



EUROPEAN COMMISSION

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**Issues paper**

**The EU role in global health**

This document does not present the official position of the European Commission. It is designed to sound out the views of interested parties. The suggestions contained in this document in no way prejudice either the form or content of any future proposal by the European Commission.

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## 1. INTRODUCTION

The purpose of this issues paper is to launch a public consultation to gather **pointers** and views from relevant stakeholders regarding the rationale, scope and strategic objectives for an EU role in global health. The document raises a number of issues that are at the heart of the debate on global health. It is based on studies carried out by leading research organisations and international agencies as well as on the European Commission's own research. Existing European Community/European Union policy frameworks, where available, are referred to in the text, as appropriate. On issues where no agreed European positions exist, the paper proposes points for discussion and exchanges of views. This issues paper will be published on the Commission's website (<http://ec.europa.eu/yourvoice/>). The consultation will run from 14 October 2009 to 9 December 2009 and is open to all interested stakeholders. Individuals, organisations and countries that wish to participate in the consultation process are invited to reply to the questionnaire annexed to the issues paper.

Consolidated contributions might be published. If you object to the publication of your contribution, please notify it. In this case the content will not be taken into account.

Furthermore, in June 2008 the Register for Interest Representatives (lobbyists) was launched as part of the European Transparency Initiative. Organisations are invited to use this Register to provide the European Commission and the public at large with information about their objectives, funding and structures<sup>1</sup>. It is Commission policy that submissions from organisations which have not registered will be considered individual contributions<sup>2</sup>.

Contributions to the consultation should be sent to: [DEV-GLOBAL-HEALTH@ec.europa.eu](mailto:DEV-GLOBAL-HEALTH@ec.europa.eu).

Enquiries about this consultation can be addressed to the European Commission, DG Development, Unit B3: Human Development, Social Cohesion and Employment, Rue de la Science 15, B-1049 Brussels, Belgium or can be sent to the above mentioned DEV-GLOBAL-HEALTH mailbox.

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<sup>1</sup> [www.ec.europa.eu/transparency/regrin](http://www.ec.europa.eu/transparency/regrin).

<sup>2</sup> COM(2007) 127.

## 2. CONTEXT AND PROBLEM DEFINITION

### 2.1. SCENE-SETTING

Global health is an extensive multi-sectoral domain that links not only the main policy areas of development, humanitarian aid, research and health, but also trade and foreign policy. Today, health is high on the global development agenda as a result of abundant scientific evidence of the links between health and development. For example, a strong global commitment on health is paramount to achieve the Millennium Development Goals (MDGs). The recent avian flu and H1N1 pandemics have shown how health is a global issue touching all sectors of the economy and policy and requiring coordinated international responses.

#### 2.1.1. *Global factors*

*Globalisation* is an ongoing process in which economies, societies and cultures are becoming increasingly integrated in a globe-spanning network of exchanges. This process has far-reaching implications for the EU in virtually every sphere. In the case of health, it offers an opportunity to advance research, knowledge and development of new methods and delivery of health care in the form of prevention and treatment. But it also creates challenges. There is a need to ensure equitable access to the advances in knowledge and tools. On the other hand, there is a growing need to predict, detect and tackle health threats early on, in order to be able to control their impact. Seizing the opportunities and addressing the challenges of globalisation in the health sector require a strong level of global coordination and cooperation to develop global capacity to identify, monitor and report health challenges and to make sure that medicines and services are available to meet them.

The *Millennium Development Goals* (three of the eight MDGs - 4, 5 and 6 - are directly related to health) remain the main international framework for efforts to improve health globally and underline the importance of health for achieving all the MDGs. This is recalled in the political guidelines issued by the President of the European Commission, which make specific reference to the need to pay closer attention to social sectors.

*Women and children* are among the groups most vulnerable to poverty, but progress towards MDGs 4 and 5, which cover maternal, newborn and child health, remains particularly slow. As a result of substantial investment, more progress has been made on MDG 6 on combating HIV/AIDS and malaria, but these and other diseases will continue to pose exceptional global challenges to social growth and development for decades to come. Overall, progress towards achieving the health-related MDGs is being hampered by weak health systems, critical shortages of skilled health workers and gender inequality.

The effects of *climate change, epidemiological transition* (increasing burden of non-communicable diseases) and the present *financial and food crisis* pose additional challenges to progress towards the health-related MDGs. Poor health in large parts of the world has serious economic *consequences*, as the burden of disease hampers countries' efforts to stimulate knowledge, innovation, investment, trade and other economic activity, which further undermines the health capacity of individual countries. Ill health also has clear effects on social cohesion, security and stability. All these factors play their part in the growing frequency and increasing impact of natural and man-made humanitarian crises, which in turn add to the risks of global health threats and further undermine social cohesion, access to health care and global progress and stability.

