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THE COMMUNITY AND THE MEMBER STATES' POLICY ON COOPERATION WITH THE DEVELOPING COUNTRIES IN THE FIELD OF HEALTH

Summary

Introduction

Article 130x of the Treaty on European Union states that the Community and the Member States shall coordinate their policies on development cooperation and shall consult each other on their aid programmes. Furthermore, Article 129 provides that the Community and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health, and that health protection requirements shall form a constituent part of the Community's other policies.

In their declaration of 18 November 1992 on "The run-up to 2000", the Council and the Member States called on the Commission to make recommendations to improve procedures for coordinating policies, operations and action taken through international bodies.

Observing the current shortcomings of coordination in this sphere, the Council in its conclusions of 25 May 1993 gave priority to the health sector and called for joint guidelines and special efforts.

In response to the requests made by the Council and the Member States, the Commission organized two meetings with health and development experts from the Member States in September and December last year. These meetings had immediate positive effects as can be seen from the joint declaration adopted at the Ottawa Conference (18-20 October 1993) and the increase in the flow of information.

The discussions between experts from the Commission and the Member States at these meetings were of great help in drawing up this communication. The ideas and guidelines put forward in it were discussed in detail during the two meetings.

It underlines the importance of a multisectoral approach to health issues and points out that poverty is the root cause of the current poor health situation.

This paper therefore focuses on the need to create an environment favourable to health, to take greater account of public health issues in formulating development policies and programmes and to invest in improving living and hygiene conditions.

In view of the enormous discrepancy between health needs and the care available and the severe structural crisis, the paper proposes supporting an in-depth reform of health care systems. At the same time as enabling health operations to focus on satisfying the most basic health requirements, the reform should improve the effectiveness of operations and the quality of care provided.

This paper highlights the need to give greater attention to the complementary aspects between development and research policies.

The paper then sets out the principles, general objectives, strategies and means of action for cooperation in the health field between the Community and Member States on the one hand and Developing Countries on the other.

It highlights the need to base operations on a comprehensive, long-term approach, designed to improve fairness and social justice. Since there is no all-purpose solution, it proposes a pragmatic approach to health issues, working on a country-by-country basis according to local circumstances, abilities and wishes.

It calls for more outside financing for this sector but makes it clear that this increase must go hand in hand with measures designed to improve effectiveness. For some countries it proposes more direct instruments for the transfer of resources in addition to the projects and programmes at present carried out.

It provides guidelines for a new investment policy and for support for the reform of health care systems.

It also lays down general principles and puts forward practical arrangements for stepping up consultation and coordination between the Community and the Member States.

I. The health situation in the developing countries

1. Unprecedented progress in the last few decades

Throughout the world greater progress has been made in the health field over the last forty years than in the whole history of mankind. The progress is due largely to advances made in the scientific field to which Europe has contributed in a major way.

The developing countries have shared in this progress. The improvements to the general state of health have been rapid and considerable. In the last forty years life expectancy has increased enormously, from 40 to 63 years.

The greatest progress has been made in reducing infant mortality (children aged less than five), which has been cut by more than half from 280 to 106 per 1 000. Adult mortality rates have dropped by almost half from 450 to 230 per 1 000. The maternal death rate has also dropped.

Although some statistics are still unconfirmed, the fall in the death rate gained pace throughout the period in question.

Major headway has also been made with regard to disease. Smallpox has disappeared. The old scourges such as leprosy, the plague, yellow fever, river blindness and sleeping sickness are definitely on the decline. Child immunization programmes have reduced the incidence of diseases such as measles, tetanus, whooping cough, diphtheria and polio.

Both the direct benefits, in terms of people's welfare and the indirect benefits, in economic and social terms, are considerable.

2. Unevenly spread progress

The overall figures conceal the sometimes very marked disparities (in the nature, pace or extent of progress) between regions, countries and social groups.

The most significant headway has been made in China and the Middle East while sub-Saharan Africa and South Asia have made much less progress.

Headway can vary from country to country within the same continent or the same region.

It is not always easy to explain the disparities between regions or countries. They do not always correspond with the level of health expenditure (cf. China, Cape Verde, Ghana, Sri Lanka).

Even greater differences sometimes exist between social groups in the same country. Clearly the economically most underprivileged groups are worst off in health terms.

