

The Dutch vision and strategy on Global Health in times of multiple crises

Last month, the first-ever Dutch Global Health Strategy (DGHS) was released.^[1] Developed jointly by the Ministry of Foreign Affairs (MFA) and Ministry of Health (MoH), the strategy will be implemented by both ministries and in cooperation with others. While we welcome this collaborative integrated government approach, which we have long argued for, there are several considerations relevant to the actual implementation of the DGHS.^[2] In this article, we will begin to unpack the strategy by positioning the policy within a wider context, and looking at its role and significance for our country's foreign and domestic health policy. We will address the main topics and approaches, and focus on three elements that require greater scrutiny: (1) The support to further privatisation of health services; (2) The role of the Netherlands in ensuring policy coherence for development objectives; and (3) the focus on health security and One Health policies. In the final section, we provide recommendations on how to take this strategy forward, considering good governance and democratic legitimacy.

THE RISE AND FALL OF GLOBAL HEALTH

David Fidler wrote in 2011 that although global health had become a prominent foreign policy issue in previous decades, political attention to the subject was declining.^[3] Commitments and development funding had been made available by western governments for certain aspects of global health. HIV/AIDS prevention and treatment received a huge boost, as did other infectious diseases. Social health protection and micro-insurances schemes were in fashion in the field of health economics, and other support was devoted to strengthening health systems and human rights – with particular attention given to primary health care, access

to medicines, and sexual and reproductive health and rights (SRHR). At the same time, there was less attention given to social determinants of health (SDH) and non-communicable diseases, such as diabetes – particularly in low and-middle Income countries (LMICs).

Major challenges in the wake of the financial crisis resulting from the worldwide international financial crisis 2008-2009 required attention at national / domestic levels.^[4] Afterwards, there was more of a focus on other issues that emerged, such as refugee and migrant flows, terrorism, and international security concerns. Global Health policy became less of a priority in Europe.

During that period, up to 2015, global health strategies were developed by the UK, US, the EU and several countries in Europe, though implementation lagged behind.^[5] Multilateral funding for health stagnated and western governments opted for dealing with business actors and philanthropists. They preferred to leverage foreign financial investments via Sustainable Development Goal 17, referring to multi-stakeholder partnerships.

Interest in global health also diminished in the Netherlands: for example, funding of the interdisciplinary Global Health Policy platform was halted.^[6] Publications with a critical analysis – like the Netherlands Centre for Sustainable Development (NCDO) publication on global health needs and the role of the Netherlands – were shelved.^[7] Meanwhile, the government invested in public-private partnerships, among others in the life sciences and health domain (through 'Top Sector' subsidies).^[8] In 2011, the focus of development cooperation was narrowed down to just four spearheads, one being SRHR (besides, food, water, and security & rule of law).^[9] Other global health topics received less interest, hence less funding from the MFA and

related agencies. Simultaneously, the MoH mainly focused on one particular issue, Anti-Microbial Resistance (AMR).

THE COVID-19 PANDEMIC AND ONE HEALTH SPIRIT

The pandemic made a difference and times seem to have changed. Covid-19 had a much bigger global impact than earlier outbreaks of infectious diseases like Ebola and Zika or the (latent) crisis as a result of AMR. Politics shape health and disease, but epidemics also shape history and politics. As the pandemic hit the centres of the global financial economy (e.g. Shanghai, London, New York), swift action and massive public investments followed. After some initial hesitation, EU member states and the European Commission stepped in to prevent an economic meltdown and social disruption. It has even been argued that the European Covid-19 pandemonium, with all its ups and down, has enabled Europe to become more strategically 'autonomous'.^[10] The European political space develops through periods of political crisis. The pandemic has been such a political crisis.

