



Mid-term Evaluation of the Third Health Programme (2014 – 2020)

Final report

Annex A

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EUROPEAN COMMISSION

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1. TASK SPECIFICATIONS

SANTE/2016/C1/006-Mid-term evaluation of the 3rd Health Programme 2014-2020

1.1. Context of the assignment

1.1.1. Description of the Policy Area to be evaluated

The 3rd Health Programme is a sectorial financial instrument under the Multiannual Financial Framework (MFF) 2014-2020 in the field of health. It underpins EU policy coordination in the area of health in order to complement, support and add value to the national policies of Member States in full respect of the responsibilities of the Member States for the definition of their health policies and the organisation and delivery of health services and medical care.

The 3rd Health Programme has been **designed** following the experience and results obtained during the implementation of the two previous Public Health and Health Programmes (1st PHP in 2002-2007 and 2nd HP in 2008-2013), and a number of programme priorities are similar to those of previous programmes. .

The **3rd Health Programme suggests that health should be seen** not only as a cost but also as an investment for growth in times of important demographic and epidemiological changes and rapid technological progress. The Programme's limited budget requires a strict selection of key objectives and priorities aligned to important policy initiatives; a particular emphasis is being put on stimulating innovation, modern health policies and effective and efficient health systems.

The 3rd Health Programme's four specific objectives were set in a very explicit and practical way setting out the kind of outputs expected and indicators for measuring the progress. 23 thematic priorities are listed in its Annex I, linked to the specific objectives. EU added value criteria have also been integrated in the legal basis and are used when establishing the Annual Work Programmes as well as in the procedure to evaluate proposals. The Annual Work Programmes have been established on the basis of a preliminary multi-annual planning exercise and respect the specific criteria set in the Programme Regulation (Annex II).

1.1.2. Specific and operational objectives of the activity/action.

The Programme is positioned to serve the Member States needs under the overarching Commission priorities:

- the link between the health status of the population and its contribution to growth and jobs through labour market participation and labour productivity;
- investment in health as a source of economic prosperity and social cohesion;
- societal challenges (such as demographic ageing; inequalities, burden of chronic diseases, effectiveness, sustainability and resilience of health systems).

The general objectives of the Health Programme are "*to complement, support and add value to the policies of Member States to improve the health of EU citizens and reduce health inequalities by promoting health, encouraging innovation in health, increasing*

the sustainability of health systems and protecting Union citizens from serious cross-border health threats." (Article 2)

These are translated into 4 specific objectives (Article 3):

1) in order to promote health, prevent disease and foster supportive environments for healthy lifestyles: identify, disseminate and promote the uptake of evidence-based and good practices for cost-effective health promotion and disease prevention measures by addressing in particular the key lifestyle related risk factors with a focus on the Union added value;

Actions under this objective concern mainly the prevention and treatment of chronic diseases (including cancer and mental health) responsible for a significant level of disabilities and premature mortality, both impacting severely on the workforce and GDP. EU governments have been spending twice as much on illness and disability benefits as on unemployment benefits. Also people with health problems show very low participation in the labour force. Consequently, the level of unemployment of such people is twice as high as that of people without a disability. Investment in human capital is crucial for a knowledge-based economy. Facing the demographic challenge also requires the adaptation of the working conditions and workplaces to the health status of an ageing workforce.

2) in order to protect citizens from serious cross-border health threats: identify and develop coherent approaches and promote their implementation for better preparedness and coordination in health emergencies;

Health threats such as pandemic influenza and other communicable diseases do not respect national borders; moreover the effectiveness of responses in one area affects other areas. This implies a need for cross-border coordination. Cooperation at EU level allows for multi-sectorial aspects to be made an integral part of crisis preparedness and management. While taking into account the interests and needs of all Member States, at the same time it keeps the internal market functioning and the borders in the EU open.

The European Union strategic framework on health security¹ connects with many policies all contributing to the prevention of, preparedness for, and response to health security threats. Strengthened intersectoral cooperation and pooling of efforts internationally is essential; in today's connected world, health security is a global issue. The EU is participating in different fora such as under the Global Health Security Initiative² (GHSI) to strengthen and promote joint work and approaches on health security collaborating further developed with international partners. The Commission has a key role in the sharing of experiences and information with the GHSI and the WHO on the basis of International Health Regulations (IHR)³.

3) in order to support public health capacity-building and contribute to innovative, efficient and sustainable health systems: identify and develop tools and mechanisms at Union level to address shortages of resources, both human and financial, and to facilitate

¹ See Decision No 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious cross-border threats to health and repealing Decision No 2119/98/EC (OJ L293 of 5. 11. 2013 pp. 1-15)

² The Global Health Security Initiative (GHSI) is an international partnership of like-minded countries to strengthen health preparedness and the global response to threats of CBRN substances and pandemic influenza.

The initiative was launched by the G7 countries (Canada, France, Germany, Italy, Japan, the United Kingdom and the United States) plus Mexico and the European Commission in November 2001.

³ The World Health Organisation leads the implementation of the revised International Health Regulations (IHR), which entered into force on 15 June 2007 and requires members of the World Health Organisation to report certain disease outbreaks and public health events to the WHO. A total of 194 States Parties to the IHR have been implementing these global rules to enhance national, regional and global public health security.

the voluntary uptake of innovations in public health intervention and prevention strategies;

Demand for healthcare is increasing driven by an ageing population, increase in the prevalence of chronic diseases, and rising expectations. Cost pressure are also increasing as new, more effective –but also most costly- treatments are developed. Significant pressures on public finances mean that expenditure must be contained or reduced, while protecting service quality: more must be done with less. This requires more effective and efficient health systems. Innovation in service delivery, technology and the workforce is a central part of the response to these challenges.

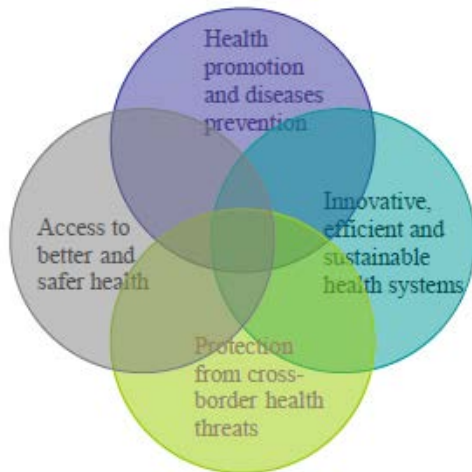
Under this objective, actions concentrating on issues such as Health Systems Performance Assessment, building capacities for investments in health, cost-effective e-health, the European Innovation Platform for Active and Health Ageing, produce technological and scientific developments which are key issues for assisting the reforms requested in Member States health systems and boost economic development and growth. Effectiveness and efficiency of health systems can also be strengthened by changes in the organisation and delivery of healthcare. In addition the implementation of EU legislation on medical devices and medicinal products guarantees smoother functioning of the internal market and support to innovation and investment due to a predictable regulatory framework conditions and lower overall administrative burdens.

4) in order to facilitate access to better and safer healthcare for Union citizens: increase access to medical expertise and information for specific conditions beyond national borders, facilitate the application of the results of research and develop tools for the improvement of healthcare quality and patient safety through, inter-alia, actions contributing to the improvement of health literacy.

For improved health outcomes, the quality and safety of healthcare should be optimal. There is scope for better exchange of evidence and practice for improving care through European Reference networks on key topics. Much can also be learnt the different models and practices in the organisation and delivery of healthcare across the EU. Moreover, some topics such as antimicrobial resistance or the sale/safety of pharmaceutical products have for the EU a cross-border dimension and are related to obligations stemming from IHR. The above requires the development of highly specialised skills and important investment in health.

The following table summarises the challenges, main aims, specific and operational objectives of the Programme in correspondence to the 23 thematic priorities.

Since 2002 the Health Programmes follow an integrated approach: the 4 specific objectives of the 3rd Health Programme are interlinked and interactions are being promoted. However for the purpose of the Programme management and monitoring, each priority and the corresponding actions funded are attributable to one objective.



This should not limit the evaluators to take a more comprehensive approach when assessing relevance and other aspects of the Programme.

1.1.3. Legal basis, budget and duration of the activity/action

The 3rd Health Programme came into force with Regulation (EU) No 282/2014 of the European Parliament and of the Council of 11 March 2014 on the establishment of a third Programme for the Union's action in the field of health (2014-2020) and repealing Decision No 1350/2007/EC⁴.

The Programme has a total budget of €449,5 million over seven years and applies from the 1st January 2014.

⁴ <http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32014R0282&from=EN>

Mid-term Evaluation of the Third Health Programme
(2014-2020)

THE CHALLENGES	GENERAL OBJECTIVES	SPECIFIC OBJECTIVES	OPERATIONAL OBJECTIVES	ACTIONS (see annex I of the Programme Regulation)	RESULTS
<p>- increasingly challenging demographic context threatening the sustainability of health systems</p> <p>- fragile economic recovery limiting the resources available for investment in healthcare</p> <p>- increase of health inequalities between/within Member States</p> <p>- increase in chronic diseases prevalence</p>	<p>Complement, support and add value to the policies of Member States</p> <p>- to improve the health of EU citizens and</p> <p>- reduce health inequalities</p> <p>Budget: €449.4 million (2014-2020)</p> <p>Management mode : Centralised direct and indirect management</p> <p>Programming and implementation on the basis of adoption of Annual Work Programmes through implementing acts</p> <p>Monitoring and reporting Mid-term review in 2017 Annual implementation report sent to EP & Council</p>	<p>1) Promote health, prevent disease and foster supportive environments for healthy lifestyles</p> <p>2) Protect citizens from serious cross-border health threats</p> <p>3) Contribute to innovative, efficient and sustainable health systems</p> <p>4) Facilitate access to better and safer healthcare for Union citizens</p>	<p>1) Identify, disseminate and promote the up-take of evidence-based and good practices for cost-effective disease prevention and health promotion measures by addressing in particular the key lifestyle related risk factors with a focus on the Union added value.</p> <p>2) Identify and develop coherent approaches and promote their implementation for better preparedness and coordination in health emergencies.</p> <p>3) Identify and develop tools and mechanisms at Union level to address shortages of resources, both human and financial, and facilitate the voluntary up-take of innovation in public health intervention and prevention strategies.</p> <p>4) Increase access to medical expertise and information for specific conditions also beyond national borders, facilitate the application of the results of research and develop tools for the improvement of healthcare quality and patient safety through, inter alia, actions contributing to improve health literacy.</p>	<p>1.1 Risk factors such as use of tobacco and passive smoking, harmful use of alcohol, unhealthy dietary habits and physical inactivity.</p> <p>1.2 Drugs-related health damage, including information and prevention.</p> <p>1.3. HIV/AIDS, tuberculosis and hepatitis</p> <p>1.4. Chronic diseases including cancer, age-related diseases and neurodegenerative diseases</p> <p>1.5. Tobacco legislation</p> <p>1.6. Health information and knowledge system to contribute to evidence-based decision making</p> <p>2.1 Risk assessment additional capacities for scientific expertise</p> <p>2.2. Capacity building against health threats in Member States, including, where appropriate, cooperation with neighbouring countries</p> <p>2.3. Implementation of Union legislation on communicable diseases and other health threats, including those caused by biological, and chemical incidents, environment and climate change</p> <p>2.4 Health information and knowledge system to contribute to evidence-based decision making</p> <p>3.1 HTA</p> <p>3.2 Innovation and e-health</p> <p>3.3 Health workforce forecasting and planning</p> <p>3.4 Setting up a mechanism for pooling expertise at Union level</p> <p>3.5 European Innovation Partnership on Active and Healthy Ageing</p> <p>3.6 Implementation of Union legislation in the field of medical devices, medicinal products and cross-border healthcare</p> <p>3.7 Health information and knowledge system including support to the Scientific Committees set up in accordance with Commission Decision 2008/721/EC</p> <p>4.1 European Reference Networks</p> <p>4.2 Rare diseases</p> <p>4.3 Patient safety and quality of healthcare</p> <p>4.4 Measures to prevent Antimicrobial resistance and control healthcare-associated infections</p> <p>4.5 Implementation of Union legislation in the fields of tissues and cells, blood, organs</p> <p>4.6 Health information and knowledge system to contribute to evidence-based decision making</p>	<p>1. Increased use of evidence-based practices at the appropriate level in MS</p> <p>2. Coherent approaches integrated in the MS preparedness plans</p> <p>3. Increased production of advice and use of developed tools and mechanisms by MS in the reform of their health systems</p> <p>4. Creation of the European Reference Networks including for rare diseases, and increasing number of healthcare providers and centres of expertise joining the ERNs</p>

1.1.4. Programme implementation

The 3rd Health Programme is the main financing instrument to support EU Member States and to help prepare and implement EU actions in the field of health. Regulation (EU) No 282/2014:

- provides for explicit specific objectives and indicators (Article 3);
- establishes a restricted number of clear thematic priorities (Annex I);
- includes specific criteria for gauging EU added value (recital 6) concerning the prioritisation of needs (Annex II) and the awarding of funding;
- formally recognises the role of national focal points (Article 15); and
- underlines the need for better dissemination of the results of actions and overall corporate communication on the Union's political priorities (Articles 13(4) and 9).

1.1.4.1. Defining annual work priorities and choosing the corresponding financial mechanisms

On this basis, and following specific criteria set in Annex II of the Regulation (EU) No 282/2014, the Commission adopts Annual Work Programmes following an Opinion of the Programme Committee. The Work Programme sets out all actions to be financially supported in a given year. The Work Programme is developed following a process to define the most relevant actions to address Member States health needs and create added value at EU level. These actions should have high public health relevance and pertinent geographical coverage; taking into consideration that the thematic priorities should be covered adequately in the overall period 2014-2020, and the budgetary resources distributed in a balanced way between the different objectives of the Programme.

Based on the Work Programme, the Consumers, Health, Agriculture and Food Executive Agency (Chafea) implements the Health Programme, mainly through competitive calls for proposals and tenders. Some actions are implemented directly by DG SANTE (i.e. service contracts on political/sensitive issues).

The Programme uses different financial mechanisms: grants for projects, joint actions with Member States, operating grants for non-governmental organisations, direct grants for boosting cooperation with international health organisations, and direct financing through procurement procedures for covering specific needs related to the support of EU health policies (e.g. for studies, development of IT tools etc.)

1.1.4.2. Underpinning EU health policy coordination and encouraging the participation of all Member States to respond to health policy needs

The Programme is an instrument to support policy development, coordination and implementation in the area of health. While competence in this area lies largely with Member States, the Programme can help them develop initiatives at EU level for more effective and efficient solutions to common health concerns.

The Programme also supports policy coordination and cooperation between Member States in areas of common interest.

All Member States and two EEA EFTA countries (Iceland and Norway) participate in the 3rd Programme while other countries have expressed interest to join the Programme.

This creates the necessary networking environment for identifying common health concerns, raising awareness of key emerging health problems and transferring knowledge in order to improve health status and address inequalities. Health can be a productive investment in the economy and plays a key role in European cohesion and inclusion. In the case of acceding,

candidate and potential candidate countries, the Programme can function as a mechanism to help countries adapt to the *acquis communautaire* in health through their cooperation with Member States in projects and joint actions.

Difficult economic circumstances should not prevent Member States from participating, so the principle of 'exceptional utility' is included in the current 3rd Health Programme as a financial incentive to involve all Member States.

1.1.4.3. Monitoring progress and optimising resources

The Programme's success can only be defined in terms of the rate of implementation, participation by Member States and take-up of the outcome of activities in the different Member States and stakeholder groups, on top of the individual results per action, compared with predefined levels. Actions should complement and support Member States' initiatives according to the general Programme objective.

