EU HEALTH CHEQUE

Save the Children

A Review of The European Commission's Support to the Health MDGs

Cover Photo: Kadija, one year old, a success story at a Save the Children-supported, government-run facility providing nutrition services in north Nigeria

Credit: Lucia Zoro/Save the Children

Save the Children works in more than 120 countries. We save children's lives. We fight for their rights. We help them fulfil their potential.

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Some names in case studies have been changed to protect identities.

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Executive Summary

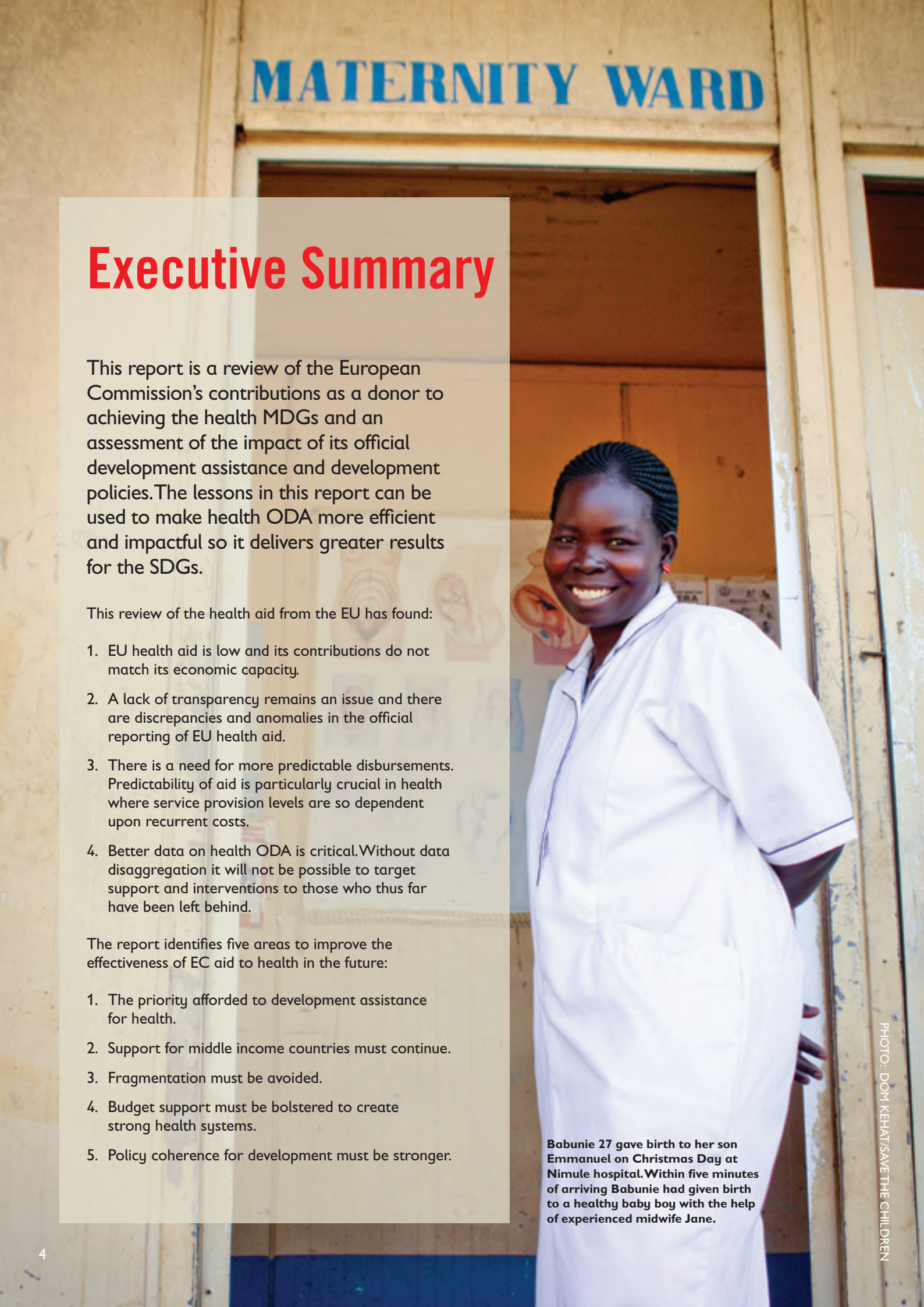
This report is a review of the European Commission's contributions as a donor to achieving the health MDGs and an assessment of the impact of its official development assistance and development policies. The lessons in this report can be used to make health ODA more efficient and impactful so it delivers greater results for the SDGs.

This review of the health aid from the EU has found:

1. EU health aid is low and its contributions do not match its economic capacity.
2. A lack of transparency remains an issue and there are discrepancies and anomalies in the official reporting of EU health aid.
3. There is a need for more predictable disbursements. Predictability of aid is particularly crucial in health where service provision levels are so dependent upon recurrent costs.
4. Better data on health ODA is critical. Without data disaggregation it will not be possible to target support and interventions to those who thus far have been left behind.

The report identifies five areas to improve the effectiveness of EC aid to health in the future:

1. The priority afforded to development assistance for health.
2. Support for middle income countries must continue.
3. Fragmentation must be avoided.
4. Budget support must be bolstered to create strong health systems.
5. Policy coherence for development must be stronger.



Babunie 27 gave birth to her son Emmanuel on Christmas Day at Nimule hospital. Within five minutes of arriving Babunie had given birth to a healthy baby boy with the help of experienced midwife Jane.

PHOTO: DOM KEHAT/SAVE THE CHILDREN

RECOMMENDATIONS

The European Commission should:

1. Commit to prioritising health in the review process of the 2014-2020 MFF and ensure that commitments to health match the levels of funding of the previous budget.
2. Aim to invest a greater amount than the 20% of EC's Development Cooperation Instrument in basic health and education that is the legal minimum benchmark.
3. Put UHC at the heart of EU global health policy to ensure that all health targets of the SDGs can be achieved, while prioritising access to health of children and mothers. Ensuring the transparency and predictability of the disbursements of funds will help foster UHC.
4. Review the process by which the EU sets priorities with partner countries to ensure that aid and needs are well aligned and health-sensitive.
5. Strengthen the capacity of EU delegations to engage in health dialogue by creating a team of regional advisers specialised in health.
6. Review aid graduation policy to ensure that withdrawal of support is sustainable. Identify and engage in other means of supporting MICs to achieve the health targets such as through EC role in GAVI and GF boards.
7. Prioritise sector budget support as the main means of financing the health sector and ensure that aid fosters integrated health systems, rather than fragmented projects.
8. Enforce strong policy coherence for sustainable development in all internal policy, including in trade and migration as part of SDG implementation to ensure that EU internal policy does not impede on partner countries' ability to achieve the SDGs.
9. Urge EU member states to recommit to the 0.7% UNGA target for ODA, a critical enabler for improving human development outcomes and generating much needed additional funding to invest in global health.
10. Support the monitoring of efforts to reach the most disadvantaged and excluded populations as part of the EU´s commitment to the SDGs: support initiatives and new methods to strengthen data collection, disaggregation, particularly by age and gender, and analysis of status and progress among population groups who are excluded.

Rabia, seven months, with her mum, at a malnutrition clinic, north Nigeria

PHOTO: LUCIA ZORO/SAVE THE CHILDREN

The Story in Numbers

The health MDGs have generated substantial progress for global health.