### 2.1.2. *National constraints*

The *capacity of individual countries* to provide accessible health care and play an active role in the global health system depends, to a large extent, on the availability and use of national resources to finance health systems, including health infrastructure, the health workforce, medicines, research, monitoring and control. This varies greatly from one country to another and determines governments' capacity to guarantee their citizens' right to health, leading to major and growing gaps in access to basic health care, resulting in huge disparities in life expectancy, under-five mortality and other health indicators between different regions and countries and within countries.

Hand in hand with availability of resources, the capacity of national health systems is equally determined by global factors. The *availability of human resources for health care and of essential medicines* depend on a progressively globalised market, as health resources (human or material) are subject to global market dynamics of demand, supply and regulation. The effects of these dynamics can be biased against weaker economies in developing countries, resulting in brain drain of health workers and restricting access to essential (often vital) medicines. The impact of global factors cannot be fully suppressed, but it does call for developing or strengthening mitigating measures within the global system that would limit existing or future global health inequities related to *migration and trade*.

Likewise, the burden of communicable and emerging diseases is closely related to the effects of globalisation. Epidemics are seldom regional but gradually turn into pandemics. Regional and global concerted action is therefore required to address *global health security*.

Experience with SARS and other epidemics shows that global health threats will not be tackled properly unless health care services and access to health care are significantly improved in low- and middle-income countries. The present H1N1 pandemic again challenges the world, creating a need for a collective effort to devise a global and equitable strategy to address the threat which it poses.

### 2.1.3. *Research gaps*

*Research and development* to find effective tools to respond to health needs and threats is also biased by market forces. New technological and medical advances, when channelled into affordable, cost-effective intervention, have a potential positive impact on both prevention and treatment. However, while developing countries are important for large-scale clinical trials, there is little commercial interest in research on neglected diseases and in low-resource communities. The '90/10' gap - with under 10% of the world's biomedical research funds allocated to addressing problems behind 90% of the world's disease burden - remains a challenge, as concluded at the 2008 Global Ministerial Forum on Research for Health in Bamako. On the positive side, investment in research and development targeted on poverty-related diseases has significantly increased in recent years, partly as a result of more active private-sector and catalytic initiatives such as public-private partnerships (PPPs) and product development partnerships (PDPs).

**Question 1:** In your opinion, does the proposed concept 'global health' cover the most relevant dimensions? If not, which other essential factors would you suggest?

**Question 2:** Are the effects of globalisation on health, on the spread of diseases (whether communicable or life-style non-communicable) and on equitable access to health care sufficiently described?

## 2.2. RELATION TO PAST AND POSSIBLE FUTURE ACTION AND TO OTHER EU POLICIES

Article 152 of the EC Treaty imposes an obligation on the EU to ‘foster cooperation with third countries and the competent international organisations in the sphere of public health’. A new Reform Treaty is also likely to include a new objective for the EU, in its relations with the wider world, to uphold and promote the Union’s values and interests and contribute to protecting its citizens. The 2008-2013 EU Health Strategy recognises that the EC and its Member States ‘can create better health outcomes for EU citizens and for others through sustained collective leadership in global health.’

The Treaty requires the EU to respect the responsibility of the Member States for defining their health policy and for organising and delivering health services. However, all health systems in the EU are based on common values and principles that are unique and very different to the values of health systems of other countries and regions with which the EU collaborates and competes. The EU health ministers have agreed that health services must be underpinned by:

- **Universality** (access to health care must be open to everyone living in the EU);
- **Access** to good **quality** care;
- **Equity** (equal access to health care regardless of ethnicity, gender, age, social status and ability to pay);
- **Solidarity** (linked to the financial arrangements for funding health systems).

They also stated that reducing **health inequalities** must be one of the aims of health systems, as well as a shift towards preventive measures<sup>3</sup>.

### 2.2.1. EU development cooperation

The Millennium Development Goals (MDGs) remain the overarching framework for EU development cooperation. Improving health in developing countries is essential in order to reduce poverty and achieve the MDGs, three of which directly relate to health: reducing child mortality, reducing maternal mortality and combating HIV/AIDS, tuberculosis (TB), malaria and other diseases. Unfortunately, progress towards achieving the MDGs has stalled. The reasons probably again lie in weak health care services and insufficient access to health care.

The overall EU policy on health and development dates back to the Commission’s 2002 Communication on health and poverty reduction in developing countries<sup>4</sup> and the subsequent Council conclusions. The policy focuses on helping developing countries to strengthen their health care systems and providing specific support for action on the main public health challenges in developing countries. More specific work has focused on the three main poverty-related diseases - HIV/AIDS, malaria and tuberculosis. Since 2001, this has led to Communications, action programmes and, most recently, the 2009 progress report on implementation of the European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action<sup>5</sup>. Since 2005, the EU has been taking action to address the critical shortage of health workers in developing countries and has developed both an EU policy and an action programme outlining specific activities at country, regional and global levels (interim report on implementation adopted in 2008). In 2008, the EU also explored the

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<sup>3</sup> Council conclusions of 22 June 2006 (2006/C 146/01).

<sup>4</sup> COM(2002) 129 of 22 March 2002.

