectancy continues to increase globally, and the fight against some infectious diseases has made steady progress. In the case of other diseases, however, progress has slowed or stalled, including global efforts to eradicate malaria and tuberculosis.'[44] In 2020 the UN warned that not enough progress was being made to achieve most of the SDG 3 targets. The COVID-19 pandemic has put efforts to achieve SDG 3 under further pressure. The rapid rise in cases of COVID-19 has caused considerable loss of human life and overwhelmed many healthcare systems. Essential health services and life-saving interventions were (and still are) being disrupted. People were unable or too afraid to visit healthcare institutions for check-ups, vaccinations and even urgent medical care. There is a risk that recent progress will be undone. In many countries, therefore, the outbreak has been a warning of crises in health and immunisation services. This is particularly true of countries whose healthcare systems have not been able to cope with the huge rise in demand because of a lack of trained medical staff, medical equipment and other medical supplies.[45] No figures are yet available for 2021, but it is expected that little or no progress will have been made due to the direct and indirect impacts of COVID-19.

The Netherlands

Statistics Netherlands (CBS) has found that Dutch policy covers the majority of SDG 3 targets in the Netherlands. In 2020 the CBS indicated that two of the targets had been achieved in the Netherlands: births attended by skilled health professionals and coverage of essential health services. Things are moving in the right direction on eight indicators: new cases of tuberculosis and hepatitis B are declining, as is unhealthy behaviour (per capita alcohol consumption, number of heavy drinkers among alcohol users, and smoking). Performance relative to other EU countries is mixed. On some indicators, such as alcohol consumption, smoking, road deaths, teenage pregnancy and maternal mortality, the Netherlands will achieve the goals.[46] However, the level of vaccination against measles is fairly low in the Netherlands, and the number of new cases of malaria is relatively high. Another striking statistic is the relatively low healthy life expectancy of Dutch women (22nd in the EU in 2018).[47] Although women live longer than men on average, they spend fewer years in good health. Woman are more likely than men to suffer from chronic conditions, such as migraine, chronic inflammation of the joints, back, neck and shoulder problems, and other conditions.[48]

The CBS reported for 2021 that the internationally agreed reduction targets under SDG 3.1 (reduce the global maternal mortality ratio to less than 70 per 100,000 live births) and SDG 3.2 (end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to no more than 25 per 1,000 live births) had been achieved in the Netherlands. Policy is focused on further reductions in neonatal and child mortality. In terms of SDG 3.3, policy focuses on preventing communicable diseases in general. It is also designed to prevent non-communicable diseases, through prevention and improved access to mental healthcare, for example. For SDG 3.5 (prevention and treatment of substance abuse) Dutch policy focuses on prevention and tackling forms of crime that undermine society.[49]

3.3 Dutch approach to global health

As a member of WHO, the UN and the EU, the Netherlands has made international commitments concerning global health, and has also developed its own approach. Most Dutch policy relevant to SDG 3 is formulated by the Ministry of Health, Welfare and Sport. The Ministry of Infrastructure & Water Management, the Ministry of Economic Affairs & Climate Policy and the Ministry of Education, Culture & Science also have national policy plans that have a bearing on SDG 3. Internationally, the Netherlands has in the past tackled health issues through development cooperation. From 2000 to 2010 it largely focused on HIV/AIDS and sexual and reproductive health and rights (SRHR).[50] The Netherlands has sought to improve the availability of priority medicines by pressing for changes to legislation and policy.[51] Its Ministry of Health, Welfare and Sport also focuses on safety and security, including through the Global Health Security Agenda (see box on GHSA in 3.1) and, more specifically, on the issue of AMR and tackling zoonoses through a One Health approach.[52] The health ministry also focuses within the EU on achieving fair access to medicines, for example through a grant to the organisation Fair Medicine. The ministry is also responsible for official multilateral relations with bodies like WHO and the European Commission.

The Netherlands also takes a more intersectoral approach to healthcare systems, with regular strategic secondment of experts to international organisations like UNFPA (2005-2019), UNAIDS (2002-2020), WHO (2002) and EU-DEVCO (2005) by the Ministry of Foreign Affairs. The Ministry of Health, Welfare and Sport currently has a specialist at the German Ministry of Health. From 2009 to 2013 the Netherlands funded the Dutch Global Health Policy and Health Systems Research programme through the Dutch Research Council (NWO), the Ministry of Health, Welfare and Sport and the Ministry of Foreign Affairs' Directorate-General for International Cooperation (DGIS). This programme brought together actors from various fields to work on global health, in the form of policy, practice and research.[53]

Around 2010 the Ministry of Foreign Affairs made SRHR a focal point of its policy, as it moved towards working in a more targeted and efficient way on the basis of themes. Its SRHR policy built on the expertise accumulated in the fight against HIV/AIDS, and on the funding of this effort. The rights-based approach to sexuality and LGBTI groups was seen as a specifically Dutch focus. However, this led to a decline in Dutch interest in and funding of broader health issues, though that same period saw the establishment of the Healthcare Task Force, a network of partners in the life sciences and health sector which collaborate from a trade and economics perspective (facilitating trade missions, for example) with partners that are suitable for the Netherlands.[54] The Netherlands began to link trade and aid, through its top sectors policy, among other things. The Life Sciences & Health top sector is supported by the Ministry of Economic Affairs and Climate Policy.[55]

3.4 International activities

The subject of global health has been on the agenda since 1945, though interest and focus have waxed and waned over the years. A number of major international initiatives launched by multilateral organisations, the EU and individual European countries to promote global health are discussed below. Though this is not intended to be an exhaustive list, it does give a rough idea of actors and activities, as requested by the House of Representatives.[56]

WHO

The World Health Organization (WHO) has a clear mission: to promote health, protect the world from outbreaks of epidemic diseases and support vulnerable groups, in order to attain the highest possible standard of health for all. WHO thus contributes directly to efforts to achieve SDG 3 and, in a broad sense, to the UN's 2030 Agenda. The organisation's current five-year plan runs from 2019 to 2023 and is built around three strategic priorities: 1) achieving universal health coverage (UHC), 2) addressing health emergencies and 3) promoting health & wellbeing.[57]

WHO's establishment on 8 April 1948 laid the foundations for international cooperation to warn of and combat infectious diseases, strengthen health services and promote health. In its constitution, health is defined as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'[58] WHO performs essential tasks associated with global health, such as knowledge development and standard-setting, coordination of the response to international health risks such as pandemics, and the mobilisation of international solidarity.[59]

In 1951 WHO adopted the International Sanitary Regulations (ISR), which stipulated that outbreaks of infectious diseases like cholera, plague, smallpox, typhoid and yellow fever requiring quarantine must be reported. The severe acute respiratory syndrome (SARS) outbreak of 2003 and the growing threat of bioterrorism after 9/11 prompted a wholesale review and expansion of these regulations, which resulted in the adoption of the International Health Regulations (IHR) in 2005. The IHR is a legally binding instrument of international law for 196 countries, including the 194 WHO member states. It provides a treaty framework that defines countries' rights and obligations in the event of potentially cross-border public health problems and emergencies. The IHR also defines the criteria for designating certain incidents public health emergencies of international concern.

WHO has six regional offices around the world that are authorised to defend regional health interests. It also has country offices that have more of an implementing role, and often work closely with national health ministries. In places where there are humanitarian crises, in particular, WHO plays a local role in coordinating actors, ensuring continuity of essential healthcare services during armed conflict, for example. The drawback of this regional structure is a lack of central direction. WHO's international policy is however determined centrally by the 194 member states, at the annual World Health Assembly (WHA).

The organisation's annual budget was around $2.5 billion in 2020, plus $1 billion for emergency aid. The funds are shared among the six regional offices and the head office in Geneva. WHO budgets are rarely spent directly on healthcare or programmes, but on providing scientific and technical advice to local authorities. Almost a third of the budget goes to the head office, for scientific research, coordination and data collection. The Regional Office for Africa receives the largest portion of the funding for regional offices, followed by the Eastern Mediterranean and Southeast Asia.

WHO's funding takes the form of assessed contributions and voluntary contributions from member states and donations from NGOs and other sources. Voluntary contributions and donations may be earmarked by the donor. Almost 70% of the organisation's financial resources were earmarked in 2019. The relatively high proportion of earmarked and thematic funding, as opposed to non-earmarked contributions and assessed contributions, means the organisation has little autonomy to decide health priorities. This entails risks in terms of its financial continuity.

The Netherlands' contribution to the WHO was EUR €38,594,214 in 2021. Of this, €19,994,575 was earmarked through the Ministry of Foreign Affairs for themes like SRHR, water and sanitation, and mental health. The Ministry of Health, Welfare and Sport had earmarked €3,868,000 for priorities like AMR (see table 1).

BZ/BHOS	non-earmarked 2021	€ 14,731,639	76% of the assessed contribution is ODA
BZ/BHOS	earmarked 2021	€ 19,994,575	Strategic Preparedness and Response Plan; SRHR, WASH monitoring & evidence, mental health, emergency fund, secondment; priorities like AMR; collaborating centres
VWS	earmarked 2021	€ 3,868,000	
Total contributions 2021	earmarked 2021 non-earmarked 2021	**€ 38,594,214** € 23,862,575 € 3,868,000	

Table 1: Dutch contributions to WHO (source: Ministry of Foreign Affairs)

WHO's position is not uncontroversial, and during the COVID crisis tensions arose when the former US president accused it of being a puppet of China, and announced that the United States would withdraw its membership. The US is now a member of WHO again.