45% fewer women and girls die during child birth

40% fewer cases of **HIV** are occurring

58% fewer people are dying from malaria and **45%** from TB

But still…

68 Million children under the age of five will die of preventable causes by 2030

44% of children under 5 dying now die within the first 28 days of life compared to **37%** in 1990

How does EU support measure up?

€3536.5 million of ODA went to health between 2007 and 2013

This represented **7.7%** of total international aid from the EC

Only **0.007%** of total EU GNI is used as development assistance for health

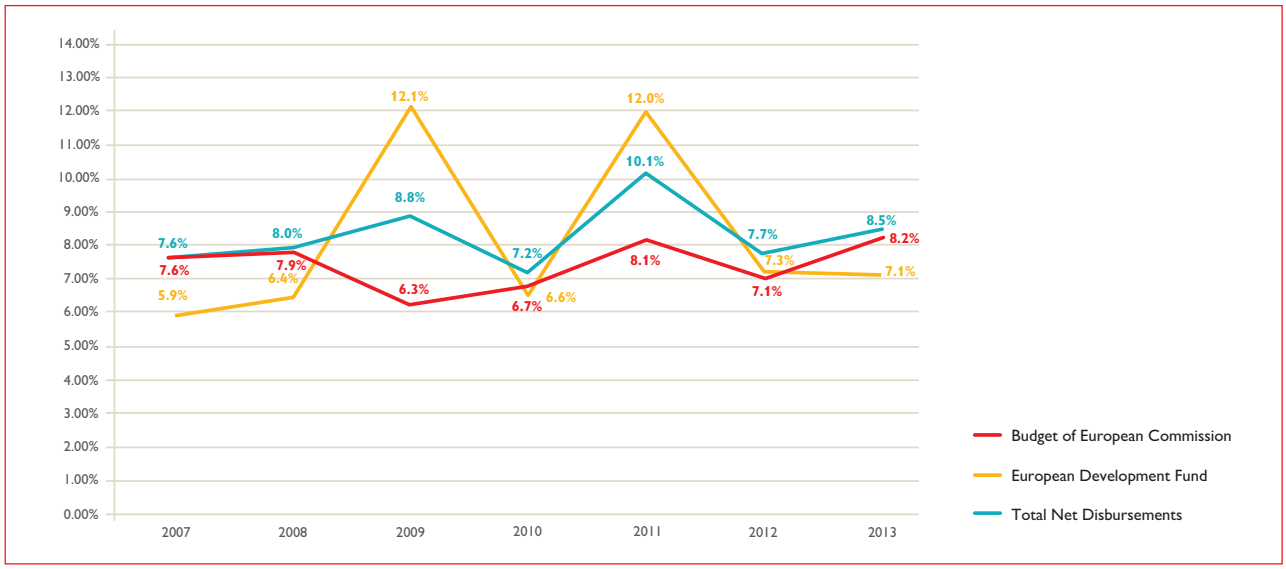
23 out of 79 – the score the EU received from partner Ministries of Health when asked whether it shared information plans for at least three years ahead with them in a 2014 international performance review (by IHP+)

What can be done?

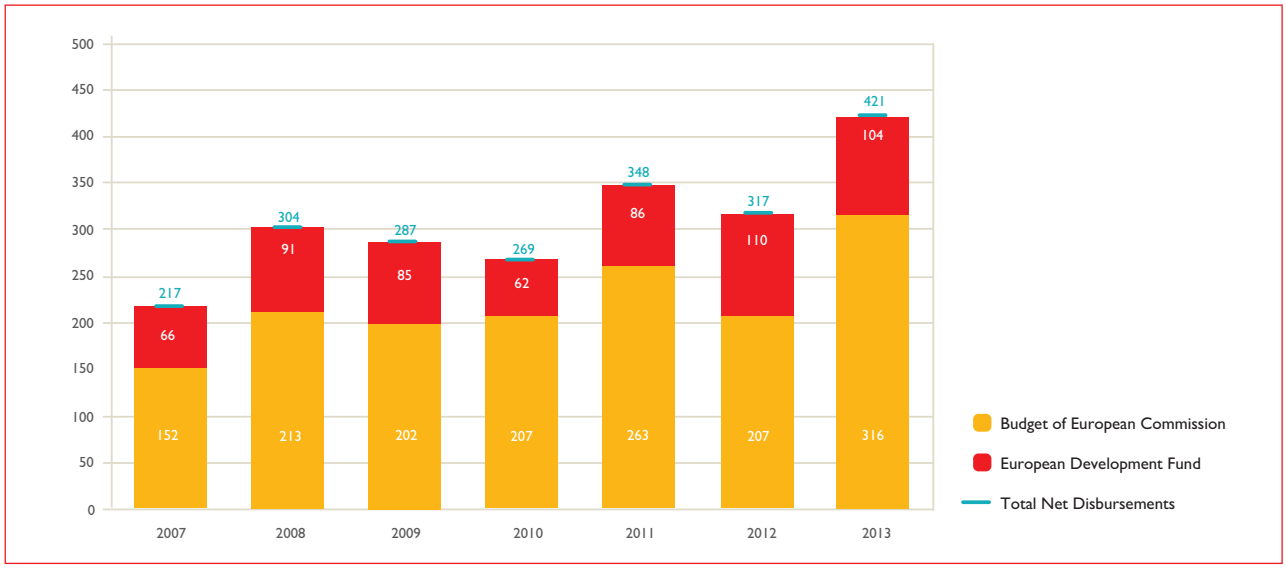
€41 billion of extra funding could be generated if the EU and its member states collectively met the 0.7% UNGA target for development assistance.

The Story in Numbers

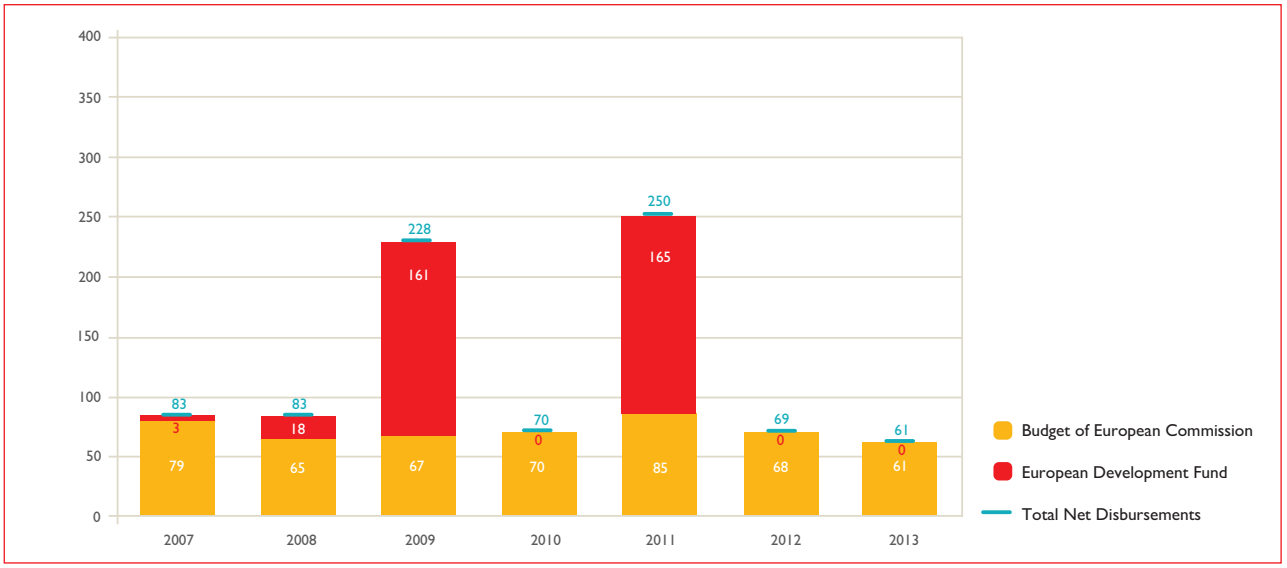
Health as percentage of total Disbursements of ODA Grants Made by EU institutions by Financing Instrument