Other factors influencing the Programme's outcomes and consequently its impact include the existence of clear links to policy initiatives, the plans for sustained follow-up efforts, the feasibility of policy change (considering the surrounding context) in the medium-term, the delineation of action scopes and objectives, plausible intervention logic, involvement of relevant partners, strong project management, constructive engagement from DG SANTE / Chafea and the choice of the most suitable financial mechanism for each action.

Progress indicators have been developed at the level of the Health Programme objectives and priorities and these indicators are further detailed in the draft annual budget procedure (see below under References).

Simplification measures have been introduced to reduce the administrative burden of stakeholders participating in the 3rd Health Programme and optimize its implementation. These are mainly the following:

- a) New electronic tools for submission of proposals, management of grants and reporting on Programme deliverables (developed jointly by DG-RTD, DG-CONNECT and DG-DIGIT).
- b) Simplification in procedures for the awarding of Joint Actions and Operating Grants.
 - Joint Actions, are now agreed via a direct negotiation with the competent authorities within the Member States, which has resulted in an increase in the number of partners in the Joint Actions.
 - To support the non-governmental organisations, multi-annual Framework Partnership Agreements with NGOs and/or other non-governmental bodies have been provided, instead of annual grants.
- c) Simplified financial and administrative rules for the management of grants by the coordinator, taking over to a large extent the model grant agreement from the HORIZON 2020 Programme.

Synergies exist at EU level with other Programmes and could play an important role (see final evaluation report of the 2nd HP 2008-2013): this cross-fertilization can not only bring new ideas to be tested in real settings through the Health Programme, but could and should also help bring about more ambitious Programme outcomes, a better uptake of results and actions which build upon each other.

Breaking down 'silos' and working more closely with other Union programmes is part of the Commission's vision for delivering on its 10 major priorities in a coordinated way. The 3rd Health Programme offers possibilities for such cooperation in supporting health in areas such as migration, dealing with emerging diseases relating to environmental factors such as climate change, innovation in health, modernisation of the social protections systems, active ageing and

global health. Finally, the Programme involves assessments of health systems and generates country-specific and cross-country knowledge to inform policies at national and European level.

1.2. The assignment

1.2.1. The legal obligation

Evaluating at mid-term the implementation of the Programme is a legal obligation stemming from Article 13 (3) of Regulation (EU) No 282/2014.

Article 14 foresees also the follow-up this evaluation should receive and ask the Commission if necessary to present a proposal for adapting the Programme adequately.

1.2.2. Purpose and objective of the evaluation

(e.g. how to use the evaluation results, contribution to the decision making process)

The purpose of this evaluation is to assess at mid-term the implementation of the 3rd Health Programme 2014-2020, in particular regarding the state of implementation of its 23 thematic priorities (set in Annex I of the Regulation (EU) No 282/2014) and their continued relevance vis à vis all Programme's objectives and their contribution to the Commission's priorities for the years 2014-2020 as defined in 10 priorities⁵ and the mission letter to the Commissioner for Health and Food Safety⁶

The results of this evaluation will feed into a Commission consideration on whether a delegated act will be proposed to amend the thematic priorities of the Regulation (EU) No 282/2014. The evaluation should also provide substantial support for the next Programming period.

1.2.3. 2.3. Evaluation issues to be addressed

The evaluation should:

- a) Provide an overview of the implementation of Health Programme during the first three years. The overview should provide a quantitative and qualitative description of set priorities, financial mechanisms used (grants/operating grants/joint actions/tenders etc), selected beneficiaries⁷ including participation rates of Member States and other stakeholders, funded actions, and intended results.
- b) Assess the relevance, effectiveness and efficiency of funded actions. It should take into consideration the fact that the large majority of the funded actions would not have provided all the deliverables, interim and final reports at the time the evaluation takes place, and thus the assessment of impact would have to be approached in more prospective terms.
- c) Assess the consistency and complementarity with other relevant EU financial programmes funded from EU budget, instruments and funds, and the utility of the Health Programme.

⁵ http://ec.europa.eu/priorities/index_en.htm

⁶ http://ec.europa.eu/commission/sites/cwt/files/commissioner_mission_letters/andriukaitis_en.pdf

⁷ Beneficiaries in the sense of funding recipients

d) Measure the progress made in view of recommendations of previous evaluations and audits⁸ and the way they have been pursued, the efficiency of the use of resources and its European added value.

Taking into consideration recent evaluations of the previous Health Programme (2008-2013), the evaluation exercise will check where and how improvement has been achieved and whether the same problems persist.

In view of the timing of the interim evaluation assessment of the effectiveness will be limited to the management of the Programme.

The evaluation will focus on actions funded around priorities that have received important EU co-funding in the first three years of the Programme. Examples of those actions that may receive special attention are:

- assessing the role of the Health Programme in supporting cooperation at institutional, national and regional level: actions on Health Systems Performance Assessment, building capacities for investments in health, Health Technology Assessment, E-health and projects co-funded to support the European Innovation Partnership for Active and Healthy Ageing;
- assessing the Programme's contribution in the inclusive growth and social cohesion: action concerning chronic diseases, risk factors, access to and quality of care, the establishment of European Reference Networks and Non-Governmental Organisations work supported by the Health Programme;
- assessing the Programme's contribution to emerging health issues and public health emergencies: actions enabling stakeholders and Member States to take-up the necessary measures and react in a coordinated manner concerning health in response to the high influx of refugees and the Programme's contribution to provide support to the Ebola outbreak in Western Africa in 2014-15.

The evaluation will also provide suggestions for a better link with the Commission's social priorities (*e.g. migration and the Health Programme response to the refugees' crisis, jobs and growth and the role of health for long-term employability*).

The evaluation is expected to assess the performance of the Programme in comparison to the previous one in order to suggest improvements especially regarding further rationalisation/simplification and elaboration of indicators related to the above mentioned Programme priorities and objectives.

In evaluating the 3rd Health Programme, contractors are expected to concentrate their work on at least 5 thematic priorities and showcase the interest of the Programme of investing in these ones. Ideally a part of these case studies should concern actions committed in 2014, 2015, 2016 and another part, priorities that may be missing and are necessary to serve the Health Programme objectives.

The contractor is also asked/expected to:

- (a) draft a matrix-based analysis explaining how the different priorities/actions serve the Commission's overall priorities,
- (b) examine the matching between Programme priorities and actions and Member States/countries participation in relation to their specific health needs (*e.g. on the basis of population health data and specific country profile information*).

⁸ Reports and recommendations from previous evaluations and audits are given in chapter 4. of the present Terms of References.

- (c) analyse the climate change related expenditure⁹ within the first 3 years of the Programme, in particular for actions under the second specific objective and through the work of the scientific committees.

1.2.4. Scope of the evaluation (operational, temporal, geographical...)

The evaluation will cover the first three years of the 3rd Health Programme implementation and will mainly examine the relevance of the choices made in the Work Programmes 2014, 2015 and 2016 and proposals submitted and awarded for EU funding under the subsequent calls. It will cover also the efficiency of the use of resources, the Union added value of the Programme, the internal and external coherence of the Programme, and simplification measures, assessing the need for change and alignment of the Programme's priorities in view of new challenges or to deliver better results.

Due to the timing of this evaluation signed grant agreements/contracts will only be available for actions funded under the calls 2014 and 2015. It is expected that for only very few of them interim or final reports will be available. Therefore this evaluation cannot yet take into account any achievements or materialised outcomes of single actions (with the exception of operating grants).

1.2.5. Evaluation questions

RELEVANCE

1. To which extent are the actions prioritised in the Annual Work Programmes relevant vis-à-vis the Programme objectives and priorities?
2. To which extent are the Programme objectives still valid and in accordance with health needs in Europe? Are the needs identified at the time of the adoption of the Programme still relevant or have new needs emerged which necessitate an adjustment of the Programme's thematic priorities?
3. To which extent are the Health Programme thematic priorities sufficient and sufficiently covered to achieve the Programme objectives and Commission wider priorities?
4. To which extent are the actions co-funded through the Annual Work Programmes relevant to achieving the objectives set out in Article 168 TFEU?

EFFECTIVENESS

5. To which extent is the process for defining and prioritising actions through Annual Work Programmes transparent, impartial and equitable?
6. How effective was the multi-annual planning for the preparation of the Annual Work Programmes?

⁹ See recital (16) of Regulation (EU) No 282/2014: "...As stated in the Commission's Communication "A Budget for Europe 2020", the Commission has committed to mainstreaming climate change into overall Union spending programmes and to direct at least 20 % of the Union budget to climate- related objectives. Spending in the Programme under the specific objective related to serious cross-border health threats should contribute in a general manner to those objectives by addressing health threats associated with climate change. The Commission should provide information on climate change expenditure within the Programme".

7. How effective is the introduction of "exceptional utility" criteria in the Regulation establishing the 3rd Health Programme in order to incentivize the participation of low GDP countries?

[8. - To which extent are the actions in the Annual Work Programmes contributing to the Programme objectives and priorities?

*9. - To which extent are the actions in the Annual Work Programmes contributing to achieving Commission policy priorities?]*¹⁰

EFFICIENCY

10. To which extent is the distribution of Programme credits among the 23 thematic priorities efficient?

11. To which extent do the simplification measures contribute to the efficiency of the Programme? Is there further scope for simplification to make the Programme implementation more efficient?

12. To which extent does the sharing of funds among general objectives, priority actions and specific mechanisms provide a good basis for an efficient implementation of the Health Programme? How may the efficiency of the Health Programme be improved regarding?

- the number of priorities,
- the available resources (financial and human),
- the various financial mechanisms,
- the established procedures,
- the intended results, and
- the political focus.

13. To what extent are the monitoring processes and resources (at the Commission and MS level) sufficient and adequate to plan and promote the results of the Health Programme and finally to incite stakeholders (internal and external) to make use of them?

EU ADDED VALUE

14. In how far have the 8 EU added value criteria led to the development of proposals that are better addressing these aspects? Are all of these criteria still relevant? Which criteria are most/least addressed?

COHERENCE/CONSISTENCY

15. To which extent have the priorities of the Health Programme led to more synergy, focus and coherence between the funded actions in delivering on the objectives?

16. To which extent are the objectives and priorities of the Health Programme externally consistent/coherent i.e. is there correspondence between the Health Programme objectives and

¹⁰ Questions 8 and 9 come from Article 13.3 of Regulation (EU) 282/2014 and despite the difficulties recognised in the Roadmap of the evaluation for the scope of this evaluation, contractors are requested to take them also into consideration and provide what is possible at this stage to answer them.

priorities and those of other public interventions (e.g. national health policies, EU policies¹¹ and Programmes, other international actions) they interact with?

UTILITY

17. To which extent is the Health Programme overall useful and, if necessary, how could its overall utility be increased? What are the specific needs of member States to which the Programme could provide a concrete solution but has not done so yet?

18. Regarding the objective n° 3 for increasing the public health capacity building, how has this been achieved a) in terms of generic public health capacity building and b) in terms of specific capacity building that supports implementation of policy priorities such as HTA, e-health and the Innovation Platform?

1.2.6. Expertise required from the evaluation team

The contractor is expected to constitute a strong and experienced team for this evaluation exercise. Since the areas in public health covered by the Programme as well as the number of countries participating are widespread, the contractor should include experts in his team who are to demonstrate familiarity with the entirety of the substance the Programme is dealing with. The team must have the capacity to work in the different fields and languages needed. It must have proven experience in evaluation related to health policies and a wide range of experts on their various aspects at national and EU level.

The offer must therefore contain details on at least two well experienced experts (at least ten years) in evaluation of EU/other international funding programmes and at least three well (at least ten years) experienced experts in the areas of public health and with, in addition, a good record of project/programme evaluation. Such experts should be fully committed to the work commissioned and can be complemented by other experienced experts tasked to specific missions. All experts contributing to the contract will be asked to declare the extent of their contribution and sign the reports.

1.2.7. Other specific tasks to be carried out under the assignment

A public consultation of the Health Programme's stakeholders as part of this evaluation is foreseen for the beginning of autumn 2016. The strategy for this consultation and the questions will be decided jointly with the Interservice Steering Group and on the basis of the mapping of stakeholders and the preliminary conclusions of this evaluation. The idea is to cross-check the evaluation preliminary conclusions on relevance, effectiveness, efficiency, coherence and EU added value and gather their views for example on the need to suspend some priorities or add new ones.

This open public consultation will respect the instructions for public consultations according to Better Regulation¹² and will last 12 weeks. It will be conducted under Commission's responsibility using the tool [Your Voice](#) in Europe and [current consultations section](#) of SANTE's website.

¹¹ Including healthcare policies and reforms within the European Semester

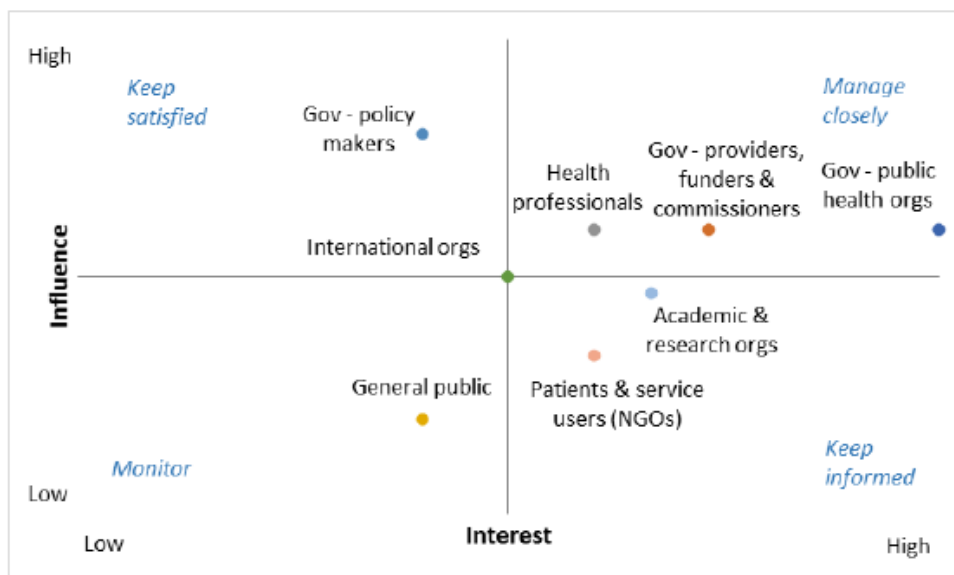
¹² http://ec.europa.eu/smart-regulation/guidelines/ug_chap7_en.htm

1.2.7.1. Assist the Commission in the conduct of a Public Consultation of stakeholders

The Commission is obliged to do an open public consultation alongside the conduct of the evaluation. The Strategy for this consultation (covering also targeted stakeholders) is presented briefly in a separate document annexed to the technical specifications. The mapping of stakeholders is one of the crucial steps in the conduct of this consultation and will permit, once accomplished, to better refine the strategy in a later stage.

So, the contractor is requested/expected to provide a detailed mapping of Health Programme stakeholders focusing on the following groups:

- Governmental policy makers
- Governmental public health organisations
- International organisations
- Academic and research organisations
- Non-governmental organizations
- Healthcare providers
- Health Professionals
- Patients and service users



The Stakeholders' mapping should be available in an electronic format that could be hosted by the Commission services and regularly updated ideally using interactive technologies.

