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HEALTH PROSPECTS IN COUNTRIES THAT ARE CANDIDATES FOR ACCESSION TO MEMBERSHIP OF THE EUROPEAN UNION

This paper summarizes the findings of a review of the WHO Regional Office for Europe's cooperation with candidate countries for accession to membership of the European Union (EU). It aims to provide some background information to support the panel discussion that will take place during the fifty-first session of the Regional Committee.

In 2001, 12 Member States in WHO's European Region are candidates for EU membership: Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia, Slovenia and Turkey. The paper briefly addresses some general aspects of EU accession for these countries; gives selected examples of their health status and resources; provides a general overview of the Regional Office's current cooperation with them; and proposes some directions for the Regional Office's future cooperation.

SOME ASPECTS OF THE EU ACCESSION PROCESS FOR CANDIDATE COUNTRIES[1]

1. The Founding Members of the European Union (EU) are Belgium, France, Germany, Italy, Luxembourg and the Netherlands. The history of EU enlargement started with the accession of Denmark, Ireland and the United Kingdom in 1973, followed by Greece in 1981, Portugal and Spain in 1986 and Austria, Finland and Sweden in 1995. In 1998 the European Commission opened negotiations with six countries: Cyprus, the Czech Republic, Estonia, Hungary, Poland and Slovenia. Formal accession negotiations with six other countries, namely Bulgaria, Latvia, Lithuania, Malta, Romania and Slovakia, were opened in 2000. Turkey was confirmed to be a country destined to join the Union, but formal accession negotiations have not yet been opened.

2. The accession process involves all candidate countries designated to join the EU. It is based on the same criteria for each country. It entails cooperation and negotiation between each candidate country and the institutions of the European Union, mainly the European Commission, and EU member states. The pre-accession strategy is a key feature of the accession process; It describes the overall strategy based on which the candidate countries can prepare themselves for membership by aligning their legislation with that of the European Community.

3. The accession negotiations are also part of each candidate country's accession process. They take the form of a series of bilateral intergovernmental conferences between each of the candidate countries and the EU member states. The accession negotiations focus specifically on the terms under which candidate countries adopt, implement and enforce the so-called "acquis communautaire". The acquis communautaire comprises the entire body of Community legislation in force, which candidate countries have to adopt in order to become members of the EU. Candidate countries also have to show that they have the institutional infrastructure to carry out their legal obligations.

4. Over the past 40 years, the acquis communautaire has built up to more than 80 000 pages of legal texts, divided into 31 chapters. Legislation related to the health system is mainly contained within provisions concerning the internal market. These affect various different areas of the health system, such as pharmaceuticals, medical devices, food safety and health professionals. Legislation on health and safety at work comes under the chapter of the acquis communautaire concerned with social policy. Legislation on water and air falls within the chapter on the environment, while other aspects are covered by the chapters on agriculture, transport policy, and science and research. Legislation related to health is thus scattered throughout the 31 chapters of the acquis communautaire. Health status per se is not a criterion for EU accession.

SELECTED EXAMPLES OF HEALTH STATUS AND RESOURCES IN EU CANDIDATE COUNTRIES

5. Most candidate countries still report lower levels of life expectancy than the lowest level found in EU member states, although the former have increased in recent years.

6. Infant mortality in most candidate countries is higher than in most EU countries. In some cases, the difference is substantial: in Romania, for instance, the level is three times the EU average.

7. Average mortality levels for ischaemic heart disease, lung cancer and chronic liver diseases also tend to be higher than in the EU according to WHO data. The rate of tobacco-related premature death among middle-aged men in candidate countries is close to twice the rate in EU countries.

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[1] See also European Commission, Directorate General for Enlargement. *European Union enlargement. A historic opportunity.* Brussels, 2000 (http://europa.eu.int/comm/enlargement, accessed 17 August 2001).

8. Suicide rates in some candidate countries are higher than anywhere else in the world. Standard death rates for suicide and self-inflicted injuries in the three Baltic States and Hungary are three times higher than the EU average. The effects of EU accession on mental health status in the candidate countries are uncertain but there are calls, for example, to pay attention to trends in mental health within rural populations, where some people may have to reorient their lives owing to the decrease of agricultural employment.