In March 2021 26 heads of government – led by the EU and the WHO Director-General – called on other world leaders to build a robust international architecture to protect the world from future pandemics and other public health crises. The core element of their plea for action was a new treaty intended to oblige countries to more effectively address diseases like COVID-19, Ebola, flu, SARS and potential new risks to health.

FAO

The UN's Food and Agriculture Organization (FAO) – established in 1945 – engages in international activities related to the food supply, food shortages in the world, and food security. FAO helps national authorities and development organisations coordinate their activities to improve agriculture and the food supply. Its activities also concern forestry, fisheries, land use and water supplies. FAO works for healthy and sustainable livestock farming, and for the combating of animal diseases and zoonoses.

WTO

Although the WTO is not essentially a health organisation, there is a relationship between trade and health. The WTO aims to promote international trade by organising negotiations to reduce import tariffs, abolish trade restrictive rules, and monitor the application of the same rules for all countries. Sanitary and phytosanitary (plant health-related) rules designed to protect public health (such as regulation of the use of hormones in meat production) are often excluded from these talks.

On 20 April 2020 the WTO and WHO Directors-General issued a joint declaration on the need for unrestricted trade in essential medical supplies and other goods and services.[60]

The WTO is also concerned with patent law and intellectual property. Intellectual property rights and the development, availability and accessibility of new medicines and vaccines are linked. The agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) was adopted in 1994.[61]

Under this agreement, companies – including pharmaceutical companies – may retain their patent for 20 years. In recent months, this provision has been the subject of debate. South Africa and India have proposed that the patents on COVID-19 vaccines be temporarily suspended to allow production to be scaled up.[62] Proponents of the waiver argue that not supporting it contravenes international human rights.[63] The EU, Australia, Norway and Switzerland were initially opposed, but a provisional agreement on the waiving of patents on COVID vaccines was reached on 16 March 2022.

IMF

The International Monetary Fund (IMF) promotes international economic cooperation, designed specifically to maintain international financial stability and monetary cooperation. Since the start of the COVID-19 pandemic, the IMF has responded effectively, increasing payments from the Poverty Reduction and Growth Trust (PRGT) and the Catastrophe Containment and Relief Trust (CCRT) to the most affected countries. This gave low-income countries more financial scope to fund the increased expenditure caused by the pandemic. In the past the IMF has been criticised for imposing too many conditions on countries concerning expansion of their fiscal base, thus discouraging public investment in healthcare systems. This must be prevented in future[64]

World Bank Group

The World Bank Group (WBG) works to help countries build healthier, more just societies and to improve their fiscal performance and competitiveness. The WBG targets investment and research in the health sector at achieving Universal Health Care (UHC) by 2030, in close collaboration with governments, donors, development partners and the private sector. Its focus areas include ending avoidable child and maternal mortality; improving the diets of infants and children; strengthening healthcare systems and funding of healthcare; pandemic prevention and response; promoting sexual and reproductive health and rights; and prevention and treatment of communicable diseases.[65]

In June 2021 and October 2021 the Director-General of WHO, the Director-General of the WTO, the director of the IMF and the president of the World Bank Group issued joint statements calling for new engagement to share COVID-19 vaccines more equitably, combat the pandemic, and increase the supply and deployment of vaccines.[66]

Examples of international initiatives

NCD-Alliance

The mission of the NCD Alliance (NCD = non-communicable diseases) is 'to unite and strengthen civil society to stimulate collaborative advocacy, action and accountability for NCD prevention and control.' The NCD Alliance is in partnership with WHO, the UN and individual governments and civil society organisations in more than 170 countries.

Africa CDC Kofi Annan *Global Health Leadership*

In May 2020 the African Union launched the Africa CDC – Kofi Annan Global Health Leadership Programme. Its aim is to support aspirational public health leaders from Africa in acquiring advanced skills and competencies to strategise, manage and lead public health programmes that will transform public health in Africa.

EU-Africa *Global Health Partnership*

The EU and Africa launched the EU-Africa Global Health Partnership in 2019. This initiative aims to increase health security in sub-Saharan Africa and Europe, building on the current partnership between the EU, its member states and sub-Saharan countries. It will speed up the development of effective, safe, accessible and affordable health technologies and health system interventions for infectious diseases, together with African partners and international funders.

COP 26

At COP26 in Glasgow (2021) 50 countries, including the Netherlands, committed to taking specific steps to develop climate-resilient and sustainable healthcare systems.

EU

The COVID-19 pandemic has influenced the agenda of the EU, too. The President of the European Commission, Ursula von der Leyen, referred in her State of the Union (2020) to the need for a strong European Health Union (EHU).[67] In its first proposal for a European Health Union, the Commission focused on emergency preparedness and response.[68] Since the pandemic began, professionals and civil society organisations have expressed support for an integrated EHU.[69]

At the meeting of the General Affairs Council on 25 January 2022, a Regulation was adopted to review the mandate of the European Medicines Agency (EMA), as part of ongoing activities to build an EHU. Approval of a stronger mandate for the EMA is part of the EHU package.[70]

During the COVID-19 crisis, in the face of geopolitical rivalry between China and the US, the EU has campaigned for an effective multilateral health system.[71] This included a proposal at the 73rd WHA (May 2020) to give WHO a central role in pandemic response. At the 74th WHA (May 2021) a resolution was adopted designed to strengthen WHO and underline the importance of international cooperation for pandemic prevention and response.[72] The need for a One Health Approach for emergency preparedness and response was also emphasised.[73] A WHA Special Session in November 2021 gave a historic mandate for a 'pandemic treaty'.[74] The EU had advocated such an agreement under the auspices of WHO. The Netherlands will co-chair the negotiating committee on behalf of the WHO Europe region.[75]

The immediate challenge is to ensure fair and equitable access to vaccines. The EU is currently one of the leading producers of COVID-19 vaccines and the biggest exporter. At the General Affairs Council on 25 January 2022, the EU reaffirmed its intention to increase its support for the countries most in need, particularly in Africa, by continuing European support for Covax (an initiative designed to

make COVID-19 vaccines available to all) on a bilateral basis.[76] The aim is to ease access to COVID-19 vaccines for millions of people in Africa, Asia, the Caribbean and the Pacific, and Europe's neighbours to the east and south.[77]

An investment package of €150 billion euros was announced at the EU-AU summit (18-19 February 2022). In addition to this, support was promised for initiatives on pandemic preparedness, health security and access to essential medical services. The number of doses of COVID vaccine pledged by EU member states came to 407 million in February 2022, most of them provided through Covax (86%). Of these, over 319 million had actually been supplied.[78] The EU has undertaken to provide at least 450 million doses to Africa by mid-2022. In financial terms this would bring the EU's contribution to Covax and the vaccinations campaigns in Africa to over $3 billion (or 400 million vaccine doses). Another €425 million was pledged to accelerate the pace of vaccination, support efficient distribution and train medical teams.[79]

Europe had policy on health prior to the pandemic, too, of course. EU development policy is largely aligned with the goals of the UN 2030 Agenda for Sustainable Development. In the EU, member states have primary responsibility for organising and providing health services and medical care. The EU has a coordinating role (for instance in ensuring access to healthcare for EU citizens outside their own country), and can initiate policy and legislation under article 168 (protection of public health), article 114 (internal market) and article 153 (social policy) of the Treaty on the Functioning of the European Union. The competences of the EU are related to global health in four ways.

Firstly, under article 168 the EU is authorised to act in emergency situations, and did so during the COVID-19 pandemic. In retrospect, it can be concluded that the EU was initially hesitant to act. Solidarity was slow to emerge. Assistance for Bergamo came from China and Cuba, rather than from the European Commission or the member states.[80] The European Centre for Disease Prevention and Control (ECDC), based in Stockholm, was barely in evidence. The European Commission played its part by negotiating with vaccine manufacturers and purchasing vaccines for part of the population of Europe. This was eventually a success, but only for EU citizens, not for the people living in the Global South. The EU could have used its buying power and its position to negotiate favourable terms for vaccines to be made available in Africa, for example.[81]

Secondly, the EU has competences regarding the manufacture and authorisation for the market of medicines, vaccines and medical devices. The EMA plays an important role in this. The member states negotiate prices with manufacturers themselves. The question is whether this leads to sufficient availability of medicines. A recent report by the European Commission on medicine shortages in the EU concluded that the past five to ten years have seen a growing shortage of painkillers, anti-inflammatories, antihypertensive drugs and cancer drugs.[82] The cause of these shortages generally lies in supply chain problems or commercial considerations, rather than any lack of ingredients. This could be related to the price paid for a certain medications in member states. Building up strategic stocks of essential drugs could overcome this problem.[83]

The outsourcing of pharmaceutical manufacturing is also regarded as a risk. European legislation protects the pharmaceutical sector, as a result of which the emphasis is on profitable production for European consumption, rather than for the needs and conditions in Africa, for example, where less may be paid for medicines, and where prevalent diseases and conditions differ. There is plenty of manufacturing capacity in India and South Africa, but this is not true of many other countries. It is important to consider how the EU can take meaningful action in response to the recognition that pharmaceutical knowledge and industries not only have private value, but also serve a major public interest.

Thirdly, the EU has had a Health in All Policies strategy since 2006 (see also 2.2).[84] The strategy has yet to be implemented in practical terms, however, particularly as regards trade relations with third countries. There is, for example, no assessment of health or working conditions, though the sustainability of products, such as wood and biofuels, is increasingly subject to assessment.