The urban population generally enjoys better health than the rural population but certain disadvantaged urban neighbourhoods face major problems.

Disease still takes a heavy toll of women and children, who are also a highly vulnerable group.

3. Insufficient progress and major challenges

Mortality rates, especially among mothers and children, remain extraordinarily high by comparison with those in the industrialized countries.

By any yardstick, the morbidity level is still high - depending on the region, two, three or four times higher than in the developed world.

Although certain infectious and parasitic diseases are on the wane, progress is fragile since the slightest let up in the measures taken results in new outbreaks or increases in the endemic level. For other diseases, such as malaria and tuberculosis, not enough has been done or the measures taken have not had as much impact as expected and several hundreds of million people fall victim each year.

Diarrhoea and respiratory infections are still the main causes of infant mortality.

Transmissible diseases therefore continue to top the epidemiological league tables but as a result of the profound economic, social and cultural changes under way in the developing countries new problems are emerging. Non-transmissible diseases, accidents, illnesses connected with urban life or drug addiction are on the increase.

To a very large extent, these new ills come on top of the old ones rather than gradually replacing them as in the developed countries. This greatly complicates the task of the authorities, who are forced both to keep up the fight against transmissible diseases and to start taking very costly action against non-transmissible diseases.

Although of a different nature, two other recent problems further complicate the situation and present considerable challenges.

In only a short time the epidemic of HIV infections has become a major public health problem and the sharp increase in AIDS cases is calling past achievements into question. The social impact of AIDS, which strikes the young and active, leaving thousands of orphans, is considerable. Because of its prevalence, gravity and the cost of treatment, AIDS has, and will have, very serious repercussions on the development of all health systems.

The emergence and spread of resistance to antibiotics and antiparasitics, mainly because of improper use of medicines, also greatly complicate the situation and make the fight against very widespread diseases even more costly. In the long run, the development of this resistance could double the number of early deaths and sharply reduce life expectancy. The capacity to address these two problems relies upon new headway in scientific research. The development of capacities and new efforts for research is in great need.

4. Rapidly growing needs and new requirements

Although population growth in the developing countries varies from one continent to another it nonetheless remains very high (average 2% per year) giving rise to a doubling of the population in thirty years.

Longer life expectancy increases the likelihood of health problems and leads to the emergence of "new" diseases.

The combination of these two factors means a sharp and extremely rapid rise in health needs.

The more information and education people have the more they aspire to enjoy better health and avoid an early death, handicaps and suffering.

Frustration and resentment ensue once increasing numbers of people realize that such aspirations are satisfied in some parts of the world or for some privileged groups and that there is a whole scientific and medical arsenal to which they have no access.

These frustrations take a heavy social and political toll.

5. Health care systems in most countries are in deep crisis. There is a wide disparity between health needs and available health care

The developing countries on their own and with international aid have done a lot to develop health care systems, set up health infrastructure networks, train health staff and carry out health activities and research in the field of health.

Yet there is no escaping the fact that current health care systems only partially meet health care needs - even the most basic.

Physical access to basic care is still limited. Scarcely more than one person out of two has actual access to any type of health service at all. This lack of access to care is still widespread in rural areas and in some towns. Nor do people have the money to pay for care or medicines.

Most countries have not yet managed to cover properly essential requirements such as child immunization, the prevention and treatment of risks connected with pregnancy, family planning methods and so on.

Health care systems are badly run in many countries. This is partly due to structural imbalance within the health care system. On the other hand, the 1980s saw a "recurrent costs syndrome" in the form of:

- deterioration of infrastructure
- limited life of the equipment installed
- partial stoppage of health care teams
- staff demotivation, resulting in the brain drain or morally questionable conduct.

Generally speaking the quality of care and services remains low.

II. Learning from experience

1. Health, a vital factor of development

Health is a vital aspect of individual and social welfare. But improving the state of health of individuals and whole populations is not just a development goal, it is also an important factor of development.

The health sector is crucial in direct economic terms: job creation, its impact on the balance of payments, public expenditure, financial availability and household finances.

It is of indirect importance to the extent that improved health is a vital factor in the development of human resources.

Better health means a longer working life, fewer working days lost and fewer production shortfalls due to illness.

It is a way of considerably increasing productivity and developing new work organization methods.