9. There have been considerable increases in the incidence of tuberculosis and syphilis in some candidate countries in recent years, when compared to the EU averages. Immunization coverage for tuberculosis has declined in candidate countries, but it still compares favourably with coverage rates in the EU countries. There are concerns about morbidity patterns for infectious diseases in the context of greater expected migration and tourism due to EU accession. This is one reason why the candidate countries and the EU countries are both paying closer attention to the surveillance of communicable diseases.

10. The temporary collapse of the economies of most EU candidate countries in the 1990s is reflected in the fact that national incomes there are still substantially below EU average levels. Gross domestic product (GDP) in most candidate countries is lower than the lowest levels in EU countries. In 1998, for example, the lowest per capita levels in candidate countries were US $5648 at purchasing power parity (PPP) in Romania and US $4809 at PPP in Bulgaria, compared to US $14 095 in Greece and US $15 787 in Portugal.

11. Moreover, candidate countries have retained the tradition of spending a smaller proportion of national income on health care than EU countries. The share of GDP spent on health in most candidate countries is lower than the lowest level of EU member states. There are concerns that public health care spending will not increase proportionally with national income because health, it is argued, does not figure among the top priorities in the economic transition process. In addition, it is sometimes reported that resources are devoted mainly to harmonizing legislation and building up infrastructures, in order to meet the requirements of EU accession. Candidate countries also have to remain within certain limits as regards their budget deficits. On the other hand, private resources may have only limited potential to supplement public funds in candidate countries with a low per capita income relative to the EU.

12. In some of the candidate countries, intrinsic difficulties in generating health care funds may add to the problem of the relatively low amount of per capita income spent on health. For example, the introduction of payroll health insurance as a new complementary or predominant form of funding in some candidate countries during the 1990s has generated less income for the health system than originally expected. This is due to numerous factors, including rising unemployment rate, the aging of the population, increased liberalization of the formal sector and the growth of the informal sector.

13. The level of resources spent in individual parts of the health sector in candidate countries may be affected by EU accession. For example, although the prices of pharmaceutical products are not subject to EU legislation, their prices and accessibility may change in candidate countries: the EU's patent protection legislation requires some candidate countries to increase the length of time for which patent protection is granted and this may be expected to have an effect on the domestic production of generic drugs. In addition, drugs imported from EU countries remain expensive for candidate countries, so patients may be forced to obtain their medicines from private pharmacies, thereby posing a problem in terms of ensuring equitable access. The extension of the single market also raises the issue of domestic pharmaceutical industries in the candidate countries having to face increased competition from multinational companies.

14. The human resources deployed in the health sector in candidate countries are another issue that is often debated in the context of the health aspects of EU accession. The number of physicians trained and employed in the health care system in many candidate countries tends to be above the levels in many EU member states. To enable the free movement of health professionals, Community legislation governing the mutual recognition of diplomas needs to be adopted by candidate countries. This has given rise to speculation about the possibility of a "brain drain", where skilled health professionals in candidate

countries may leave for EU countries with better socioeconomic conditions and social and financial status. However, this debate over the assumed migration of health professionals and its effect on health services and, ultimately, on people's health status in the candidate countries remains controversial.

WHO COOPERATION WITH CANDIDATE COUNTRIES

15. Cooperation between the candidate countries and the WHO Regional Office for Europe is based on agreements jointly negotiated between WHO and the candidate countries' health authorities. It includes work on the surveillance and control of communicable diseases and on health information, two areas of direct relevance for EU accession. The Regional Office cooperates with the candidate countries in the development of early warning systems and specific disease networks, and it functions as the secretariat for the disease surveillance networks in the central European countries. These are similar in nature to the surveillance networks in EU countries, so such work facilitates a seamless transition to standardized communicable diseases surveillance throughout the EU.

16. In the area of health information, cooperation with candidate countries includes formal agreements with the European Commission. These cover reports that give a picture of the public health issues in each candidate country, in relation to other candidate countries and the EU. The Health Promoting Schools network is another example of cooperation between the Regional Office and the candidate countries, based on a joint venture by the Office, the European Commission and the Council of Europe.

17. Other areas of cooperation with candidate countries are: the prevention of premature mortality and morbidity due to noncommunicable diseases, including the promotion of mental health; the reduction of tobacco and alcohol consumption and other risk factors such as illicit drug use; the development of food and nutrition policies and food laws; the promotion of infant health and breastfeeding; the promotion of reproductive health; and the development of pharmaceutical policy and regulation.