In 2007 the European Commission adopted a health strategy, 'Together for Health: A Strategic Approach for the EU, 2008-2013'. The goal of this strategy was to develop, for the first time, an overarching strategic framework for health issues. After this period, the political focus on health weakened, due in part to the financial crisis of 2008. It was not until the Ebola outbreak in 2014 (see 3.1) that health returned to the international policy agenda, albeit mainly as a security issue.

Fourthly, Europe has taken several global health initiatives. In 2010 the Council of the EU discussed the EU's role in global health. The conclusions highlighted 'the need to take action to improve health, reduce inequalities and increase protection against global health threats.'[85] The Council also concluded that 'economic and social conditions are crucial determinants of health. Efforts to address social exclusion, power structures that impede equity, and gender equality are of key importance, as well as a strong focus on policy coherence for development in particular the "Equity and Health in All Policies" approach.'[86]

European countries: two examples

Germany - Global Health Strategy
Germany is a leader on matters of global health. It published its first global health strategy in 2013, and a new version appeared in October 2020. The German strategy aims to make an effective and sustainable contribution to the health of all people worldwide by 2030. The federal government intends to build up international cooperation and expand strategic partnerships, particularly with WHO. The German government is using this strategy to tackle new challenges, set new goals and promote coordination and cooperation between all actors. The strategy also demonstrates the federal government's engagement with global health policy and efforts to achieve the SDGs relating to health, particularly SDG 3. There are four parts to Germany's global health strategy: i) guiding principles; ii) values and rules; iii) strategic priorities; and iv) challenges.

United Kingdom
The United Kingdom (UK) presented its own Global Health Strategy in 2008, focusing on the do no harm principle, the MDGs and international cooperation. No completely new health strategy has been published since, though a position paper published by the UK in December 2021 endorses a comprehensive, broad view of health and explicitly links the strengthening of health systems, health security and UHC. (UK, 2021, 'Health Systems Strengthening for Global Health Security and Universal Health Coverage')

Civil society organisations, the private sector and knowledge institutions are important partners, catalysts and drivers of global health policy, alongside governments and international organisations.

Private sector

The private sector has a major impact on global health in numerous ways, including production of medicines, hospital care, trade in medical equipment and technology, IT and management of big data. In many cases the public and governments depend on the private sector. Conversely, the private sector depends on government for things like regulation.

Pharmaceutical sector

The private sector is bound by government regulations when it comes to market access for medical products. Patent protection is regulated by the WTO under the TRIPS agreement, and in the EU data protection is regulated by European medicinal products legislation. These protective systems have long been the target of criticism. Data protection and patent protection by the pharmaceutical industry limit the potential for generic versions of drug treatments to be copied and supplied more cheaply (see also 3.4 on the WTO). One argument advanced in favour of data protection is that it represents reasonable recompense for the costs of development, without which innovation would not occur. This debate was reignited by the COVID-19 pandemic. Critics calculated that billions of euros and dollars of public money had been spent on the development of COVID-19 vaccines, yet Pfizer, BioNTech and Moderna have made billions in profit from them.[87] AstraZeneca is marketing its vaccine at cost price for the duration of the pandemic.

Things could be done differently. Mariana Mazzucato has been calling for mission-oriented innovation policy for years.[88] She argues that innovation in the health sector is not sufficiently concerned with global health (public need), and is too focused on private profit: 'the pharmaceutical sector consistently puts profits before people'.[89] She emphatically believes that patents must not be misused to create monopolies and the prices of medicines should reflect the public contribution to their development. Making this radical change will require implementation of existing agreements, such as the right to health, and the introduction of new rules.

Yet patents are not the biggest problem, it would seem. A greater issue is the knowledge, skills and capacity to produce medicines. Steps have been taken to improve the situation in recent years. Senegal, for example, is almost in a position to produce innovative drug treatments and vaccines itself. India and Cuba have had proven expertise in vaccine and medicine production for even longer. Cuba is developing medicines based on cane sugar, shares knowledge with countries in Africa and South America, and earns revenue from licences for hepatitis treatments, for example. China has its own COVID-19 vaccines and its own strategic agenda. In short: European and American firms no longer have a monopoly. This is therefore the right time for a shift in policy. Essential medicines and vaccines should be regarded as public goods. Governments are partially responsible for their development, and pay some of the costs. The Netherlands could press for the international agreements on the right to health to be respected, guaranteed and implemented, with new regulations on essential medicines.

Criticism of the profits some firms have made on COVID-19 vaccines must not however overshadow the fact that in 'normal' times there is often no commercial benefit from investing in vaccines, new antibiotics or medicines to treat diseases of poverty, given that they are often unprofitable. Nor is it profitable to keep large stocks of face masks or other medical products. After all, there is no guarantee that they will ever be purchased. There is certainly a willingness in the pharmaceutical sector to cooperate with the authorities. The Holland Bio partnership has launched effective joint ventures – some of them with government support and via facilitating platforms. They have proved capable

of ensuring mutual benefits and thus reinforcing international ties. The Healthcare Task Force is another good example. This platform for the Dutch Life Sciences & Health sector works to improve international healthcare by connecting Dutch companies, NGOs, knowledge institutions, healthcare providers and authorities.[90]

There is at present extreme global inequality in access to vaccination.[91] This is not a tenable situation, as evidenced by the many pleas issued by WHO Director-General Tedros Adhanom Ghebreyesus. At the recent EU-AU summit he announced that the first six countries in Africa would receive the technology required to manufacture mRNA-vaccines.[92]

The Netherlands manufactures a significant proportion of vaccines. Around a third of the vaccines administered in Europe are made in the Netherlands. The Life Sciences and Health top sector has called for a thorough approach encompassing vaccine development, production capacity, logistics and testing laboratories, and for cooperation with government to expand facilities for vaccine production and invest in pandemic preparedness.[93] Agreements must be made stipulating guaranteed minimum purchases. The investment risks and costs must be shared in a way that is reasonable for all parties. An active role for government would enable Dutch industry to make a bigger contribution globally.

Non-medical sectors

Given the Health in All Policies and One Health approaches, it is not enough simply to focus on the medical and pharmaceutical sector. The food sector, agriculture, industry, transport – virtually all sectors have a direct or indirect negative or positive effect on people's health. Positive impacts include the production of healthier food containing less sugar and salt, or the production or use of cleaner cars that do not adversely affect air quality in urban areas. Negative impacts include degradation of the living environment, unhealthy working conditions or business models based on unhealthy diets.

The private parties whose core activities have an indirect bearing on health are very diverse. There are for example major international players, small and medium-sized enterprises (SMEs), and startups whose activities can have a major positive or negative impact. There is however no systematic monitoring of health impacts. Besides their core activities, many larger firms have established charitable foundations to try and make a positive contribution to global health in this way.

Civil society organisations and funds

There have long been initiatives and funds in the Netherlands that focus on certain aspects of health, such as childhood disability, the health of women and girls, or sexual health. This specific focus has led to relatively good results in the past. The drawback, however, is that it promotes a blinkered view of and approach to health and wellbeing.

There are similar initiatives at international level, too, including the Red Cross, which focuses mainly on providing emergency assistance, and Médecins Sans Frontières, which works in regions in crisis or at war. But there is a blinkered approach at international level, too. This can be seen in major organisations like the Global Fund, a partnership which was set up to accelerate the response to HIV/AIDS, tuberculosis and malaria and initially focused exclusively on these conditions. It mobilises and invests over $4 billion a year in support of programmes implemented by local experts in over a hundred countries. The Bill and Melinda Gates Foundation, the biggest private foundation in the world, has donated some $300 million to the global response to COVID-19, including support for vaccine studies by companies like Inovio Pharmaceuticals, AstraZeneca and Moderna Inc. It aims to make vaccines available to seven billion people. Gavi, the Vaccine Alliance, is one of the biggest partnerships in the field of health. It aims to increase access to vaccination in low-income countries and introduce new and underused vaccines to these countries. Gavi does not have its own country offices, but works closely with WHO at regional and country level. WHO offices help national health authorities draft applications for Gavi support, and provide technical support with the implementation of immunisation programmes.

There has been a shift among the civil society organisations working in the field of health, both internationally and in the Netherlands. Whereas they initially operated largely in specific areas and specialisms, they now take a broader view of and approach to health. In the Netherlands, the Dutch Global Health Alliance (DGHA) is a good example of this broader approach. The members of the DGHA (Aids Fund, Amref Flying Doctors, Cordaid, Royal Tropical Institute (KIT), KNCV Tuberculosis Foundation, Until No Leprosy Remains (NLR), PharmAccess, Netherlands Refugee Foundation and Wemos) 'are dedicated to raising awareness about the need for more concerted global health action and to working towards concrete policy options for the Dutch government that will contribute to stronger health systems worldwide.'[94]

Phasing out harmful pesticides?

