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**Getting better:
the European Union's performance
in the World Health Organization**

Abstract

This paper analyses the performance of the European Union (EU) in the World Health Organization (WHO). It sets out a framework for analysing the EU's performance in relation to unity in external representation. EU unity is assumed to be derived from European Community (EC) competence, the preference homogeneity of EU member states, and the socialization into EU practices of their representatives. The article discusses the increased Europeanization and internationalization of health issues. It argues that this makes it almost inevitable that the EU is becoming a more unified actor within WHO negotiations. At the same time, it points to limitations impeding the EU's performance that are to be taken into account, notably EU member states being cautious about ceding competences to the EU on health issues, them having widely diverging preferences on issues such as reproductive rights, and not fully trusting the European Commission to take over external representation in WHO negotiations.

Keywords

European Union, EU foreign policy, EU external relations, global health governance, international organizations, international health negotiations, preference homogeneity, preference alignment, European socialization, European Community health competence, Lisbon Treaty, global health and foreign policy, global health and development cooperation.

Preface

Europe – defined as both the geographical grouping of European countries and the political entity, the European Union – has long been an important global health actor. As a group, the European countries and the European Union are major donors and a key political player in shaping global health governance. They are also a significant driving force behind the determinants of health and the global economic system.

The European Union is both the world's largest trading bloc and the largest provider of development assistance. Yet these two factors have not been linked in a coherent manner in their impact on health. Only recently has it been recognized that there is a need for greater strategic direction in relation to global health within and between European countries and at European Union level. This is as much due to global developments as it is to the fact that the European Commission now has a formal legal personality that can enter into binding international agreements on behalf of member states.

By 2010, the European Union's global health activities will have reached a major milestone with the release of the European Commission's first framework communication on the European Union's role in global health. In light of the ongoing work for this new policy, Global Health Europe has commissioned a series of papers that investigate the role of the European Union as a global health actor – past, present and future. The aim is to present a consolidated view of the European Union's current and multifaceted role in global health. Through this research, and related online discussions and events, Global Health Europe advocates for stronger European engagement in global health and new policies that capitalize on what Europe has already accomplished.

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Getting better: the European Union's performance in the World Health Organization

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1. Introduction

This paper will analyse the European Union's emerging role in international health issues and, in this respect, focuses on its activities within the World Health Organization (WHO). The European Union (EU) is gradually becoming a more unified actor in a range of policy areas where international cooperation is intensifying, including health. This is the result of expanded internal competence, increased pressure to operate with a single voice – the result of a declining role in the international system for individual EU member states – and an ambition for global leadership. At the same time, the political dimension of international health issues and reasons to cooperate on them are increasingly being recognized. WHO is no longer considered just another implementing UN agency, but instead a serious international organization with a key role in agreeing rules on international health issues. This combination of circumstances provides an interesting setting for analysing the evolution of the EU's position in WHO, particularly regarding the procedures and methods that it uses for coordination and external representation.

This paper will consider if and why EU member states are willing and/or legally obliged to operate with a single voice on issues discussed within WHO. It analyses the EU's performance and assumes, in this context, that the EU can perform better if EC competence exists, if the preferences of EU member states are rather homogeneous, and if the representatives of EU member states consider it appropriate to coordinate their positions.

The empirical information presented here is not only based on a study of documents, literature and other written materials. During the summer of 2008, the author conducted

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about 20 telephone interviews with representatives of EU member states and other experts involved in WHO negotiations. These interviews focused on WHO negotiations around two strategies: one on diet, physical activity and health (DPAS, 2004), and the other on public health, innovation and intellectual property (PHI, 2008). [For further details on the specific findings on these cases, refer to Van Schaik, 2009]. The interviews also included more general questions on the evolution of the process of EU coordination in the World Health Organization. This also allowed them to be used for this paper. In addition, further telephone interviews were conducted to confirm and update information.

This paper proceeds as follows: firstly, a framework for analysing the EU's performance in international organizations will be presented; secondly, the overall relationship between the EU and WHO will be discussed; thirdly, the EU's internal and external competences are analysed with regard to issues being discussed within WHO; and lastly, the preference homogeneity of EU member states and the processes of EU socialization are examined. What are the advantages and disadvantages of EU coordination when it comes to achieving the preferences of the member states? And do their representatives consider it inevitable to operate with a single European voice? The concluding section will examine how the EU's role within WHO differs from its role in other international organizations. It will also consider whether the EU's new Lisbon Treaty could offer opportunities for strengthening EU health diplomacy.

2. A framework for analysing the EU's performance in international negotiations

Most researchers studying EU foreign policy assert that the way in which the EU decides its international positions and organizes its external representation influences its performance in international negotiations (Keukeleire and MacNaughton, 2008; Cameron, 2007; Sapir, 2007; Bretherton and Vogler, 2006; Vanhoonacker, 2005). The procedures for adopting mandates and conducting external representation could influence its capacity to negotiate and, therefore, its bargaining power (Meunier, 2000; Frieden, 2004; Gstöhl, 2009). In the discussions on EU institutional reform, which led eventually to the Lisbon Treaty, a more supranational method for EU foreign policy was advocated, which assumed this would make the EU more effective in international affairs (European Convention, 2002; Lamy, 2004). The significant upgrading of the position of High Representative and the establishment of the European External Action Service (EEAS) indicate a decision was taken towards a more uniform external representation (Duke, 2008).