Healthier children and young people mean higher school attendance levels and a greater capacity for learning and personal fulfilment.

Health schemes can also help to make better use of land and natural resources as can be seen from the action programmes against river blindness and malaria.

Preventive and promotional measures and certain therapies are proving to be worthwhile investments. Although hard to quantify, the direct and indirect human and economic costs of the deaths, handicaps and suffering prevented are considerable.

In the developing countries, like everywhere else, improved health is a major social and political issue. A proper health policy can strengthen social cohesion at the same time as helping to reduce poverty and redistribute wealth more fairly.

These points serve to underline the importance of investing in health for the developing countries and their partners.

2. Poverty and bad living and hygiene conditions are among the main causes of the poor health situation

All the studies carried out show that the state of health of a nation, and the individuals of that nation, is the result of an extremely complex set of factors and attitudes. It is particularly difficult to pick out the most significant.

Clearly, however, the state of health is closely related to household income. Maps of poverty and morbidity levels broadly match. **Poverty thus emerges as one of the main causes of the poor health situation.**

The level of education, particularly of women, also plays a decisive role in health.

Together with poverty, poor living and hygiene standards are fundamental causes of bad health. Existing studies highlight the importance of the availability of food supplies, water and food hygiene and proper waste and sewage disposal for the health of the individual and the nation.

Improving the state of people's health therefore requires more than just developing health care systems. Public health issues must be taken into account in development policies, particularly in the formulation of a comprehensive social policy framework and policies and strategies to combat poverty.

3. Inadequate health resources are not the only explanation for the current situation

In most developing countries less than 5% of GNP is spent on health. This has been aggravated by the recent drop in per capita GNP in many developing countries.

The economic difficulties which have beset many countries since the 1980s have checked the momentum achieved in the previous decades. These difficulties have essentially meant freezes, and in many cases cuts, in public expenditure on basic investment (education, water, research, housing) and on health care systems.

These cuts were only partially offset by shifting costs to households, whose incomes were frozen or fell in that same period. Since this transfer of charges and the methods of cost recovery took no account of patients' incomes, the poorest were hardest hit.

As a result of the freeze or cut in health expenditure there was a sudden brake on national investment in developing health care systems. This also had a heavy impact on the way services operate and the quality of treatment provided.

Inadequate resources alone do not explain all the current problems and the crisis in the care system.

They are also the result of ill-adapted health development strategies, which are responsible for the disparity between health needs and available care and the loss of effectiveness of the resources mobilized.

Policies and strategies focused too much on the development of health care systems, were often aimed at satisfying an urban elite and concentrated on curative medicine, the development of hospital services and expensive treatments, resulting in less cover for people's basic needs.

In addition, the concentration of resources on the public sector and the over-centralization of powers did not allow full advantage to be taken of individuals' or communities' initiatives or abilities.

Selective strategies, which were often given outside encouragement, and a proliferation of projects and programmes led to imbalances in the share-out of technical resources and were at the root of further loss of effectiveness. All these very specific initiatives (targeted at a single illness or a single health problem) do not add up to a coordinated health strategy.

As several countries have proved, it is possible to improve people's state of health significantly with only limited resources. **Although an increase in resources now seems vital, it must go hand in hand with a policy review and far-reaching institutional reform.** Such steps are already being taken in several countries.

4. External aid is essential. Overall it is insufficient, often badly coordinated and slow to adapt to new situations

Support from the international community for the developing countries' health sector was, is and will continue to be essential.

Without the external support provided, many countries would have been unable to develop their health systems, train their executive staff, back operations and thus make as much progress as they have.

Without technical assistance, ideas and policies would have developed more slowly and many mistakes would not have been avoided.

Some countries have such enormous handicaps to overcome in their economic development that it will be a long time before they are able to allocate sufficient funds to cover even their population's most basic health needs.

This support has remained limited. Following sharp growth during the 1970s, external aid remained unchanged in real terms in the 1980s. In 1990 it accounted for less than one ecu per capita, per year and only two ecus in sub-Saharan Africa, even though aid was concentrated there.

It also has to be said that:

* the aid provided did not tie in properly with national health policies as it often tended to reflect donors' concerns rather than the needs and priorities of the recipient countries;

* the aid was targeted too much on developing health care systems;

* the aid was very largely focused on investment and too little attention was given to matters connected with running health services and the quality of care;

* the proliferation of initiatives, projects, programmes and procedures for channelling aid greatly complicated the task of the authorities in the recipient countries.