It is increasingly clear that there is a link between exposure to pesticides and poor health. Exposure can lead to certain forms of cancer, fertility and reproduction problems, respiratory conditions, disruptions to the hormone system, the immune system and the nervous system, and associated decline in cognitive ability. Two examples of harmful pesticides are glyphosate (known by the brand name Roundup) and paraquat. Glyphosate was widely used as a herbicide in farming, as well as in public spaces and by private individuals. WHO concluded in 2015 that glyphosate is 'probably carcinogenic to humans'.[95] The pesticide paraquat, which is now banned in the EU but still exported from Europe and used in large quantities elsewhere, has been linked to a global increase in Parkinson's Disease, of which there are forecast to be 17 million cases by 2040.[96]

Such major transnational health and safety risks, involving big commercial interests and agriculture (food production), are regulated at European level in the first instance. The EU has the mandate to determine whether such chemical products are safe enough to be admitted to the single European market. Private use of glyphosate in gardens, and use in public greenery, was banned in 2016. In 2017 the European Parliament voted by majority for a universal ban on reintroducing glyphosate, but the outcome of the political process was a further five years of authorised use in the European Union. Eighteen member states, including the Netherlands, voted to extend authorisation for glyphosate.[97]

Knowledge institutions

The approach to global health also requires international cooperation on research and development, as became apparent during the COVID-19 pandemic. The speed with which the genetic code of the virus was shared, vaccines were developed, and scientists all over the world exchanged data was impressive. It showed not only how vital close international cooperation is, but also the huge importance of well-equipped knowledge and research institutions in normal times. When a crisis occurs, it is not possible to suddenly build up sufficient capacity. Existing knowledge infrastructures and international cooperation, using local knowledge, expertise and research facilities, are absolutely vital.

Over the past ten years several attempts have been made to bring actors together to facilitate a more coherent approach to Dutch global health action and policy. The National Committee for International Cooperation and Sustainable Development (NCDO) has for example published a dossier on global health, as part of a series on globalisation, with the aim of prompting debate at various levels. Kaleidos Research published a report on the significance of global health for the Netherlands. The Netherlands Institute of International Relations 'Clingendael' organised several meetings that resulted in a publication on the Netherlands' role in global health. The Ministry of Health, Welfare and Sport investigated support for policy on global health, including expert consultations. The National Institute of Public Health and the Environment (RIVM) issued a publication on health threats to the Netherlands. The Dutch Global Health Alliance (DGHA) wrote about the need for a

Dutch global health strategy. The Dutch Society for Tropical Medicine and International Health (NVTG) recently started facilitating a global health knowledge platform funded by the Ministry of Health, Welfare and Sport. Global health is also a popular subject of study in the Netherlands, albeit that provision is somewhat fragmented.

Many Dutch universities with a medical faculty organise global health summer schools, minors and electives. Some 200 students a year graduate with a Master's in Global Health.

The COVID-19 pandemic

After two years of COVID-19 a picture is slowly emerging of its impact and the lessons that can be drawn from it. In mid-February 2022 there have been 412 million confirmed cases worldwide and 5.8 million deaths, bringing this pandemic close to the estimated 500 million cases of Spanish flu in 1918-1920 – though at 25 million the death toll was much higher then. By way of comparison, the ongoing HIV/AIDS pandemic has caused 32.7 million deaths worldwide since the mid-1980s.

WHO's Pan-European Commission on Health and Sustainable Development has made several specific recommendations intended to improve health policy in the pan-European region (which besides the EU also includes the other countries in WHO's Europe region). One of those recommendations concerns the establishment of a Pan-European Network for Disease Control, as a successor to the European Centre for Disease Prevention and Control (ECDC) in Stockholm. Another is to establish a Pan-European Health Threats Council convened by the WHO Regional Office for Europe. The Commission calls for multilateral development banks and development finance institutions to prioritise investments in data-sharing.

The Independent Panel for Pandemic Preparedness and Response (IPPPR) made the following six recommendations to ensure preparedness for a future pandemic.

1. Elevate leadership to prepare for and respond to global health threats to the highest level by establishing a Global Health Threats Council and negotiating a Framework Convention.
2. Focus and strengthen WHO's independence, authority and financing.
3. Invest in preparedness now to create fully functional capacities at national, regional and global level.
4. WHO should establish a new, versatile international system for surveillance, validation and alert capable of speedy action in the face of potential pandemics.
5. Establish a pre-negotiated international platform for sharing medical supplies before a pandemic occurs.
6. Raise new international financing for the global public goods of pandemic preparedness and response.

To what extent these recommendations will be adopted at the various levels is difficult to say at this juncture, but in drawing up a Dutch global health strategy it would be advisable to bear them in mind. It is vital that specific interventions and more general support for health systems are mutually reinforcing.

Next steps

4.1 Progress, but not enough

The COVID-19 pandemic has once more made it painfully obvious that health policy can be neither viewed nor guaranteed from a national perspective alone. It takes international cooperation. Clearly, this is not just a matter of pandemic response. Achieving global health requires a structural focus and action in numerous interrelated areas.

Setting out health policy will require well-founded choices about interrelated dilemmas. Better healthcare leads for example to a larger global population, with longer average life expectancy, which will place demands on food security and create a bigger ecological footprint, leading to other health risks.

Another dilemma is the economy. Demographic ageing combined with technological and pharmaceutical innovation is causing healthcare costs to rise sharply. Extrapolating the current trends provides some idea of the limits of the affordability of care, and the availability of staff for this sector.

A third dilemma concerns the form in which care is provided. It goes without saying that it is in everyone's interest that the availability and accessibility of adequate healthcare be regulated everywhere in the world. At the same time, it is not possible simply to transpose or export one particular model. The specific context will have to be considered in each case, including local practices, possibilities and impossibilities. The role of IT, in the form of remote healthcare, for example, will also need to be explicitly considered.

Global health policy is not simply about preventing acute crises like pandemics. It should be a permanent focus of attention. Policymakers must constantly consider the impact of social, ecological, demographic and behavioural factors on health, such as lifestyle and living conditions, as well as the intrinsic value of health and solidarity, and how health is associated with our living environment.

Last but not least, ethical dilemmas associated with care will also need to be considered. Ultimately, the overarching issue is which and whose problems should be prioritised, and who decides this.

Chapter 3 examined attempts by many actors over the past few decades to improve global health in many different ways. Many of their goals have not yet been achieved, and there is a great deal of room for improvement in health policy at national, European and global level. Global efforts to achieve SDG 3 are under pressure. The COVID-19 pandemic has delayed the goal's attainment even further, and the prospects of it being achieved any time soon are remote. WHO continues to function, though with great difficulty, as a result both of its internal regional structure and uncertainty concerning external support.[98] Moreover – despite many warnings, and positive steps like the adoption of the IHR and the establishment of the European Centre for Disease Prevention and Control (ECDC, see 3.4) and similar institutions in other parts of the world – pandemic preparedness is still inadequate.[99]

The failure of all these efforts to yield adequate results is due partly to the complexity of the issue. Firstly, health policy is regarded above all as a national responsibility, shouldered by a single government ministry. More comprehensive policy is needed, and that requires the involvement of several parties, ministries and international institutions.

Secondly, well-meant policies sometimes turn out to be counterproductive, or in medical terms: undesirable side effects occur. In this connection, it is worth stopping to consider the do no harm principle. Do no harm is one of the best-known principles of medical ethics, which goes back to Hippocrates, a Greek doctor who, in around 400 BC, laid the foundations of medical ethics and the medical oath. In short, the do no harm principle means that sometimes it is better not to give medical treatment than to take the risk that the intervention will do more harm than good.[100] The article 'Do No Harm: The Global Health Challenge' (2007) argues that there is a downside to the growing attention being given to global health by major funds.[101] The availability of large amounts of funding to fight tuberculosis, HIV/AIDS, malaria and other diseases has led to the establishment of specialist clinics in many African countries. These clinics do useful work, but the high salaries paid by NGOs draw medical and nursing staff away from regular healthcare institutions, which have to close as a result. This reduces access to regular healthcare. Western countries' recruitment of African nurses only exacerbates this problem. In the context of global health, do no harm also means: prevent a brain drain caused by the international migration of healthcare workers, consider the local situation and prioritise the expansion of existing healthcare institutions.[102]

Many centuries later, Hippocrates' do no harm principle is still one of the core tenets of thinking on sustainability. The Netherlands Environmental Assessment Agency (PBL) describes it as follows: activities undertaken in the *here* and *now* must taken into account the effects later and *elsewhere* in the world.[103] Do no harm is one of the guiding principles of policy on the environment, nature and biodiversity, but it can also be applied to human health: direct and indirect damage to health must be prevented. The authorities and business have a responsibility in the event of direct or indirect damage to health, and there is also chain responsibility.[104]

In this connection, it is important to note that not all companies consider a do no harm approach to be sufficiently inspiring. These firms want not only to operate without doing any harm, they also want to add something positive. Such activities could be described as falling under the principle 'do good', or even 'do better'. Activities based on this principle go further in social terms than do no harm and are part of a company's primary operations. Do good can refer to a whole range of things: providing health insurance for staff, educating about health, making resources available and restoring ecosystems are just a few examples. Some firms have also set up separate charitable foundations to put their social engagement and responsibility into practice.

Thirdly, there is a lack of coordination, both nationally and internationally, and actors do not agree on the best approach. Roughly speaking, there are two ways of achieving better coordination: a centralised approach and a decentralised approach. Both are needed. In terms of the centralised approach, it makes sense to invest in stronger global cooperation, with WHO as lead organisation, issuing guidelines and coordinating monitoring and reporting. A centralised approach led by WHO will require the support of its member states, and that will need to be achieved through diplomacy.

A decentralised approach considers the circumstances and situation in each country or region. Donors like the Global Fund look at what each country needs, what its strengths are and what capacity it has. A decentralised approach is also better for anticipating specific issues, demand for care or cultural factors. Different initiatives can be coordinated locally with those regional circumstances in mind. This approach is in line with the desire to avoid simply adopting wholesale the norms, priorities and design of Western health systems.[105] When it comes to international cooperation, the goal must be to strengthen each country's own capacity to build up a well-functioning health policy, a healthcare system and facilities that are suited to national or regional conditions. Coordination is then more a matter of exchanging knowledge and competences than issuing guidelines. There are of course intermediate forms between the centralised and the decentralised approaches, and in practice action occurs on several levels at once. The Netherlands is, for example, active on behalf of health at national, bilateral, European and global level (predominantly through WHO). It is important that action taken at all levels is based on the same principles and the same policy (multilevel governance).