Although it seems reasonable to assume that a more unified EU stance in international affairs increases its influence, only a small number of case studies have systematically analysed the EU's performance in international negotiations and have linked it to its institutional set-up (Smith, 2006; Rhinard and Kaeding, 2006). This is not surprising given the difficulties in measuring the EU's performance in international negotiations – in this instance, its ability to translate its policy objectives into outputs by WHO (Kissack, 2009). Whether the EU performs well is very much influenced by its negotiating partners, and is subject to the perception of those who were involved in the negotiations, or of those who observed them (for example, the media). Here, we will also focus on these perceptions of performance. We expect the EU to perform better when it operates with a single voice that is actively supported by all EU member states. This expectation is in line with other research (Laatikainen and Smith, 2006; Bretherton and Vogler, 2006; Jørgensen, 2009). However, it is less clear what factors enable EU unity, how they interact and what side effects emerge from a more or less compelling model of EU coordination and external representation.

2.1 EC competence

Scholars studying the influence of institutions have pointed out that member states' options and preferences are influenced by legal rules and procedures (Vanhoonaeker, 2005). Where EU external relations are concerned, procedures for external relations are strongly related to the degree of EC competence. When EU countries transfer legislative powers to the EC level, the EC also obtains a competence for external representation (Hoffmeister, 2007; Eeckhout, 2004). The existence of EC competence implies that operating from a common position is obligatory. Who will be assigned to lead the negotiations depends on whether the main thrust of the matter lies with the EC – in which case the Commission leads – or with the member states – in which case the rotating presidency of the EU Council is in charge. If no EC competence exists, EU countries are free to conduct their own external representation, in which case they may still opt to combine their collective voices.

The need for a unified external representation where EU legislation exists is understandable since international agreements often contain policy obligations that affect it. Where the Commission is not involved in negotiations on such issues, this could undermine the Community system, in particular, the Commission's right of initiative to enact new EU legislation. It could offer EU member states an opportunity to bypass the Commission, by shifting issues from the European to the international arena.

EU member states may not always realize the implications for international negotiations when (internal) competences are transferred by amending the EC treaty or adopting legislation. This is a relevant notion when it comes to the transfer of competence on external representation, which appears sensitive by definition, because a single EU voice in international negotiations can be viewed as a sign of statehood (Laatikainen and Smith, 2006). This is not only sensitive for EU member states, but also does not fit well with the logic of most international organizations. In these organizations, nation states control decision-making and membership is a reflection of the sovereign equality of these states (Laatikainen and Smith, 2006; Govaere et al, 2004). EU member states following this logic have the right to represent their own positions. Member states tend to cherish this right, particularly where it concerns issues such as the financing of international organizations and the election of officers. They fear ceding competences to the EU – something they consider to be irreversible.

In addition, other states do not always understand or accept the EU operating with a single voice. They are particularly critical when EU member states are unwilling to give up national voting rights. Voting rights are typically allocated only to nation states; a reflection that the nation state is the traditional constituency of international organizations. Negotiating partners may also try to demand return favours if statutes need to be changed to allow for EC membership.²

As a result, a plethora of models is used for EU coordination and external representation in international organizations, ranging from a rather centralized system for trade negotiations to voluntary cooperation in other areas, such as education and culture (Gstöhl, 2009). It should be noted that even in more centralized models, unity in external representation is not a given. For instance, in World Trade Organization (WTO) negotiations, tensions between the Commission and EU member states have surfaced at regular intervals (Young, 2003; Kerremans, 2004).

Therefore, EC competence is likely to influence the extent to which EU unity in external representation is displayed, but is not the only factor influencing it (Gstöhl, 2009). Member states may consider it a legal straitjacket limiting their options, and may fear the Commission's involvement may require asking for EC membership to the International Organization. This, in turn, may form part of the negotiations with non-EU states. As a result, the emergence of actual unity in external representation is also likely to depend on other factors – most importantly, if EU member states are able to agree on a common position and are willing to actively support it throughout the negotiations – a process that is likely to be facilitated by their preferences being aligned and the emergence of EU socialization.

2.2 Preference homogeneity

It is usually accepted that operating with a joint position and a single voice enhances the powers of individual EU member states – including the bigger ones – which, on a global level, are only middle-range powers (Sapir, 2007). It would prevent other states, such as Russia and the USA, from exploiting their negotiating power vis-à-vis individual member

² Officially, only the European Community has legal personality and can join international treaties and organizations. Under the Lisbon Treaty, the European Community will be renamed the European Union. The legal personality is also extended to those issues currently covered by the Treaty on European Union – in addition to the issues currently covered by the Treaty on European Community.

states. Operating as a European bloc could prevent deals that may offer benefits for an individual member state, but not for the EU as such. Operating through the EU, particularly

for small EU member states, would therefore not only be a legal obligation, but also of vital importance to maximize influence in world affairs.

Moreover, it can be expected that interdependence among EU member states resulting from the process of European integration, a shared normative and cultural orientation, and relatively similar geographical interests, shapes their preferences regarding international negotiations and makes them more homogeneous (Young, 2003 p. 57). Nevertheless, on specific issues, EU member states may have different interests and viewpoints, making it difficult to arrive at a common position. Representatives operate on the basis of nationally defined instructions and may find it difficult to depart from them in order to find agreement. Preference heterogeneity, even in cases where EU member states may be closer to each other than to non-EU states, may still prevent EU unity from emerging, thereby jeopardizing the EU's performance in negotiations.

Frieden (2004) points to the costs of forcing heterogeneous actors to adopt a common policy position. The pooling of international representation would require member states to weigh up the potential benefit of a common policy against the potential cost of a policy not to their liking. A trade-off may occur between the advantages of scale and the disadvantages of overriding heterogeneous preferences. If preferences are more heterogeneous, then EU member states are also more likely to put more effort into controlling the representative that negotiates on their behalf, resulting in increased transaction costs (Kerremans, 2004; Young, 2003; Meunier, 2000).