Many of the mistakes, oversights, duplication of efforts, inefficiency, wastage and unfortunate repercussions could have been avoided or limited if aid had been better coordinated.

The lack of coordination is due both to the technical complexity of planning and programming operations and to the diversity and in some cases incompatibility of donors' instruments, procedures and timetables. Poor administrative capacity is another major handicap.

It is also the result of a lack of political will on the part of recipient countries and donors alike.

In the last few decades there has been a change in the approach to cooperation in the health field. There has been a growing interest in the multisectoral dimension of health and a growing concern for people's fundamental needs, prevention, and basic health services, etc. This change has been slow to come about and has taken a while to produce results.

At the same time the attention initially given to strictly medical matters was switched to epidemiological issues. It then shifted to economic aspects, questions of cost-efficiency and cost-benefit, without forgetting the necessity to continue efforts in the above-mentioned fields. There is now a need to examine the social and sociological impact of health operations and institutional and organizational issues.

III. Principles and goals, general objectives and priorities for the Community and the Member States with regard to aid and cooperation in the field of health

1. Principles and goals

Both an end and a means of development, improving people's state of health is one of the main goals and top priorities of development aid operations.

Cooperation in the field of health is a long-term goal in the overall context of human resources development and the fight against poverty. It is part and parcel of the search for greater fairness and social justice. It encourages effective individual and group participation in devising and supervising health operations.

Because of the multisectoral nature of health problems and their solutions it is essential for all development aid policies and programmes to take account of health issues. Similarly, cooperation in the field of health must involve more than just measures to do with health care systems.

Cooperation in the field of health is not intended to replace the recipient countries' capacities and efforts. It is a means of encouragement and help. It is not intended to meet all problems and needs but rather to help the developing countries satisfy people's most basic requirements and particularly those of the most disadvantaged and vulnerable groups.

There is no all-purpose method for organizing health systems. Therefore, sharing knowledge and experience and comparing the various solutions are indispensable to facilitate decision-making. The diversity of experience gained by the Community and Member States, both within the Community and in developing countries represents an invaluable asset which should be put at the disposal of developing countries.

Experience has often shown that it is not easy to transplant solutions which have worked well in certain countries and/or circumstances. Cooperation, in this field as in others, must therefore take account of specific characteristics, human and financial capacities and local wishes.

Nowadays we have the knowledge, methods and means of preventing and treating most of the main diseases. More research, both pure and applied is, however, still needed. Cooperation in the health field must help to provide support and backing for the scientific efforts of the developing countries. (A specific communication on health research issues could be presented to the Council in the near future).

2. General objectives and priorities:

The general aims of cooperation in the health field are to **help the developing countries:**

* **to formulate and implement policies** designed to satisfy their peoples' most fundamental needs in an effective and lasting manner;

* **to build and develop viable and efficient health care systems.**

In the current situation the priorities are to facilitate and speed up:

- the adaptation of national policies and strategies;

- the creation of an environment more favourable to health;

- the reform of health care systems.

2.1 Helping to adapt national policies and strategies

Each country must, in the light of its specific characteristics, formulate and adapt its national health policy, lay down objectives and strategies and draw up health development plans.

It is vital for the developing countries to formulate or adapt their health policy in order to guarantee national independence, make efficient use of available resources and maximize the impact on the population's health.

In aid terms this is a vital step towards making more appropriate and effective use of the aid provided.

External assistance must help to remove the present constraints and in particular it must help to strengthen institutional facilities for:

- collation and analysis of data
- evaluation of health operations
- preparation of possible scenarios
- planning and programming.

2.2 Helping to create an environment favourable to health

A complex set of factors determines a population's state of health. The developing countries must devise a public health strategy which tackles the root causes of their peoples' health problems.

External aid can contribute by helping the countries:

- to take account of public health issues when formulating development policies, establishing the overall social policy framework and preparing structural adjustment programmes, investment programmes and budgetary frameworks;

- to step up consultations and dialogue between health officials and officials from other areas with an impact on health (education, the promotion of women, agriculture, water supplies, town planning and so on);

- to strengthen the capacity for scientific research, and in particular the collaboration between developing countries and European institutions;

- to invest in identifying and implementing primary prevention and public health promotion schemes (health education, health legislation and monitoring in the workplace, water quality control and so on).