The contractors is also requested/expected to assist the Commission in analysing and synthesizing contributions from stakeholders responding to the public consultation planned as part of this evaluation exercise. The results of this public consultation including the contributions received will be publicly available. They should also be taken into consideration when developing conclusions and recommendations stemming from this mid-term evaluation.

1.2.8. Reporting and deliverables

(e.g. subject, structure and contents of reports)

The assignment includes the submission of a series of deliverables: reports and presentations.

The evaluators will deliver the following reports at key stages of the evaluation process: inception report, interim progress report, draft final report and final report. Each report should be written in English, professionally edited, and critically assessed as it provides the basis for tracking the quality of the work done by the evaluator. The contractor will attend four to five specific meetings with the Steering Group to present and discuss the progress of the evaluation work after the inception report, the interim report and the draft final report. These meetings will be held in Luxembourg or Brussels. The contractor is requested to take notes at the meetings and to submit them to the Steering Group for adoption the week following the meeting.

More precisely, the following reports and presentations shall be delivered:

Kick-off meeting report- within one week after the kick-off meeting

Members of the contractor's evaluation team will attend a kick-off meeting with the Steering Group. The contractor will give a presentation at the kick-off meeting, describing the methods, timing and quality assurance. The purpose of this meeting is to verify:

- the team's understanding of the Task Specifications;
- the proposed general approach to the work (methodology, scope, etc.);
- the composition of the full evaluation team.

Inception report – within 1 month of signing the contract

The inception report completes the structuring phase of the evaluation. It should give a concise and comprehensive description of the overall approach, the methodology applied, the work plan and the organisation of the work. It should set out in detail how the methodology for data and evidence gathering, for analysis and reaching the conclusions. It should describe how the methodology will be implemented, and in particular lay out clearly in tabular form how the method allows each evaluation question to be answered via establishment of judgement criteria and within these, of evaluation indicators. In addition the table should have a further column indicating the evaluation tools chosen. The inception report should be a stand-alone document of maximum 40 pages (without annexes) and include enough detail for the Steering Group to gain a good understanding of the evaluation tools and related methodological steps proposed.

The report may supplement with detailed sub-question evaluation questions as considered necessary to answer the evaluation questions. As such, this document will provide an opportunity to make a final check on the feasibility of the method proposed and the extent to which it corresponds with the task specifications.

The known sources of information, use of tracers, case studies, contact persons in Member States, as well as the way the contractor will interact with Member State representatives will be fully clarified at this stage.

The inception report will be submitted to the Steering Group which will discuss on this basis with the contractor and may request changes and improvements. The contractor is expected to present the inception report in a summarized way at the occasion of the meeting. The final versions of evaluation questions suggested by the contractor and the evaluation indicators to be used will be validated by the Steering Group at this stage. After the meeting the contractor will submit a final version of the inception report.

Intermediate report – within 4 months of signing the contract

This report will provide information on the initial analysis of data collected. The evaluator should already be in a position to provide: a) aggregate data and an overview of the first three years of the implementation of the Health Programme, b) preliminary findings and c) preliminary answers to the evaluation questions. It should contain a suggestion for the structure of the final report and not exceed the size of 80 pages (without annexes).

The report will provide the evaluation manager and the Steering Group with an opportunity to check whether the evaluation is on track and whether it has focused on the specified information needs.

The contractor will submit a final interim report with the necessary updates after discussion with the Steering Group in a specific meeting. At this meeting, the contractor will define in agreement with the evaluation manager and the Steering Group the table of contents and structure of the draft final report. A document outlining the latter must be submitted by the contractor at least one week in advance of the meeting. It will serve as a basis for the discussion. The contractor is expected to present the interim report in a summarized way at the occasion of the meeting.

Draft final report – within 7 months of signing the contract

This document will provide the preliminary conclusions of the evaluator in respect of the evaluation questions. These will be based on evidence generated through the evaluation. Any judgements provided should be clear and explicit. The draft final report should also contain substantiated recommendations/options for change made on the basis of the conclusions reached by the evaluator. It will also provide a technical overview of the evaluation process, highlighting limitations and possible bias therein.

The draft final report should be structured along the lines of Commission Evaluation Standards. It will not exceed the length of 100 pages (without annexes) and it will include an executive summary of not more than 10 pages (factual data concerning the implementation of the Programme and summary of analyses and conclusions) in EN, FR and DE, the main report (presenting the results of the analyses in full, conclusions and recommendations) and technical annexes (one of which will be these Task Specifications) and a draft one-page summary on the Key Messages (conclusions and recommendations in bullet form) of the evaluation.

The draft final report will be discussed with the Steering Committee and the contractor in a meeting. The contractor is expected to present the draft final report in a summarized way at the occasion of the meeting.

Final report – to be submitted 10 months after signature of the contract

The final report should have the same structure and length as the draft final report. It will take account of the comments and discussions with the Steering Group regarding the draft final report insofar as they do not interfere with the autonomy of the evaluators in respect to their conclusions.

Other deliverables

The contractor should also provide a PowerPoint presentation of final key aspects and findings of the study, together with speaking notes. At the request of the Commission, the contractor should provide a maximum of two presentations to interested stakeholder groups such as the Programme Committee. The contractors, in these cases, will be requested to be physically present at those meetings/events with one or maximum two members of their team. These are organised exclusively in Luxembourg in the Commission premises. The Commission will hold the copyright of the reports, annexes and presentations.

Deliverables regarding the public consultation

- Mapping of stakeholders in electronic format (*including their names, e-mail and internet addresses*). The contractor is requested to identify persons and groups on the basis of lists that DG SANTE and Chafea will provide to him, clean, systematise-categorise them and complete this information by contacting on behalf of the Commission national Focal Points and Programme Committee Members or other relevant sources.
- The analysis of the contributions received through the public consultation, and suggestions for reply to the stakeholders (the size of this document depends on the number of contributions to be received) It is worth note that although the questionnaire for this public consultation will be only in English the replies may be received in all 24 EU languages.
- A report presenting the main comments/contributions and how these can be integrated in the evaluation work. (*The requirements for the content of this report will be discussed further with the Steering Group Members*) The report of the stakeholder consultation will also be publicly available on the consultation webpage.

Requirements applicable to all above-mentioned deliverables

It is essential that all the reports are clear, unambiguous and comprehensive. They should also be understandable for non-specialists. The reports should be provided to the European Commission in Word format and the raw data and charts in Excel. They should be accompanied, where requested, by appropriate annexes. All reports and presentations are to be submitted in electronic format in accordance with the deadlines set in the time-schedule specified below.

Data protection rules have to be respected. If personal data is collected and processed, the processing has to comply with the Regulation (EC) 45/2001 on the protection of personal data. Regarding the consultation, it will be clearly stated that contributions are going to be published

on the dedicated website, unless respondents provide a substantial justification for their opposition to the publication of their contribution.

Through the Transparency Register, organisations that wish to submit comments will be asked to provide the Commission and the public at large, with information about their interests they represent and how inclusive their representation is. Submissions from organisations that choose not to register will be treated as "individual contributions" unless they are recognised as representative stakeholders via relevant Treaty provisions.

1.2.9. Organisation and timetable

1.2.9.1. Organisational framework and methodological considerations

The evaluation will be organised through a specific request for service within the framework contract SANCO/2012/02/011 with reopened competition for the provision of evaluation, impact assessment and related services to the European Commission. Lot 1: Public Health This contract is managed by the Directorate-General for Health and Food Safety.

As part of the bid, the contractor should identify the team of evaluators to be involved, describe their skills and qualifications, quantify the input of each member of the team in terms of days and explain the distribution of tasks between the different evaluators. As part of the tender documentation, the team to be involved should be identified, describing their skills and qualifications, qualifying the inputs of each member of the team and quantifying them in terms of days and showing the distribution of tasks between the consultants involved. All staff-related issues will be clarified during the kick-off meeting.

The contractors should propose different methods and tools that are considered appropriate to answer the evaluation questions suggest benchmarks and define suitable indicators. Contractors can propose other tools for data collection and analysis as they see fit, including desk research, use of tracers, case studies, workshops, bibliometrics, focus group interviews, concept mapping, Delphi methods etc. It would be appropriate to concentrate the present evaluation work more on desk work, case studies and research scrutinising relevant internal documents such as Annual Work Programmes, call documents, project evaluation reports, project deliverables, statistics and not reduce it to only e-surveys and interviews.

Methods and tools for answering each evaluation question should be proposed in the bid and further developed in the inception report.

The mid-term evaluation of the 3rd Health Programme must comply with the quality criteria and the state of the art in the field, and assessments should be well argued on the basis of rigorous qualitative and quantitative analysis. It should also be conducted in such a way that the results can be used to improve policy decision-making and thus improve action taken in future.

The evaluators are expected to develop an appropriate method to address the evaluation questions, not losing sight of the following transversal issues:

- Health Programme intervention logic; (*see in annex*, the priorities of the Commission, the Commissioner's mission letter and the resulting strategic objectives defined by DG SANTE in its recent planning exercise. This intervention logic should be verified and completed.)
- Causality factors;
- Partnership strategies;
- Programme management.

In addition to above mentioned evaluation questions to which evaluators should provide their input and build their conclusions and recommendations, overall conclusions covering shortly the

relevance, effectiveness, efficiency, EU-added value, utility and coherence-consistency of the 3rd Health Programme 2014-2020 are also expected.

1.2.9.2. Time schedule for reports and meetings

A detailed work plan should be submitted together with the bid building on the time-schedule summarised below. It should be updated, if needed, in the Inception Report. The following general timetable must be strictly respected.

1	Kick-off meeting	Within 1 week after contract signature
2	Inception Report Inception meeting	Contract signature + 1 month
3	Interim Report Meeting to discuss/adopt the Interim Report	Contract signature + 4 months
4	Draft Report Meeting to discuss/adopt the Draft Report	Contract signature + 7 months
5	Final Report End of the evaluation exercise	Contract signature + 10 months

1.2.9.3. Quality assurance

In order to ensure the necessary level of quality for the independent evaluation requested contractors should always bear in mind that:

- the evaluation must respond to the information needs, in particular as expressed in these Task Specifications and following discussions with the Inter-service Steering Group;
- the methodology and design must be appropriate for obtaining the results needed to answer the evaluation questions;
- the collected data must be appropriate for their intended use and their reliability must be ascertained;
- data must be analysed systematically to answer the evaluation questions and to cover all the information needs in a valid manner;
- findings must follow logically from and be justified by, the data/information analysis and interpretations based on the pre-established criteria and rationale;
- To be valid, conclusions must be non-biased and fully based on findings;
- Particular attention shall be given to the recommendations. These must be practical and helpful. All areas which need improvements must be identified in conformity with the conclusions, and the suggested options must be realistic and impartial.

The quality of the evaluation and of the subsequent reports will be followed systematically during the whole evaluation period. Specific criteria for quality assurance will be used to ensure that the quality of the overall evaluation exercise is the optimum: e.g. before the adoption of the draft final and final report, the Inter-service Steering Group will provide its own comments and marks on the basis of a Quality Assessment Checklist which is annexed here as part of the task specifications.

The quality assessment will be public as a measure of transparency and accountability for the evaluation conducted under this assignment.

1.2.10. Duration and Budget

The contract duration is 10 months. It is expected to start by end March 2016.

Contractors are requested to submit an offer which clearly makes a distinction between both parts:

A. The evaluation

B. The public consultation

The price band is from Euro 160.000 up to a maximum of Euro 200.000 for the evaluation assignment covering points 2.1 until 2.6.

The price band is from Euro 30.000 up to a maximum of Euro 50.000 for the public consultation (point 2.7).

The financial offer for the public consultation should include

1. A main part covering the mapping of the stakeholders, the analysis of the contributions received (for a maximum of 200 contributions) and the reporting.
2. The costs per additional batch of maximum 50 contributions (up to a total of 200 additional contributions, i.e. 4 extra batches).

The Commission will pay invoices only for the services effectively rendered by the contractor.

Contractors should use annex III to submit their offer.

Award of the contract shall be based upon the total price (evaluation + public consultation).

1.2.11. Special requirements

All experts involved in this assignment should not have participated as applicants/beneficiaries in the 2nd and 3rd Health Programme. Their independency should be documented by a declaration of non-conflict of interest. The template for this declaration is provided in Annexe to the Technical Specifications.

1.3. References

1.3.1. Annexes to the Task Specification

(Documents to support the drafting of the offer by the contractor, e.g. list of Stakeholders, reference documents, existing data)

The priorities of the Commission, the Commissioner's mission letter and the resulting strategic objectives defined by DG SANTE



10.3.2015 Note on Health Priorities.pdf



Health priorities note clean version without

Commission Staff Working Document Brussels, SWD(2014) 200 final of 26.6.2014 SWD(2014) 200 final : "Overview of the Monitoring, Reporting and Evaluation Frameworks for the MFF 2014-2020 Programmes" accompanying the " Report from the Commission to the European Parliament and Council on the evaluation of the Union's finances based on the results achieved "



Evaluating results of
HP 2014_2020.pdf

Consultation Strategy



Consultation
strategy.docx

Quality Assessment Check-list



Checklist quality
assessment.d...

1.3.2. Other existing documentation/data and how to access it

(Documentation/data to support the implementation of the assignment, e.g. studies, statistical data.)

- Planned spending /Commitments in 2014 and 2015



planned spending
WP2014+2015.xlsx

- Programme Progress Indicators



20130110_ProgramSt
atement_PH_input C-[Statement 24Apr15_cl



HP Programme

- Indicators for Operating Grants



2015 11 19
HP-SGA-OG REP...

- DG SANTE and CHAFEA will provide for the mapping of stakeholders the following lists:
 - List with names and e-mail addresses of Programme beneficiaries (grant recipients) of 2nd and 3rd Health Programme
 - List with names and e-mail addresses of recipients of the E-health Newsletter
 - List with names and e-mail addresses of experts in health advisory groups and Committees
 - List of organisations receiving the alerts for calls for tender
 - List with names and e-mail addresses of unsuccessful applicants to the calls of the Programme

- List with names and e-mail addresses of organisations that demonstrated interest in the 3rd Health Programme (info day of 11 April 2014, other info-days, presentations of the Programme and dissemination activities)
- List of Health Policy Forum participants

1.3.3. Useful web-links

(e.g. to the relevant SANTE activity on Europa)

Documents related to the 3rd Health Programme (e.g. *impact assessment, Annual Work Programmes, Annual Reports* etc.) can be found at DG SANTE Website http://ec.europa.eu/health/programme/policy/index_en.htm

These documents constitute the basis for understanding the rationale of the Programme and its overall functioning.

Other information on the functioning of the Programme available on the Chafea's Website will be used in the evaluation

especially the database: and publications and info sheets regarding a series of *Programme actions*

http://ec.europa.eu/chafea/publications/publications_for_health_programme.html

http://ec.europa.eu/chafea/health/hp-infosheets_en.html

ECHI indicators http://ec.europa.eu/health/indicators/echi/index_en.htm

2. DATA ANALYSIS

Introduction

This section presents an analysis of data on the Health Programme (HP), with a view towards providing insight into how the HP has been implemented so far. The analysis covers in full the years for which all implementation data was available, namely 2014 and 2015. Where possible, we also provide insight about the HP's implementation in 2016, though data for this year was not complete at the time of writing.

We present the analysis in terms of funds allocated (overall and by year, by objective / thematic priority and via the different funding mechanisms), the spread of actions across the Member States and the kinds of organisation engaged in the implementation of the Programme. In order to structure the analysis, we present the results corresponding to four key research areas which are briefly described below.

1. High-level budget structure and management

This section shows how the HP budget is divided between DG SANTE and Chafea and provides detail about the breakdown between recurrent spending and more flexible spending that allows the 3HP to adapt to emerging needs.