<sup>5</sup> COM(2004) 726 of 15 December 2004; COM(2005) 179 of 27 April 2005; and SEC(2009) 748 of 29 May 2009.

range of options for joint EU action on financing health systems and on social protection in the health sector.

All the policy areas mentioned are priorities in the policy dialogue and collaboration with developing countries in the area of health. However, there is not yet a comprehensive EU strategy aiming at strengthening the overall capacity of health systems in developing countries to deliver accessible health care – covering the priorities in mother and child care and communicable and non-communicable diseases – to wide strata of the population and at sharing other responsibilities inherent in being part of the global health system.

### **2.2.2. *International dimension of the EU health policy***

The EU is working for strong international agreements on health which are of great relevance to EU and non-EU citizens, in particular by supporting full worldwide implementation of the International Health Regulations (IHR)<sup>6</sup> and of the WHO Framework Convention on Tobacco Control (FCTC)<sup>7</sup>. These areas are included in a more comprehensive health dialogue held on a regular basis with candidate countries, potential candidates and European Neighbourhood Policy (ENP) countries, also working via regional groupings where they exist. The EU also plays a key role in the intergovernmental discussions on issues that affect health globally, such as access to medicines (the EU accounts for a large share of global R&D and patent-holders' production and a significant share of generic production) and the availability of human resources for health (with internal imbalances within the EU and, collectively, a large share of the destinations for health workers from developing countries). This ties in with the WHO-led debates on public health, innovation and intellectual property<sup>8</sup> and the World Health Assembly's<sup>9</sup> call on countries to consider establishment of mechanisms to mitigate the adverse impact on developing countries of the loss of health personnel via migration.

In the context of the enlargement policy, the Commission helps legal alignment with the *acquis* in the area of public health in the candidates and potential candidates<sup>10</sup>, and supports and monitors the implementation and effective enforcement of national legislation through various instruments of pre-accession strategy. It also monitors the public health situation in these countries.

The EU has also been a strong player in the response to global health threats and has been participating in the G7+ Global Health Security Initiative. It supports full implementation of the International Health Regulations (IHR) within the EU and is promoting implementation of the IHR outside the EU, together with the objective of reinforcing global responsiveness. In this respect, the European Centre for Disease Prevention and Control (ECDC) in Stockholm<sup>11</sup> is playing a growing international role in monitoring, assessing and responding to health threats posed by communicable diseases. Related to health threats, the EU, as the world's largest food importer, is promoting high levels of food safety, animal and plant health along with product safety at multilateral level, with a view to facilitating trade under safe conditions and improving the contribution made by these policy areas to overall health protection.

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<sup>6</sup> <http://www.who.int/ihr/en/>.

<sup>7</sup> <http://www.who.int/fctc/en/>.

<sup>8</sup> <http://www.who.int/phi/en/>.

<sup>9</sup> WHA resolution 2004.59.23.

<sup>10</sup> Candidates (Croatia, Turkey, the former Yugoslav Republic of Macedonia), potential candidates (Albania, Bosnia and Herzegovina, Iceland, Kosovo (under UNSCR 1244/99), Montenegro, Serbia).

<sup>11</sup> <http://ecdc.eu.int/>.

### **2.2.3. Global health research**

Health research features prominently in the EU Framework Programmes (FPs), the main instrument for funding research at European level. One of the objectives of EU international cooperation under the FP is to address specific problems facing non-EU countries or with a global dimension. In the area of health research, particular emphasis has been placed on poverty-related diseases, neglected infectious diseases and health systems research, particularly in Africa (the continent worst-off in terms of health indicators and progress towards the MDGs). EU-funded research activity can make a major contribution to development and universal access to basic health services. This was recognised by the EU in the 2009 report on policy coherence for development<sup>12</sup>.

However, although the FP is supporting innovation by means of investigator-led research projects in consortia linking institutions and countries, it does not necessarily have the appropriate mechanisms to facilitate long-term international product development programmes that require sustained and flexible funding. Therefore, other mechanisms have been developed, for example collaborative research with developing countries in the European and Developing Countries Clinical Trials Partnership (EDCTP). The EDCTP has a remit to develop both therapeutic and preventive technologies to combat HIV/AIDS, TB and malaria and also to engage communities and partner countries in product development partnerships, capacity-building and health research policy dialogue<sup>13</sup>, an agenda far exceeding the resources it currently has available. The EU is only one of many global players involved and private ventures (notably the Bill and Melinda Gates Foundation) are playing an increasing role.

The current focus on poverty-related diseases (HIV/AIDS, malaria and TB) should not relieve the international community of its responsibility to seek treatments and cures for currently neglected diseases. Research must also seek to develop solid and comprehensive national health strategies to ensure access to the treatments and cures developed.

**Question 3:** Do you consider the health-related MDGs a sufficient framework for a global health approach? If not, what else should also be considered?

**Question 4:** In your opinion, which are the main strengths and weaknesses of the current EU policy on health and development cooperation, and which dimensions should be given greater attention in order to face the challenges ahead?