Fourth: a concept like One Health requires the economy, food production and society as a whole to be organised in a fundamentally different way. It is no simple matter to reorganise agriculture on a smaller scale and in a more sustainable way, and still produce enough food. It is difficult to reach agreement on how specifically this should be done, as shown by the example of glyphosate. Pesticides are often needed to produce sufficient food to feed the world's population, but used injudiciously or on too large a scale they can cause long-term damage.

Fifth: inequality in access to essential healthcare also results from legislation and international agreements. They can be amended, but major interests are involved. Change requires a great deal of persuasion and perseverance. New technology and digitilisation can help simplify and optimise access to health services, particularly in remote areas.

Sixth: health problems often manifest themselves acutely and immediately. After diagnosis, treatment must begin immediately. This is also the way we tend to look at health policy. There is a tendency to put all our energy into alleviating acute need and neglect long-term problems.

More attention is generally given to cure than to prevention. What is needed is a structural, integrated approach based on a consistent recognition of the connection between human, animal and planetary health, and the health of the ecosystems, societies and environments in which they co-exist. This is true both of the One Health approach and the Health in All Policies approach.

Seventh: there has been underinvestment in healthcare for decades.[106] Health systems in the Global South, particularly in Africa, including infrastructure and facilities, trained staff, information and medicines, often fall short. This is a problem for a large proportion of the population, especially in rural areas and in informal settlements. This is generally not merely a matter of weak health systems, but also of a lack (or complete absence) of public services. As a result, countries across the entire continent respond in different ways, whether it be individually, or in collaboration with international organisations, INGOs and NGOs. There have been some experiments involving various approaches, intervention models and funding models for healthcare, with varying results.

Finally, many different interests are involved, both globally and within the Netherlands. The lack of any clear task allocation is one of the main reasons for the failure to agree a strategy.[107] The allocation of duties and responsibilities associated with global health among the ministries involved remains unclear to this day. For a long time, the Netherlands lacked any sense of urgency on global health, with the exception of the activities carried out as part of development cooperation. Global health is not merely a matter for the health and foreign ministries (including foreign trade and development cooperation), but also for the Ministries of Economic Affairs & Climate Policy (including Climate & Energy), Infrastructure & Water Management, Agriculture, Nature & Food Quality, Education, Culture & Science, and Defence. The intention set out in the coalition agreement to develop a Dutch global health strategy is a step in the right direction.

The AIV acknowledges that this is a complex matter, and that action is difficult, but it must also conclude that the costs of inaction could be considerable, as we have learned from the recent pandemic. Yet there is still no more formal platform or process for the further development of a Dutch or global health strategy.

4.2 Building blocks

The considerations set out above have led the AIV to identify the following building blocks for the 'foundation for the development of coherent policy regarding global health issues'.[108] In accordance with the House of Representatives' request, these building blocks set out principles that should enable the development of a comprehensive and coherent strategy on the basis of which the Netherlands can roll out its own strategic agenda. An abridged version of these building blocks appears at the beginning of this advisory report in the form of a set of recommendations.

The AIV welcomes the announcement of a Dutch global health strategy in the coalition agreement. It is important that the Netherlands adopts a clear position and formulates a contribution to a global health strategy, including priorities and potential action. When it comes to implementation, the AIV would recommend a coherent approach at national and international level, and a multisectoral platform that allows relevant sectors and actors to have the necessary input.

1. **Specify the goal of the Dutch global health strategy within existing international frameworks**
   The Netherlands' global health strategy should help to achieve global health and implement the right to health as described in SDG 3 and previously reaffirmed in several international agreements, on the basis of the Universal Declaration of Human Rights. SDG 2 (End hunger, achieve food security and promote sustainable agriculture), SDG 6 (Clean water and sanitation for all), SDG 13 (Climate action), SDG 14 (Life below water) and SDG 15 (Life on land) also contribute to global health. Within these broad international frameworks, it is important that good use is made of the Netherlands' strengths. The AIV is thinking here of the promotion of coherent policy based on collaboration between different disciplines and actions, to capitalise on the connections between the SDGs. The Netherlands also has specific, high-quality knowledge at its disposal, on antimicrobial resistance and microbiology for example. It can moreover build on past contributions relating to sexual and reproductive health and rights (SRHR), HIV/AIDS and mental health, and continue to work to strengthen international institutions working in the field of global health.

2. **Guarantee international institutional embedding and a long-term focus**
   A Dutch global health strategy must be aligned with and strengthen existing international institutions and frameworks. The Netherlands must therefore step up its input to WHO and the EU on matters of health. This can be achieved through substantive and diplomatic activities, with a focus that encompasses more than simply a few specific diseases or humanitarian emergencies.

   a) By continuing to support WHO as a standard-setting and, in some cases, implementing organisation (politically, financially and in terms of policy), and by collaborating within the EU, the Netherlands can help achieve a coherent global health system. The Netherlands can align the content of its strategy with WHO's three strategic goals: 1) achieving universal health coverage (UHC); 2) addressing health emergencies; and 3) promoting health & wellbeing.

   b) Efforts within and via the EU will enable the Netherlands to contribute to a robust global policy. The AIV believes that the EU could make better use of its purchasing power and focus on democracy, legislation and sound governance to lower the prices of medicines and vaccines in the Global South. Given that it is generally the member states that negotiate prices, this is also a responsibility for national governments. The European Commission could play a coordinating role for a number of essential medicines by coordinating public investments and ensuring that the benefits are shared equitably. EU legislation on medicines should also be screened with the aim of removing obstacles to the sharing of knowledge and building of production capacity. It would also be worth considering

introducing a health impact assessment of trade and other policies. Finally, the EU could show political leadership as Team Europe to set up an inclusive Global Compact for Health mechanism that would release financial resources for pandemic preparedness, global public goods and efforts to strengthen health systems in low-income countries.[109]

3. **Choose strategic priorities**
By stepping up international cooperation, the Netherlands can set out strategic priorities that are aligned with those of WHO:(Universal Health Coverage (UHC), health emergencies and promoting health & wellbeing.

   a) **From emergency aid to health infrastructure:** To cope with current and future health issues, it is important that the focus is not only on meeting acute needs, but also – even in the case of emergency aid – working towards a strengthened health infrastructure. The Netherlands could propose, via the EU, a model that would enable countries to build their healthcare capacity and report emerging health threats by providing investments, expertise and technology. The EU and African countries could use their partnership to play a pioneering role in putting such an approach into practice.

   b) **Prepare for future pandemics:** A powerful and effective plan to improve pandemic preparedness is needed in order to respond better to infectious diseases and pandemics. This requires investment, in laboratory capacity for example, which means thorough fleshing out of the European Commission's proposal for a European Health Union.

   c) **Coherence:** Health is influenced by a whole range of factors that are not covered by health policy strictly speaking. Policy coherence is a prerequisite for real improvements to global health. At national level, this could be achieved by aligning the activities of different ministries, civil society actors, the private sector and knowledge institutions as well as multilateral cooperation between authorities at various level on aligning their health policy. Health is the result not merely of individual factors, but also of socioeconomic circumstances and the broader living environment. It should therefore be a key focus not only of health ministries but also of other ministries. Better coordination of and coherence in government action in virtually all areas is needed, as well as a guiding agenda. This could for example be achieved by re-examining existing policy and, in every new policy memorandum or draft legislation, explicitly stating whether and how health has been considered (see also 4b).

4. **Set out guiding principles for a global health strategy**
Assuming a rights-based approach, and thus the right to healthcare and protection of health, the AIV recommends that the following principles be incorporated into the Dutch global health strategy.

   a) ***One Health:*** This approach is based on the understanding that humans, animals, ecosystems and the natural environment are connected. Several sectors and disciplines are involved in One Health, and the aim is to prevent or respond to emerging and endemic threats to health.

   b) ***Health in all Policies:*** This approach encourages the inclusion of health considerations in policymaking in all sectors that impact on health, such as macroeconomics, transport, agriculture, housing, social security, public safety and education. The Health in All Policies approach is based on ideas about the social determinants of health, and emphasises reduction of inequality and promotion of social justice.

c) ***Do no harm:*** It is difficult to develop and enforce global legally binding codes of conduct for all sectors, but the introduction of a do no harm principle for governments, civil society organisations and the private sector could have a more immediate impact. The AIV would like to explicitly highlight the fact that not acting is also a choice. Such a principle should certainly not remain limited to a moral appeal, but should also take the form of an explicit obligation to report applying to the entire chain of production, the monitoring of activities and effects, health impact assessments and application of the precautionary principle. This will take a different form for a company than for an NGO or donor, for example. Governments and civil society organisations will have to engage in critical monitoring to understand the unintended effects of their policies and interventions. In the private sector this might take the form of an ex-ante health impact assessment of manufacturing, production processes, methods of funding, forms of transport, etc. A call for some form of reporting, such as the Environmental, Social & Governance (ESG) reports, or (in due course) a reporting or due diligence obligation can help raise awareness. The SER report 'EU Legislation to Encourage Sustainable Supply Chains' (2021) on effective European due diligence legislation makes some suggestions as to how this might be achieved.[110]

   Many companies are sufficiently motivated to commit as well to 'do good' (to contribute to the common good, in other words).[111] Government could promote this, provide frameworks or act in a regulatory capacity to encourage companies to adopt the do good principle as part of their business process. It could for example ask companies to explicitly state their values on the matter, ask for reports, guarantee investments, or support matchmaking between demand (clients from the Global South) and supply (companies in the Netherlands).

d) **Context-specific approach:** Health is not merely a global issue, of course. It also has a national, regional and/or local context. A global health strategy cannot work if it is not based on demand or need in a specific context. Any such strategy must consider the fact that policy, regulation, organisation and funding for healthcare is shaped first and foremost at national or subnational level. Introducing a universally applicable health model, let alone imposing such a model, is not the right approach. Real cooperation implies being willing to learn from another context in order to further one's own development, learn from each other and take account of each other. What the Netherlands can offer should be viewed from such a context-specific approach, considering what knowledge and resources the Netherlands can make available to strengthen capacity in other countries.