2. Delivery through financial mechanisms

This section presents the allocation of the 3HP's resources across its different financial mechanisms, as well as giving detail on how this has varied over time

3. Thematic focus of the 3HP

Here we show how funding has been split across the 3HP's four specific objectives and 23 thematic priorities, in addition to looking at the number of actions funded.

4. Beneficiary involvement

To understand the access to and participation in the 3HP, we look at the types of organisations involved and the MS where they are based in.

Note on data sources

The analysis is based on the following information sources:

- **Thematic focus:** *Manual link up with thematic priorities from AWP provided by DG SANTE and Chafea respectively for 2014 and 2015. For 2016 this was done by the evaluation team.*
- **Budgetary and beneficiary data:** *For actions implemented by Chafea 2014 and 2015: a composite of information retrieved from their grants management system and their IT warehouse, while for contracts managed by DG SANTE retrieved from their financial administration unit. Note that data for 2016 beneficiaries is not available.*

1.1 High level budget structure and management

For each year, the Annual Work Programme (AWP) sets out a list of actions to be supported under each specific objective and thematic priority. The actions are a mixture of new and recurring actions. On the basis of the agreed AWP, either Chafea or DG SANTE (depending on the nature of given actions) will either award / negotiate funding directly or issue calls for proposals, responses to which are then assessed and support awarded according to the appropriate procedures. The sums awarded are defined as *committed* amounts. The committed annual operational budget was €53.8 M for 2014 and €55.4 M for 2015. The budget for 2016 is €56.4¹³.

Table 1: Budget allocation between DG SANTE and Chafea, 2014 - 2016

	2014	2015	2016 ¹⁴	TOTAL
Chafea	€44.4 M	€48.6 M	€47.2 M	€140.2 M
DG SANTE	€9.4 M	€6.8 M	€9.2 M	€25.4 M
TOTAL	€53.8 M	€55.4 M	€56.4 M	€165.6 M

Source: Chafea and DG SANTE

Note: Figures are rounded

The **majority (85%) of the committed funding is implemented by Chafea** through a mixture of different types of grants and procurement contracts, while the remaining **15% is managed by DG SANTE**. This funding consists mainly of procurement contracts but it also includes a mix of other actions, such as direct grant agreements to international organisations, administrative agreements, sub-delegations, specific indemnities to experts, etc. As the executive agency, Chafea is responsible for most HP grant funding (through different funding mechanisms, such as joint actions, projects, operating grants and direct grant agreements) and certain procurement contracts. The actions managed by DG SANTE consist of strategic and institutional support needed to operationalise the HP.

Recurrent spending and adaptability to emerging needs

Recurrent spending is funding which is allocated on a recurring multiannual basis. It includes a range of different types of actions addressing an identified need, some large and some small. For example, smaller sums include biannual spending on “Monitoring of the EU Platform for Action on Diet and Health”¹⁵, while larger sums go to “Operating Grants” for non-governmental bodies which support the HP goals¹⁶ and (a range of) IT services¹⁷.

In the first two years of the 3HP, **over a quarter of the total annual budget has gone to “recurrent spending” (27 and 28% respectively)**. Projections indicate this is **likely to increase** in 2016 (to 37%) and 2017 (to 53%)¹⁸. This is important because the balance between recurrent and unassigned spending will determine how much funding is available to respond to unidentified or emerging needs.

¹³ Note this figure may change once all the budgets for actions are finalised and committed. For instance the sum for SANTE managed direct grant agreements and “other” actions, and Chafea-managed joint actions for which some calls are ongoing.

¹⁴ Ibid.

¹⁵ approximately €300,000 every two years

¹⁶ around €5 M per year

¹⁷ €1.4 M per year in 2014 and 2015

¹⁸ These figures are based on an assessment of HP budget data conducted by DG SANTE and shared with the evaluation team.

While the HP budget is largely allocated according to the AWP, there is also some flexibility to adapt to quickly changing circumstance. This has been the case most notably in the summer of 2015, when funding was quickly allocated to the emerging migrant crisis. In practical terms, this started with funds originally allocated to supporting the legislation for medical devices not being utilised (because the legislation was not adopted according to the foreseen schedule). An amendment to the AWP 2015 then allowed the 3HP to channel this funding into support related to the exceptional situation arising from the influx of migrants. This was to support Member States to help *“address the health-related issues of arriving migrants while preventing and addressing possible communicable diseases and cross-border health threats.”*¹⁹ For example a direct grant agreement provided support to the International Organisation for Migration, and there were a number of specific projects for NGOS dealing with migration²⁰.

1.2 Delivery through financial mechanisms

The HP is implemented through **funding mechanisms** that reflect the different kinds of actions and objectives pursued. These are summarised in the table below.

Table 2: Financial mechanisms

Financial mechanism	Description
Direct Grant Agreements (DGA)	Cooperation with international organisations or governments (for example WHO, OECD, membership fees, presidency conferences)
Operating grants	Support for the functioning of non-governmental bodies
Procurement contracts - CHAFEA	Studies and other service contracts to cover specific needs related to the support of EU health policies
Procurement contracts - SANTE	Service contracts and payment of individual experts, IT infrastructure, strategic studies requested by the Commission services, etc., as well as support for which the legal basis for action requires it to be implemented by the Commission. ²¹
Projects	Cooperation projects at EU level (lasting 12 – 36 months)
Joint actions	Actions jointly undertaken by Member State health authorities (lasting 12 – 36 months)
Conferences	Funding is available for certain conferences, namely thematic conferences on health topics to mark Presidency of the EU
Others	“Payment of membership fee and reimbursement of expert mission costs”, “Reimbursement of auditor mission costs”, “Cross sub-delegation to EUROSTAT”, “Administrative arrangements”, etc.

¹⁹ Commission (2015), Commission implementing decision of 28.10.2015 amending Decision C(2015)3594 of 2.06.2015 concerning the work programme for 2015 in the framework of the third Programme of the Union’s action in the field of health (2014-2020) and the EU financial contribution to the WHO Framework Convention on Tobacco Control, serving as a financing decision, C(2015)7414 final

²⁰ For example: Common Approach for Refugees and other migrants’ health; 8 NGOs for migrants/refugees’ health needs in 11 countries and Supporting health coordination, assessments, planning, access to health care and capacity building in Member States under particular migratory pressure (SH-CAPAC)

²¹ For example, actions supporting the implementation of Union legislation in the field of medical devices, medicinal products and cross-border healthcare.

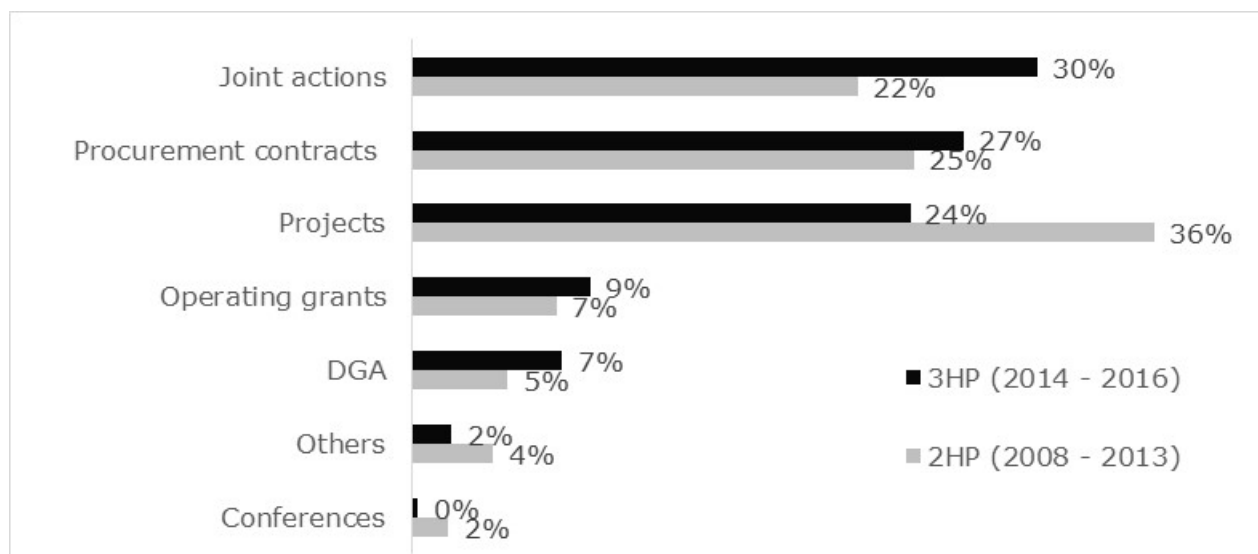
The 1HP used three types of instruments: projects (calls for proposals), direct grant agreements and procurement contracts. The ex post evaluation of the 1HP showed that the bulk of the financial envelope had been allocated to projects (93%) and therefore there was a need to adapt the instruments to:

- Better take into consideration the accounting requirements of the projects funded – which led to the introduction of **operating grants** to provide financial support towards the functioning of an organisation in its core activities over a period that is equivalent to its accounting year.
- Enable collaborative effort, involving research or design – which led to the introduction of **joint actions** to provide funding of joint activities of the Commission and third parties.
- Allow for (more) focused outcomes – as reflected in the increased use of **procurement contracts**.

Under the 2HP there was a shift away from projects (36%) towards joint actions (22%), operating grants (7%) and procurement contracts (25%), which give the Commission more control in the design of work carried out.

In the first three years of the 3HP, we can see the **continuation of trends observed during the 2HP**. Joint actions (34%) and DG SANTE- and Chafea-managed procurement contracts (27%) have received the highest proportion of funding, followed by projects (24%). Operating grants and direct grant agreements (DGA) took a consistently smaller proportion of the budget each year but still as much 9% and 7% in total, respectively. Allocations to “other” mechanisms and conferences took a very small share of the budget.

Figure 1: Proportion of total funding by mechanism for 2HP and 3HP (2014 – 2016)



Sources: 3HP DG SANTE and Chafea; 2HP Annual implementation reports
 Note: Percentages are rounded to the nearest whole percentage point

The table below provides a detailed breakdown of the allocation of funding and number of actions by financial mechanism in the first years of the 3HP. The most notable change in this time is the increase in spending through Chafea-managed procurement contracts in 2016. Looking into these contracts, there are a number of high-value contracts, which was not the case in previous years²². We note that while there appears to be a big fluctuation in 2016

²² For example: Pilot specific training modules for health professionals, border guards and trainers in migrants and refugees (value €1 M) and Support to health workforce planning and forecasting expert network (again, value €1 M) and European Reference Networks -Assessment of applications of Network and membership proposals (value almost

regarding DG SANTE-managed procurement contracts, this is likely to relate more to the way IT services have been accounted for than a major shift in the amount of such services that have been procured.

Table 3: Detailed breakdown of allocation by financial mechanisms, 2014 - 2016

	2014		2015		2016		TOTAL	
	Funding	#	Funding	#	Funding	#	Funding	#
Joint Actions	€18.5 M	8	€17.8 M	4	€14.2 M	5	€50.5 M	17
Projects	€12.7 M	13	€14.9 M	12	€12.6 M	7	€40.2 M	32
Procurement contracts - SANTE	€7.5 M	158	€5.7 M	144	€9.2 M	31 ²³	€22.4 M	333
Procurement contracts -Chafea	€5.2 M	19	€6.4 M	11	€10.6 M	20	€22.1 M	50
Operating grants	€4.7 M	14	€5 M	13	€4.7 M	13	€14.4 M	40
Direct Grant Agreements (DGA)	€3.8 M	25	€3.8 M	10	€4.5 M	6 ²⁴	€12.1 M	41
Others	€1.3 M	9	€1.4 M	6	€0.5 M	1 ²⁵	€3.2 M	16
Conferences	€0.2 M	2	€0.2 M	3	€0.1 M	2	€0.5 M	7
Total	€53.8 M	248	€55.3 M	203	€56.4 M	85	€165.3 M	536

Source: DG SANTE and Chafea

Note: Figures are rounded and figures 2016 SANTE managed actions are preliminary

The figure below compares the funding mechanisms in terms of the minimum, maximum and average budget (total budget divided by total number of actions) which has been allocated in the first years of the HP. To put the amounts in context, we also highlight the highest, average and lowest value for each.

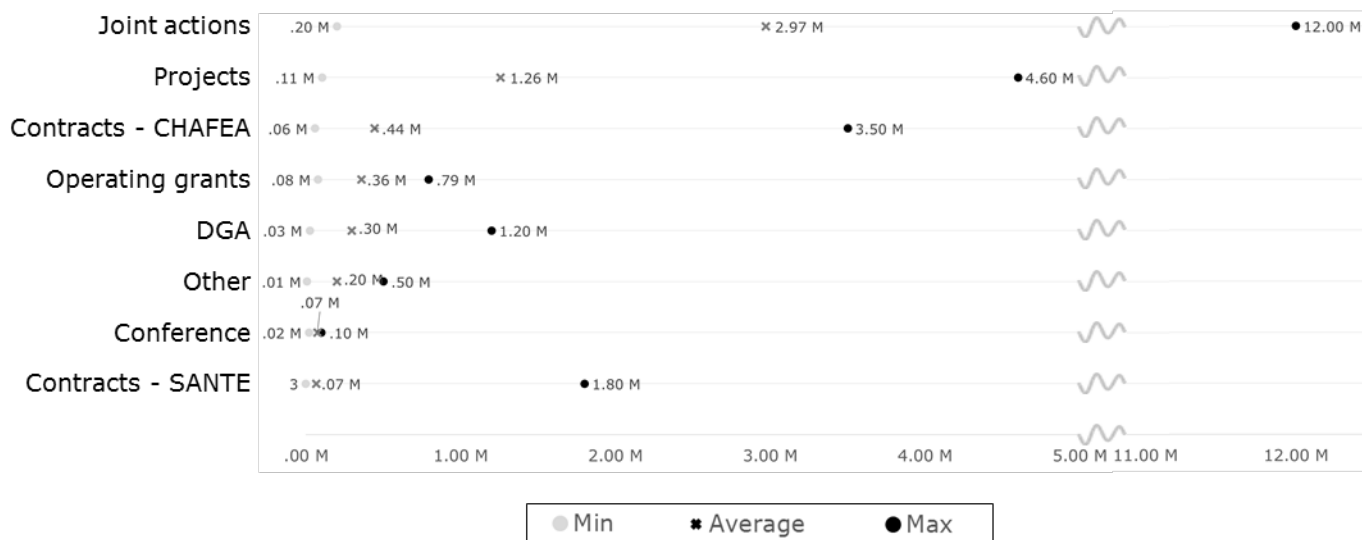
€1.8 M) and Promotion and dissemination of information on EU health policies and results of the Health Programme including translations (€1.8M).

²³ These data are preliminary

²⁴ Does not include "direct grant agreements" actions managed by DG SANTE (data not currently available)

²⁵ Does not include "other" actions managed by DG SANTE (data not currently available)

Figure 2: Comparative data for funding mechanisms²⁶ (2014 – 2016)



Source: Chafea and DG SANTE

Note: Figures are rounded

- The **largest range is found in joint actions** where funding has ranged from € 200,000 for the Joint Market Surveillance Actions on medical devices intended to be re-sterilised focusing on information in the Instruction for use and validation data necessary for the re-sterilisation by the user to €12 M for the third joint action related to the setting up of the European Network for Health Technology Assessment.
- The **highest average budget** for a given financial mechanism is also joint actions (at nearly €3 M). It is worth noting that the number of beneficiaries for joint actions (which is discussed in more detail below) is higher than for other actions (for the first two years²⁷ it averages 28), and their duration is also longer.
- The **lowest average budget** is found for DG SANTE procurement contracts (€67,400), which includes a total of 333 actions in the first three years.
- The **most consistency (i.e. the smallest range)** is found for conferences and “other” actions.