Bilateral ODA Disbursements in the form of Grants for Health Sector Programmes, in million euro



Multilateral ODA Disbursements for Health, in million euro

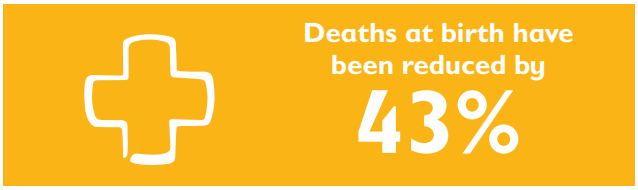


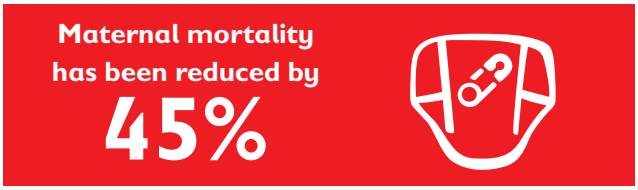
Deye Lomong is three years old. When he was brought by his mother Nawii Lomong, to the stabilisation centre in Riwoto, Kapoeta North in March 2012 with cough and diarrhoea, he weighed just 10kg – a healthy boy of Deye's height should weigh 13kg. After just five days of treatment, Deye had already gained 500g. He had progressed from therapeutic milk to therapeutic; he was able to sit up alone, feed himself, and had fully regained his appetite. Deye is from Kop village in Paringa Payam, Eastern Equatoria state.

PHOTO: AMY REED/SAVE THE CHILDREN

Introduction

In 2000, the European Union, along with many states and institutions, made a pledge to support the achievement of the Millennium Development Goals (MDGs). Health was the most prioritised issue among the MDGs with three of the eight goals focused on the world's main health challenges. Since the onset of the MDGs, many accomplishments have been made amongst which:





Despite these accomplishments, none of the health goals were achieved by the target year of 2015. **It is estimated that 68 million children under five will die by 2030,** mainly from preventable causes, unless the international community takes bolder steps to prevent this[1].

Health is fundamental to the process of development. In many developing countries, health challenges are robbing children of their opportunity to learn, to thrive, and to survive. Significant progress is still needed not only to attain the targets set out by the MDGs, but to take on the new agenda of the Sustainable Development Goals (SDGs). SDG 3, the health goal, aims to 'ensure healthy lives and promote well-being for all at all ages' by tackling various global health challenges across the world. It includes a set of thirteen targets and a broader range of health issues such as non-communicable diseases (NCDs), road traffic accidents, and a target on strengthening capacity to mitigate and manage the risks associated with epidemics.

The SDGs also offer an important new target on the achievement of universal health coverage (UHC). This target on UHC is important because it embodies the overarching principle that will allow countries to meet the rest of the health targets that deal with specific diseases, reforms, and population groups. Put simply, having access to quality health care, for all people, regardless of where they are from and what they can pay, is critical to meeting other health challenges and raising indicators. Supporting UHC through access to free services at the point of delivery, particularly by targeted intervention for those groups which are currently excluded, such as children who are excluded by their ethnicity, gender, or by the region in which they live, is part of the solution to reducing the risk of preventable child death.

In light of the more ambitious SDG health agenda, focused on systemic change, an understanding of why the achievement of the health MDGs has failed is required. This report serves as a review of the European Commission's contributions as a donor to achieving the health MDGs over the 2007-2013 Multi-Annual Financial Framework (MFF) and an assessment of the impact of its official development assistance (ODA) and development policies. The European Commission (EC) is an important development actor. It is one of the largest health donors in the world and it has the unique capacity to coordinate among the 28 member states of the European Union making it a key actor in delivering aid more efficiently. The lessons in this report can be used to make health ODA more efficient and impactful so it delivers greater results for the SDGs.

Mobile health clinic set up by Save the Children in San Dulag, Philippines

PHOTO: KRISTA ARMSTRONG/SAVE THE CHILDREN

SECTION 1:
THE CHECK-UP

In 2004, the European Parliament (EP) adopted a benchmark to allocate 20 percent of EU ODA under the Development Cooperative Instrument (DCI) to basic health and education by 2009. The purpose of the benchmark was to encourage the EC to invest more on human development. Despite this however health has always represented less than 10% of overall EU budget funding (see Table 1). **Over the course of the last MFF, the total disbursements on health from the EU budget totalled €3536.5 million and averaged at approximately 7.7% of total ODA.**

A key finding is that while the EU does provide large contributions to health as the third largest provider after the US and UK, its contributions visibly do not match its economic capacity. Even when health funding from the EU budget is combined with health funding from the European Development Fund (EDF) it still represents just 0.007% of total EU GNI[3]. This is disappointingly low given that development assistance for health is facing a difficult period. Current trends indicate that many DAC donors including EU member states are reducing their ODA for health. This is despite WHO estimates in 2001 that if DAC donors contributed just 0.1% of their Gross National Income (GNI) to global health, it would be possible to deliver universal health coverage in almost every low income country[4]. The only exception to this trend has been the UK, which continues to increase its funding as percentage of GNI to the health sector[5]. Most EU DAC donors have failed to achieve the 0.7% GNI commitment to ODA established in a UN General Assembly resolution as well as the 0.1% of GNI target contributing to the underfunding of health sectors. It is estimated that the collective failure of the EU to meet this 0.7% target has resulted in a funding gap of €41 billion for development[6].

This funding gap in ODA has devastating consequences for the health sector. Such a disparity between the financial support to health and its priority as a development objective has been highlighted by the European Court of Auditors in its health reports. While much of current aid rhetoric has focused on domestic resource mobilisation and increased expenditure to health by developing states, most of the poorest countries remain unable to allocate funds from their budgets, frequently due to fiscal pressure placed on them by international financial institutions to reduce government expenditures, that are substantial enough to meet even the most basic health needs, even if they meet the 15% health expenditure target set in Abuja[7]. For this reason, it is crucial that European Commission commits itself to increasing its support for health.

	2007	2008	2009	2010	2011	2012	2013
Health ODA	465.3	508.5	458.6	470.6	573.2	486.1	574.2
Total ODA	5,768.9	6,307.9	7,020.7	6,859.4	6,616.7	6,588.2	6,589.3
Health as % of total ODA	**8.1%**	**8.1%**	**6.5%**	**6.9%**	**8.7%**	**7.4%**	**8.7%**

TABLE 1 DISBURSEMENTS DURING MFF 2007-2013 (IN € MILLIONS)[2]

Lack of transparency remains an issue impacting health and other sectors. Many of those interviewed for the purpose of this research stated their concerns about the differences between the European Commission's commitments and the actual disbursements of aid. Part of this is due to delays in disbursements on the ground, but also due to the methodology used by the EC for calculating its own ODA. The Commission uses different DAC codes in its annual reports than those used in aid reporting to the OECD, creating large mismatches with what is reported from one source to another. This creates lack of clarity about how much ODA is really being allocated. When the European Commission was contacted for the purpose of this review, the amounts of health ODA they reported from the EU budget totalled only €1769 million, only half of the amount that we calculated[8]. In order to account for the quality as well as quantity of spend, including to the taxpayer, there must be greater transparency in data on aid.