2.3 Supporting the reform of health care systems

Institutional reform is needed in most developing countries.

External aid must be used to help devise and implement measures designed:

- to correct the structural imbalances in health care systems;

- to ensure a better share-out of responsibilities and tasks among the various parties and particularly between the public and the private sector;

- to develop financing systems capable of mobilizing and managing resources efficiently, ensuring greater fairness;

- to give priority to the most effective operations and improve the quality of the care provided.

Correcting structural imbalances basically consists of strengthening basic services.

Restructuring health care systems does not mean less involvement on the part of the authorities but rather:

- stepping up the role played by the central administration with regard to formulation, coordination, supervision and monitoring;

- transferring responsibility for programming and management of activities to regional level and giving large establishments and bodies independent management;

- transferring responsibility for implementing activities to individuals or groups and associations, as part of agreements or contracts under the direct control of the authorities and communities which they serve.

With regard to the reform of financing systems, it is less a question of increasing the volume of households' contributions than collecting them in a transparent manner and managing them more rationally. It is just as important to allocate public resources more effectively and to translate national health policy guidelines more effectively into budgetary terms. In some countries more extensive sickness insurance schemes should be set up or further developed.

Health services should focus on the most essential and effective activities, in particular the preventive ones, i.e. a minimum package of activities designed to meet the most serious and widespread problems.

IV. Means of action, strategies and instruments

1. Means of action

During the 1980s, despite appeals to help develop human resources, external aid remained unchanged and the proportion of total aid allocated to health fell from 7% to 6%.

It is vital to increase the resources allocated to this sector, particularly in the least developed countries. This increase must, however, go hand in hand with measures to increase the relevance and the effectiveness of aid, in particular through increased emphasis on public health requirements.

In some countries where economic development is severely hampered, this transfer of resources should not simply take the form of investment, projects and programmes but should also help to finance the running of health care systems. This, however, should be contemplated only in the context of reciprocal undertakings.

2. Strategies

The Community and its Member States need to adopt a new investment policy.

First and foremost this means increasing investment in improving living and hygiene conditions. This new policy, which is part of the strategy to combat poverty and supplements support for the education sector, sets out via labour-intensive schemes to improve access to drinking water, the hygienic distribution of foodstuffs, sewage disposal, housing conditions and so on.

Secondly, the aim of this new policy with regard to investment in health care systems is:

- to curb severely schemes to create new infrastructure in the hospital sector. A moratorium on the building of new tertiary-sector hospitals should be proposed. Instead major efforts should be made to improve basic and what are know as first-referral services;

- to focus action on rehabilitating existing health structures, improving the maintenance of technical equipment and raising the level and quality of the care provided;

- to maintain a high level of resources to finance priority operations the cost-effectiveness of which has been clearly demonstrated and in particular health protection and disease prevention activities.

To support the vital institutional reforms, special efforts should be made:

* to strengthen the central administrations' technical facilities and resources, particularly with regard to planning, programming, legislation and monitoring;

* to facilitate and accelerate the process of decentralization and devolution by helping to develop facilities at provincial level;

* to help the countries to establish new codes of practice for the health professions, in both the contractual and strictly private context;

* to encourage non-governmental initiatives on health (by communities, associations and private individuals).

In addition to measures to ensure that a sufficient level of public financing is maintained, external aid must be used to mobilize household health-care contributions more efficiently and reduce the cost of care.

In this connection the aid should primarily be used to help countries rationalize the supply, distribution and use of medicinal products. Aid should focus on supplies of the most essential medicinal products, encourage the use of the cheapest effective, safe products and help to train the medical staff who write prescriptions.

Support for training schemes and further training for health staff and health education campaigns are also strategically vital.

3. Instruments

To a large extent aid will continue to be provided via projects and programmes. These should be less compartmentalized and fragmented than in the past and they should follow a coordinated approach in keeping with national guidelines and strategies.

Because of the state of human and institutional capacities in the developing countries, more direct transfers of resources should be encouraged, for example in the context of structural adjustment support, general and sectoral import programmes and/or budget aid.

Technical assistance will have to change in the next few years.