While the highest average budget is allocated to joint actions and projects, these tend to involve a high number of organisations. Beneficiary data for 2014 – 2015 show that:

- on average **28 organisations** are involved in a single joint action
- on average **nine organisations** are involved in a single project²⁸.

This means that despite a high average funding per action, on average the funding per organisation is a lot smaller for joint actions and projects compared to other actions where the funding is typically awarded to single organisations such as operating grants or direct grant agreements which go to a single organisation, for example. In addition, it is worth noting that projects and joint actions are typically implemented over periods of between 1 – 3 years, which is again different to other activities which are usually implemented over a year or less. The

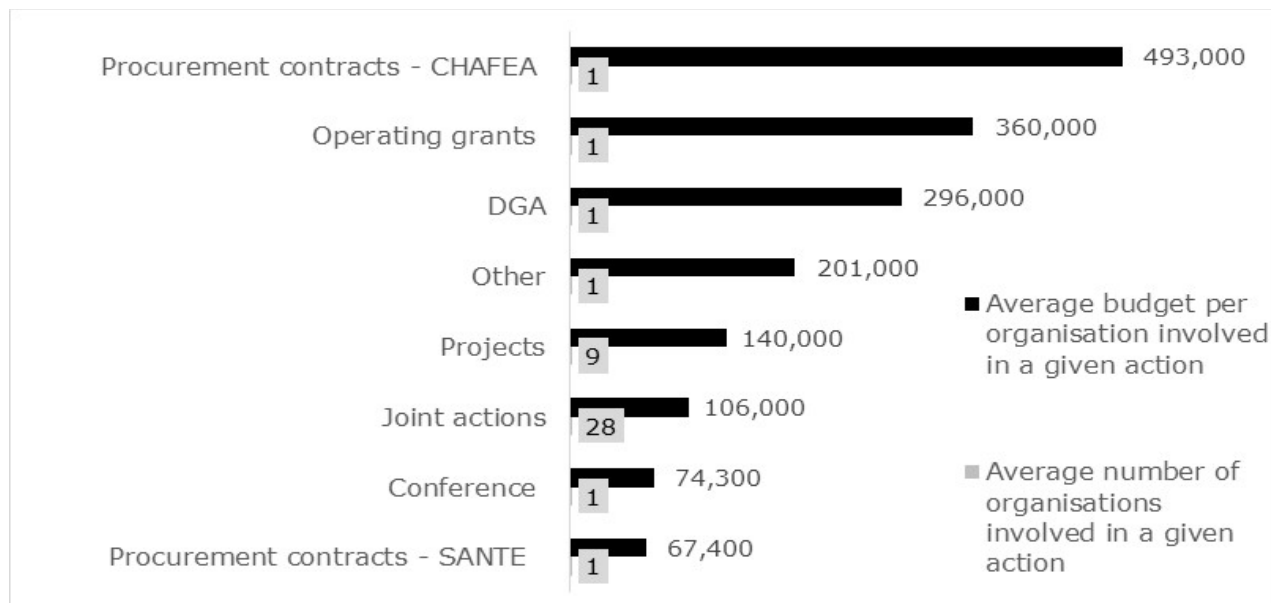
²⁶ Note that the individual sums awarded for operating grants in 2016 were not available.

²⁷ As noted elsewhere, there is no beneficiary data currently available for 2016

²⁸ As noted above, there is no beneficiary data currently available for 2016, therefore these figures are based on the first two years of the 3HP implementation.

relationship between the average funding per action and average funding per organisation typically involved in an action is presented below.

Figure 3: Comparative data for funding mechanisms (2014 - 2016)



Source: Chafea and SANTE

Note: Figures are rounded; two figures in the figure are based on data from first two years of the 3HP only: average number of organisations involved in projects and joint actions²⁹

1.3 Thematic focus of the 3HP

A key feature of the 3HP is the organisation of funded actions according to 23 thematic priorities, each of which is grouped under one of four specific objectives. This evaluation has therefore sought to explore the extent to which organising the HP in this way has helped to increase its focus and thereby address pan-EU needs and maximise EU added value.

Spending by objective

As presented in the table below, over the first three years of the 3HP, the largest share of funding has supported objectives 1 (health promotion activities) and 3 (activities which contribute to innovative, efficient and sustainable health systems), which aligns with the selected areas outlined in the Commissioner’s note on health priorities for the period 2015-2019: (i) promote good health and reduce both chronic diseases and communicable diseases, linking prevention to disease management, and (ii) support health systems. The remaining funding has been split between objective 4 (better and safer healthcare), horizontal or cross-cutting activities and objective 2 (which specifically targets cross border health threats).

²⁹ As explained elsewhere, the beneficiary data for joint actions and projects for 2016 has not been shared with the evaluation team

Table 4: Allocation of budget by objective, 2014 - 2016

Objective	2014	2015	2016	2014 – 2016
1 Promote health, prevent disease and foster supportive environments for healthy lifestyles	31%	23%	43%	33%
2 Protect citizens from serious cross-border health threats	10%	3%	8%	7%
3 Contribute to innovative, efficient and sustainable health systems	33%	45%	16%	31%
4 Facilitate access to better and safer healthcare for Union citizens	20%	11%	26%	19%
Horizontal	7%	18%	6%	10%

Source: DG SANTE and Chafea

Note: percentages are rounded to nearest whole number; 2016 is based on available data

It is worth noting how this compares with previous iterations of the HP (which have been structured slightly differently, focusing on three objectives: health promotion, security and information). While the 1HP saw the largest share of funding allocated to **health information** (39%), closely followed by **health promotion** (37%), under the 2HP, the emphasis was clearly on **health promotion activities** (which received 57% of total funding) while spending on health security and information was shared more evenly (23% and 21% respectively). The emerging trend for the 3HP is a sustained effort for health promotion to tackle chronic and communicable diseases (through objective 1) and to build sustainable, innovative and efficient health systems (through objective 3).

Spending by thematic priority

A more refined breakdown of spending by thematic priority shows significant variation of funding across the 23 priorities; the range is from over €17 M awarded to cross-cutting elements (“horizontal” activities), and tackling chronic diseases (priority 1.4), to none for “health information and knowledge system” (priority 2.4).

As highlighted in the table, the **largest amount of funding was allocated to:** tackling chronic diseases (priority 1.4) and risk factors (priority 1.1) which both fall under health promotion (objective 1). Action to tackle HIV / AIDS, TB and hepatitis (priority 1.3) and develop Health Technology Assessment (priority 3.1) were next highest recipients of funding. European Reference Networks (priority 4.1) which contribute to facilitating access to better and safer healthcare (under objective 4) have also been built up through the 3HP.

By contrast, **the lowest sums** were channelled to supporting: 2.4 Health information and knowledge system to contribute to evidence-based decision-making (€0); 2.1 Risk assessment additional capacities for scientific expertise (€70,000); 4.6 Health information and knowledge systems (€150,000); 4.4 AMR & control healthcare-associated infections (€455,000) and 1.2 Drugs-related health damage (€600,000)³⁰.

³⁰ Figures are rounded

Table 5: Allocation of budget by thematic priority, 2014 - 2016³¹

	2014	2015	2016	2014	2015	2016	Total	Total
Horizontal	€3.7 M	€10.0 M	€3.6 M				€17.3 M	
1.4 Chronic diseases	€6.6 M	€0.8 M	€9.9 M				€17.2 M	
1.1 Risk factors	€5.2 M	€4.8 M	€4.6 M				€14.6 M	
1.3 HIV / AIDS, TB & hepatitis	€3.3 M	€5.3 M	€4.6 M				€13.2 M	
3.1 Health Technology Assessment	€0.3 M	€12.0 M	€0.4 M				€12.7 M	
4.1 European Reference Networks	€5.5 M	€0.4 M	€6.7 M				€12.6 M	
3.5 EIP on Active & Healthy Ageing	€5.4 M	€6.8 M	€0.0 M				€12.2 M	
3.6 Union legislation	€4.0 M	€3.8 M	€4.2 M				€12.0 M	
3.7 Health information	€5.0 M	€1.3 M	€2.9 M				€9.2 M	
2.2 Capacity building	€1.8 M	€1.4 M	€4.3 M				€7.5 M	
4.5 Union legislation	€3.3 M	€1.9 M	€2.1 M				€7.3 M	
4.3 Patient safety & healthcare quality	€0.9 M	€1.0 M	€4.2 M				€6.0 M	
4.2 Rare Diseases	€0.8 M	€2.3 M	€1.6 M				€4.7 M	
1.5 Tobacco legislation	€0.2 M	€1.4 M	€3.1 M				€4.7 M	
1.6 Health information	€1.5 M	€0.4 M	€1.8 M				€3.8 M	
2.3 Union legislation	€3.5 M	€0.0 M	€0.0 M				€3.5 M	
3.2 Innovation and e-health	€2.4 M	€0.1 M	€0.3 M				€2.8 M	
3.4 Mechanism to pool expertise	€0.3 M	€1.0 M	€0.5 M				€1.8 M	
3.3 Health workforce	€0.2 M	€0.2 M	€1.0 M				€1.3 M	
1.2 Drugs-related health damage	€0.0 M	€0.0 M	€0.6 M				€0.6 M	
4.4 Antimicrobial resistance	€0.0 M	€0.4 M	€0.0 M				€0.5 M	
4.6 Health information	€0.0 M	€0.2 M	€0.0 M				€0.2 M	
2.1 Risk assessment	€0.0 M	€0.0 M	€0.1 M				€0.1 M	
2.4 Health information	€0.0 M	€0.0 M	€0.0 M				€0.0 M	

Source: DG SANTE and Chafea

Note: figures are rounded; 2016 allocated budget is based on available data.

The above findings are better understood when seen in light of how the budget has been utilised across the different financial mechanisms. The figure on the next page provides a visual depiction of how the funding has been shared across different funding mechanisms for different priorities.

³¹ We note that the organisation of funding by thematic priority does not allow for a clear distinction of allocations to actions in relation to migrant health. This is dealt with in the main report under external coherence (Chapter 7) where details of nine actions which deal with migrant health are listed, and total nearly €15 m. Furthermore, we note that the sums allocated to certain operating grants which are recorded under thematic priorities 1.1 may span the objective more widely.

Table 6: Allocation of budget by thematic priority and funding mechanism, 2014 - 2016

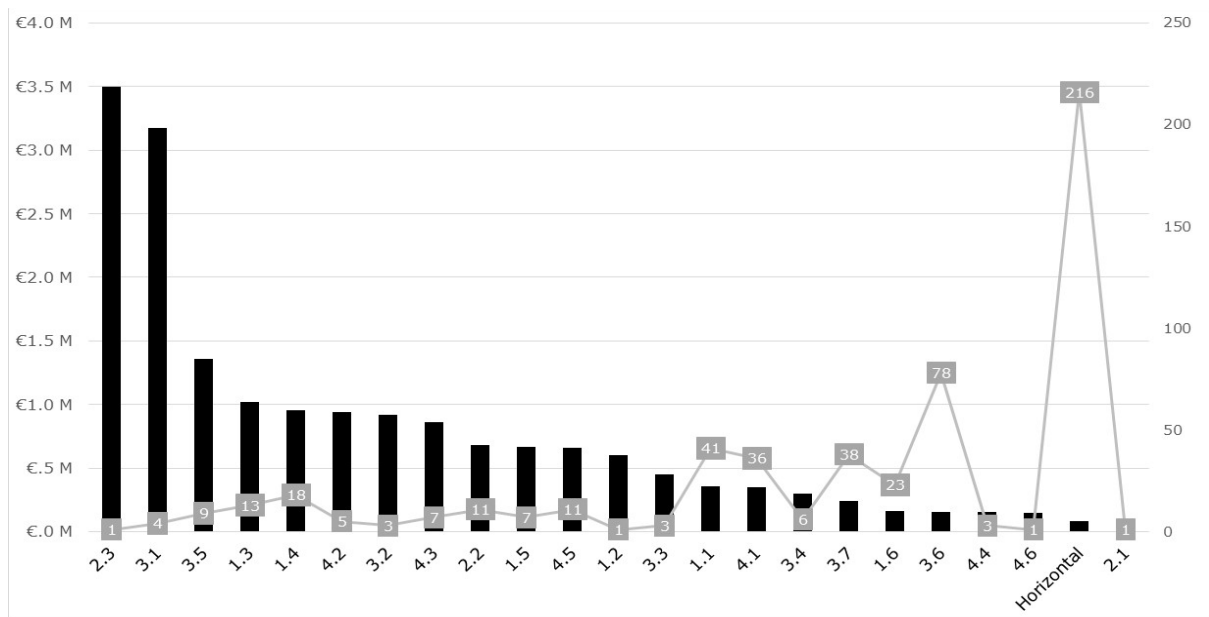
Thematic priority	TOTAL	Joint actions	Project	Procurement contracts - SANTE	Procurement contracts - Chafea	Operating grants	DGA	Other	Conferences
Horizontal	€17.32 M		€6.23 M	€8.04 M	€1.16 M		€1.75 M		€0.14 M
1.4 Chronic diseases	€17.19 M	€6.50 M	€6.65 M	€0.01 M	€1.30 M	€2.23 M	€0.50 M		
1.1 Risk factors	€14.58 M	€1.20 M	€2.23 M	€2.07 M	€0.30 M	€6.36 M	€1.70 M	€0.45 M	€0.26 M
1.3 HIV / AIDS, TB & hepatitis	€13.25 M	€5.00 M	€4.17 M		€2.70 M	€1.38 M			
3.1 HTA	€12.68 M	#####			€0.38 M			€0.10 M	
4.1 European Reference Net	€12.64 M	€4.38 M	€4.60 M	€1.34 M	€2.32 M				
3.5 EIP Active & Healthy Ageing	€12.20 M	€3.44 M	€8.75 M						
3.6 Union legislation	€12.04 M	€0.85 M	€0.30 M	€5.24 M	€1.54 M		€3.35 M	€0.76 M	
3.7 Health information	€9.16 M		€3.50 M	€1.57 M	€0.29 M		€2.16 M	€1.65 M	
2.2 Capacity building	€7.49 M				€7.49 M				
4.5 Union legislation	€7.27 M	€3.53 M	€2.01 M	€0.25 M	€0.20 M	€0.79 M	€0.50 M		
4.3 Patient safety	€6.03 M	€4.00 M			€0.37 M	€1.63 M			€0.02 M
4.2 Rare Diseases	€4.70 M	€1.50 M	€1.20 M			€2.00 M			
1.5 Tobacco legislation	€4.65 M	€2.00 M		€0.68 M	€1.57 M		€0.40 M		
1.6 Health information	€3.76 M			€2.36 M	€0.26 M		€1.13 M		
2.3 Union legislation	€3.50 M	€3.50 M							
3.2 Innovation and e-health	€2.76 M	€2.40 M			€0.36 M				
3.4 Mechanism to pool expertise	€1.77 M			€0.79 M	€0.72 M			€0.26 M	
3.3 Health workforce	€1.35 M				€1.20 M		€0.15 M		
1.2 Drugs-related damage	€0.60 M		€0.60 M						
4.4 Antimicrobial resistance	€0.45 M			€0.01 M			€0.34 M		€0.10 M
4.6 Health information	€0.15 M						€0.15 M		
2.1 Risk assessment	€0.07 M			€0.07 M					
2.4 Health information	€0.00 M								
TOTAL	€165.63 M	€50.50 M	€40.24 M	€22.44 M	€22.17136 M	€14.41 M	€12.14 M	€3.22 M	€0.52 M

Source: DG SANTE and Chafea

Note: Figures are rounded. 2016 SANTE data for "DGA" and "Other" is not yet available

In turn, the average spend per action also varies substantially by thematic priority. In the figure below, for each thematic priority the bars show average amount of spending per action, while the line illustrates the number of actions funded. As the chart makes clear, for two thematic priorities in particular (namely 2.3 and 3.1) funding has gone to a relatively small number of large actions (i.e. joint actions). Others (3.5, 1.3, 1.4, 2.2 and 4.5) have received funding for a larger number of substantial actions. Thematic priorities 1.1, 4.1, 3.7, 1.6 and 3.6 have been allocated funding for large numbers of smaller actions. Other thematic priorities have not been highly utilised so far.