There is need for more predictable disbursements. The EC has committed to being an accountable donor through its membership to the International Health Partnership (IHP+), a global partnership of international organisations, bilateral institutions, and states committed to applying principles of aid effectiveness and development cooperation to development practice in health. But monitoring from the partnership shows there is progress to be made. The 2014 Performance Review, calculated by surveying partner Ministries of Health, gave the Commission a score of 79% below the target of 90% on the predictably of the disbursements of funds in 2013. This is a substantial decrease from the 2010-2011 period when it achieved a score of 93%. On the indicator for whether partner governments had information on the Commission's expenditure plan for at least three years ahead, the EC scored a very poor 23% compared to the target of 79%. This is contrary to the agenda set out in the "EU's Role in Global Health" Communication which outlined that EU health ODA should offer predictability of at least three years. While the MFF allocation reviews have previously remained stable, partners do not experience this predictability at country-level. This has huge consequences for a sector like health. Whether it is building hospitals, training doctors or delivering better maternity care, predictability is key to being able to invest in the sector for the long term.

Better data on health ODA is crucial. Currently it is unclear how much of EU health ODA goes to rural versus urban areas or to different regions of a country, despite these being important clues into whether or not aid is reaching the most vulnerable. Monitoring this type of information, which at the very least should include gender and age, through the development of disaggregated data sets, called for by Agenda 2030, would allow us to ensure that those who have the most need are not left behind by EU funding.

PHOTO: ABIR ABDULLAH/SAVE THE CHILDREN

Village doctor Ibrahim Chowdhury (60) at his small chamber at Ratnabazar, Poilarkandi, Hobiganj

SECTION 2:
THE DIAGNOSIS

While levels of funding are important, assessing the use of those funds and their impact is also key. Save the Children conducted interviews with several actors in the sector in Brussels and at country level to evaluate the impact of EC policies and approaches to global health and the achievement of the health MDGs. These included individuals working on global health within NGOs and other civil society organisations, within the WHO, and within the European Institutions themselves. These discussions identified five recommendations to improve the effectiveness of EC aid to health in the future:

1 **Development assistance for health** must be prioritised.

2 **Support for middle income** countries must continue.

3 **Fragmentation** must be avoided.

4 **Budget support** must be bolstered to create strong health systems.

5 **Policy coherence** for development must be stronger.

1. DEVELOPMENT ASSISTANCE FOR HEALTH MUST BE PRIORITISED.

The Agenda for Change is causing a de-prioritisation of health and the EU must ensure that it reverses this trend. The Agenda, adopted in 2011, is the EU's latest development policy framework aimed at increasing the impact and effectiveness of its aid. Prior to the inception of the Agenda, partner countries could select multiple sectors to receive support in, which allowed for more flexible and multi-dimensional interventions. Now, EU support is limited to no more than three priority sectors, proving to be a key barrier to ensuring that health remains a priority. As a result, it is estimated that the Commission now only assists 19 countries in health within its geographical programming.

Part of the reason for de-prioritisation is that there is **little opportunity to champion health during the cooperation negotiation process.** Priority-setting on cooperation is highly dependent on the expertise in delegations but there is very little capacity for health dialogue within them. Very few delegations have personnel qualified in health or medicine and where such experts exist, few work solely on health. Moreover Ministries of Health are rarely invited to the negotiation table and have a low capacity to advocate for themselves. This reduces further the space to set health as a priority for partnership. **In addition to this, interviewees reported a negotiation process that lacked local ownership.** Rather than selecting priority areas based on the domestic needs of partner countries, they were imposed by EU delegations. This was corroborated through interviews with officials from the Nigerian Federal Ministry of Health who reported the imposition of a cooperation agenda[9]. This gap between what the EU is willing to help with and what is needed at country level must be addressed.

Concerns about capacity for health dialogue are not new. This issue was flagged early in the MDG period by the Commission itself. It recognised its own lack of in-house capacity for health dialogue at country-level. There is a solution: the EU could develop a regional team of health specialists that could provide support to delegations and improve health capacity.

The decreasing commitment to health puts the achievement of health targets at severe risk at a critical time. DAC reporting for 2014 indicates that

the EU Institutions had only committed 2.9% of ODA to health (€481.58 million in current prices). Such a low level of support for health is at odds with the goals set out in the European Consensus for Development and the Development Cooperation Instrument which outlined the EU's commitment to reducing poverty worldwide by assisting in the achievement of the MDGs and which prioritised human development, including health, as one of the key areas of activities the EU would work on with partner countries. The fact that health spending represents a slice of an overall shrinking pie is one issue: the budget for the Development Cooperation Instrument in 2014 is 11.4% lower than that of the previous year at €2341.0 million. This inevitably suggests that even if the EC continues to pursue the 20% benchmark to health and education, funding will be approximately €300.6 million less than it was previously. Yet continued funding for health is crucial if we are to achieve UHC since many of the world's poorest are faced with paying out-of-pocket payments (OOPs) in order to receive the health care they need. Currently, OOPs are so important that in developing countries patient fees represent 30% of the financing for health systems, creating unequal access to health care in regions where need is greatest[10]. It is crucial that the European Commission recommits itself to prioritising the right of the world's poor to receive the health care they need and increases its funding across countries in order to ensure that no one is left behind in the achieving SDG3.

PHOTO: COLIN CROWLEY/SAVE THE CHILDREN

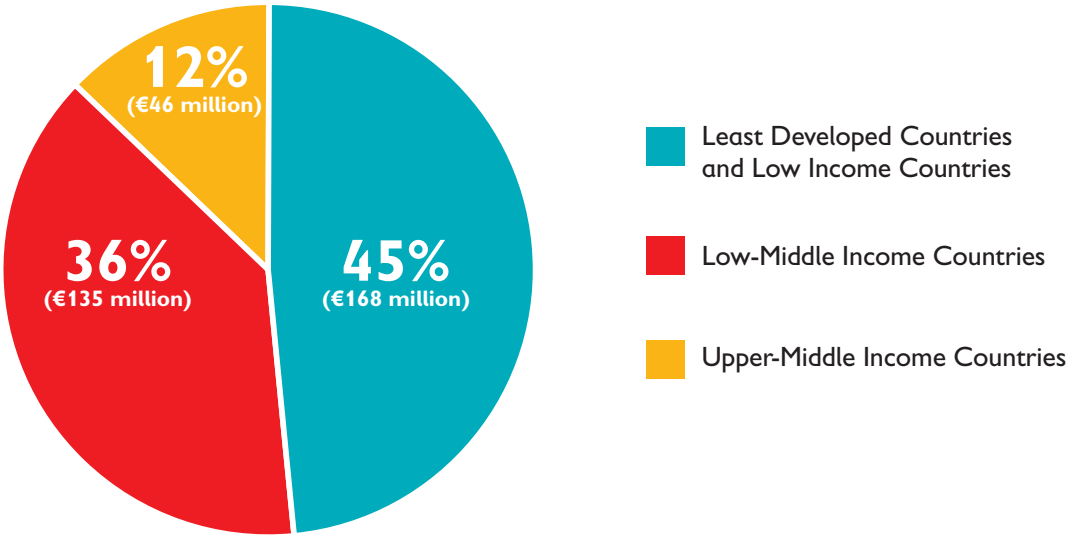
Save the Children doctor Hillary Okiya examines Gabriel, two, in the pediatric ward at the Nimule Hospital in South Sudan.