Where agreement is reached, it is still not clear whether this indicates that issue-specific preferences (and underlying interests) are becoming more aligned, or whether a general preference to operate as a European bloc has convinced EU member states to give in on issue-specific preferences. In the latter case, member states may have intentionally chosen to combine their positions in international affairs, or may merely have considered it appropriate to do so (March and Olson, 1998; Smith, 2006). Indeed, the processes of EU socialization may contribute positively to representatives of EU member states finding it easier to align their preferences – an issue we will now examine.

2.3 EU socialization

EU unity in external representation may not be the result of EU actors being aware of the existence of EC competence, or of explicit deliberations to closely coordinate with the European partners because of expected scale benefits. It may just be the result of those being involved accepting an invitation to attend an EU coordination meeting like their predecessors did; or of others approaching them as EU actors. On the other hand, representatives of EU member states may want to emphasise their role as national representatives or may not trust the EC/EU representative. In short, informal norms are also likely to influence EU unity.

Research indicates that representatives of EU member states can be expected to become socialized in EU practices when these are established (Checkel, 2003; Beyers and Trondal, 2004). The reasons for attending EU coordination meetings may just be to find out what the negotiations will be about and what positions other EU member states are taking (Smith, 2006). But, over time, increased exposure to EU coordination is likely to engender a sense of 'we-ness' among representatives of EU member states, leading them to identify with the common European position.

When non-EU states and interest groups clearly refer to the EU and not to the national affiliation when approaching EU member state representatives, this could boost their sense of being a European actor. They are clearly Europeanized when they consider explaining and defending the EU position in their capitals as among their main tasks. A number of studies indicate that EU socialization has occurred during the process of EU coordination in international organizations, particularly at civil servant level (Smith, 2006; Niemann, 2006; Laatikainen and Smith, 2006; Groenleer and Van Schaik, 2007).

The European Commission and the half-yearly rotating presidency of the EU Council are likely to contribute to the emergence of EU socialization. Taylor (2006) argues that the Commission, as supranational EC representative, uses a 'logic of synthesis' among the member states by reiterating commonly adhered to EU objectives and statements. EU presidencies can be expected to simulate unity in external representation as well. Once in the driving seat, they have a clear interest in representing a united EU (Schout and Van Schaik, 2008). In fact, in many international negotiations, the EU's performance becomes closely intertwined with the presidency conducting the negotiations on behalf of the EU member states (Smith, 2006).

The question is: how are EU socialization and preference homogeneity related? Increased exposure can be expected to lead to mutual understanding, resulting in national instructions being based on similar considerations. But, perhaps, EU socialization can only start

to emerge when at least a basic agreement on overarching objectives is in place. Preference homogeneity and EU socialization are likely to reinforce each other, but it is less clear which of the two is more important for EU unity to emerge and, by extension, for EU performance to improve. This article is unlikely to answer this rather fundamental question on the origin of national preferences, but concludes that it is important to look at both the role of preferences and informal norms. Both are expected to influence EU unity in external representation, as well as EU competence on health issues. In the following sections, we will analyse this and consider how they are related to the EU's performance within WHO.

3. The European Union and the World Health Organization

The competences of the European Community in the field of public health have always been modest, and this is also the case for its international dimension. The Treaty on European Community stipulates that the “Community and the Member States shall foster cooperation with third countries and the competent international organizations in the sphere of public health” (Article 152:3, Treaty on European Community). It falls short of obliging the member states to operate with a common position when matters concerning public health are discussed. However, the situation differs when issues where the EU does have more elaborate competences are discussed, such as trade-related issues. As a result, EU member states sometimes operate in WHO on the basis of a common EU position, and sometimes on the basis of their own positions. For certain issues, it is obligatory for them to operate with a single voice, whereas it is optional when most other issues are discussed.

Institutionalized cooperation between the European Community and WHO started at the beginning of the 1980s with an exchange of letters between the European Commission and the director-general of WHO³. EC–WHO cooperation developed gradually and now covers many cross-border health issues. Priority areas for EC–WHO cooperation identified in 2000 included health information, communicable diseases, tobacco control, environment and health, sustainable health development, and health research⁴. The EU has never sought membership of WHO. This would also be difficult since, according to WHO's statutes, membership is only open to states. The 193 WHO member states include all of the EU member states. The EC, represented by the European Commission, has observer status at the World Health Assembly, on the Executive Board and on the regional committees. It participates within the category of ‘representatives of other intergovernmental organizations’, while at World Health Assembly meetings its desk is situated between the Holy See and the Palestinian Authority.

3 On 28 October 1982, the Official Journal L 300 published an “exchange of letters between the European Communities and the World Health Organization (WHO) laying down the procedure for cooperation between the two organizations – Memorandum defining the arrangements for cooperation between the World Health Organization and the European Communities”.

4 Exchange of letters between WHO and the Commission concerning the consolidation and intensification of cooperation, published on 4 January 2001 in the Official Journal C1/7.

With regard to the EU's role within WHO, two developments seem most relevant:

- increased political attention on the foreign policy aspects of health questions
- increased attention on EU coordination and external representation procedures in international organizations, including in WHO

In addition, a greater number of issues are being discussed at WHO where EC competence exists, such as (aspects of) the tobacco agreement, the international health regulations to combat communicable diseases, and the strategy on health, innovation and intellectual property. The EU's expanded competences in health and health-related fields will be discussed in the next chapter.

3.1 Increased attention on the relationship between health and foreign policy

WHO was established in 1948 to foster the attainment by all peoples of the highest possible level of health around the globe. Its aims include fighting disease, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries, and monitoring and assessing health trends.