Figure 4: Average funding per thematic priority (total funding divided by number of actions) and total number of actions, 2014 – 2016



Source: Chafea and SANTE

1.4 Beneficiary involvement

The award of grants and contracts to different organisations is best analysed through the lens of the different financial mechanisms. The financial mechanisms involve different types (and numbers) of organisations and also reveal patterns in terms of participating countries (as detailed in the table below)³².

Table 7: Comparative information for financial mechanism and beneficiaries

Financing mechanism	Typical organisation(s) involved (# organisations per action)	Implications for country involvement
Joint actions	Collaborations between public bodies, research organisations, academic organisations (the number of participating organisations ranged from 10 to 61 but on average 28 organisations were involved in a given joint action).	The involvement of organisations is based on nominations from national health authorities; all MS authorities are asked to put forward suggestions for participants when a joint action is negotiated. Most MS had organisations involved in at least half of all the joint actions (more detailed information below)
Projects	Collaborations between research institutes, academic organisations, public bodies (number of organisations ranged from 3 to 31 but on average 9 organisations were involved in a given project).	Most participating countries are involved in projects but to varying degrees (more detailed information below).
Procurement contracts DG SANTE ³³	Private entities and EU institutions (single recipients).	Participation concentrated in organisations based in BE ³⁴ , and five other MS: NL, LU, FR, the UK and DE ³⁵ . A further 14 MS, managed 1 or 2 actions each. Many actions (23) were non-national in nature ³⁶
Operating grants	NGOs and umbrella organisations (single recipient, which has many members ³⁷).	These organisations are typically EU-wide with membership spanning the MS (more detailed information below).
Procurement contracts Chafea	Typically international organisations (single recipients).	These organisation typically have their headquarters in LU (e.g. SOGETI), BE (e.g. PWC), the UK (e.g. Public Health England) and NL. There are some exceptions, such as the consultancy "NOOKOM" with headquarters in SK.

³² The data do not allow for a statistical analysis. There are some gaps in the data (for example, organisations are sometimes recorded as "other" or left blank) and some inconsistencies (which make it an unreliable source for statistical analysis).

³³ As previously mentioned, DG SANTE manages actions which provide the HP with strategic and institutional support, for example the payment of experts, IT services and solutions and membership fees, among others. Some of these are horizontal, cross-cutting support and others are more specific to the implementation of thematic priorities, such as the establishment of a European Reference Network.

³⁴ 40% of all actions

³⁵ which, combined, managed 46% of actions

³⁶ For example, indemnities to experts, conferences, promotional tools and materials.

³⁷ the total number of members can vary from around 30 (for instance "The European network for smoking prevention" <http://ensp.org/> and "The Smoke Free Partnership" <http://www.smokefreepartnership.eu/>) to over 130 (for instance "Aids Hilfe" <https://en.aidshilfe.de/aids-service-organizations>)

Direct grant agreements	International organisations (e.g. WHO and OECD) and MS authorities ³⁸ (single recipients).	The organisations are typically international or MS authorities determined by the presidency of the EU.
Others	Payments to other Commission authorities (e.g. Eurostat or JRC) and payments to individuals (i.e. experts)	Involvement ranges from individuals/experts to EU institutions.

Source: DG SANTE and Chafea³⁹

The subsequent analysis is focused on analysing participation and receipt of funding in different participating countries, with a focus on those mechanisms where these issues are most relevant, namely joint actions, projects and operating grants.⁴⁰ This dimension is less relevant for certain financial mechanisms where there is a single recipient which could be a national or non-national, international or multi-national organisation (i.e. DGA and procurement contracts). Note that, beneficiary data are available for 2014 – 2015 only.

In the context of analysing the geographical distribution of funding, it is important to highlight that, as with previous iterations of the HP, one of the general objectives of the 3HP is to reduce health inequalities.

Typically, organisations receiving money through joint actions, project and operating grants can receive a grant of 60% of eligible costs, while the remainder must be obtained from co-funding. Based on the assumption that the required co-funding may discourage / act as a barrier to participation for organisations from countries with a low GNI, an “exceptional utility” selection criterion was introduced during the second half of the 2HP⁴¹. In case the “exceptional utility” criteria is met for a given action, all participating organisations involved in that action are eligible for the higher rate of funding (80%).

The criterion varies slightly different for each funding mechanism, but generally counts organisations from countries with a GNI per inhabitant of less than 90% of the EU average. This is calculated every year based on data compiled by Eurostat⁴². The precise list of eligible countries can vary by year but has so far in the first years of the HP consistently included all those MS who joined the EU after or on July 1st, 2004⁴³, as well as EL and PT. From 2015, ES has also been classified as “low GNI”.

Joint actions

As mentioned above, the involvement of countries in joint actions is facilitated by national authorities. The table below provides a detailed breakdown of the proportion of joint actions countries have been involved in in the first two years of the 3HP. Just one country was involved in every joint action (Italy) but most countries were involved in at least half. The reasons for lower participation in some countries cannot be gleaned from these numbers directly. However, there is a pattern whereby countries with a lower

³⁸ Presidency conferences are also funded through this mechanism and have to date been held in Latvia, Italy, Luxembourg and the Netherlands.

³⁹ Note that data on beneficiary involvement is only available for 2014 and 2015.

⁴⁰ For operating grants this is through the umbrella organisation

⁴¹ Under the 2HP the EU funding co-financing rate could be raised to 70 or 80 % (depending on whether the action was co-financed by the competent authorities of participating countries or by NGOs mandated by competent authorities).

⁴² See http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=nama_inc_c&lang=en

⁴³ i.e. BG, CZ, CY, EE, LV, LT, HU, HR, MT, PL, RO, SI, SK

population tend to be less heavily involved, for instance Iceland, Luxembourg, Denmark, Slovakia, Cyprus, Estonia, and Latvia.

Table 8: Proportion of joint actions participating countries are involved in⁴⁴

% of joint actions countries involved in	Participating countries
100%	IT
83%	FR, NO, EL, ES, HU, HR
75%	AT, BE, IE, PL, RO, LT
67%	DE, NL, FI, UK, BG
58%	CZ
50%	SE, MT, SI
42%	EE, LV
33%	CY, SK
25%	DK
17%	LU
8%	IS

Source: Chafea

In terms of the funding received and the average funding for organisations in each participating country, the data confirms that funding is concentrated in large, high GNI countries, and that on average, countries with high GNI receive high levels of funding:

- Organisations based in seven countries received the majority budget managed through delivery of joint actions (65%). These were: Germany (13%); France (12%); Italy (11%); UK (9%); Spain, the Netherlands and Austria (all 7%) (**Figure 5**). Just one of these countries was categorised as a low GNI country in one of the two years (Spain).
- Countries with organisations receiving above average funding are all from high GNI countries: UK, the Netherlands, Germany, France, Austria, Finland, Italy, Sweden, and Denmark (**Figure 6**).

⁴⁴ To avoid double counting when several organisations from a single country participate in an action, this table lists the number of different Joint Actions countries participated in.

Figure 5: Allocation of funding for joint actions across participating countries

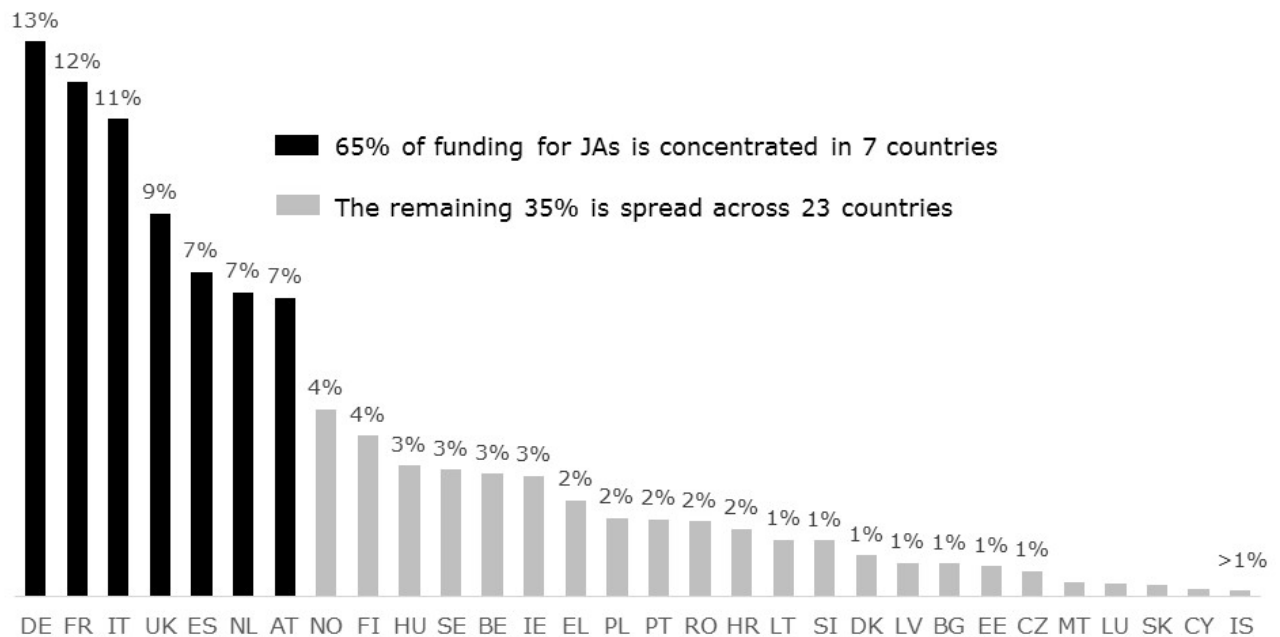
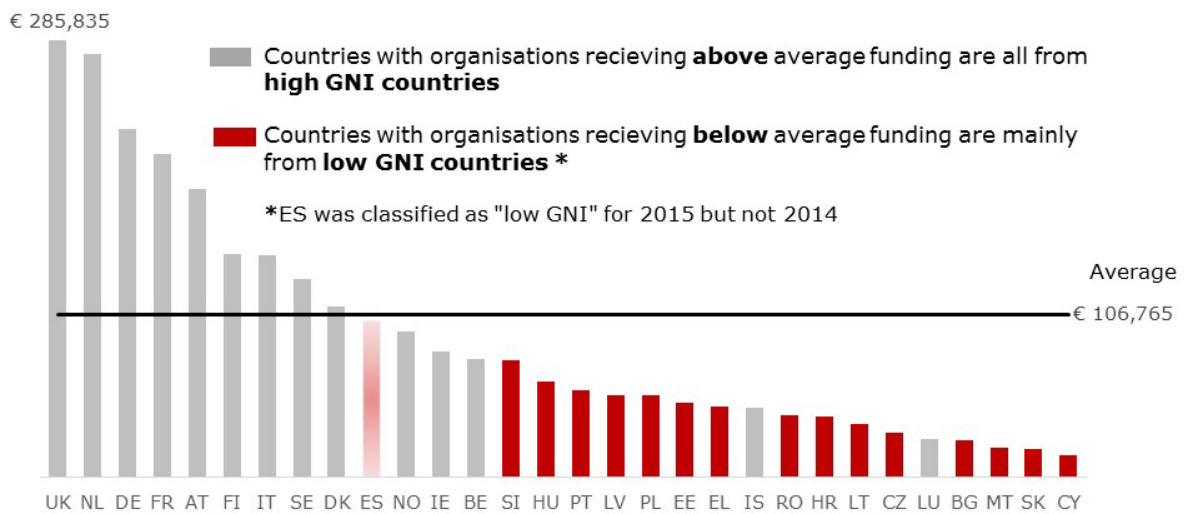


Figure 6: Average funding received for organisations participating in joint actions by participating country



Source for both figures: Chafea

As explained above, in order to encourage the participation of lower income countries, the “**exceptional utility**” criterion allows for higher levels of co-funding under certain conditions. In the case of joint actions these criteria are as follows:

1. At least 30% of the budget of the proposed action is allocated to Member States whose gross national income (GNI) per inhabitant is less than 90% of the Union average. This criterion intends to promote the participation from Member States with low GNI.
2. Bodies from at least 14 participating countries participate in the action, out of which at least four are countries whose gross national income (GNI) is less than 90% of

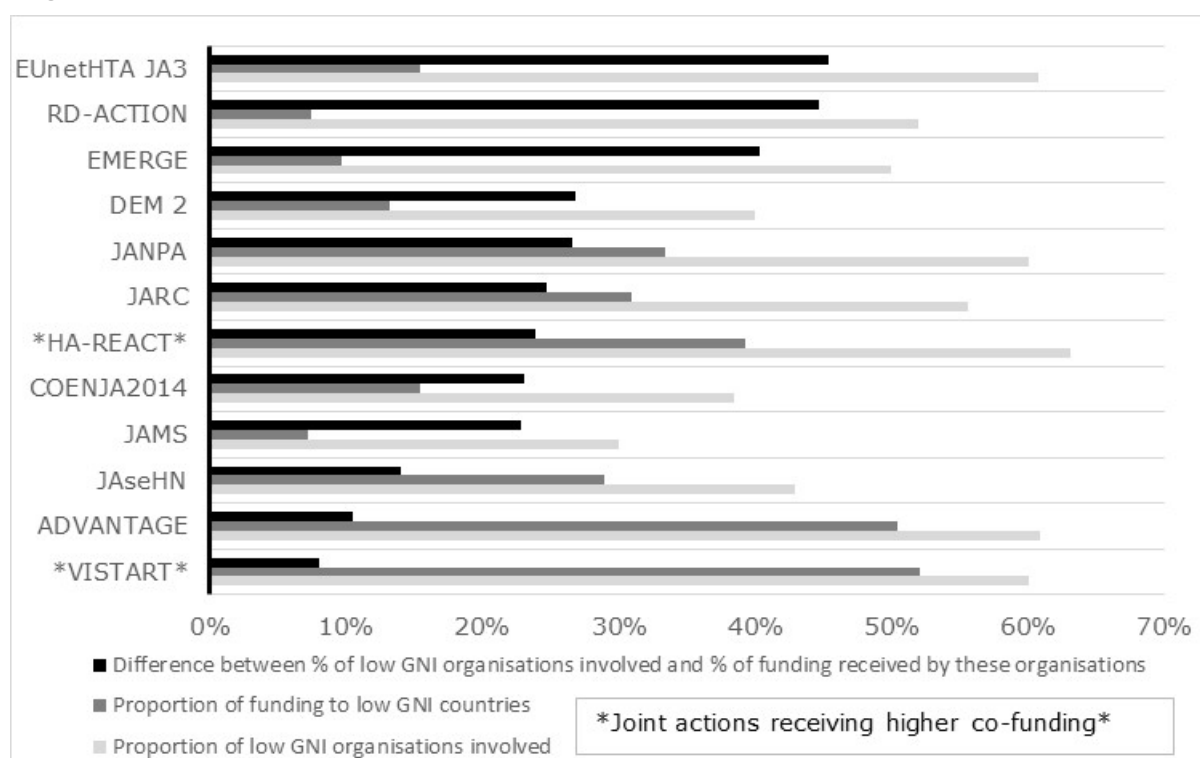
the Union average. The criterion promotes wide geographical coverage and the participation of Member States authorities from countries with a low GNI⁴⁵.