2. SUPPORT FOR MIDDLE INCOME COUNTRIES MUST CONTINUE

EU financial support to middle income countries is decreasing but the EU must look at other means of supporting MICs to achieve their health targets. Under the Agenda for Change, grant-based bilateral aid to 'more advanced developing countries' was considered no longer viable and led to the introduction of the principle of differentiation. Under this principle, upper-middle income countries are beginning to graduate from EU support and EU focus is shifting towards low income countries with the view of having greater impact and to promote poverty reduction.

The problem with this shift is that it contradicts the Agenda for Change's focus on poverty reduction given that up to 80% of the world's poor live in Middle Income Countries (MICs)[11]. The 19 countries initially selected for graduation, three of which were later 'saved' by the European Parliament in its negotiations on the Agenda for Change, represented an estimated 79% or 751 million of the DCI's poor in 2009, suggesting that the DCI already had a strong pro-poor focus before differentiation came into play[12] By relying too heavily on traditional income indicators like GNI to determine who should graduate from support, the EC has shifted itself away from a multi-dimensional understanding of poverty that incorporates the variations in wealth distribution, country needs, and country capacity. Whereas the distribution of health assistance was already favourable to low income countries (LICs) and least developed countries (LDCs) before differentiation was introduced.

FIGURE 1 DISTRIBUTION OF SUPPORT BEFORE AGENDA FOR CHANGE (2010)



Differentiation based on a country's income status is also problematic because it means dismissing the differences in political space within graduating countries. Some of MIC states are not willing to provide support for contentious health issues, most notably sexual and reproductive health (SRHR) and HIV/AIDS due to the stigma and cultural taboos still attached to them.

While middle income countries should be able take care of their own populations and respond to their health needs, in practice their capacity to do so vary far too much. Many MIC income countries, including those who have recently been upgraded to upper-middle income status are still struggling to develop or sustain strong health systems. In Latin America and the Caribbean for example child mortality varies greatly depending on parental socio-economic status. Children from low income homes are five times more likely to die before their 5th birthday[13]. Access can vary vastly depending on rural or urban settings, which region of a country a person lives in, what gender they are, what religion or caste they belong to, their migration status, among others. With the wealthy able to buy health services not publically available, it is the poor and those most in need that are left vulnerable.

Data projections on where the poor will be in the future appear to be conflicting; some studies suggest that more of the poor will live in LDCs, while some forecast that the number of poor living in MICs will continue to grow as more LICs enter into middle income status[14, 15, 16]. This lack of clarity serves to further emphasise the need for the Commission to focus on equity, regardless of changing income status in its future development policy for health.

During graduation negotiations the EC had promised that aid to upper-middle income countries would be phased out over time; in reality no transition policy was put into place and aid was cut abruptly putting the progress made in those countries at risk. This premature withdrawal has been problematic for countries where the decrease in aid has not been matched by a rise in tax revenues to immediately fill the gap[17]. Additionally MIC status means that certain countries' accessibility to more lenient external loan terms is very low, particularly as multilateral development banks have not increased the opportunities for funding, despite the growing number of countries eligible for them[18].

Some interviewees reported that there has been recognition from within the Commission recently that the implementation of this withdrawal strategy has been problematic and that it is looking at ways to provide support for graduate countries that goes beyond financial assistance. The Commission should use its position on the boards of the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance in order to ensure that graduating countries would continue to receive immunisations at discounted prices or be eligible for funding from these organisations where appropriate. This non-financial support is important to empower all MICs to achieve the health SDG targets.

3. FRAGMENTATION MUST BE AVOIDED

The EU commits a high proportion of its support for health to multilateral organisations. These accounted for 15.7% of total health ODA with the bulk of that going to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Disbursements to this organisation totalled €367 million over the seven years of the last MFF[19]. The EU member states individually also contribute significant amounts to GFATM with eight of them figuring among its top 15 donors. Together with the Commission, they represented 45.8% of pledges in its previous replenishment round for 2011 to 2013, making the EU a significant contributor to global initiatives or vertical funds[20].

Global initiatives have had a significant impact on the MDGs. They became a useful instrument for rapidly generating attention and resources for some of the most pressing health problems from the early 2000s. Despite the successes of this type of funding however, views on its benefits shifting in the post-2015 context and many are beginning to express their concerns about vertical funding and the barriers that global initiatives create to health systems strengthening (HSS).

Because of their narrow focus on specific diseases, vertical funds require separate strategic plans, separate monitoring mechanisms, separate funding streams and separate implementation streams[21]. Such programme silos lead to duplication and the creation of parallel structures within national health systems that add to system and transaction costs and make the task of governance increasingly difficult for countries which already suffer from low capacity[22]. Vertical initiatives invest little in developing an integrative system that aligns their programmes with strengthening the health system and because they aim primarily at disease control they do not encompass the 'bigger picture' of HSS in their approaches. According to Warren et al, an estimated 37% (€341 million) of Global Fund's Round 8 budget went to HSS, but of this 62% (€210 million) went to disease-specific system strengthening rather than integrative HSS. Alarmingly, vertical funds also tend to promote the exodus of health workers from the public sector into vertically-funded programmes run by NGOs as a result of large differences in salaries between their contracted staff and those of public health workers[23].

The focus on disease-specific funds that target MDG 6 (the goal to combat HIV/AIDs, malaria, and other diseases) has also too frequently translated into the neglect of other health challenges. MDG 6 is estimated to have accounted for 58% of all ODA that excluded budget support while only an estimated 10% of global health ODA went to addressing MDG 5 which aimed to reduce maternal mortality and was the most off-track of the health goals[24]. The heavy focus on global initiatives is leading to a funding gap for sexual and reproductive health that will only increase as vertical funds become increasingly popular. Many EU donors are turning to multilateral organisations as their main source of health funding: in 2013, France gave 73% of its health ODA to multilaterals, mainly GFATM; Germany gave 61%, and the UK gave 44%[25]. As one of the new targets of the SDGs is universal access to sexual and reproductive services, the EC must take steps to ensure that this does not happen. The key is maintaining a healthy balance between funding to global initiatives and other types of funding.

In March 2016, the Commission announced that it would contribute €470 million to the GFATM over 2017 to 2019[26]. This is an increase of €100 million compared to the previous funding cycle. The Commission has also pledged €200 million to the GAVI Alliance for 2016 to 2020. While the MDG framework encouraged the development of siloed approaches, the SDG targets are much more interlinked and interdependent. The SDGs demand a more integrated and holistic approach[27]. Coordination is one of the core principles of the Agenda for Change, it emphasises avoidance of fragmentation and the need for a simpler and faster programming process. The EC must champion this approach and it can use its position on the boards of GAVI and the Global Fund to shape these mechanisms into more integrative tools for better results for HSS. Moreover while vertical funds might be efficient from a donor perspective, it is important that the EU recognise their limitations and that it allocates aid to them accordingly. We cannot guarantee universal coverage of health care and resilient approaches to future health crises if we help build narrow systems that are only equipped to tackle specific health issues[28].