**Question 5:** Could you identify health problems that have been neglected by the EU and international health research agenda and propose the best means to support innovation to address them, especially in low- and middle-income countries?

### **2.3. THE EU ADDED VALUE**

The EU needs to act in coordination with the rest of the world in order to generate greater coherence and impact on a global scale. EU Member States are gradually recognising the need for a strategic course, policy coherence and common values on global health. A stronger EU commitment would guarantee multifaceted support for multilateral organisations and for countries receiving development assistance. The European Commission has a key role to play in this process.

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<sup>12</sup> COM(2009) 461 final.

<sup>13</sup> Progress report on implementation of the European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007-2011), July 2009.

Three main aspects explain why the role of the EU in global health should be strengthened:

1. EU Member States and the European Commission are collectively the world's leading trading bloc, importer of food and donor of development and humanitarian assistance;
2. The increased importance of public health in the new Treaty;
3. Health research has come a long way in the EU, offering a broad spectrum of centres of excellence in training and research.

The EU should press ahead with championing globally the same overarching values on which all EU health systems are based (as defined by the Council in 2006): universality, access to good quality care, equity and solidarity. These values should underlie the principles applied in bilateral and regional relations with non-EU countries, while respecting ownership based on inclusive leadership and democratic governance.

The objectives of the proposed Communication are: to set out the present global situation and challenges regarding global health; to examine the present EU role; to determine the EU's potential for enhancing its added value on the global scene; and to promote the European social model for global health and the principles of working in partnership. The Communication should also identify guiding principles, priority areas for action and coordinating mechanisms for an enhanced cross-sectoral and collective EU 'vision, voice and action'.

### **3. THE MAIN GLOBAL HEALTH CHALLENGES TODAY**

#### **3.1. LIMITED ACCESS TO BASIC HEALTH CARE SERVICES AND SLOW PROGRESS TOWARDS HEALTH MDGS**

The report by the WHO Commission on *social determinants of health*<sup>14</sup> provides evidence of wide *disparities* in health between and within countries. Poor nutrition, unsafe water and sanitation, unsafe sexual relations, household and workplace conditions, poverty, exclusion (a strong factor in women's inequality) and poor education are the main causes of ill health. Health disparities correlate, not surprisingly, with developmental inequalities and the poverty gap<sup>15</sup>.

At least 20 million people die prematurely (half of them before the age of five) in developing countries every year for lack of adequate *access to basic health care*. They die from causes preventable or treatable at a cost of only €20 to €30 per person per year. Some fifty developing countries have to get by on public budgets below this threshold. There is wide scope for increasing existing or potential domestic revenue in developing countries which could and should give priority to health-related investment and services. Yet, even with an increased share of public revenue, at least thirty countries would need external support if they are to have any chance of addressing their citizens' right to equitable basic health care. International *aid for health has tripled* over the last decade, leading to broader coverage by services such as childhood vaccines and AIDS treatment. However, overall, health aid has

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<sup>14</sup> [http://www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/).

<sup>15</sup> The widest gap is between developed and developing countries. This gap is widest with Africa, with close to 50% loss of potential healthy lives compared with the burden of disease and average life expectancy in the European Union.

been fragmented and volatile and has not always led to improved public spending that would strengthen the capacity of health systems as such.

When public funding and pooling systems are low and weak, financing of health care is left to individuals' expenditure out of their own pocket, which has a detrimental impact on many. More than 100 million people in developing countries alone fall into poverty each year due to low economic access and paying for health care at a cost which is catastrophic for their limited incomes.

Besides the loss of health and life itself, poor health has serious *consequences* for the economy today (because of the disease burden on the active population), limits the prospects for future development (because the ill health of children undermines their education and skill acquisition), reduces social cohesion (because of health inequalities) and has an impact on security and stability (because communities affected by ill health mistrust governments and institutions unwilling or unable to guarantee their citizens' basic right to health care).

Chronic poor health and low access to health services, combined with the effects of climate change and the food and financial crises, have a direct effect on the increasing humanitarian crises. Natural disasters and political and social upheavals affect over 40 countries, leaving a combined population of more than 1.3 billion facing emergencies and humanitarian crises. Around 25 million internally displaced people and more than nine million refugees worldwide lack the most basic health care. In acute or prolonged emergencies, the health system often collapses, leaving local and national infrastructure unable to meet basic health needs. In these contexts, emerging and re-emerging health threats are more frequent and have a greater impact. Humanitarian health action can go some way towards addressing such health threats, but greater linkage with stronger pre- and post-crisis health assistance would be more effective.

There is a need to increase the coordination, levels, predictability and effectiveness of domestic and international health financing. This needs to reflect democratic and evidence-based prioritisation of national strategies aimed at universal coverage by basic health services. Information and communication technologies can support global health by providing wider access to medical knowledge and data<sup>16</sup>. Health ODA (overseas development assistance) needs greater alignment, linked to an evidence-based and participatory health sector dialogue. The EU has clear opportunities within its ODA commitments, the division of labour, the Paris and Accra commitments and the need for a more effective and coordinated health sector dialogue.