Traditionally, WHO was seen predominantly as a technical implementing agency for health matters; but, in recent years, a number of issues in which WHO is involved have attracted political attention. The most important was the spread, around the world, of dangerous infectious diseases such as SARS, and new and particularly infectious forms of influenza (for example, H1N1). The destabilizing effects of AIDS in certain regions of the world, notably in sub-Saharan Africa, and the increased fear of bioterrorism were identified as international security threats, including in the 2003 European Security Strategy (McInnes and Lee, 2006; Keukeleire and MacNaughtan, 2008: pp. 249–252). Discussions on a number of other issues, such as obesity and access by developing countries to affordable medicines, highlighted the link with international trade rules. These rules proved key obstacles to health-promoting policies in these areas (Kickbusch and Lister, 2006; Van Schaik, 2009). Health is, moreover, a key issue in the field of development cooperation, where Millennium Development Goals 4, 5 and 6 concentrate solely on achieving health indicators. In the past decade, international aid for health tripled (Kates et al, 2009).

As a response, foreign ministries have become more involved. In June 2009, the UN secretary-general organized a high-level forum in New York on advancing global health in the face of crisis. Within the context of the Foreign Policy and Global Health (FPGH) initiative, the for-

eign ministries of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand have been meeting about twice a year since 2007 to discuss issues high on the global health agenda⁵. Another development is that WHO has moved more into treaty-making practices – for example, on tobacco – whereas, previously, its role was primarily to provide expertise and assistance to member states, while sometimes discussing and adopting non-legally binding resolutions. Because of its increased ambition to set regulatory frameworks, WHO comes much closer to the world's greatest regulatory power: the EU (Majone, 1996). Furthermore, the strengthening of the interface between foreign policy and health issues makes negotiations within WHO more challenging and exciting (Chan et al, 2008; Kickbusch et al, 2007). It also makes it more important for the EU to demonstrate its ability to perform well in these negotiations.

3.2 Increased attention on the role of the EU in international organizations, including in WHO

In relation to the politicization of global health matters, the general process of globalization and an increased interest in the EU's position in world politics, a debate emerged on the EU's role within WHO. The main advocate of a more coordinated EU representation in WHO is the European Commission. It is, apparently, active in upgrading its status in a wide range of international organizations, including WHO (Hoffmeister, 2007; Taylor, 2006). In its most recent White Paper on health policy from 2007, it argues that strengthened coordination on health issues within international organizations, such as WHO, will enhance the EU's voice in global health and increase its influence and visibility to match its economic and political weight⁶. This point is also likely to surface in a forthcoming communication on the EU's role in global health⁷.

The EU's role within WHO was a point of considerable discussion in 2005, when the European Commission wanted to join WHO bodies discussing matters of EC competence (Eggers and Hoffmeister, 2006: pp. 160–161). The debate was triggered because the USA questioned the role of the European Commission in a meeting of the WHO Executive Board's drafting committee in 2005. Up until the late 1990s, the Commission did not play a very visible role in WHO. It was curbed by the EC, having only observer status, while WHO was regarded as responsible for dealing with matters falling outside the EC's competence. EU member states

5 The ministers of foreign affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand. 'Oslo Ministerial Declaration – Global health: a pressing foreign policy issue of our time', *The Lancet*, Volume 369, pp. 1373–1378, 2007.

6 Commission White Paper, (2007), *Together for Health: A Strategic Approach for the EU 2008–2013*

7 This communication is expected to be adopted by the Commission in February 2010, followed by Council conclusions planned for June 2010.

hardly ever coordinated their positions. Their Geneva-based health attachés were not very well connected with Brussels (Eggers and Hoffmeister, 2006). Nor did they invest much effort in establishing and operating on the basis of common EU positions. If the Commission spoke, it did so as observer after several EU member states had delivered their statements, sometimes – but not always – merely restating the same messages. Just a few issues on the agenda of the World Health Assembly would be discussed in the EU Council working party on public health and, only when agreement by consensus could be reached, were Council conclusions adopted.

This changed with the negotiations on the Framework Convention on Tobacco Control (FCTC), where the Commission had a relatively large role given the existence of internal legislation on matters being discussed in these negotiations, such as advertising (Guigner, 2009b; Princen, 2007). It represented the EU from behind the seat of the country holding the EU presidency on those issues where exclusive competence existed (Guigner, 2009b). The EC eventually ratified the FCTC. A similar situation unfolded with the negotiations on the International Health Regulations (Eggers and Hoffmeister, 2006). The expanded role of the Commission was accepted but did not remain uncontested, as demonstrated when the USA questioned the status of the European Commission in 2005.

In response, the EU presidency and health commissioner wrote a joint letter to the chair of the Executive Board in which they indicated the Community's intention to participate fully in the deliberations of the Executive Board's 117th session in January 2006. The request was formally presented by four EU member states sitting on the Executive Board, which comprises a total of 32 elected members reflecting an equitable geographical distribution. As a result, the Commission could, from that point onwards, participate in relevant meetings, that is, those where issues falling within the remit of Community competence were discussed. Another consequence of the discussions were plans to strengthen EU coordination, also on issues falling within the remit of member states' competence. It did not lead to an open discussion on EC membership of WHO.

Since then, the European Commission – on behalf of the European Community – has also become more involved in other negotiations, most notably in those on the Global Strategy on Public Health, Innovation and Intellectual Property (2007–2009).

Despite the importance of the issues in which the Commission became more involved, on most other issues discussed at WHO, EU member states are still the dominant actors and EU

coordination on sensitive issues, such as reproductive rights⁸, is not automatic. The scale of EU coordination depends very much on the half-yearly rotating presidency, which calls and facilitates meetings and, in the event of a common position being adopted, represents the EU member states externally. To non-EU states, non-governmental organization representatives and others involved in WHO matters, it is not always clear on which issues the EU is operating on the basis of a common position, and who is representing it. This issue is still debated within the EU from time to time.