Two joint actions (which together accounted for 15% of joint action funding) met these criteria and were awarded the higher co-financing rate in the first years of the 3HP:

- “VISTART” (dealing with Blood transfusion and tissue and cell transplantation)
- “HA REACT” (tackling HIV and co-infection prevention)

For given joint actions, the chart below depicts the difference between the proportion of organisations from low-GNI countries and the share of funding awarded to those organisations.

Figure 7: Difference between proportion of organisations from low GNI involved in a joint action and proportion of EC funding received by those organisations, 2014 - 2015



Source: Chafea

Where the difference between the proportion of organisations from low GNI countries and the proportion of funding received by those organisations is low (such as for VISTART), it shows that organisations from low-GNI countries have been heavily involved; where it is high (as with EUnetHTA JA3), it implies that organisations from low GNI countries have played a proportionately smaller role. As the chart illustrates, there are four joint actions (“ADVANTAGE”, “JaseHN”, “JAMS” and “COENJA2014”) where the difference is lower than for the other joint actions receiving the higher co-funding rate (HA REACT).

Joint actions are organised into work packages and each work package is led (or sometimes co-led) by an organisation in the consortium. In order to better understand

⁴⁵ Article 7, Regulation 282/2014 establishing third Programme for the Union’s action in the field of health (2014 – 2020)

the extent to which organisations from low GNI countries are involved in leadership positions, the table below presents (for the two joint actions for which exceptional utility was awarded) the proportion of work packages led by organisations from low GNI countries, and the proportion of person months allocated to the work packages led by such organisations. The data provide more detail on one of the findings presented above, namely that low GNI organisations had a leading role in “VISTART” but this was not the case for “HA-REACT”.

Table 9: Extent to which organisations from low GNI countries have leadership roles in joint actions

	Number of work packages led / total number of work packages	Person months for low GNI work package leads / Total person months for low GNI work package leads
VISTART	4/10	50%
HA-REACT	1/8	13%

Source: Chafea

Since the exceptional utility criterion under the 3HP is new⁴⁶, it is interesting to compare a high level breakdown of total funding to date through the 3HP joint actions for low and high GNI countries and compare it to the same breakdown for the 2HP⁴⁷.

Table 10: Balance of funds to joint action beneficiaries from low and high GNI countries

	Low GNI	High GNI
2HP	29%	71%
3HP⁴⁸	25%	75%

Source: Chafea

The data show that on the one hand, there is not a major difference, which we might expect given the evidence of the targeted and selective use of the instrument (i.e. just two joint actions). However, as illustrated above, low GNI countries have – to date – actually received a slightly lower proportion of funding allocated to joint actions in the 3HP (by 4 percentage points) compared to under the 2HP. This is surprising in the context of the new rules for exceptional utility and some (albeit limited) use of the exception utility criterion. However, the aggregate figures do not tell the full story and context is important. To give one example, the largest joint action launched under the 3HP by far is “EUnetHTA” (budget of nearly € 12 M), this accounts for almost a third of the total budget to joint actions in the first two years and, since low GNI countries receive a relatively low proportion of the budget in this joint action (15%) this impacts negatively on the overall proportion received by low GNI countries. Indeed, excluding “EUnetHTA” and calculating the total budget received by low GNI countries in the 11 other joint actions gives: 30% of funding to low GNI and 70% to high GNI countries (which would imply a slight improvement compared to the 2HP).

⁴⁶ As mentioned previously, the criterion was introduced in the 2HP but the criteria were different.

⁴⁷ The calculation is based on the full list of low GNI countries (i.e. including ES)

⁴⁸ The figure corresponds to 2014 and 2015 committed spending

Projects

The findings for allocation of funding show some contrast with the findings for joint actions. Most importantly there is less of a clear demarcation in the receipt of funding for organisations based in high and low GNI countries. As shown below:

- Organisations from Spain (a low GNI country from 2015⁴⁹), Italy, the UK and the Netherlands received just over half of the budget (Figure 8).
- Organisations in Romania, Greece, and Croatia (all low GNI countries) received above average allocation of funding when they participated in projects (Figure 9). However, this might relate to the fact they were involved in few projects but with a substantial role or to factors that are unlikely to predict similar levels of involvement in the future. For example in Greece a considerable proportion of the funding received by organisations was in relation to migrant health but also a number of other areas⁵⁰. The situation in Croatia was different, with just two projects and both were related to migrant health⁵¹. In Romania, organisations were involved in a total of three projects (not specifically related to migrant health) but in each case, the projects involved a substantial role for the Romanian organisations⁵².

⁴⁹ We note that Spain stands out as the only low GNI country (as per the HP definition) which is not eligible for Cohesion Fund spending. We also note from a review of the projects funded through the 3HP to date that organisations based on Spain have been involved in many projects related to health care systems (i.e. capacity building which may typically receive funding from Cohesion Funds, for example). Unlike most of the other “low GNI” countries, Spain has been a member of the EU for 30 years, since 1986.

⁵⁰ Through [EUR-HUMAN](#) - European Refugees-Human Movement and Advisory Network - [CARE](#) - Common Approach for REfugees and other migrants' health, [8 NGOs in 11 States](#) – for migrants' health, [TOB-G](#), [PATHWAYS](#), [SIMPATHY](#), [SPIM EU](#), and [ACT-at-Scale](#)

⁵¹ [Euro GTP II](#), [EUR-HUMAN](#) - European Refugees-HUMAN Movement and Advisory Network - and [CARE](#) - Common Approach for REfugees and other migrants' health

⁵² [TOB-G](#), [E-DETECT TB](#) and [HEPCARE EUROPE](#)

Figure 8: Allocation of budget to organisations across participating countries, 2014 and 2015

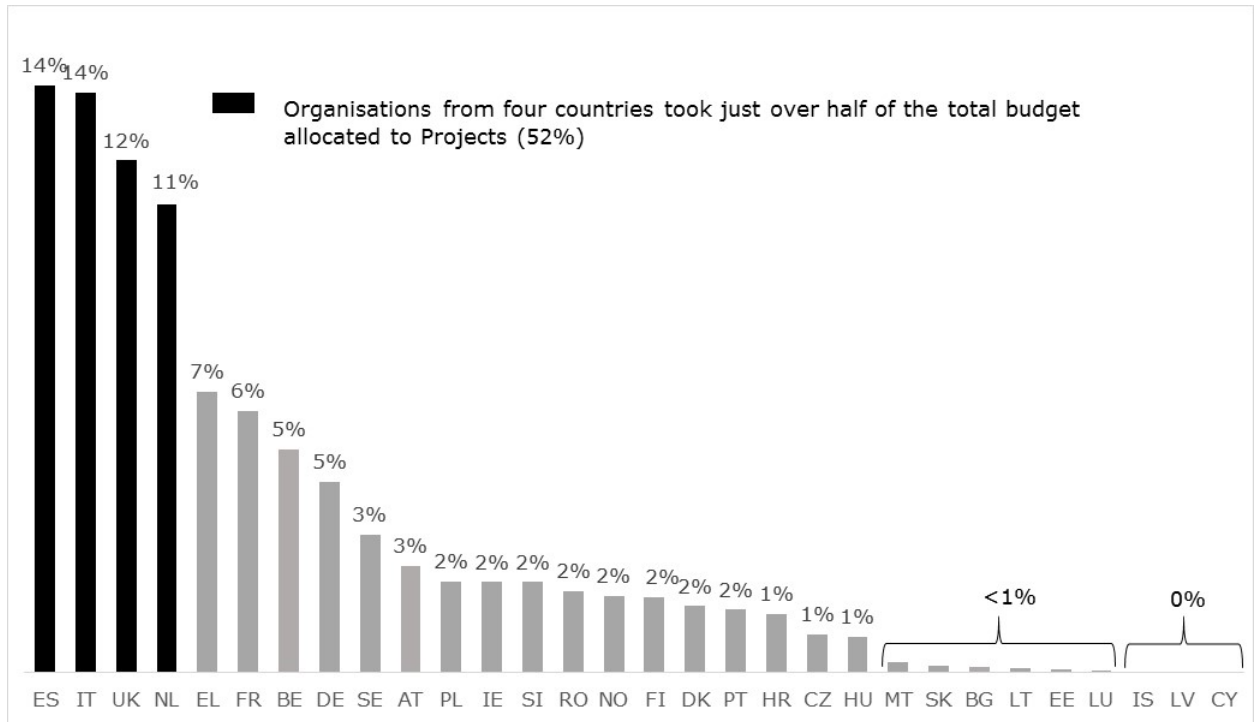
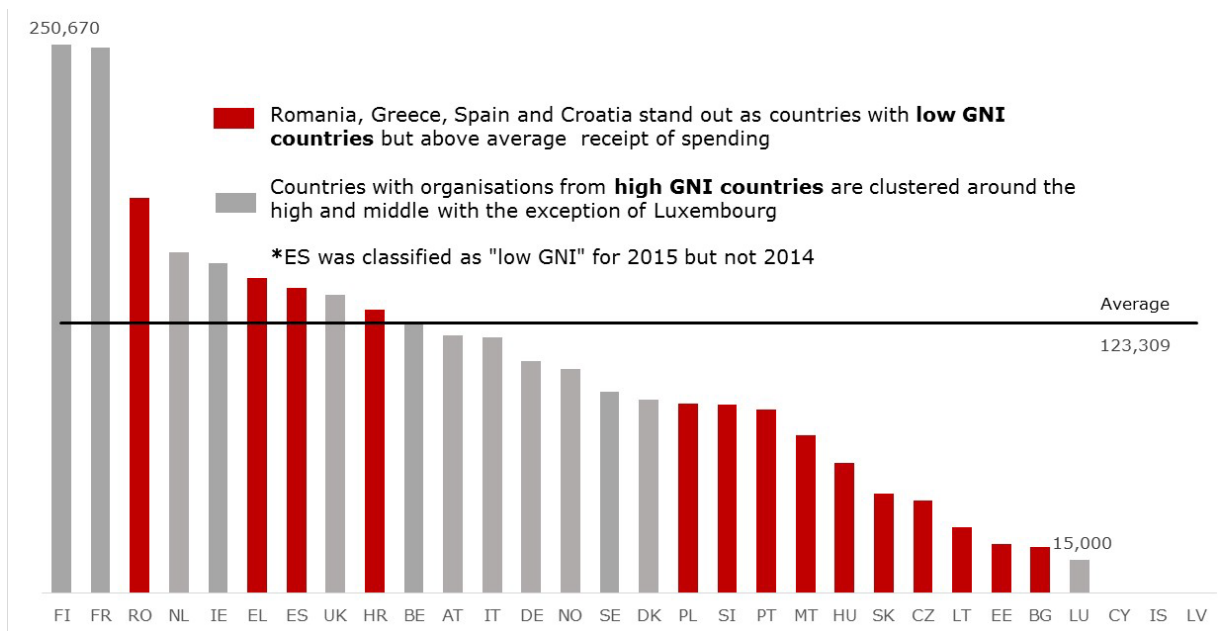


Figure 9: Average sum received by organisations based in participating countries, 2014 and 2015



Source for both figures: Chafea

For projects, the 'exceptional utility criterion' to encourage participation from low-GNI countries is defined as follows:

1. *At least 60% of total budget must be used to fund staff. This criterion intends to promote capacity building for development and implementation of effective health policies*
2. *At least 30% of the budget of the proposed action is allocated to MS whose gross national income (GNI) per inhabitant is less than 90% of the Union average. This criterion intends to promote the participation of health actors from MS with low GNI.*
3. *The proposal must demonstrate excellence in furthering public health in Europe and a very high EU added value.*⁵³

Four Projects (which together accounted for 10% of project funding) met the conditions to be recognised as a situation of "exceptional utility" in the first years of the 3HP:

- Euro-GTP II (set up the good practices applied to tissues and cells preparation processes and patient follow-up procedures)⁵⁴
- SIMPATHY (Stimulating Innovative Management of Polypharmacy and Adherence in the Elderly)⁵⁵
- ALCOOL (Raising awareness and action-research on Heavy Episodic Drinking among low income youth and young adults in Southern Europe)⁵⁶
- TOB-G (To develop and implement an innovative and cost effective approach to prevent chronic diseases related to tobacco dependence)⁵⁷

As with joint actions, the figure below presents the percentage point difference between the share of organisations from low GNI countries and the share of funding received by those organisations (i.e. in the case of "CARE" organisations from low GNI countries make up five out of six – or 83% - of the organisations delivering the action, but they receive just 55% of the funding).

Compared to the situation with joint actions, there are four projects (including three which received higher co-funding) where the organisations from low GNI countries receive a higher share of funding compared to the share of organisations which are from these countries. While two of the four projects benefiting from the exceptional utility criterion fall into this group, funding from the other two (FRAILTOOLS and FOCUS) still goes mainly to organisations from high-GNI countries.

As such, although you would expect a more consistent picture with organisations from low GNI countries more involved in projects when they receive higher co-financing, this makes it more likely but it is not a guarantee.