	2007	2008	2009	2010	2011	2012	2013
EU budget	79.5	64.9	66.5	70.2	85.4	68.3	60.7
As % of total health ODA	**17.1%**	**12.8%**	**14.5%**	**14.9%**	**14.9%**	**14.1%**	**10.6%**

TABLE 2 MULTILATERAL FUNDING DURING 2007-2013 MFF (IN EURO MILLIONS)

4. SECTOR BUDGET SUPPORT MUST BE BOLSTERED TO CREATE STRONG HEALTH SYSTEMS.

The EU and its member states must not use vertical funds as an alternative to budget support, which remains the most effective method of building strong health systems. As untied aid, budget support allows assistance to be aligned with national development strategies, fostering greater country ownership and decision-making power in allocating the funding. Crucially, budget support offers greater predictability for recipient countries as well, allowing them to budget for several years. All these elements serve to make strong budget support a necessary component of health system strengthening.

Despite its importance to HSS however, budget support is rarely sufficient enough to be used as funding for health. This is largely due to the fact that countries use up to 70% of general budget support (GBS) to pay off debt[29]. Budget support is not currently enough to expand the fiscal space to cover both sector budgets and national debts, so governments in developing countries are forced to pick and choose where they will allocate these funds. Save the Children's analysis of GBS revealed that only €146.1 million of EU GBS grants (0.32% of total ODA), went to health over the seven years of the last MFF[30]. These figures are clearly too low to have a substantial impact on the budget of Health Ministries. Sector Budget Support (SBS) fares better. SBS, denoted in the table above as 'health sector programmes', represents the largest chunk of health ODA at €1558.6 million but still represents only 3.4% of all ODA.

Sufficient and impactful budget support is needed for health system strengthening. There are concerns about whether bilateral support has had real impact after the Ebola crisis. Sierra Leone received €22.85 million in ODA grants from the Commission over 2007 to 2013, Guinea received €2.37 million and Liberia €20.35 million, yet none could manage the crisis. The combined efforts to fund the Ebola response cost the EC €869 million, leading to questions about how much money could have been saved had health ODA been more effective in creating strong, sustainable, and resilient health systems. The crisis also highlights the need to stop de-prioritising health as the refusal to put health at the centre of external priorities runs the risk of leaving countries vulnerable to similar disease outbreaks in the future and risks periodic spikes in humanitarian aid that could be prevented. The Ebola crisis was an important moment in global health because it showed up the deep impact that weak health systems have on development. The affected region suffered not only the health impact, but local trade and tourism plummeted with devastating consequences for GDP growth and population income. The World Bank estimated that the crisis has had an epidemiological and economic impact of $2.8 billion since 2014 and that GDP per capita has been reduced by an average of $125 per person. In Liberia there has been a 40% decrease in those working since the onset of the crisis, mostly women who worked before the crisis. In Guinea nearly 10% of households have stopped sending their children to school[31]. The consequences of a weak health system impacted education, gender equality, and many more important components of development and stability.

The role of sector budget support is important because foreign aid remains an important source of funding for the health sector, representing as much as 40% of public expenditure in countries which have a per capita gross domestic product of less than $2000[32]. The EC's support is vital to the health systems of its partners in development. Whether support takes the form of SBS or GBS, support must be high enough to increase expenditure to social support sectors, including health.

	2007	2008	2009	2010	2011	2012	2013
Health sector programmes	151.5	212.7	202.2	206.7	262.5	206.7	316.3
General Budget support (health)	10.3	9.8	16.6	41.7	23.5	28.3	15.9
Other – Issue specific	194.2	186.3	144.6	125.2	167.6	156	146.9
Total Bilateral support	**356.0**	**408.8**	**363.4**	**373.6**	**453.6**	**391.0**	**479.1**

TABLE 3 BILATERAL ODA GRANTS FOR HEALTH IN MFF 2007-2012 (IN EURO MILLIONS)

	Total	% of total EU Budget ODA
HIV	243.2	0.53
Reproductive Health	176	0.38
Child health	310.6	0.68
Immunisation	25.5	0.06
Other	365.6	0.80

TABLE 4 ISSUES SPECIFIC INTERVENTIONS BILATERAL HEALTH GRANTS IN MFF 2007-2013 (IN EURO MILLIONS)

Laxmi, 23, cradles her 3-day-old 2nd child, in the Bardiya District Hospital one hour's walk from her village in Bardiya, mid-Western Nepal.

5. POLICY COHERENCE FOR SUSTAINABLE DEVELOPMENT MUST BE STRENGTHENED

The European Commission must ensure that EU employment policies and member state health policies match the commitments it has made to development in both the European Consensus on Development and the Agenda for Change. Better policy coherence would help alleviate the human resources for health (HRH) crisis in developing countries. Currently, 61 countries fail to meet the WHO threshold for the minimum amount of health workers needed to provide basic health services (23 per 10,000 people)[33]. Many health workers are migrating out of developing countries into Europe and as a beneficiary of this migration the EU has a responsibility to support the countries of origin.

Intakes of health workers from developing countries are a result of the EU's own shortage of health workers. International recruitment is an attractive solution given that member states are able to acquire more staff, while incurring no training costs. Member states like the UK, Ireland, and Germany continue to heavily recruit from developing countries despite stated efforts to stick to the letter of the WHO Code on health workforce recruitment[34]. This is particularly problematic for Africa, which has the highest disease burden in the world but the lowest proportion of health workers (0.8 for every 1000 person)[35]. Each year an estimated 20,000 health workers emigrate from the region[36]. These shortages impact on the quality of care, cause origin countries to be burdened with the cost of lost education, the additional costs of recruiting replacements, and creates low morale among static staff who stay behind as their workload drastically increases[37]. These problems are likely to continue to grow as the EU deals with an ageing population that is representing an increasingly large portion of society and further recruits foreign medical professionals to care for them.

The EU's political commitment to tackling the crisis has been strong and has included the EU Strategy for Action on the crisis in 2005[38], the Programme for Action[39] in 2006 and the adoption of the WHO Code of Practice on International Recruitment of Health Personnel. The EC also developed the Action Plan for the EU Health Workforce, promising to support member states' implementation of the WHO Code. Still, little progress has been made in adopting measures to ease the crisis and according to its own PCD report, there is little evidence that the EU has contributed to reducing the migration of health workers to the EU. The lack of progress is partially due to the voluntary nature of the WHO ethical recruitment code. A first step then would be to make its integration into the EU Action Plan legally binding for all member states.

Secondly, ethical recruitment codes must apply to the private sector. Currently private sector organisations and private recruitment agencies can bypass rules on ethical recruitment adopted by the state. The sector must be better regulated in order to ensure that the code is implemented in both the public and private sector recruitment.

Thirdly, better data on health workforce migration is needed. Only 13 EU member states contributed more than five years' worth of data on health workforce migration to the OECD. That data only measures foreign-trained doctors, and does not differentiate between doctors from within the EU and doctors from developing countries. Moreover it does not take into account doctors from developing countries that receive training within the recipient country. Data on the outflows of foreign-doctors is also not measured though this is needed to determine to how many migrant health workers are returning home where the origin country can benefit of any new skills or training they received in the EU. Better data is crucial to understanding the scale of the problem and to better addressing it.

Finally, the EU must tackle the root causes of its own shortages to avoid recruiting large amounts of doctors from developing countries. By investing in EU health workers such as by improving work conditions, combatting underpayment, cutting overtime hours, and providing better career progression structures, the EU and its member states can not only resolve their own health worker shortages but contribute to decreasing brain drain. Creating more incentives to study medicine, training more doctors and improving technology and training opportunities at member state level could play a preventative role in overcoming the lack of health personnel[40].