**Question 6:** Do you think that ODA commitments for health should increase, and how do you think that other sources of financing could contribute to addressing global health and universal access?

**Question 7:** How do you think fragmentation of aid for health could be reduced, with a view to increasing aid effectiveness and preventing detrimental health spending?

**Question 8:** In the context of aid effectiveness and alignment of financing to national priorities, what can be done to make sure that adequate attention is paid to health priorities and to strengthening health systems?

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<sup>16</sup> In particular, provision of mobile services and web facilities for information-sharing and training needs of health care providers is the key for health professionals working in remote primary care facilities and small district hospitals.

**Question 9:** What are your suggestions for striking the right balance between addressing health priorities and providing support for developing health systems?

**Question 10:** What are the main opportunities for increasing the level and enhancing the effectiveness of health aid from the EU?

**Question 11:** In your opinion, what are the links between health, governance, democracy, stability and security and how could the right to health be put into operation?

**Question 12:** What impact will the global crisis (climate change, food prices and economic downturn) have on global health and what could be done to help mitigate their ill effects?

**Question 13:** What should be the role of civil society in the health sector, at national and local levels?

### **3.2. INADEQUATE RESPONSE TO THE CHALLENGES WHICH GLOBALISATION POSES TO HEALTH**

Besides the correlation between ill health and poor economies with weak public financing and services, the effects of globalisation are increasingly affecting the health of every country. On the one hand, global knowledge is fuelled and shared by the exponential growth of communication and digital information, bringing progress in knowledge and tools leading to better health. On the other, the increasing flows of people, goods and potential health risks (infectious agents and toxic substances) create opportunities but also threats to every country. The net effects of globalisation are often negative on poor economies and countries with weaker institutions, thereby widening the global health inequities.

#### **3.2.1. Health workers' migration and brain drain**

*Migration* has both a direct and an indirect impact on health. Some 200 million people live in a country other than the one in which they were born. One third of them moved from a developing to a developed country. A disproportionate share of workers moving to developed countries are university-educated. The better working and living conditions, combined with the shrinking skilled workforce in developed countries, are leading to a growing brain drain from the public to the private sector - including NGOs and international agencies - from rural to urban areas and from developing to developed countries.

The crisis in human resources for health is global, with 75 countries having fewer than 2.5 health workers per 1 000 population, which is the minimum necessary to deliver basic health services, such as 80% immunisation coverage. Sub-Saharan Africa is the region facing the greatest shortage. Despite numerous bilateral and regional agreements, the pull effect of widening economic gaps is continuing to drain knowledge, skills and social commitment away from developing countries.

In 2006 the EU adopted a policy and action programme<sup>17</sup> to tackle the critical shortage of health workers in developing countries. At the same time, it is beginning to explore options for action to produce and manage its own health workforce (the Green Paper on the European workforce for health adopted in 2008<sup>18</sup>), as it too is suffering from an internal and external brain drain. The EU is the biggest sender of health professionals to the USA. Various Member States are finding it increasingly difficult to attract health professionals to under-served areas

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<sup>17</sup> COM(2006) 870 of 21 December 2006; and SEC(2008) 2476 of 16 September 2008.

<sup>18</sup> COM(2008) 725 of 10 December 2008.

and sectors. But in tackling its own health system challenges, the EU must face up to the challenge of *ensuring the coherence of its internal and external policies*. It must tackle its own health system challenges in a way that has no negative impact on the capacity of health systems in non-EU countries. EU health systems would equally benefit from sharing learning with classic sending countries on how to retain health staff in under-served settings.

The WHO-led work on a *code of conduct for international recruitment of health personnel* offers a framework within which the EU can play a significant role and work towards delivering on its own commitment to adopt a set of principles to guide recruitment from developing countries. The EU and other regions should share best practice, particularly on understanding the scale, relevance and directions of health professional mobility, the reasons behind it, its possible implications and the best ways to respond to it.

### **3.2.2. Access to medicines**

The growing levels and liberalisation of international *trade in goods and services* have a direct effect on access to basic medicines and commodities in developing countries. In particular, GATS (General Agreement on Trade in Services) negotiations have the potential to limit the effectiveness of health care delivery if they are geared too much to disease control, thereby limiting patients' opportunities to receive comprehensive care for other, equally threatening, conditions. Developing countries account for more than 80% of the world's population, but for only about 10% of global sales of medicines (totalling over €600 billion). The market alone, and the incentives that propel it such as patent protection, cannot address (by means of research, development and affordability) the health needs of developing countries by themselves.