3.3 Reform of the EU's external relations

Discussions around the EC's participation within WHO are linked to a much broader debate on EU membership of international organizations, a strengthening of EU coordination within these organizations, and a more unified external representation (Hoffmeister, 2007). As a result of the EU's enlargement, and the attention devoted to the EU's position in the world in the EU reform debate leading to the Lisbon Treaty, the way in which the EU operated in international organizations was, and still is, subject to reconsideration. The Lisbon Treaty foresees the creation of two new actors designed to streamline EU external relations and make them more coherent: the new position of High Representative of the Union for foreign affairs and security policy and the establishment of the European External Action Service (EEAS).

The High Representative will chair and represent the Foreign Affairs Council, and will hold the position of vice-president in the European Commission. In November 2009 Baroness Ashton was nominated for the post. According to the Lisbon Treaty she will ensure the consistency of the EU's external action and coordinate it (Treaty on European Union, Article 18). EEAS will be answerable to the High Representative and will be composed of Commission, Council and national diplomats. It is not yet clear if and to what extent these new EU foreign policy actors will take over responsibility for issues such as trade and health, or development cooperation, since they currently fall largely outside the remit of EU foreign affairs ministers. However, they may take on a general or coordinating role regarding the EU's activities within international organizations (Van Schaik, 2008). This debate is currently ongoing in Brussels. It could be argued that a greater involvement of the High Representative and of EEAS could boost the EU's visibility and negotiating performance within WHO. It could, however, also lead to disengagement by health ministry experts, or encounter opposition from member states who consider health to be a national prerogative.

8 With regard to the issue of reproductive rights, some EU member states, because of their close ties to the Catholic faith, take a very different position to other member states, which consider reproductive rights a key health objective.

4. EC activities and competence expansion on health-related issues

The reason the Commission could claim a greater role for the EC was that a general competence expansion at EC level had occurred with regard to issues being discussed within WHO. In the field of health policy, formally the EC only has a complementary competence⁹. This has not prevented the EU from agreeing on health-related policies. At first, they were primarily related to the internal market¹⁰ and are still limited when compared to other policy fields (Mossialos and Permanand, 2000; Guigner, 2006). An example is Directive 2001/37/EC concerning the manufacture, presentation and sale of tobacco products, which was adopted on the basis of internal market and trade provisions in the EC treaty. The health article, Article 152, only allows for Community regulation in two specific fields: veterinary and phytosanitary standards; and organs, substances of human origin and blood.

The Lisbon Treaty adds EU regulatory powers for medicinal products and devices for medical use¹¹. It allows the EU to set up spending programmes aimed at reducing tobacco and alcohol use. It also contains a provision on monitoring, early warning of and combating serious cross-border threats to health (c.f. article 168, Treaty on the Functioning of the European Union).

It is no surprise that the EU conducts policies in the field of health, since many diseases do not stop at national borders. Within the EU, the potential spread of disease is amplified by the internal market and the free movement of people, goods and animals, which increases flows and reduces the options for controlling communicable diseases (Guigner, 2009a). The recognition of health worker qualifications, healthcare for travellers, and laws banning (the transportation of) unhealthy products, foodstuffs and animals, are typical areas where the EU soon started to regulate. The EU also has an impact on specific issues, such as doctors' working hours and patient mobility, where case law from the European Court of Justice overruled national provisions¹². This particular case made member states realize that the

9 This means that, in accordance with the principle of subsidiarity, the EC can only act in areas where its involvement creates clearly identifiable added value.

10 The EC has primarily been involved in the field of health and safety in the workplace, pharmaceuticals, and in the area of health professions.

11 Lisbon Treaty, Article 168

12 For a detailed description of this case, refer to Greer (2006) and Guigner (2009a).

EU is increasingly involved in a wider range of health policies, while they still consider it a national prerogative (Greer, 2006). Besides, EU citizens see hardly any role for the EU in health matters (Guigner, 2009a based on the 2007 Eurobarometer survey). EC health policy is guided by public health programmes and strategies. The most important policy documents are the first health programme covering the period 2003–2008 (which was adopted in 2002) and the second health programme covering 2008–2013 (adopted in 2007). The second health programme addresses the need to take health objectives into account in other EU policies and discusses challenges, such as ageing, bioterrorism and illnesses related to unhealthy lifestyles. Investment in infrastructure and human resources for health, as well as improved cooperation in border regions, is included in the EU's regional funds. The European Health Insurance Card (EHIC), which entitles the holder to state-provided medical treatment within the country they are visiting, ensures that basic and emergency healthcare is provided to those in need, no matter where they are in the EU.

The establishment of a specific Commission Directorate General for Health and Consumers (DG SANCO) in the late 1990s increased the EU's capacity to develop health policies. However, DG SANCO is still relatively weak where health matters are concerned, mainly because its public health division is rather small and based in Luxembourg. Two EU agencies exist in the field of health, in addition to a small executive agency that disburses funds for health and consumer protection¹³. The European Medicines Agency (EMA) employs about 530 people and is based in London. It is responsible for the scientific evaluation and marketing authorization of medicines. It thereby enables the functioning of the internal market for medicines. The European Centre for Disease Prevention and Control (ECDC) was created in 2005. It is based in Stockholm and has a staff of about 300. It works to intensify the fight against communicable diseases by supplying scientific data, monitoring health risks, launching alerts, and by coordinating national alert networks, as well as national policies aimed at responding to epidemics and bioterrorist attacks.

Although the EU has taken a giant step forward by establishing ECDC, EU member states failed to coordinate their efforts to combat the spread of the H1N1 virus. Instead, they placed early orders to purchase vaccines for their own population, thereby undermining a common effort and displaying a lack of solidarity with poorer EU member states unable to compete for vaccines. It was subsequently discovered that some EU member states had over-purchased. They agreed to sell their surplus to others¹⁴.