The WHO estimates that there is a shortage of over 7.2 million health workers across the world[41]. Without medical professionals, it is impossible to deliver UHC and HRH is crucial to achieving the health targets. This is why the SDGs feature a target on HRH which aims to "substantially increase health financing and the recruitment, development, training and retention" of health workers in developing countries. As the terms 'substantially increase´ are vague, it is important that the EC defines its own measurable endpoint for this target and puts more emphasis on policy coherence for development. With strong PCD, the EU can make its aid more impactful and efficient and ensure that every child has access to a health worker.

SAFEGUARDING ACCESS TO MEDICINES THROUGH EU TRADE POLICY

Achieving UHC will only be possible if the cost of medicines and immunisations remains competitive and safeguarding access to affordable essential medicines and respecting the TRIPS agreement is now part of SDG 3. More than 40 million already fall into poverty in India due to the cost of drugs[42]. Ongoing EU free trade agreement (FTA) negotiations between the EC and India are jeopardising access to low-cost drugs. India is the most important supplier of affordable generic drugs for the developing world and the EU has promised that it would keep to its commitments to safeguard access to medicines agreed in the Doha Declaration on Trade-Related Aspects of Intellectual Property Rights (also known as the TRIPS agreement). Reports indicate however that these negotiations have not concluded precisely because of the EC push for strict intellectual property rights (IPR) enforcement and data exclusivity which puts the production and distribution of generics at risk. The EC has on several occasions chosen to push for IPR provisions that are more rigorous than those set in the TRIPS agreement. Such strict terms have the greatest impact on the poorest countries which lack the capacity to mitigate the effects of price inflation, putting the affordability and the access to medicines of those living in poverty at high risk[43]. When negotiations move forward, the European Commission must ensure that its trade policies do not undermine access to essential medicines required for maternal and child care in developing countries by unnecessarily pushing for TRIPS plus provisions.

PHOTO: JONATHAN HYAMS/SAVE THE CHILDREN

Tsahara brings her son Habou, three, to see the doctor at their local health centre in Kentche, Zinder region, Niger.

TACKLING POVERTY-RELATED AND NEGLECTED DISEASES WITH EU RESEARCH AND DEVELOPMENT POLICY

The EU can play a direct role in tackling the diseases that affect children living in poverty through its allocations to research and development (R&D) of medical innovations and immunisations. Children are the most vulnerable to poverty related and neglected diseases (PRNDs) which affect over 1 billion people, primarily in developing countries[44]. Yet during the MDG period only 4% of new drugs and vaccines to reach the market were developed to take on these diseases[45]. The EU has taken strong steps to addressing this gap as the third largest public funder for this sector[46]. There are however other ways in which the EU could contribute to preventing, managing, or curing these diseases.

The EU can help by:

1. **De-linkage –** High costs of medicines are often the result of R&D investments made by pharmaceutical developers. The EU can help find an alternative to de-link research costs from the price of a product by allowing developers to immediately recoup their costs such as by offering prizes to encourage development.
2. **Open innovation –** The EU can help ensure that information sharing such as technical expertise, know-how and platforms happens to stimulate the development of new products. This can happen by creating structures such as open laboratories where relevant stakeholders can participate equally in sharing their knowledge.
3. **Licensing for access –** The EU can create pooling mechanisms for proprietary rights so that interested parties who do not own patents on certain compounds can use them to generate new products or combinations that are suited to children and to particular needs in different contexts[47].

SECTION 3:
THE CLINICAL TRIAL – CASE STUDY OF EU-NIGERIA PARTNERSHIP

PROGRESS TOWARDS HEALTH MDGS

MDG 4:
Child Mortality

Under-Five Deaths per 1000 live births

- **1990: 213**
- **2014: 89**

MDG 5:
Maternal Mortality

Deaths per 100,00 live birth

- **1990: 1000**
- **2014: 243**

MDG 6:
Malaria, TB, HIV/AIDS

Vaccination coverage for children aged 12-23

- **2003: 12.9%**
- **2013: 25.4%**

Nigeria made remarkable strides during the MDGs. The country has managed to reduce under-five child mortality by 49%. Maternal mortality has also seen a dramatic reduction. Despite this progress, all of the health targets could not be achieved and the country still has one of the highest maternal and child mortality rates in the world.

EU COOPERATION

EU bilateral contributions to Nigeria in ODA grants for health from 2007 to 2013 totalled €102.56 million, of which €19 million came specifically from the EU Budget specifically[48]. The Nigerian government´s own total expenditure to health as a percentage of the country's GDP was only 3.7% in 2014 and its total expenditure per capita was €183. As a result of low state health expenditure, 60% of health expenditures come from OOPs.

EU support to the health sector in Nigeria during the MDGs focused on immunisation. There are four areas in which it provided support:

1. Management capacity building
2. Infrastructure (eg.: building cold rooms and rehabbing health facilities)
3. R&D including data analysis and interpretation
4. Polio eradication

Health projects supported by the EU are implemented through the state, NGOs, and international organisations. Implementing partners include WHO, UNICEF and the National Primary Health Care Development Agency (NPHCDA) of Nigeria to whom the EU provided funding for three different projects.

IMPACT

Progress has been made in vaccination coverage for children, which has increased by 12.5% in ten years, but the greatest impact has been on the fight to eradicate polio in Nigeria, which the EU has been a significant partner in addressing. The last case of the disease was signalled in July 2014 and interviewees felt that EU support, along with that of other donors, had contributed to this progress. The goal now is to reach three years without another case in order to be eligible to become a certified polio-free country. The WHO polio eradication campaign focuses on delivering vaccines to children below the age of five. Children under one also get screened for other common diseases and receive routine immunisations, providing an integrated service that targets vulnerable children. Part of the success related to polio eradication push is likely partially due to the strong in-house capacity for health dialogue from the EU delegation in Nigeria. The Health Unit has many staff members who come from a background in medicine or health planning.

Alia, two years old, has just arrived at a Save the Children-supported, government-run facility providing nutrition services.

COUNTRY OWNERSHIP

EU bilateral funding goes through the Federal Ministry of Budget and National Planning which then transfers the funds for immunisation projects to the National Primary Health Care Development Agency. There is no coordinated entry into the health sector and the EU goes directly to the activity. Proposals for the health sector come from the Budget and National Planning Ministry whom must cite specific activities in order to make a request for funding to the EU Delegation. The proposals then return to the Planning Ministry before finally arriving at the NPHCDA. This means that the Ministry of Health bares no direct role in developing health sector proposals with the EU. Interviewees at the NPHCDA also acknowledged that projects are designed by the EU, which prefers to focus on one aspect of health and to have more control over a programme. As a result, officials from the Federal Ministry of Health (FMOH) reported feeling bypassed and there was little sense of country ownership from them over the projects.

The FMOH stated that because priority setting negotiations take place between the EU and the Ministry of Budget and National Planning, there is an in-house issue of lack of push for prioritising health. Though this has been signalled to the relevant stakeholders, this has not changed and the FMOH is still not invited to the negotiation table. When questioned about this, an official from the EU delegation expressed the fact that they believe the EU should support the FMOH only on policy and regulation, not on programming and that they see it as the FMOH and NPHCDA's role to information-share with the Budget and National Planning Ministry on EU cooperation.

TRANSPARENCY

Transparency failings mark the current approach: of the six officials interviewed from the Federal Ministry of Health, not one was aware of the amount of financial support the EU gives to Nigeria for the health sector. According to them, EU funding and support, like other development partners, goes directly to the projects they are meant. They stated that while other donors occasionally provided support to health without the involvement of the FMOH, the EU was the most pronounced case.