5. Put one's own house in order

To make a useful contribution to global health, the Netherlands will have to put its own house in order. Currently, no ministry is mandated to develop and implement global health policy. Furthermore, the policies of different ministries are often inadequately coordinated.

a) **Give the Ministry of Health, Welfare and Sport a clear mandate to take ultimate responsibility for coordination on matters of health:**
   - Help with the further substantive reinforcement and funding of global health policy, preferably through WHO.
   - Contribute via WHO to global surveillance for the purpose of drafting and monitoring a national plan for future pandemic preparedness.
   - Help to identify gaps in policy, using knowledge developed in the Netherlands and elsewhere.

b) **Give the Ministry of Foreign Affairs responsibility for coordinating diplomatic aspects of health and efforts to strengthen joint political and institutional ability to achieve results.**

- Contribute through diplomacy and professional collaboration to the development of a comprehensive global health strategy, better coordination of currently fragmented initiatives and a coordinated approach through WHO and the EU.
- Acknowledge the need for and the security dimension of global health, including within the EU, G7 and G20, and in bilateral diplomacy outside these forums.
- Ratify the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, which would more firmly embed the right to health in the Netherlands' own law.
- Appoint a health envoy for the Netherlands to guide and promote the international dimension of the Dutch strategy.
- Use foreign trade and development cooperation funds to make a targeted, demand-driven contribution to efforts to strengthen healthcare, and guarantee there is enough expertise for this at the ministry. This could take the form of a response to a request for assistance from the government in question (see also: AIV advisory report no. 118, *'Social Protection in Africa'*).
- Set up a programme in collaboration with the Ministries of Health, Welfare & Sport and of Economic Affairs & Climate Policy and top sector policy, designed to strengthen the healthcare system in the Global South.
- Work with the Ministry of Economic Affairs and Climate Policy to use part of the funds released from the financial schemes for the fossil fuel industry to provide export guarantees in the field of health, sanitation and sustainable food production.

c) The following ministries should at any rate be involved (in alphabetical order):

- **Agriculture, Nature and Food Quality** can develop more knowledge and policy on zoonotic and foodborne diseases and help farmers reduce their use of pesticides.
- **Defence** has a role to play in pandemic preparedness, providing border protection and emergency aid, among other things. Knowledge of the risks associated with and protection from biological weapons is also needed.
- **Economic Affairs and Climate Policy**, including Climate & Energy, can help flesh out the guiding principles. The ministry can discuss the prerequisites for contributions by Dutch companies with the Health & Life Sciences top sector and set priorities in areas where the Netherlands is able to make a unique contribution. The ministry can also encourage collaboration with private funders and NGOs and give substance to the do no harm principle by performing health impact assessments and working with knowledge institutions. It is also important that co-benefits be highlighted, such as the switch to renewable energy sources and improvements in air quality.
- **Education, Culture and Science** can support the exchange and development of knowledge through EU programmes, international partnerships and bilateral cooperation. The ministry also plays a role in disseminating knowledge on focus areas of Dutch expertise (incl. AMR and virology).
- **Infrastructure and Water Management** plays a role in designing a living environment in which health must be a major consideration. The ministry also has a role in approval processes for chemical substances (within the EU).
- Sufficient support and collaboration will be required to make this process work.

d) Oblige the cooperating ministries to draw up a joint annual progress report (The State of Global Health Policy), with the Ministry of Health, Welfare as publication coordinator:
An annual progress report describing the state of Dutch international health policy would support coordination between ministries and help achieve coherent policies.

6. **Provide a framework for multisectoral collaboration**

There is no coherent framework at national level to integrate and optimise the input of actors other than ministries – such as industry, civil society, financial institutions and knowledge institutions – to a global health strategy. In AIV advisory report 99, *'The Dutch Diamond Dynamic'*, the AIV indicated the desirability and likely benefits of collaboration between all sectors in the Netherlands. The facets (actors) of the Dutch Diamond (authorities, industry, knowledge institutions, civil society and financiers, including the health sector) can all help provide a Dutch contribution to global health. There should be a platform where all relevant actors in the Netherlands could work together to tackle global health challenges, with the same goal, the same strategic priorities and the same guiding principles. Given the complexity of global health, a multisectoral approach is needed. With such a comprehensive approach, the Netherlands can seek to become a lead nation on certain carefully selected focal points.

a) **Authorities:** The authorities in the Netherlands can facilitate and use such a platform by setting out a framework encompassing all sectors to optimise the input of non-state actors, within which private and civil society actors could contribute to global health without harming individuals' health or the living environment. The role of the authorities is to guide this process by means of management, regulation, funding and leadership and to introduce or abolish subsidies and fiscal support and stricter legislation to curb negative effects and promote positive effects on health. Ways of doing this include training and exchanging policymakers and technical experts with other countries and international institutions, strengthening the capacity of counterparts of the Netherlands' National Institute of Public Health and the Environment (RIVM) in other countries, or calling regulators and other countries to account for their duty to recognise and promote health as a human right.

b) **Industry:** Companies active in the medical or health sector can draw up standards for themselves and/or innovate in their business model. Examples include re-investing company profits in public health; customised innovation, making products and services suitable for the Global South; sharing knowledge with partners in the Global South (both patents and expertise); and adjusting the prices of vaccines, medicines and medical equipment (as often happens now) for countries with limited health budgets. Pharmaceutical companies can help draw up a framework for improving access to essential medicines in the Global South. Companies in other sectors can collaborate on giving substance to the do no harm and/or do good principle. Companies also have a responsibility to organise adequate health insurance for their staff and families, and make medical assistance available in the workplace (see also: AIV advisory report no. 118, *'Social Protection in Africa'*). Many private parties recognise the benefits of a sustainable business model.

c) **Civil society organisations:** Participatory methods can allow civil society organisations to help identify health problems at local, national and international level. They also play a role in advocacy, generating solidarity and support, and holding the organisations and authorities concerned to account.

d) **Funders:** Healthcare accounts for a considerable and steadily growing proportion of government budgets, not only in wealthy countries but increasingly in poorer ones as well. There are calls everywhere for more money to be put into healthcare, at both national and international level. The constant emergence of new treatment methods, technology and pharmaceutical products, combined with a global increase in life expectancy and demographic ageing, is leading to bigger and bigger health bills. Making money available is in fact a kind of global triage system. It is not only a matter of expanding, distributing or redistributing public funds. Explicitly including contributions from public funds (for research, for example) in the profit models of companies can also generate more resources.

The existing foreign trade and development cooperation (BHOS) budget is already invested in numerous activities, including SRHR activities. The coalition agreement states that activities on HIV/AIDS will be continued. Though the budget for international cooperation has been increased somewhat in the coalition agreement, the extra funding is expected to be spent in its entirety on climate and migration. These two issues are of course directly related to health, and as such expenditure on climate and migration will also benefit global health (have co-benefits).[112] In addition, investments must be made at national and international level in global public goods (knowledge, preparedness, coordination, international standards and enforcement) in order to respond effectively to future health threats.[113] While more funding is important, however, money is not the only means available: coherent policy can avoid extra costs and negative developments. The focus must be on exchange of knowledge and policy coherence (concerning trade and intellectual property, for example). This makes medical treatment more affordable and thus also accessible. Focusing on prevention can also yield measurable results.

e) **Knowledge institutions:** Knowledge is the key factor linking all options for improvement. Exchange of knowledge is vital, and a basic prerequisite for a successful and widely supported approach. This requires effort, to share and provide access to vital knowledge concerning prevention, vaccine development and production, treatment methods, public health insurance, medicines and a healthy ecosystem and living environment. Knowledge sharing can also change the relative balance of power, for example in the pharmaceutical domain. Achieving this will require research programmes that explore how best to tackle complex health problems.

   Transfer of knowledge is also badly needed for innovation and the scaling up of care nationally. This all needs to be organised, funded and facilitated. Preferably, a framework should be formulated for the expansion of SDG 3-related research, knowledge exchange and innovation (for example through digitalisation). Given the growth in e-health, it is vital that access to and ownership of digital data be improved, particularly in the Global South. Legislation is needed to shrink the digital divide (see also AIV advisory report no. 115, *'Digitalisation and Youth Employment in Africa'*). It is interesting to note, incidentally, that on this matter the interests of consumers in the North and South are aligned. Dutch government can play an important international role on this matter: firstly, because of its track record on legal protection; secondly, because as Europe's second largest data hub and seventh largest in the world, it can be a role model. Specifically, this can be achieved by working with initiatives in the Global South and North campaigning for e-health data ownership, and by advocating a binding framework at UN level, in line with the Dutch Digitalisation Strategy.[114]

7. **Focus on affordability and accessibility of healthcare**

Change the way essential medicines, vaccines and medical devices are regulated in favour of affordability and accessibility. The current system protects the patents and data of innovative manufacturers. This is necessary in many cases so that they can recoup research and development costs. Excessive profits are not justified, particularly because new active ingredients are often developed on the basis of publicly-funded research. Patents must not be abused to create monopolies. Mission-oriented innovation policy is needed, in line with the ideas of Mariana Mazzucato.[115] Innovation must focus not only on development of drug treatments for markets in prosperous countries, but also on the population, conditions and infrastructure of the Global South. The prices of medicines and vaccines must reflect the contribution from the public purse.