13 Executive Agency for Health and Consumers (EAHC)

14 'EU states to share swine flu vaccine supplies', EurActiv.com, 16 September 2009. Available at www.euractiv.com/en/health/eu-states-share-swine-flu-vaccine-supplies/article-185497

Other areas where the EU is active are research and the inclusion of health in EC development cooperation. For research, its European scale enables it to conduct broad epidemiological studies and to compare disease patterns and policies used in the different EU member states. A prominent example where EU research has made a difference is a research project on cancer that was conducted jointly with WHO in the 1990s¹⁵. This extensive research project demonstrated the positive effects of fruit and vegetables on certain cancers and, conversely, the devastating effects of tobacco and alcohol (Guigner, 2009a). Another example is a smaller-scale research programme recently established to investigate the impact of marketing on children's diets¹⁶. The EU has also been active in the field of research into rare diseases, where research at the EU level is more appropriate given the size of the population in relation to the occurrence of the disease. Within the EU's 7th Framework Programme for Research, covering the period 2007 to 2013, health is the second largest budget item, accounting for up to 6 billion euros¹⁷. The aim is to improve the health of EU citizens, to boost the competitiveness of health-related industries and businesses, and to address global health issues.

EU research funds therefore also address global issues. Some of the projects specifically target health problems and diseases that mostly occur in developing countries or that include global partners in the research consortium. An interesting example is a project to support capacity development to respond to pandemic influenza in Asia (AsiaFluCap)¹⁸. The project brought together partners from Germany, Indonesia, the Netherlands, Taiwan, Thailand, the United Kingdom and Vietnam. The European and Developing Countries Clinical Trials Partnership (EDCTP) deserves specifically to be mentioned¹⁹. It engages in a public-private partnership constellation between African and European researchers to develop vaccines and drugs for HIV/AIDS, malaria and tuberculosis. The EU supports the project with 200 million euros. Concerns have been raised about the ethics of conducting clinical trials in Africa. These concerns would be relevant were the trials supporting the development of drugs mainly used in Europe. However, EDCTP focuses on diseases that mainly affect Africa.

Health in itself is one of the key priorities of development cooperation. EU member states channel about one-sixth of development aid through the EC. For the health sector, this fig-

re is roughly the same (Kates et al, 2009). The EC's activities are supposed to complement the activities of EU member states, and donors are to coordinate their efforts. In reality, it is not clear to what extent the aid activities of the EC in the area of health are distinct from those of the EU member states. Despite the close relationship between health and development cooperation, this area was not included as a stand-alone item within the EU's activities on policy coherence for development (PCD). EU commitments to PCD call on EU decision-makers to take the impact of EU policies on developing countries into account, and focuses on 12 policy areas to achieve this²⁰. Health was only included indirectly, for instance, in the areas of research, trade, climate change and migration. In the area of research, attention was paid to the development aspects of the EDCTP research project. In the area of trade, the protection of intellectual property rights and access to medicines in developing countries were mentioned. In the area of climate change, the increased spread of disease caused by a changing climate was highlighted. In the area of migration, the brain drain was highlighted, that is, the migration of highly trained or qualified workers from developing countries to the EU. This is particularly prevalent in the field of health. The phenomenon aggravates the shortage of health workers in many developing countries. To a lesser extent, migration of health workers also occurs within the EU, between the poorer and richer EU member states. Currently, the EU's PCD policy is subject to revision, possibly leading to a smaller number of focus areas²¹.

All in all, the EU is much more involved in health issues than is often assumed. [See also Greer, 2006, and Guigner, 2009a.] This has implications for its activities within WHO. EC competence exists not just in areas that are related to trade, such as intellectual property rights and food, but also in purely health issues, such as combating the spread of communicable diseases. Even on issues related to development cooperation and research, the EC may claim a role. This is important to realize before discussing why it may or may not be advantageous for EU member states to operate jointly in WHO.

15 This project is known as the European Prospective Investigation into Cancer and Nutrition (EPIC).

16 This project is known as the Assessment of POLicy Options for MARKeting Food and Beverages to Children (PolMark).

17 Presentation by the Directorate General for Research at the launch of the 7th Framework Programme. Available at http://ec.europa.eu/research/fp7/pdf/fp7_press_launch.pdf. The largest budget item is information and communication technologies (ICT).

18 See www.asiaflucap.org/AsiaFluCap.html

19 See www.edctp.org

20 Council Conclusions on Policy Coherence for Development (included in the Conclusions on the Millennium Development Goals), 24 May 2005

21 The Commission Communication 'Policy Coherence for Development – Establishing the policy framework for the whole-of-the-Union approach' of 15 September 2009 suggests the following priority areas: climate change, food, migration, intellectual property and security.

5. Towards more a more united approach? EU preferences and socialization

This chapter will go beyond the competence question and consider why EU member states would be willing to intensify coordination on global health issues. It looks at their preferences and the extent to which their representatives consider it necessary and normal to operate on the basis of a coordinated position.

5.1 Bringing EU preferences into line

Member state representatives operating in WHO generally consider it beneficial to operate with a joint position. This maximizes influence, for example, because the EU is always offered a seat in informal negotiations between the key players. A clear drawback would be the amount of time spent in EU coordination. Another drawback is that EU coordination generally leads to a position that is too rigid. It is, apparently, difficult to bring the preferences of EU member states into line. Differences exist with regard to the importance attached to public health, development cooperation and country-specific commercial interests (for example, whether generic or research-based medicines are produced, whether their tobacco, alcohol or unhealthy food is produced by domestic companies). EU member states also have different views on ethical issues, such as birth control and euthanasia.