The realisation that future pandemics are likely, and that these are related to economic inequities, food insecurity, and the biodiversity and climate crises compelled the government to develop a global health strategy. The strategy was developed in consultation with several actors (10), and integrates key principles from a thematically related policy report from the Dutch Advisory Council on Foreign Relations.^[11] Due to political pressure, the strategy was developed remarkably quickly (in less than 6 months) – a commendable achievement, though it is questionable to what extent it reflects the dialogue and representation of all parties engaged in the process.

The new strategy is convincingly structured on three overarching themes:



(1) Strengthening global health architecture and national health systems; (2) Improving international pandemic preparedness and minimizing cross-border health threats; (3) Addressing the impact of climate change on public health, and coordinating intersectoral policies including water management and food security. It also promotes responsibilities and commitments to multilateralism, a policy action perspective, principles for policy coherence, and contextualised approaches. The strategy is hence a strong basis for a more specific intersectoral global health action plan, including indicators, timelines and budgetary approaches. Nevertheless, some elements are downplayed or neglected in the strategy. Broadly, these are the following.

First, Wemos already pointed out that the strategy is overly positive about the role of the private health sector.

^[12] Several claims are made about the contributions of Dutch commercial and philanthropic initiatives in strengthening health systems. This perspective is misleading. We see that in many LMICs progress in Universal Health Coverage (UHC) has stalled in the wake of the Covid-19 crisis. ^[13] By now, there is abundant evidence that private sector involvement requires countries to develop and implement context-specific and appropriate policy and regulatory instruments and a workforce to implement them. Moreover, accountability mechanisms are needed to ensure that any public-private partnerships serve the health of the population and the goal of UHC. ^[14] However, LMIC authorities are often unable or unwilling to regulate the private health sector, given the financial power of the transnational medical companies involved and the conflicts of interest involved. ^[15]

Second, with regard to the Do No Harm principle, improving food security, access to medicines, and promotion of policy coherence, there is too little recognition of the structural role that the Netherlands and several Dutch non-state actors have had in actually undermining public health systems, common goods, and development processes in LMICs. For example, Dutch

transnational corporations in the food domain contribute to driving commercial determinants of health that are leading to an obesity and NCD epidemic in children and young adults in LMICs as well as in Europe itself. These determinants include the promotion of sugary drinks and ultra-processed foods. ^[16] These are also promoted through EU trade agreements with countries and regions around the world. ^[17]

The DGHS promotes local production of medicines and vaccines and mentions its experience with Product Development Partnerships. However, the EU, and hereby implicitly NL, has eventually abandoned the global public goods approach in ensuring access to Covid-19 vaccines globally. The EU continues to defend, via trade policies, the private monopolies and intellectual properties owned by a handful of pharmaceutical corporations, thereby undermining access to essential medical products. ^[18] Indeed, there is policy coherence in the NL approach, but one could cynically argue that these actually benefit private financial interests instead of minimizing global public health risks and actually do more harm than good.

Lastly, with the One Health focus and attention on pandemic prevention, preparedness and risk, as well as anticipating the impact of climate change, there is a strong focus on health security and risk management. The question here is: health security for whom and security from what is being prioritized? ^[19] The focus is on transnational health threats and enhancing the structures, means and capacity to contain these risks, mostly identified as infectious disease threats. But these risks are in general considered risks for European countries. Health risks are far from evenly distributed in our globalized societies. While there is a strong focus on the One Health approach to mitigating the zoonoses, Antimicrobial Resistance, and viral pathogens that could lead to epidemic episodes, there is relative silence about other, more structural health risks in other parts of this world. ^[20] For instance, in most African countries Covid-19 was only a minor problem. ^[21]

In Africa, South East Asia and the Middle-East, health issues are related above all to economic impoverishment and food insecurity. It is also difficult to organize health services for migrant and refugee populations that have increased tremendously due to conflicts and extreme weather events. ^[22] The strategy does not mention the health situation in fragile contexts and states, whereas in 2022 fragile contexts involve a quarter (24%, 1.9 billion) of the world's population, most of them living in extreme poverty. ^[23] On top of this, comes a shortage of health workers, and here also the West plays a role by attracting doctors and nurses.