DELAYS IN RELEASING FUNDS

Disbursements of funds from the EU were inconsistent and there are often delays. In one instance, a project, EU-SIGN, was approved from Brussels in 2009 but funds for implementation were not released until May 2013. Finally, the implementers were only able to withdraw money from the project account in August 2013. Despite these delays that were out of the hands of the local government the EU refused to allow an extension to cover the delays.

REMEDIAL STEPS

The lack of a role provided to the FMOH in EU-Nigeria cooperation suggests that there is urgent need for a better flow of communication from all parties with the Federal Ministry of Health. EU support to Nigeria, though impactful, is very much led by the EU itself. The FMOH must a bigger part in the planning process if EU cooperation is to achieve the long term goal of building a strong self-sufficient health system. Officials at the FMOH emphasised their desire to see support take the form of health system strengthening and to see a move towards budget support, which would put funding allocations through the national budget instead of separate agencies. This would also allow the Nigeria health ministry to develop its own projects to improve the health system, giving it greater ownership.

SECTION 4:
THE TREATMENT

The European Commission must continue to fund health adequately. The new SDG framework offers us a new chance to create positive and lasting impact on health in developing countries. It is important to remember that the health MDGs sought to take on preventable deaths. This means we already have the tools necessary to significantly reduce death rates, including maternal and child mortality. Strong financial and political support from donors like the European Commission can create meaningful change to tackle these problems. The European Commission should no longer tolerate preventable deaths and as a major donor it must play its role in bridging the funding gap for health.

With its international cooperation and development assistance, the EC **must show strong commitment to UHC in particular.** Commitment to UHC in both policy and programming is crucial to achieving the health targets of the SDGs. The EU can ensure that children survive by accelerating the progress towards achieving the universal coverage of health, including by supporting national UHC plan. The European Commission should show leadership and invest in UHC by contributing strong and impactful health system financing to increase health services and to abolish OOPs, creating the provision of services that are free at the point of delivery, particularly for the most vulnerable including pregnant women and children so that they can access essential quality care without financial hardship. This is the crucial step to reducing preventable child and maternal mortality where possible.

The progress we have seen with the MDGs is the direct result of continued commitment and the engagement and actions of multiples stakeholders, which include national governments, civil society, and the international community including donors. This commitment must continue into the SDGs so even greater progress can be made. Since 2000, 48 million lives of children have been saved. The responsibility and the ability to save even more over the next fifteen years rest with donors like the European Commission.

RECOMMENDATIONS

We are at a critical juncture in the quest to improve global health, so that we have adequately resourced and strengthened health systems to meet the SDG targets, including the aim to end preventable deaths, and secure a future in which no one is left behind.

The European Commission should:

1. Commit to prioritising health in the review process of the 2014-2020 MFF and ensure that commitments to health match the levels of funding of the previous budget.
2. Aim to invest a greater amount than the 20% of DCI in basic health and education that is the legal minimum benchmark.
3. Put UHC at the heart of EU global health policy to ensure that all health targets of the SDGs can be achieved, while prioritising access to health of children and mothers. Ensuring the transparency and predictability of the disbursements of funds will help foster UHC.
4. Review the process by which the EU sets priorities with partner countries to ensure that aid and needs are well aligned and health-sensitive.
5. Strengthen the capacity of EU delegations to engage in health dialogue by creating a team of regional advisers specialised in health.
6. Review aid graduation policy to ensure that withdrawal of support is sustainable. Identify and engage in other means of supporting MICs to achieve the health targets such as through EC role in GAVI and GF boards.
7. Prioritise sector budget support as the main means of financing the health sector and ensure that aid fosters integrated health systems, rather than fragmented projects.

8. Enforce strong policy coherence for sustainable development in all internal policy, including in trade and migration as part of SDG implementation to ensure that EU internal policy does not impede on partner countries' ability to achieve the SDGs.

9. Urge EU member states to recommit to the 0.7% UNGA target for ODA, a critical enabler for improving human development outcomes and generating much needed additional funding to invest in global health.

10. Support the monitoring of efforts to reach the most disadvantaged and excluded populations as part of the EU´s commitment to the SDGs: support initiatives and new methods to strengthen data collection, disaggregation, particularly by age and gender, and analysis of status and progress among population groups who are excluded, extremely poor or not covered by conventional household surveys, such as displaced persons, street children, slum populations and persons with disabilities.

This is 18-year-old Maria's first child, a baby girl unnamed. The baby is approximately 1 hour old. She gave birth in a clinic in Salala about half an hour drive from CH Rennie hospital. She had a postpartum hemorrage. The baby was feverish. Maria had been admitted three times in the previous weeks for anemia and malaria. Both mother and baby were held for tests.

PHOTO: RAJ YAGNIK/SAVE THE CHILDREN

ANNEX

1. CALCULATION OF EU ODA SPEND TO HEALTH DURING THE 2007-2013 MFF AS RECEIVED FROM THE EUROPEAN COMMISSION

	2007	2008	2009	2010	2011	2012	2013	Total
Non-EDF	269	268	335	274	85	187	351	**1769**
EDF	154	200	75	405	156	233	161	**1384**
Total (€ million)	**423**	**468**	**410**	**679**	**241**	**420**	**512**	**3153**

2. ANNUAL HEALTH DISBURSEMENTS TO GLOBAL FUND TO AIDS, TUBERCULOSIS AND MALARIA

	2007	2008	2009	2010	2011	2012	2013
EU budget	62.0	50.0	50.0	50.0	65.0	50.0	40.0
EDF			150.0		165.0		
Total	**62.0**	**50.0**	**200.0**	**50.0**	**230.0**	**50.0**	**40.0**

TABLE 5 GFATM FUNDING DURING 2007-2013 MFF (IN EURO MILLIONS)

3. ANNUAL HEALTH DISBURSEMENTS TO NIGERIA

	2007	2008	2009	2010	2011	2012	2013
EU budget	0.81	1.29	2.70	1.90	4.46	4.38	3.46
EDF	14.92	21.92	9.32	2.25	16.39	7.74	11.02
Total	**15.73**	**23.21**	**12.02**	**4.15**	**20.85**	**12.12**	**14.48**

TABLE 6 HEALTH ODA TO NIGERIA DURING 2007-2013 MFF (IN EURO MILLIONS)

ENDNOTES

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Princess, 20, gave birth to Jallah, 3 days old and her first child at CH Rennie Hospital. She had to have a c-section because Jallah was so large. Her mother Afua shows her daughter how to breastfeed.

PHOTO: SAVE THE CHILDREN

EU HEALTH CHEQUE

Save the Children

In light of the ambitious Sustainable Development Goal health agenda, focused on systemic change, an understanding of why the health Millennium Development Goals failed to be achieved is required.

The European Commission (EC) is an important development actor. This report serves as a review of the European Commission's contributions as a donor to achieving the health MDGs over the 2007-2013 Multi-Annual Financial Framework (MFF). The EU's record on health can provide an insight into the impact of EU's official development assistance (ODA) and development policies.

The lessons in this report can be used to make health ODA more efficient and impactful so it delivers greater results for the SDGs

The report urges an increase in the priority afforded to development assistance for health.

Outlines why and how support for health for middle income countries must continue.

Details why and how fragmentation in the health sector must be avoided.

Recommends that budget support be bolstered so as to create strong health systems.

Provides specific recommendations on how EU policy coherence for development (PCD) must be stronger for health.

The ten specific recommendations of the report are important at a time when the EU is revising its Consensus on development, devising its strategy to implement the SDGs and undertaking the mid-term review of its long term budget – the MFF.

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