The position of the ‘Big three’, the UK, Germany and France, is rather important when it comes to bringing preferences into line. The UK is regarded as being most active in promoting global health issues, but rather reluctant when it comes to ceding competences to the EC level. As a matter of principle, it opposes an expansion of the EU’s role in international matters and, more specifically, is also sceptical about a wider EU role in health issues. Germany has been also rather unfavourable towards EU coordination; in negotiations on tobacco, diet, physical activity and sports, intellectual property rights, and access to health, it was strongly promoting industrial interests, thereby jeopardizing EU unity (Guigner, 2009b; Van Schaik, 2009). France has generally adopted a rather neutral stance, although its opposition to the phasing out of tobacco subsidies has been noted. The Scandinavian countries also coordinate within the context of the Nordic countries. Ireland, the

Netherlands and Finland are reportedly rather progressive when it comes to government intervention to protect health.

It has often been said that the smaller EU member states would not be able to exert much power in negotiations in international organizations without combining their forces. In this respect, it may be helpful to look at the example of Norway and Switzerland, which are also relatively small countries but not EU member states. Both are said to punch above their weight, for instance in the WHO negotiations on access to health, innovation and intellectual property (Van Schaik, 2009). This could be due to specific industrial interests amongst the issues being negotiated, as well as having good delegates. They would, moreover, be perceived as neutral and thus able to play a bridging function, particularly since the rest of the negotiating spectrum is divided into big blocs: the USA, the EU, the emerging economies and the least developed countries. But they can also be more flexible in adjusting their position as they do not have to coordinate 27 member states and the European Commission.

Nevertheless, most of the EU representatives involved in WHO negotiations consider that it strengthens their position to operate on the basis of a single position and voice. Despite drawbacks in terms of the amount of time spent, the need to reach a compromise and a perceived inflexibility of the resulting EU statement, diplomats and officials still clearly consider EU coordination advantageous. The EU would be a “good pool for combining competencies, experiences and information” and deliberations among EU actors would result in “new and smart ideas” (Van Schaik, 2009). Norway and Switzerland would only be able to play a mediating role because, nowadays, the EU operates as a bloc on most issues.

The optional character of EU coordination is inevitable, but sometimes considered confusing. Because the arrangements for EC participation in WHO are in flux, they can be contested each time a single member state does not agree with the emerging consensus between the other EU member states. This draws attention away from the process of forging a solid EU position and considering an accompanying negotiating strategy to pursue it. However, since the issue of deciding on a more permanent arrangement for EU coordination in WHO is a politically sensitive one, the current set-up is favoured in order to maintain some flexibility.

On some issues, EU coordination would not provide added value. For instance, on the issue of reproductive rights it would be impossible to align positions since some Catholic countries, such as Ireland, Poland and Malta, take a more principled position, opposing birth control restrictions. It also proved difficult to agree upon EU candidates for important

WHO posts. When a new director-general had to be elected in 2006, EU member states came up with five different candidates without having consulted each other.

Yet, on other issues, it is considered of the utmost importance to have a common EU position. Support for public health in the Palestinian areas is considered politically so sensitive that having a clear EU position is essential. Some representatives of member states involved in WHO negotiations refer to the WTO negotiations as an example where EU coordination would be too much of a straitjacket. It would be too difficult to control the Commission in these negotiations. Greater coordination and an acknowledgement of EC competence could, moreover, result in the Commission claiming a need for EC membership of WHO. It is already a member of WTO, the UN Food and Agriculture Organization (FAO), and the Codex Alimentarius Commission, and has signed up to various multilateral environmental treaties, such as the Kyoto Protocol and the Biodiversity Convention. It also joined and ratified the Framework Convention on Tobacco Control (FCTC). The accession of the EC as member of WHO could prompt other similar entities, such as MERCOSUR and ASEAN, to claim this right as well.

Although opposition to the Commission claiming the lead within WHO negotiations abounds, the negative aspects of the rotating presidency system are also frequently mentioned. The significant role given to the EU presidency in representing the EU externally incurs an inherent risk for in continuity, while the EU's influence would rely too heavily on the ability and capacities of the government and the person in charge. According to one health expert, who follows WHO negotiations closely: "It is almost unbelievable that the EU allows its interests to be defended by someone, who is just in this position since he is coming from a government holding the EU presidency." Representatives of EU member states referred to problems arising from the presidency's essential role in setting the political agenda and taking care of the most politically sensitive negotiations.

To summarize, drawbacks include the time spent in coordination, the risk of having to accept a lowest common denominator position, inflexibility regarding the specifics of the EU position, and dependency on the negotiating capacities of the presidency. Forging EU unity can be cumbersome, thereby negatively affecting its performance in the negotiations. But, overall, most EU member state representatives consider it advantageous to operate as a bloc.

5.2 EU socialization

On WHO matters, an extensive process of EU coordination among Geneva-based EU diplomats and health attachés takes place. The Brussels-based Council Working Party on Public Health hardly ever discusses WHO affairs nowadays; neither does the Council formation in which EU ministers responsible for public health meet. One exception was the recent discussions at EU level on the H1N1 pandemic and WHO's role in reducing the spread of the disease. EU coordination in Geneva is, to a large extent, dependent on the EU presidency, but does take place on a regular basis; on average, every two weeks, but more frequently in the run-up to key meetings such as those of the Executive Board or the World Health Assembly.

If a common EU position can be agreed upon, it will be represented by a single voice. Most often, the presidency is the EU's main spokesperson, but on some issues the European Commission may take on the external representation (for example, on trade-related issues). The issue of whether other member states should also be able to make interventions complementary to the EU intervention is still being debated. This strategy is used in other international organizations, such as the Codex Alimentarius, the International Maritime Organization (IMO) and UN human rights bodies. Complementary interventions would make it clear that the EU is composed of a large number of states.