IMPLEMENTING A GLOBAL HEALTH STRATEGY: THE DEVIL IS IN THE DETAILS

Let us consider that the glass is half full. The DGHS, original in its ambition and intersectoral scope, provides a decent basis for 'the start of a process – together with relevant partners – to arrive at an agenda based on set priorities, so that we can best contribute to a healthier future for the world and the Netherlands. ^[1] The strategy also forms a solid basis to contribute to the debate on a new EU global health strategy. There are some governance mechanisms outlined in the strategy on how to follow up with implementation. There is reference to a) an interdepartmental steering committee b) a Dutch Global Health Hub and c) the need for international coordination. These are all much needed and relevant, though the following considerations are relevant in that regard.

Most importantly, the initiation of an interdepartmental steering committee should be followed by a Terms of Reference that outlines mandate, responsibilities, leadership, governance modalities, and policy frameworks that the committee can work with. What is the timeline of action, what is the budgetary space of the committee, and how can it be kept accountable when an implementation plan is agreed upon? Although the MoH and the MFA have a shared mandate to lead the DGHS implementation, technical global health policy expertise is mainly at the MoH, while the DGHS budget is earmarked according to the budget

lines in the MFA'S Strategy for foreign trade and development cooperation. ^[24] This division requires clarification and a shared responsibility approach.

Furthermore, there are also considerations on the modalities of collaboration with non-government actors and how to prevent any conflicts of interests. How to ensure that the political 'fashion of the day' does not interfere with a longer-term agenda and its sustainability, while allowing adaptiveness in relation to upcoming crises? In most countries with global health strategies, it has proven difficult to sustain structure and such agenda implementation. ^[5]

A clear aim and budget are also relevant for the development of a global health hub. Will such a hub have a clear meaningful mandate? Will it be structurally financed and analytically supported via a secretariat, or is it merely a 'talk shop and networking place' for those who can afford time to participate? This relates to questions of democratic legitimacy: what is the input legitimacy of those involved, which constituencies do they represent, and how is policy dialogue and discussion promoted? Then there is the output legitimacy: how to keep such a hub and its programme accountable, how to guarantee transparency of the actors involved, including the interests they may bring, and lastly how to ensure that the hub is actually relevant and effective? ^[26]

Regarding international collaboration, similar questions can be asked: will commitments to multilateralism actually improve much needed collaboration on global public goods or will it actually further fragment the landscape? Will the focus be on the WHO or rather on other initiatives such as the global public private partnerships? A decent mapping and power analysis is required here. ^[27] In this respect, recent discussions during the World Health Summit in Berlin ^[28] illustrate different (critical) viewpoints on what kind of partnerships are preferable and what kind of actors are excluded. The One Health approach and upcoming global health strategy by the EU are expected to focus primarily on health security. Here also

there may be questions about whose security and interests are served and who is actually neglected. This may enhance European strategic autonomy, but is this considered legitimate by non-European countries? To what extent are matters like debt relief or debt restructuring for LMIC considered in these times of multiple crises? This necessitates open and honest policy dialogues with international partners.

In short, the next steps in the implementation of the global health strategy need to be inclusive. Consultations with relevant stakeholders and the general public may take some time since trust in government, science and politics has declined in these times of polarisation and multi-crisis. Attention to democratic processes and governance processes are hence important, as they seem to be much under pressure. ^[29] With so much attention on multi-crisis management, including in the DGHS, we emphasize that concerted action and responsibility by the richer countries is still needed to eradicate the structural conditions of poverty that cause the spread of a disease such as Covid-19 on a world scale. ^[30] Health and disease are a transnational concern, and a genuine Dutch contribution that addresses health concerns of international partners could stretch beyond narrowly defined interests and recognise that societies share a destiny for health and wellbeing on this small planet.



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