Digitalisation (telehealth) can also help make care more accessible. It is important that proper consideration be given to the ownership of data, and to ways of preventing new monopolies from emerging. Sharing knowledge is important, but not enough in itself. What matters is

making knowledge accessible in a range of local or regional situations. The learning process must be mutual, and new knowledge should be developed in this way.

8. **Do not wait for the next health crisis**
   A great deal of attention is currently being given to global health. It is important that this focus not weaken. Health is a global public good. The roadmap towards improvement of global health must do justice to the complexity of the global health issue, and this will require collaboration at national and international level. Start, for example, with a launch conference involving the appropriate ministries, with partners from the Global South and the Dutch players concerned: companies, knowledge institutions and NGOs. Learn from the experiences of the COVID-19 pandemic. Ask participants what they can contribute, what they can do to prevent zoonotic disease, for example, to apply the do no harm principle, or to make healthcare accessible and affordable for all. Ask experts how concretely to assess the health impact of legislation and policy. Ask companies how they can monitor and report. See whether the responses are enough to flesh out the Dutch global health strategy. Identify missing elements of the roadmap as quickly as possible, and seek a path that will bring results in the short term, without losing sight of the long-term problems.

Closing comments

As this report was being written, the severity of the COVID-19 pandemic was decreasing in intensity in the Netherlands and many other countries. At the same time, the pandemic is still having a considerable impact in many places, and there are still concerns about new variants of the virus or new outbreaks. One matter of particular concern is that the huge health inequalities that became apparent still exist, and have even grown worse. New health problems associated with the way we produce and consume are continuing to emerge. This has been set out in detail in this report, and requires action, new priorities and, above all, cooperation. The Netherlands can help achieve SDG 3 and can bring new energy to efforts to achieve the vision of the 1948 WHO constitution, which enshrined for the first time the right to and importance of health.

The building blocks will have to be used in a process in which the government takes the initiative and responsibility, and companies, knowledge institutions and civil society organisations are each invited to contribute in their own way on the basis of their own expertise. The process must be based on the idea that joint action means progress for all, and that collaboration with partners in the Global South is mutually beneficial.

Endnotes

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Request for advice

Mr Jaap de Hoop Scheffer
Chairman of the Advisory Council
on International Affairs
P.O. Box 20061
2500 EB The Hague

Date: 25 February 2021
Re: Request for advice on the framework for a Dutch global health strategy

Dear Mr de Hoop Scheffer,

Today, 25 February 2021, the House of Representatives decided, pursuant to article 30 of the Rules of Procedure of the House of Representatives of the States General, to request an advisory report from the Advisory Council on International Affairs (AIV) on the framework for a Dutch global health strategy.

The objective of the report is to lay the foundation for the development of coherent policy regarding global health issues, which the Netherlands can use to implement its strategic agenda and, leading by example, participate in international forums addressing global health issues and developing multilateral strategies. The report can thus also serve as a basis for the new government in drafting a global health strategy policy document.

On behalf of the House, I would kindly ask you to comply with this request.

Yours sincerely,

Khadija Arib
President of the House of Representatives
of the States General

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ANNEXE

Further explanation of the request for advice on a Dutch global health strategy by the Parliamentary Committee on Foreign Trade and Development Cooperation

The Parliamentary Committee on Foreign Trade and Development Cooperation proposes requesting the Advisory Council on International Affairs (AIV) to produce an advisory report setting out the framework for a Dutch global health strategy. The objective of the report is to lay the foundation for the development of coherent policy regarding global health issues, which the Netherlands can use to implement its strategic agenda and, leading by example, participate in international forums addressing global health issues and developing multilateral strategies. The report must expressly take into account the interministerial relevance of the topic of global health.

Background of the request

Global efforts to expand access to healthcare and combat disease have been part of Dutch policy on international cooperation for decades. In a number of areas the Netherlands is in fact a leading player internationally. What is more, the Dutch business community, civil society and academic community also play an important role around the world. For example, the KNCV Tuberculosis Foundation is a global leader in the fight against tuberculosis, the Leiden-based pharmaceutical company Janssen has developed a vaccine against COVID-19, and Philips has swiftly redirected its business model towards the production of medical devices. The Netherlands has relatively limited resources, but given its abundance of available expertise it can play a driving role worldwide in strengthening global health.[1]

The COVID-19 pandemic has shown how interconnected the world is. A virus knows no borders and can wreak havoc from one day to the next. The global response to the pandemic has made clear that there are many different perspectives on the right approach to fighting the virus. It has also shed light on major inequalities in terms of capacity and available resources. Through greater coherence, we can be better prepared for and more effective in tackling global health crises of the sort we are now experiencing. To be able to help resolve the current crisis and mount a more effective response in the future, it is essential to develop a coherent global policy framework – or, at the very least, gain insight into where the strengths and weakness of global healthcare lie – with due respect for local customs, traditions and preferences. Perhaps even more important is the need to take account of the differing levels of healthcare around the world. The principle 'leave no one behind' is especially relevant in terms of strengthening global health systems.[2]

During the 2021 debate on the Foreign Trade and Development Cooperation budget, the House of Representatives adopted with a large majority the motion submitted by MP Anne Kuik on establishing a Dutch global health strategy (Parliamentary Paper 35 570 XVII, no. 22). The motion considers that the COVID-19 pandemic has demonstrated the need for a global health strategy. Various international initiatives are in place to improve the coherence of health systems.

[1] https://www.dutchglobalhealthalliance.org
[2] https://unsdg.un.org/2030-agenda/universal-values/leave-no-one-behind

By adopting this motion, the House of Representative agrees that the Netherlands should participate in these initiatives where doing so adds value. The motion calls on the government to conduct a study on the added value and opportunities of a Dutch global health strategy. In the light of the great urgency of the current global health situation, it is not advisable to wait too long in implementing the motion. Due to the upcoming general elections in the Netherlands, implementation of the motion could easily be delayed by over a year. However, the need for a global health strategy is too pressing for the Dutch government to wait.

The motion was prompted in part by the German Global Health Strategy, which was established by Germany's Federal Ministry of Health in October 2020.[3] The German strategy calls for healthy lifestyles and greater efforts in disease prevention. In addition, it draws a connection between climate change and health issues. The strategy examines how to strengthen health systems and defines major risks and dangers for the future. The objective of the German study is to ensure the efficiency and sustainability of efforts in the area of global health, so that a significant contribution can be made to the health of all people worldwide between now and 2030.

Framework of this request

The primary purpose of the AIV's advisory report is to provide recommendations to the next government regarding a comprehensive Dutch global health strategy. To this end, it should also clarify the context in which the Dutch government can establish a coherent policy framework for a strategic global health agenda for the decades ahead. The AIV is requested to cover at least the following points in its report:

- Define a global health strategy from the Dutch perspective.
- Review how the Netherlands has participated in efforts to address global health issues in the past.
- Take stock of what initiatives other European countries, the European Union and multilateral organisations such as the United Nations and the World Health Organization have already pursued to establish a global health strategy.
- Advise on where the Netherlands can add value with a global health strategy and on the areas in which the Dutch government must invest (both domestically and internationally) to have a greater impact on global health.
- Assess what added economic value a global health strategy would have for the Netherlands.
- Explain the role that emergency medical aid plays in a global health strategy.
- Shed light on the strengths and weaknesses of global health infrastructure and medical supply chains.
- Provide recommendations on how to increase coherence among health-related topics within Dutch development cooperation policy.
- Clarify the role that different ministries could/should play in a Dutch global health strategy.
- Pinpoint areas the Netherlands should focus on (topics, diseases and medical products) in order to achieve and retain a position as a global leader in this field.

[3] Global Health Strategy, PDF (Bundesgesundheitsministerium.de).

- Clarify the role of research and innovation in disease control and prevention, and the opportunities for the Netherlands in this regard.
- Advise on the role of prevention in strengthening global health.
- Take stock of existing systems in the global distribution of medicine and medical devices, and make recommendations on how they can be improved.
- Draw up a road map for how the Netherlands can establish an comprehensive global health strategy.

Timetable
The House of Representatives requests the AIV to complete its advisory report and submit it to the House in the second half of 2021. This will allow the new government to incorporate recommendations from the report when drawing up a global health strategy policy document.

Response to request for advice

The House of Representatives requested an advisory report from the Advisory Council on International Affairs (AIV) on the framework for a Dutch global health strategy, clarifying the context in which the Dutch government can establish a coherent policy framework for a strategic global health agenda for the decades ahead. The House of Representatives also set out 14 more specific requests. The AIV has done its best to respond to most of these, and its responses are spread across this report. For convenience, the requests and responses are listed below.

1. **Define a global health strategy from the Dutch perspective**

In this advisory report the AIV supplies building blocks for a global health strategy. The key idea underlying these building blocks is that such a strategy should not be devised solely from a Dutch perspective. It must fit into an international framework, and must especially be aligned with the EU and WHO. There are several reasons to make an effort to formulate such a strategy from a Dutch perspective. A global health strategy is in the Netherlands' interests, if only because of the fact that infectious disease is a cross-border problem. There are other considerations as well. Chapter 2 lists five motivating factors. The Netherlands has knowledge and skills to contribute. The AIV mentions a number of examples of significant Dutch expertise (virology, AMR, SRHR), but does not select priorities, as this is a matter for those tasked with fleshing out the details of a global health strategy. The AIV does not have a mandate or sufficient expertise in the field of health to make such choices.