During the decade now drawing to an end, the TRIPS Agreement (on the trade-related aspects of intellectual property rights) has provided an appropriate framework, in particular due to the flexibility it offers, to allow access to medicines for developing countries. Generic competition has significantly cut the price of antiretroviral combination therapies in developing countries (20-fold decrease). There is no reason for this trend to stop, even though countries like India, which is the main source of generic medicines, have been under an obligation to implement patent product provisions of the TRIPS Agreement since 2005. New challenges are likely to appear in the years ahead, as least developed countries will also need to apply the pharmaceutical-related provisions of the TRIPS Agreement by 2016. Another global challenge is the growing number of bilateral and free trade agreements. The Commission makes sure that nothing in the agreements it is negotiating will affect access to medicines, in particular for the poor and least-developed countries.

The WHO *Global Strategy and Plan of Action for Public Health, Innovation and Intellectual Property* provides a framework in the TRIPS Agreement by promoting access to medicines while also promoting innovation.

### **3.2.3. Vulnerability and response to global health threats**

The exponential increase in international travel, migration and trade, together with other factors such as climate change, is adding to the risk of emergence or re-emergence of *international disease threats* (epidemics and antimicrobial resistance) and other *global health risks*. There is wide recognition of the need to prevent, predict, detect and react to the international spread of disease. These challenges are addressed by the *WHO's global alert and response system*. The major disease control programmes and the frameworks for

screening and controlling *food and environmental safety* are key components of the global and national health security strategies.

Over the last decade, the threats of both SARS and avian flu pandemics have mobilised resources and coordination systems. As a result, the world today is better equipped for data collection, analysis and communication than ever before. During the next decade Europe has an opportunity to maximise the contribution made by its collective resources and capacity (including the growing role of the ECDC) to combating the global health security challenges. The response to health threats requires a global coordination mechanism which the WHO should lead effectively and also needs to be equitable.

The 2007 *International Health Regulations* -a legally binding agreement between 194 States - lay the foundation for coordinating management of public health emergencies of international concern. However, developing countries face limitations as they strive to improve their surveillance and response capacity so that they will be operational by 2012. The structural problems are very similar to those mentioned in connection with the challenges facing overall health systems. At global level, the present H1N1 flu threat, in which almost all the production capacity is fully booked by wealthier countries, is a clear example where a global governance framework promoting equity should overrule market dynamics.

To sum up, the brain drain and poor access to comprehensive care and medicines are further widening the global health gaps and undermining the response to global health threats. Clear global frameworks have been established, or are starting to be, or have been developed to address this challenge in which the EU can and should play a major role while also increasing the coherence of its internal and external policies and action on global health.

#### **3.2.4. Global health governance**

The interdependence produced by globalisation has turned health into an increasingly important challenge and responsibility for foreign policy and governance at all levels. Whereas the UN and its specialised agencies should formally lead on global health, there is a risk that, even with the best intent, non-inclusive initiatives (there are over 140 global health initiatives at present) could undermine democratic governance and the effectiveness of responses to the challenges posed by growing interdependence.

There is therefore an urgent need to find shared values and approaches in the area of global health that would be embodied in relations between countries. Recognition of the need for policy coherence, strategic direction and a common value base in global health is beginning to emerge at the level of nation States. A few European countries are beginning to address global health more consistently at national level by mapping many global health activities across all government departments, establishing new mechanisms for coordination within government and developing a 'national global health strategy', frequently on the initiative of the international departments in the Ministries of Health. The financial crisis has also pushed foreign security policy-makers to set a clear agenda for moving at least global health security higher up the foreign policy agenda. But foreign policy and global health are not only relevant to national health security and development.

Health and foreign policy are also crucial for alliances, for reputation and for trade issues. In all these areas, health and governance are intrinsically entwined.

Foreign policy, for instance, has a significant impact on development cooperation, but the same is true for the influence of development on foreign policy.

The objectives at EU level are, pursuing a multilateral approach, to build strategic alliances and collaborate effectively with global health partners, to enhance the EU's role and effectiveness in global health and to contribute to shaping the global health agenda. In order to achieve these objectives, the Community and Member States will need to examine how to reduce the fragmentation and increase the coordination and coherence between their existing activities. In this context, a more strategic partnership should be developed with the WHO at both global (WHO HQ) and European (WHO EURO) levels to ensure synergies and policy coherence.

**Question 14:** Which action do you think the EU should take to stem the brain drain of health workers, while respecting their freedom of movement?

**Question 15:** What role do you see for new technologies (including telemedicine) in enabling developing countries to provide access to care even in remote areas and to allow better sharing of knowledge and expertise between health professionals, and how can the EU support this?

**Question 16:** What are the keys to ensuring equitable access to medicine and how could the EU help to do more on this, including by supporting innovation and management of intellectual property rights?

### **3.3. LOW LEVEL AND EQUITY OF INVESTMENT IN GLOBAL HEALTH RESEARCH**

In a changing world with growing inequities and health threats, there is an even greater need for more research addressing the health needs of poor populations, including those diseases which disproportionately undermine their health and livelihoods. This research must be translated into effective policies and action.