Some representatives of EU member states involved in WHO discussions clearly consider themselves European actors whereas, for others, the national affiliation remains the most important. They indicate the need to respond to national reporting lines as one of the reasons. National instructions from the capital remain the central reference point for most of the representatives of EU member states participating in WHO negotiations. On more technical issues in the negotiations, they tend to have less detailed instructions and more room to discuss and coordinate national positions. The European orientation is demonstrated by member state representatives who consider supporting the EU presidency a key task during the negotiations. For instance, during the negotiations on the strategy on public health, innovation and intellectual property, some delegates felt responsible for providing information and suggestions, also on those issues not prioritized in their national instructions (Van Schaik, 2009).

Although many delegates nowadays consider it normal to operate together with their EU partners, they do not always feel comfortable with the Commission's role in underlining the importance of EU unity and its eagerness to take over the external representation. The reason health experts from EU member states are concerned about the Commission becoming involved in WHO matters is that they suspect the Commission of being primarily concerned

with its own economic agenda, and not with “what is healthy for the citizens of Europe and other countries”. Research by Guigner (2006) confirms that the Commission would favour economic interests. Within the Commission, the Directorate General for Trade would be more powerful than DG SANCO, having a negative effect on the health and development perspective in discussions on access to medicines in developing countries, for instance.

The split between representatives of EU governments prioritizing health objectives and those prioritizing economic objectives is also linked to viewpoints on the preferred organization for negotiations affecting both objectives. Princen (2007) studied tobacco and alcohol policies and found that EU health experts feel most comfortable with WHO, whereas trade experts favour WTO as the relevant platform for negotiations. They, in turn, are the most critical of WHO’s role in what they consider to be trade issues.

Moreover, the Commission is suspected, by the representatives of the member states, of competence expansion. Guigner (2006) argues that, since the Commission only recently became active on health issues, it faces challenges to establish its position. It would compete with other entities, such as the Organisation for Economic Co-operation and Development (OECD), the Council of Europe, and the WHO Regional Office for Europe. The presidency is trusted more by the representatives of EU member states as it is ‘one of the club’. It appears to be judged primarily for its ability to manage the EU and less for achieving EU objectives in the negotiations. Indeed, the focus on EU coordination and ensuring a unified EU external representation seems to divert attention from exerting influence in the negotiations. It is considered of vital importance to “keep the EU united before the eyes of the world”. To non-EU actors, the extent to which they consider the EU to perform well seems very much related to the degree of unity it displays in the negotiations.

5.3 EC competence, preferences and socialization processes

In the negotiations on tobacco, the international health regulations and access to health and intellectual property, the Commission – claiming EC competence – made the EU member states realize it was obligatory to operate with a single voice. However, this also encountered opposition from the member states, jeopardizing EU unity. Member states did not fully trust the Commission to negotiate in line with their preferences when taking over the negotiations. They feared the EU would not become a better negotiator, but merely a defender of economic interests. At the same time, the need to coordinate themselves made member states realize the advantages of operating jointly. In addition, a process of EU socialization emerged.

6. Conclusions

The process of EU coordination in WHO is improving over time. It has gradually become institutionalized and it frequently coordinates positions whereas, in the past, this was far from being a given. But, EU coordination does not always strengthen the EU’s performance in negotiations. The EU struggles with who should represent it, with both the rotating presidency and the Commission having their own shortcomings. It spends a considerable amount of time in internal coordination, something that is related to the requirement to agree by consensus on common positions. It also has to deal with member states being resentful of their prerogatives in the field of health. They appear to fear an EU takeover, and some of them are unwilling to compromise on sensitive issues such as reproductive rights. But also, on issues where internally the EU has already obtained a competence, member states still seem reluctant to agree or to use WHO discussions on, for instance, trade-related issues, to reinforce the health perspective.

A brief review of the EU’s conduct in other policy areas indicates that the tensions between the Commission and the EU member states, the criticism regarding the rotating presidency, and the time-consuming character of EU coordination are recurring themes (Bretherton and Vogler, 2006; Smith, 2006; Woll, 2006; Meunier and Nicolaïdis, 2006; Coeuré and Pisany-Ferry, 2007; Groenleer and Van Schaik, 2007; Taylor, 2006; Gstöhl, 2009). There seems to be no simple solution to improving the EU’s performance in international negotiations.

Nevertheless, strategic issues, such as the accession of the EC to WHO, could be considered more openly in line with a debate on the actual and preferred role of the EU in health policy matters. This requires EU member states to discuss EC competence on health matters and their international dimension more explicitly. For those cases where EC competence is already shared or complementary, a more explicit choice between the Commission and the presidency to lead the EU in negotiations could be made.

An alternative would be to investigate whether the new EU foreign policy actors, established by the Lisbon Treaty, could replace the rotating presidency or coordinate aspects of the EU’s external representation in WHO. The involvement of the High Representative

and the European External Action Service would mean a greater involvement of European actors. However, they would – most probably – be less embedded within the European Commission. They can be expected to aim to present a united EU and to pursue a more diplomatic approach. However, they may have insufficient expertise compared with experts from health ministries.

In order to reinforce the EU's negotiating capacity, the support provided to the lead negotiator could be strengthened, for instance, by forming negotiating teams with experts from EU member states. Another option would be to appoint lead negotiators from among the member state delegates to cover a specific negotiation issue (for example, a new strategy or a specific agenda item). Such lead negotiators could operate under the formal responsibility of the presidency, as with the climate change negotiations (Oberthür and Roche-Kelly, 2008).

Similarly, another option may be to consider including overarching principles and policy guidelines within the EU's forthcoming Communication on Global Health. These could deal with issues such as the relationship between free trade and health objectives, health-related security threats, and health-related aspects of EU development cooperation. This would facilitate agreement on EU positions and could strengthen EU health diplomacy by enabling it to develop consistent messages on key issues. Perhaps most importantly, the rules for external representation need to be clarified, so that they are not continually contested. This would allow the EU to focus clearly on achieving its objectives in negotiations without constantly having to consider how it will operate.

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