2. **Review how the Netherlands has participated in efforts to address global health issues in the past**

Section 3.3 sets out how the Netherlands has participated in efforts to address global health issues in the past. In recent years, the Netherlands has been active mainly in the field of SRHR and mental health. This is described from the perspective of the emergence of global health policy (3.1) and various international activities (3.4). Section 3.5 examines the role of non-state actors (Dutch and others).

3. **Take stock of what initiatives other European countries, the European Union and multilateral organisations such as the United Nations and the World Health Organization have already pursued to establish a global health strategy**

Section 3.4 describes the main international initiatives (taken by WHO, EU, WTO, FAO, IMF and World Bank), as well as several other examples of international initiatives, including the EU-Africa Global Partnership and the Global Health Security Agenda. There is no single clear, comprehensive strategy that is embraced by all these actors. There is however a joint SDG agenda, in which health (SDG 3) plays a prominent role. The subject of health is not addressed in SDG 3 alone, however. SDG 2 (End hunger, achieve food security and promote sustainable agriculture) and SDG 6 (Clean water and sanitation for all) are vital for improving health. Moreover, in view of the One Health approach, SDG 13 (Climate action), SDG 14 (Life below water) and SDG 15 (Life on land) also contribute to global health. Universal Health Coverage (UHC; see box) was also adopted as a target in 2015 as part of the SDGs.

4. **Advise on where the Netherlands can add value with a global health strategy and on the areas in which the Dutch government must invest (both domestically and internationally) to have a greater impact on global health**

The building blocks constitute a suggested comprehensive approach to the development of a global health strategy. The Netherlands can add value by:

- promoting coherent policy (Health in All Policies), based on the One Health approach;
- promoting cooperation between different disciplines and actors. Building block 6 (take a multisectoral approach) considers the contributions of actors in the Dutch Diamond;
- contributing specific knowledge. The Netherlands can also build on previous work on HIV/AIDS,

mental health, ARM and microbiology. New specialisations may of course emerge in future;
- focusing on international cooperation and strengthening global institutions, which will require an active role within WHO and the EU.

5. Assess what added economic value a global health strategy would have for the Netherlands

The AIV has not assessed what added economic value a global health strategy would have for the Netherlands, as this depends on the details of the strategy decided on by Dutch policymakers. There are many factors that could have a positive or negative impact on one or more sectors of the economy. Reducing the risk of zoonotic disease might for example require changes to livestock farming, or reductions in the number of animals kept on each farm. This could affect earning potential. A coherent policy, or more and better use of medical knowledge in the Netherlands, could strengthen the economy. Due to the many factors at play, the question as to the added economic value of a global health strategy is very difficult to answer and, in the AIV's opinion, is not always the most significant issue.

6. Explain the role that emergency medical aid plays in a global health strategy

Building block 3 states: To cope with current and future health issues, it is important that the focus in international cooperation is not only on meeting acute need, but also – even in the case of emergency aid – working towards a strengthened health infrastructure.

The AIV believes that strengthening the health infrastructure in the Global South must be a strategic priority. It would improve countries' ability to withstand adverse events. Support should therefore focus, in the medium term, on increasing Universal Health Coverage, with due consideration for the do no harm principle.

7. Shed light on the strengths and weaknesses of global health infrastructure and medical supply chains

This question is addressed to some extent in section 3.5 (on the private sector). The manufacture of medicines takes place mainly in the private sector. Interviews and a European report have revealed that ingredients are not the problem; the problem is affordability and global availability (distribution). Though production capacity is being built and strengthened in the Global South, this process needs to be accelerated. The recent pandemic has highlighted this fact once more. The report also considers the role of patents and knowledge sharing.

8. Provide recommendations on how to increase coherence among health-related topics within Dutch development cooperation policy

The report notes that the Netherlands has made certain choices in its development cooperation policy. The AIV recommends that the Health in All Policies building block be used to make Dutch policy more coherent and ensure it no longer regards international health issues only from the perspective of development cooperation. This is also in line with the One Health approach. Several ministries need to be involved. The AIV suggests ways to elaborate the approach further by involving ministries, stakeholders and representatives of the Global South.

9. Clarify the role that different ministries could/should play in a Dutch global health strategy

Building block 5 (Put one's own house in order) describes the role of the most relevant ministries, and how management and collaboration could be better organised. Achieving coherence will require a great deal of collaboration and further elaboration. The AIV makes suggestions as to how this might be done, recommending that a platform for cooperation be established, for example, and describing how substance can be given to the do no harm principle (through health impact assessments and reporting).

10. Pinpoint areas the Netherlands should focus on (topics, diseases and medical products) in order to achieve and retain a position as a global leader in this field

The report notes that the idea that the Netherlands could be a global leader may be a little overambitious at the moment. Not only is the Netherlands far from the first country to present such a strategy; also – and above all – it has not yet developed a comprehensive national strategy itself. Nevertheless, the Netherlands can play a leading role in certain areas, using its own position, influence and expertise as part of existing strategies and international partnerships. These areas include virology and AMR. The Netherlands' efforts in support of SRHR are highly regarded. The Netherlands could also retain and strengthen its leading position by seeking synergy with earmarked WHO contributions.

In addition, building block 5 states that the Ministry of Economic Affairs and Climate Policy, including Climate & Energy, can help to flesh out the guiding principles, discuss the prerequisites for contributions by Dutch companies with the Health & Life Sciences top sector, encourage collaboration with private funders and NGOs and give substance to the do no harm principle by performing health impact assessments and working with knowledge institutions, and highlight co-benefits such as the switch to renewable energy sources and improvements in air quality.

11. Clarify the role of research and innovation in disease control and prevention, and the opportunities for the Netherlands in this regard

Building block 6 considers the opportunities for knowledge institutions and the need to share knowledge. Preparations are suggested under the heading 'knowledge institutions' in section 3.5. Learning from partnerships with countries and knowledge institutions in the Global South would present an opportunity for the Netherlands.

12. Advise on the role of prevention in strengthening global health

The importance of prevention is highlighted throughout the report (see sections 2.1, 2.5 and 3.2 and the work programmes of various international institutions). One Health and Health in All Policies are essentially about prevention. The importance of prevention is reiterated in the conclusions and in various building blocks.

13. Take stock of existing systems in the global distribution of medicine and medical devices, and make recommendations on how they can be improved

Section 3.5 considers the desirability and necessity of preventing monopolies. See also request 7. It is important that essential medicines and medical devices are seen as public goods and dealt with accordingly. Public authorities often finance fundamental research. In such cases, it is important that the knowledge generated can be used by multiple companies. The companies that develop medicines and perform clinical trials must of course receive reasonable compensation for their efforts.

14. Draw up a road map for how the Netherlands can establish a comprehensive global health strategy

The advisory report provides a foundation and building blocks, and also outlines a structure. It is difficult to set out precisely how these should be used effectively to flesh out an Dutch global health strategy. The AIV does however identify a starting point: a meeting or series of meetings at which participants are asked what they can contribute, and under what conditions. This information could then be used as a basis for policy. Gaps could also be identified, of course.

List of persons consulted

External experts were consulted the preparation of this advisory report. The AIV is grateful for their insights and input.

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List of abbreviations

ANV	National Network of Safety and Security Analysts
AU	African Union
BZ	Ministry of Foreign Affairs
CBRN	chemical, biological, radiological and nuclear
CBS	Statistics Netherlands
CCRT	Catastrophe Containment and Relief Trust
DGIS	Directorate-General for International Cooperation
ECDC	European Centre for Disease Prevention and Control
EHU	European Health Union
EMA	European Medicines Agency
ESG	Environmental, Social & Governance
FAO	Food and Agriculture Organization
Gavi	The Vaccine Initiative
GDP	Gross Domestic Product
GHSA	Global Health Security Agenda
H5N1	an avian influenza virus subtype
ICESCR	International Covenant on Economic, Social and Cultural Rights
IHR	International Health Regulations
IMF	International Monetary Fund
IPPPR	Independent Panel for Pandemic Preparedness and Response
ISR	International Sanitary Regulations
LGBTI	Lesbian, gay, bisexual, transexual and intersex
LNV	Ministry of Agriculture, Nature and Food Quality
MDG	Millennium Development Goal
MERS	Middle East respiratory syndrome
NCD	non-communicable disease
NCDO	National Committee for International Cooperation and Sustainable Development
NGO	non-governmental organisation
NWO	Dutch Research Council
ODA	Official Development Assistance
PBL	Netherlands Environmental Assessment Agency
PEPFAR	President's Emergency Plan For AIDS Relief
PRGT	Poverty Reduction and Growth Trust
RIVM	National Institute of Public Health and the Environment
SARS	Severe Acute Respiratory Syndrome
SDG	Sustainable Development Goal
SER	Social and Economic Council of the Netherlands
SMEs	small and medium-sized enterprises
TGF	Global Fund to Fight Aids, Tuberculosis and Malaria
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UN	United Nations
WBG	World Bank Group
WHA	World Health Assembly
WHO	World Health Organization

List of figures

Ensure healthy lives and promote well-being for all at all ages

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.

3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents.

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.

3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate.

3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.

3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.

3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.