Twenty years ago, the *Commission on Health Research for Development* found that only 5% of the total funds were spent on research addressing the problems facing developing countries, which were bearing 93% of the global burden of disease. It called for an increase in international support for health research (setting targets of 2% of national health expenditure and 5% of international health ODA) and for more effective coordination and compliance with the principles of 'essential national health research' (ENHR) addressing ownership, participation and the pertinence of health research (the 'Alma-Ata' of health research).

In the current decade resources for health research and innovation have increased considerably (more than five-fold since 1986 to €150 billion/year), coinciding with increased interest by new players (philanthropists, public-private partnerships and product development partnerships<sup>19</sup>). These positive developments have led to diversification but also fragmentation of research funding, raising the issues of critical mass, thematic overlap and the accountability and transparency of the individual bodies and organisations funding research relevant to global health.

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<sup>19</sup> In May 2009, the draft Commission Staff Working Document entitled 'Progress report on the implementation of the European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007-2011)' reaffirmed the pivotal role of product development partnerships.

Investment in research remains necessary, but the results must reach low-income countries as well. Local ownership, training and retention of human resources for research are crucial. Over half of global health research is financed by the private sector and this area is expanding faster. The deficits surrounding health research mirror those in health care provision: *volume, equity, ownership* and the link between the two as regards *evidence-based decision-making*.

As regards the levels of health research in developing countries, very few countries have progressed towards the 2% target. Overall there is still a 90/10 gap, while health disparities between and within countries are widening. North-South research partnerships must be designed in an equitable fashion and funding needs to be sustained beyond the often short-term investment in a research project.

Health research agendas are often dominated by basic science to develop new treatments. However, it has been shown that increased research on delivery and use of such treatments can be far more effective<sup>20</sup>. Greater attention to implementation science and health services research is therefore warranted.

While over 40% of health ODA takes the form of ‘technical assistance’, it is not always based on current research and the best evidence available. Policy-makers and researchers must make continuous efforts to transmit and translate research findings into evidence-based decisions. Evidence-based policies can only be grounded in country-led research and learning that can be backed up by global support. This requires domestic leadership and sustained investment in local capacity-building for analysis and learning, robust systems for monitoring and evaluation, and better direct access for country-based researchers to funding opportunities. This will allow design and management of health systems that offer universal and equitable access with the necessary inputs (financing, HR, supplies, IT, governance, etc.) that are based on the best evidence available and respond to local needs and realities.

Participatory and action-led health systems research in line with the ENHR principles should be supported. As with access to medicines, the WHO *Global Strategy and Plan of Action for Public Health, Innovation and Intellectual Property* provides the framework.

### **3.3.1. The challenge of global public goods**

Besides the challenges of health research itself, the agenda on ‘*global public goods for health*’ (GPGH) is stagnant. Many definitions and consequent priorities have been suggested. The underlying argument is that investment in GPGH, either globally or with a focus on developing countries if required, offers a direct return and benefits for the developed world as well. The clearest example is eradication of a disease (e.g. polio, by a vaccine), which will bring global and generational gains. In a related sequence, development of new and improved drugs, vaccines, diagnostics, microbicides and tools for disease control or prevention (e.g. an AIDS vaccine) or detection or development of basic knowledge of a priority global health problem (e.g. Alzheimer’s pathogenesis) would deserve concerted global attention and financing in addition to development funds. Other proposed global public goods include the international legislation on health and trade (see section 2.2.2) and provision of health systems as access goods.

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<sup>20</sup> Leroy, J.L. et al.: ‘Current priorities in health research funding and lack of impact on the number of child deaths per year’, *Am. J. Public Health*, (207) 97; 219-223.

Creating a common framework for health systems research (research methods to assess strengths and weaknesses of health service intervention and factors influencing them) that can be applied equally in low-resource settings could be one such global public (access) good. The EU could be in the best position to help create such a framework, building on the ongoing comparative analysis of and joint learning from the different health systems in the EU that are all based on the common principles of universality, equity and solidarity.

To sum up, global health research lacks equity, to the detriment of the health challenges facing developing countries. A strategic analysis parallel to the analysis of the challenges facing health systems in developing countries can be applied to global health research. It will require higher levels of health research from and for developing countries (both in bio-medical fields and on organisation of health care systems and policies), greater equity and pertinence, improved ownership and participation and a more structured and effective link with evidence-based decision-making. The goals of harmonisation and alignment must be applied equally to global health research, where the funding is currently fragmented. To complement these principles, the agenda on global public goods for health offers solid arguments for global investment in the advance of humanity in the health sector, beyond and in addition to development and research efforts. In the EU, the new partnership for international S&T cooperation<sup>21</sup> could play an important role in helping to coordinate the many separate research and development activities undertaken by the European Community and Member States.

**Question 17:** What could the EU do to improve the research funding for global health?

**Question 18:** How, in your opinion, could the EU research funding effectively address the systemic weaknesses of health systems worldwide?

**Question 19:** How do you think national capacity and local scientists in low-income countries could be empowered to conduct research relevant to their countries' priorities?

**Question 20:** Which kinds of global public goods for health should be given priority and how should they be financed and managed?