18. Most environmental health cooperation with EU candidate countries is based on the implementation of national environmental health action plans. These instruments for improving the environment and health in the candidate countries are distinctive in that they integrate the legal, institutional and capacity requirements for accession to the EU in the area of environmental health and safety.

19. Cooperation also focuses on specific population groups such as mothers and children, adolescents and the aging population.

20. One important development for WHO's cooperation with candidate countries is the new exchange of letters between the World Health Organization and the Commission of the European Communities concerning the consolidation and intensification of cooperation.[2] With priority areas for cooperation such as health monitoring and communicable diseases surveillance and response, the agreement covers fields where candidate countries will have to align their policies on those of the EU in the course of the accession process. In addition, a new "Programme of Community action in the field of public health (2001–2006)" is currently undergoing the co-decision procedure within the European Community.[3] This new programme is intended to replace the eight existing action programmes in the field of public health. It focuses on three strands of action: improving health information and knowledge, responding rapidly to health threats, and addressing health determinants. This programme, once adopted, will also become relevant to the candidate countries.

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[2] World Health Organization/European Commission. *Exchange of letters between the World Health Organization and the Commission of the European Communities concerning the consolidation and intensification of co-operation.* Brussels, 2000 (http://europa.eu.int/comm/health/ph/key_doc/who_letters_en.html, accessed 17 August 2001).

[3] Commission of the European Communities. *Amended proposal for a decision of the European Parliament and of the Council adopting a programme of Community action in the field of public health (2001–2006).* Brussels, 2001, COM(2001)302 final (http://www.europa.eu.int/comm/health/index_en.html, accessed 17 August 2001).

21. Overall, the accession process provides a different context for WHO's cooperation with candidate countries, compared to the time before they applied for EU membership. More organizations are now cooperating with the candidate countries, and they are cooperating with them in different ways. This applies not only to EU institutions but also to other international organizations with an interest in health. Indeed, an increasing number of international health conferences, working groups and research consortia, as well as bilateral activities, have been initiated in recent years to address the health aspects of the EU accession process, while generating an increasing body of information and knowledge.

PROPOSED DIRECTIONS FOR THE REGIONAL OFFICE'S STRATEGY FOR COOPERATION WITH CANDIDATE COUNTRIES

22. The health impact of the EU accession process for candidate countries is uncertain and sometimes subject to controversy. This provides the rationale for more coordinated and systematic generation of information and knowledge on the impact of EU accession on health status and health systems in candidate countries. There is already a considerable body of experience from former accession countries that can be drawn on by those countries that are currently negotiating accession. This may also be of interest to current EU member states, and possibly also to other WHO Member States in the European Region. One proposed direction for the Regional Office's strategy therefore focuses on the generation and management of information and knowledge. In practice, this may involve carrying out observational case studies into the effect of the EU accession process on, for example, alcohol consumption, the accessibility of medicinal goods, food safety standards, movements of health professionals, and epidemiological developments in communicable diseases. These activities will be incorporated in the Regional Office's observation and health impact assessment function. It is also suggested that the management of information and knowledge will involve work on improving countries' access to information on the health impact of EU accession.

23. Consistent with the new Regional Office's new country strategy "Matching services to new needs",[4] internal coordination of the Regional Office's programmes with this group of countries will be enhanced. WHO's support to candidate countries will continue to be based on agreements jointly negotiated between WHO and the candidate countries' governments. The new contracts, entitled "Biennial Collaborative Agreements", will be concluded with each candidate country individually, but the Regional Office will pay particular attention to identifying health needs and priorities for cooperation that are common to the candidate countries. This should also allow the Regional Office to optimize organizational arrangements to support candidate countries at this particular time, when they are acceding to membership of the EU. In addition, the enhanced cooperation between WHO and the European Commission will cover countries that are candidates for membership of the EU.

[4] World Health Organization Regional Office for Europe. *The WHO Regional Office for Europe's country strategy: Matching services to new needs.* Copenhagen, 2000 (http://www.who.dk/RC/RC50/English/PDF%20eng/doc10.pdf, accessed 17 August 2001).