Support in the form of technical expertise is still necessary in most countries. It provides a special means of exchanging ideas, comparing experiences and jointly examining problems and their solutions. This change will entail a gradual withdrawal of substitute technical assistance as national capacities develop. More use will have to be made of the know-how of individuals and organizations in the developing countries themselves for projects and programmes financed by the Community and the Member States.

European technical expertise should, however, be stepped up, with regular but intermittent support being given, for example, to developing relations between institutions of a similar nature as part of decentralized cooperation.

V. Towards closer consultation and coordination between the Community and the Member States

1. General principles

Coordinating aid is one of the best ways of maximizing its impact on people's health and improving the effectiveness and efficiency of operations. It is preferable for the developing countries to negotiate with all donors together rather than each of them separately. This obviously means first stepping up coordination among donors.

Because of the amount of aid the Community and the Member States provide in the field of health and their relations with other donors (particularly the WHO, World Bank and UNICEF), they can and must play a central role in coordinating donors.

The Community and its Member States also enjoy a special position because of the extent and wealth of their experience in the health field.

In view of the current shortcomings it is clearly essential to step up Community coordination.

This involves establishing principles and a consistent framework for action, ensuring that the various European partners' operations respect these principles, and providing for consultation.

The ideas put forward in this paper should help to establish the policy framework which is to be adopted by the Council.

The Community and the Member States will have to ensure, country by country, that their operations are complementary and coordinated.

Initially, efforts must be focused on the exchange of information and sharing of experiences. These will help to identify points of convergence, objectives, priorities and common guidelines for action and thus fashion a first generation of complementary projects and programmes. In time there will be joint reviews and joint identification of a coordinated framework for operations.

It is on this joint basis that each Member State and the Community will be able to open the dialogue with each of the recipient countries and together prepare operations which are in keeping with national policies, guidelines and strategies.

In this process it will be up to the Commission to initiate and maintain consultations on policy and to monitor the progress made on the operational coordination front.

In each of the recipient countries, a European partner may be chosen by common accord to assume the lead in this area and take any steps needed to strengthen coordination.

The various Committees (EDF, ALA, MED and the Committee of the life sciences and technologies programme for developing countries) could also be used as a focal point for coordinating the Community and the Member States' approaches to each recipient country, keeping a regular check on application of the common guidelines adopted by the Council and evaluating operational coordination systems.

2. Practical arrangements for stepping up coordination between the Community and the Member States

With regard to **policy consultations**, the Commission will organize meetings on a regular basis (at least once a year) of health experts and officials from the Community and the Member States in order to compare views, develop a dialogue on matters of substance and identify points of convergence, basic principles and common objectives and guidelines.

After a first phase covering the general aspects of cooperation in the health field, these meetings will provide an opportunity:

* to refine approaches vis-à-vis particular geographical areas (South-East Asia, Latin America, Sahel and so on);

* to keep public health requirements under review;

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* to hold detailed consultations on specific subjects (medicinal product policies, financing systems, staff training and so on);

* to step up inter-departmental consultations and the multisectoral approach to health issues.

Prior to each of these experts' meetings a working paper will be drawn up as a basis for discussion, containing:

* a review of the situation and the problems resulting from the formulation and implementation of policies and strategies in the area or subsector under consideration;

* proposed common principles and guidelines for action.

The conclusions of these experts' meetings will be used by the Commission and the Member States to tackle problems in the health field on a more consistent basis.

Operational coordination must be ensured by measures and action at two levels - the central level of cooperation bodies and ministries and the level of representatives' offices in each of the countries.

Operational coordination at central level could be stepped up by means of annual meetings on the state of cooperation with groups of countries. The Commission and the Member States could share responsibility for arranging these meetings.

In each of the recipient countries one of the European partners must be put in charge. It would be chosen by common accord and on the basis of its experience of coordination with the country in question and the scale of the support provided.

The leader would then be in charge of disseminating information, organizing ad hoc coordination meetings and preparing an annual report on the Community and the Member States' operations in the sector. In the long term it would be responsible for joint preparation of sectoral and subsectoral reviews and a coordinated operational framework.

With regard to coordination in international bodies, the principle of systematic consultation must be followed during meetings, conferences and seminars themselves. This consultation should be based on the principles and policy guidelines defined here above.

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