#### **4. MAIN POLICY OBJECTIVES**

The objective of this consultation is to identify the global situation and challenges and the present EU role and potential added value on the global scene and to promote the European social model for global health. This will allow identification of guiding principles, of priority areas for action and of coordinating mechanisms for enhanced cross-sectoral and collective EU leadership.

In this context, the main principles which could apply to all internal and external EU action related to global health would be based on the common values that underpin all health systems in the European Union<sup>22</sup> and include:

1. **Subsidiarity and local ownership:** The EU will continue to promote good governance with participatory and democratic processes to enable national and local

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<sup>21</sup> COM(2008) 588 final of 24 September 2008, Communication from the Commission to the Council and the European Parliament 'A Strategic European Framework for International Science and Technology Cooperation'.

<sup>22</sup> Council conclusions of 22 June 2006 (2006/C 146/01).

decision-makers to take the most effective and evidence-based decisions when they reform their country's health system.

2. **Equitable and universal access to good quality health care:** Everyone in every country should be able to benefit from health care and innovations in medical sciences. EU policies should give priority to populations at greater risk and with lower resources to access quality health care. The EU social model could be a model for universal coverage of basic health care, responding to the priority health needs of every citizen in the world.
3. **Solidarity:** The health needs of all citizens in the world need to be taken into account when formulating EU policies related to health. In order to address the present equity challenges effectively, the EU will maximise its potential solidarity and its cohesion and external aid procedures to address internal and international health challenges. The EU, as the world's leading donor, will make every effort to comply with its ODA commitments, including paying the appropriate attention to health.
4. **Evidence-based policies for health:** The EU will support the research necessary for managing and delivering effective health care. It will also ensure that global health policies are based on sound evidence. Learning from experience in other parts of the world will help to improve the health of Europeans as well.
5. **Coherence:** The above-mentioned principles should apply to all EU policies which directly or indirectly affect health in the EU and non-EU countries. The main policies which will require special attention are development (of local capacity), mobility (mitigation of the effects of brain drain), trade (ensuring access to essential medicines for the poor) and research (equity of priorities on global health research and development of new medicines and measures).

The main priority areas include the need to:

1. *Increase fair access with a view to universal coverage of basic health care:* Partner countries' strategies and efforts need to enhance access to basic health care. The EU is playing a major role in complementing those efforts and leading health support in emergencies. There is a need to increase the collective EU levels of ODA (linked with the EU Agenda for Action on MDGs and the prospects beyond 2010 and the existing commitments on ODA: 0.7% of GNI), to address the geographical distribution of health ODA (linked to the need to apply the division of labour to key sectors, such as health) and to ensure the continuum of health support and delivery of services in fragile contexts. In parallel, EU health ODA is highly fragmented and its level of alignment needs to be increased (in line with the commitments given in Paris and Accra) behind comprehensive national health strategies, based on coordinated and effective health policy dialogue (as recommended by the Court of Auditors). At the same time, the European Commission will update health and development guidelines in order further to support the EU's collective capacity and voice in the health sector dialogue and to work with Member States on developing innovative approaches to strengthen the EU's competence and capacity for health policy dialogue.
2. *Improve the EU's coherence and enhance the EU role in global health:* The EU's internal policies and action on migration of health workers, trade and access to medicines and the response to global health threats need to be coherent with the EU Consensus on Development and the overarching EU principles on global health outlined in the Framework Communication. Such coherence will enhance the EU's

role and voice in the global frameworks already established, or starting to be, or being developed in these areas.

3. *Strengthen joint learning through global health research:* In parallel and coordinated with the challenges and priorities for EU health ODA, global health research requires more (bio-medical and public health) research from and for developing countries, greater equity and pertinence to the priorities in developing countries, improved ownership of the national institutions and participation by civil society and a more structured and effective link with evidence-based decision-making, closely linked to the EU challenge of enhanced bilateral and multilateral dialogue on health sector policy. The global research funding arrangements need to be better harmonised and aligned and attention needs to be paid, at international level, to the challenge of *global public goods for health*, including global investment in health, beyond and in addition to development and research efforts.

**Question 21:** Which do you think are the priority areas for coherence on global health policies, and how should they be addressed?

**Question 22:** How could the legitimacy and efficiency of the present global health governance be improved and which role should the EU play in this?

**Question 23:** Do you think a definition of a universal minimum health service package would facilitate a rights approach and progress towards more equitable coverage of services? If so, how could such a universal minimum standard be defined?

**Question 24:** What, in your opinion, should be the main principles guiding equitable social protection for health?

**Question 25:** Which fair financing principles and mechanisms should apply to health system financing to ensure equitable and universal coverage of basic health care?

**Question 26:** What is the role of civil society in global and national health governance and how can potential conflicts of interest between advocacy and service provision be avoided?

**Question 27:** What, in your view, is the main added value offered by the EU in the field of global health?

**Question 28:** Do you think that an EU social model could inspire global health equity?