⁵³ Annex VII of the AWP (it should be noted that this last requirement is under consideration and may be dropped during the second half of the 3HP)

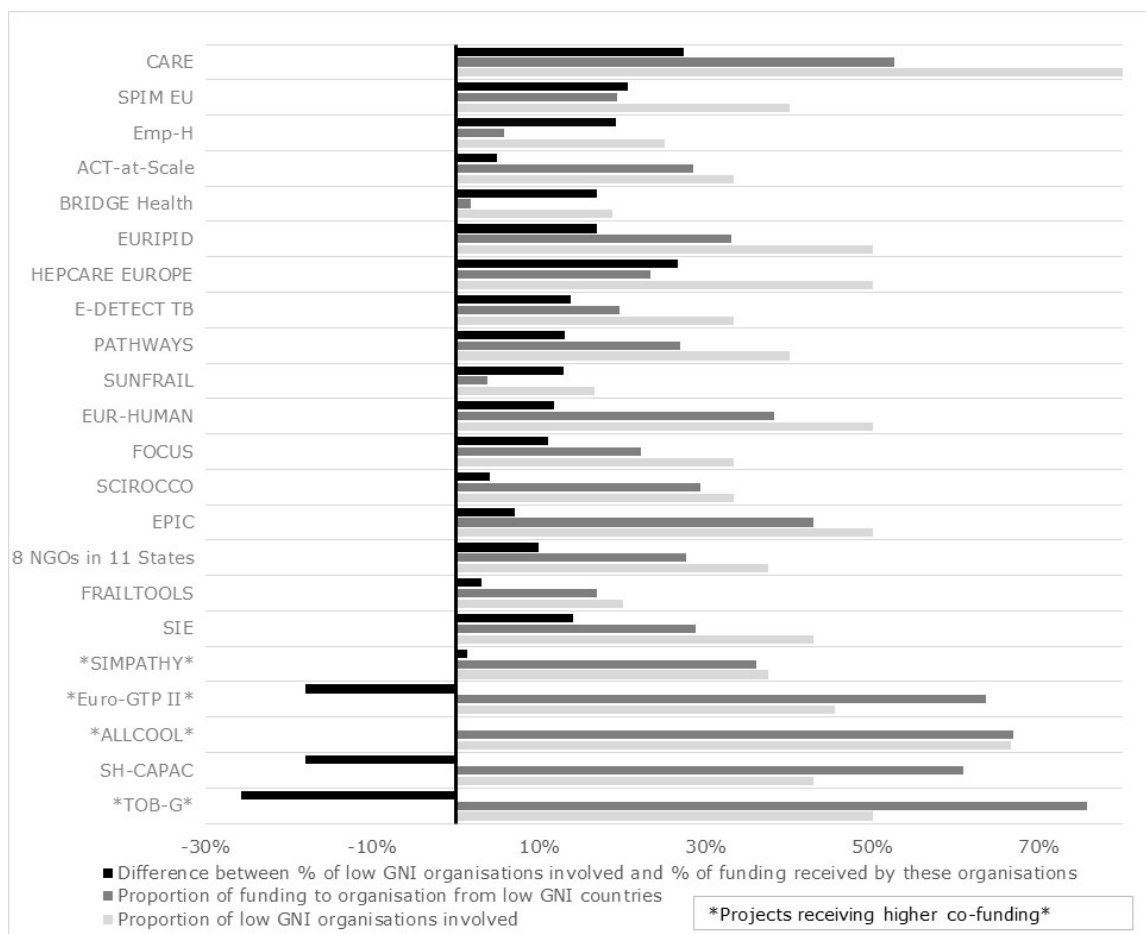
⁵⁴ <http://goodtissuepractices.eu/>

⁵⁵ <http://www.simpathy.eu/>

⁵⁶ <http://ec.europa.eu/chafea/projects/database.html?prjno=710063>

⁵⁷ <http://tob-g.eu/>

Figure 10: Difference between proportion of organisations from low GNI involved in a project and proportion of EC funding received by those organisations, 2014 - 2015⁵⁸



Source: Chafea

Looking at the extent to which organisations from low GNI countries are involved in leadership roles in projects, the proportion of work packages led by such organisations, and the proportion of person months allocated to low GNI country leads are presented below. The data provide an interesting story, which is somewhat different to the one presented above on overall participation. As shown in the table, projects receiving higher co-financing are largely led by organisations from low GNI countries. In the case of “ALCOOL” and “TOB – G” – five out of six of the work packages are led by organisations from low GNI countries. This implies that for projects the ‘exceptional utility’ criterion is starting to have the desired effect.

⁵⁸ Note there were three projects which did not involve a single low GNI country (Appropriate care paths for frail elderly patients: a comprehensive model - [APPCARE](#), European Cornea and Cell Transplantation Registry - [ECCTR](#) and Innovative Prevention Strategies for type 2 Diabetes in South Asians Living in Europe - [InPreSD-SA](#) – they had a combined budget of €1.8 m)

Table 11: Extent to which organisations from low GNI countries have leadership role in projects

	Number of work packages led / total number of work packages	Person months for low GNI work package leads / Total person months for low GNI work package leads
SIMPATY	4/7	60%
TOB-G	5/6	89%
EURO-GTP II	5/9	53%
ALLCOOL	5/6	95%

Source: Chafea

Looking at the overall breakdown of total funding to date through the 3HP projects for low and high GNI and comparing this with the same breakdown for the 2HP shows that, as with joint actions, there is not a huge difference in the overall allocation.

Table 12: Balance of funds to projects beneficiaries in low GNI and high GNI countries

	Low GNI	High GNI
2HP	28%	72%
3HP⁵⁹	26%	74%

Source: DG SANTE and Chafea

However, for projects, low GNI countries have received a slightly lower proportion of the total funding allocated to date (2 percentage points lower compared to the 2HP) which is similar to the picture for joint actions. But as discussed above, the figures do not give us the full picture: there may be a number of potential factors impacting this situation which makes it difficult to isolate the impact of the exceptional utility criteria. While the legal framework has changed, there are only a few projects which have met the criteria. The specific context (for instance the participation of low GNI countries – particularly Greece – in projects responding to health needs of migrants, none of which qualified for exceptional utility) would push the proportion to low GNI countries upwards regardless of the criterion. At the same time, there remain structural reasons which prevent low GNI countries from participating in the 3HP (including capacity, experience in preparing bids, etc.). Indeed, this is clear from the fact that organisations from low GNI countries consistently form a minority of project participants.

Operating grants

Operating grants are typically awarded to networks / NGOs and associations which – although registered in a MS (typically BE, NL, LU, FR or the UK⁶⁰) – operate at the EU level. The exceptional utility criteria are defined as follows:

1. At least 25 % of the members or candidate members of the non-governmental bodies come from Member States whose gross national income (GNI) per inhabitant is less

⁵⁹ Years 2014 and 2015 committed amounts only.

⁶⁰ There is also one operating grant awarded to the SO Europe Eurasia Foundation which is based in Ireland, and two awarded to organisations based in Germany.

than 90 % of the Union average. This criterion intends to promote the participation of non-governmental bodies from Member States with a low GNI.

2. The reduction of health inequalities at EU, national or regional level is manifested in the mission as well as the annual work programme of the applicant. This criterion aims to ensure that co-funded non-governmental bodies directly contribute to one of the main objectives of the third Health Programme, i.e. to reduce health inequalities⁶¹

In the first years of the 3HP, 13 organisations have been awarded annual funding through operating grants⁶². Five of these organisations benefited from the exceptional utility criteria:

- So Europe Eurasia Foundation
- Forum Europeen des Patients
- European network for smoking prevention
- DEUTSCHE Aids-Hilfe
- Smoke Free Partnership (in 2015 only).

This accounted for 35% of the total budget allocated to operating grants overall in these first two years of the 3HP.

Four out of five of the organisations awarded higher co-financing support thematic priorities under objective 1 (health promotion), while the other ("Forum Europeen des Patients") supports objective 4 (better and safer healthcare).

Given the nature of operating grants - which provide core funding for beneficiary organisations with wide geographic membership– the financial and participation data do not tell us how funding has been allocated within the organisations themselves (or how much of the funding has been implemented in low GNI countries). Rather, organisations whose membership includes many such countries have been eligible for exceptional utility funding based on an assumption. The assumption that by providing higher co-financing to organisations which have a wide geographic membership and a mission in line with the objective of reducing health inequalities, the intended re-distributive effect will be achieved.

⁶¹ Annex of the AWP

⁶² One organisation ("SHE network") was awarded funding for 2014 but the organisation has since ceased operations.

3. EXCEPTIONAL UTILITY CRITERIA UNDER 3HP AND 2HP

	3HP (2014 – 2016)	2HP (2011 – 2013)
Joint Actions	<ol style="list-style-type: none"> At least 30% of the budget of the proposed action is allocated to MS whose gross national income (GNI) per inhabitant is less than 90% of the Union average. This criterion intends to promote the participation from MS with low GNI. Bodies from at least 14 participating countries participate in the action, out of which at least four are countries whose gross national income (GNI) is less than 90% of the Union average. The criterion promotes wide geographical coverage and the participation of MS authorities from countries with a low GNI. 	<ol style="list-style-type: none"> At least 60% of the total budget of the action used to fund staff...to promote capacity building for development and implementation of effective public health policies. At least 25% of the budget of the proposed action allocated to MS with a GDP per capita in the lower quartile of all EU MS... to contribute to the reduction of health inequalities among EU MS A score of at least 5/8 marks for all the award criteria under the policy relevance block ... to promote the improvement in the health of European citizens, in the sense of enhancing policy relevance. At least 10% of budget allocated to organisations that have not received any funding under the 1HP and 2HP in the past 5 years...to promote the involvement of new actors for health. Bodies from at least 10 participating countries or bodies from three participating countries, where the action is proposed by a body from a MS which has acceded to the EU since 1 May 2004 or by a candidate country, should participate in the joint action.
Projects	<ol style="list-style-type: none"> At least 60% of total budget must be used to fund staff. This criterion intends to promote capacity building for development and implementation of effective health policies At least 30% of the budget of the proposed action is allocated to MS whose gross national income (GNI) per inhabitant is less than 90% of the Union average. This criterion intends to promote the participation of health actors from MS with low GNI. The proposal must demonstrate excellence in furthering public health in Europe and a very high EU added value⁶³. 	<ol style="list-style-type: none"> At least 60% of the total budget of the action used to fund staff...to promote capacity building for development and implementation of effective public health policies At least 25% of the budget of the proposed action allocated to MS with a GDP per capita in the lower quartile of all MS...to contribute to the reduction of health inequalities among MS. A score of at least 5 out of 8 marks must be achieved for all the award criteria of the policy relevance block mentioned in Annex II. This criterion aims at promoting the improvement of the health of European citizens, in the sense of enhancing policy relevance. At least 10% of the budget allocated to organisations that have not received any funding under the 1HP and 2HP in the past 5 years... to promote the involvement of new actors for health. (Also, "No more than 10% of funded projects should receive EU co-funding of over 60%")
Operating grants	<ol style="list-style-type: none"> At least 25% of the members or candidate members of the non-governmental bodies come from MS whose gross national income (GNI) per inhabitant is less than 90% of the Union average...to promote the participation of non-governmental bodies from MS with a low GNI. The reduction of health inequalities at EU, national or regional level is manifested in the mission as well as the AWP of the applicant... to ensure that co-funded non-governmental bodies directly contribute to 1 of the main objectives of the 3HP, i.e. to reduce health inequalities 	<ol style="list-style-type: none"> At least 25% of the members or candidate members of the non-governmental bodies or organisations forming the specialised network come from MS with a GDP per capita in the lower quartile of all EU MS. The reduction of health inequalities at EU, national or regional level is manifested in the mission as well as the annual work programme of the applicant organisation/specialised network.

Sources: 3HP and 2HP AWP

⁶³ This last part "and a very high EU added value" was removed in the 2016 AWP.

4. OVERVIEW OF MS HEALTH STRATEGIES

MS	Health Strategic Priorities	Thematic health plans / health-related documents (examples)	Sources / Comments
AT		Quality strategy for the Austrian Healthcare system (2010), Occupational safety and health security, etc.	No legal definition of public health exists in AT and there is no public health act (Ladurner, J. et al. (eds.), Public Health in Austria, Observatory Studies Series 24, 2011)
BE		Cancer	No national health strategy found
HR	Priority 1: Informatisation and e-Health development; Priority 2: Strengthening and better use of human resources in health care; Priority 3: Strengthening of management capacities in health care; Priority 4: Reorganisation of the structure and activities of health care institutions; Priority 5: Fostering quality in health care; Priority 6: Strengthening preventive activities; Priority 7: Preserving financial stability of health care; Priority 8: Cooperation with other sectors and the society in general		National Health Care Strategy 2012-2020- abridged version September 2012
CY		National Strategy for Cancer 2009; National Strategy for Controlling Smoking 2012; National Strategy for Rare Diseases 2012; National Strategy for Rheumatic Diseases 2012; National Strategy to promote breastfeeding 2011; National Strategy for Diabetes 2016	No national health strategy found
CZ		National Strategy for the Development of eHealth in the Czech Republic for the period 2015 - 2020	No national health strategy found

DK	<p>1. Rationalisation of the health system, creation of a registration system with GP, cooperation between health stakeholders at different levels</p> <p>2. Strengthening equity of access to healthcare, with efforts to tackle socio-economic health determinants</p> <p>3. A&E capacity building and renewed effort to fight cancer</p> <p>4. Enhancing quality of health care</p> <p>5. Enhancing efficiency of the service (e.g. simplification, introduction of IT system, introduction of performance targets)</p>		2013 National strategy for public health system
EE	<p>Overall objective is a long life and quality of life (life expectancy in Estonia is lower than the rest of Europe, that constitutes the main health challenge). This objective will be achieved through activities in five different fields: social cohesion; children's and young people's health; the environment; healthy lifestyles; and health care.</p> <p>Priorities: Joint responsibility and mutual care (reducing inequality and enhancing social cohesion), Healthy and safe development for children and young people, Living, working and learning environments which support good health, Healthy way of life (nutrition, physical activity, less risk-associated behaviour, self-care, etc.), Patient-centred health care system</p>		National health plan 2009-2020
FI	<p>1. A strong foundation for welfare: Health and welfare in all policies Longer working careers through wellbeing at work Balancing the various areas of life Sustainable social protection financing</p> <p>2. Access to welfare for all Reduce differentials in welfare and health Customer-oriented services New service structures and operating practices Strong sense of social inclusion</p> <p>3. A healthy and safe living environment Strengthen the viability of the environment Ensure that society can continue to function under exceptional circumstances</p>	Mental health and substance abuse work	Socially Sustainable Finland 2020 Strategy for social and health policy (2011)

FR	1. Prioritize prevention over curative actions to improve health determinants; 2. Better organisation of care for patients, guarantee equality of access on the basis of a territorial approach; 3. Building on decentralization and strengthening health democracy	National Plan for the fight against HIV/AIDS & STDs 2010-2014; National programme for nutritional health 2011-2015	Stratégie nationale de Santé, Feuille de route (2013)
DE		The National Action Plan for the prevention of poor dietary habits, lack of physical activity, overweight and related diseases	Health strategies are adopted at the regional level because of the division of responsibilities between the Federal State and the Laender.
EL	Axis 1: Ensuring universal access to quality care; Axis 2: Transparent, inclusive and modernized health governance through effective and efficient public administration; Axis 3: Fair and sustainable financing of the health system	National Action Plan on HIV / AIDS, 2008-2012	ESPA Health Policy 2014-2020
HU	1. Improve basic care, create tasks related to basic and expert care and optimise management; 2. Develop professional services, service management and decentralised decision-making; 3. Enhance capacity planning at national and regional level, incl. patient management; 4. Strengthen the evidence base of health policy and raise citizens' awareness in health		Healthy Hungary 2014-2020 (2014 draft)
IE	1. Increase the proportion of people who are healthy at all stages of life (address risk factors and promoting protective factors at every stage of life); 2. Reduce health inequalities (address the wider social determinants of health); 3. Protect the public from threats to health and wellbeing (ensure effective strategies and interventions to protect the public from new and emerging threats to health) ; 4. Create an environment where every individual and sector of society can play their part in achieving a healthy Ireland (promote society-wide health and wellbeing)	Ireland HIV and AIDS Education and Prevention Plan 2008-2012	Healthy Ireland, A framework for improved health and wellbeing, 2013-2025
IT			No national health strategy found from 2014 on
LV	1. Eliminate inequality in the field of healthcare services, by implementing measures to ensure equal opportunities for all Latvian inhabitants to access healthcare services; 2. Decrease morbidity and mortality rates from non-infectious diseases, and address risk factors. 3. Improve the health of mother and child, and decrease infant mortality; 4. Promote healthy and safe living and an equally safe working environment,		Public Health Strategy for 2011-2017

	and decrease trauma and mortality from external causes of death; 5. Decrease morbidity from infectious diseases.		
LT	Strategic goal: Increase healthy years and life expectancy, improve population health and reduce health inequalities. Objectives: 1. Create a more secure social environment, reduce health inequalities and social exclusion; 2. Create a healthy environment; 3. Develop a healthy lifestyle and culture; 4. Ensure the quality and effectiveness of health care based on a people-centred approach		DĒL LIETUVOS SVEIKATOS 2014-2023 METŲ PROGRAMOS PATVIRTINIMO
LU		Strategy and action plan concerning the fight against HIV/AIDS 2006-2010	No national health strategy found
MT			No national health strategy found
NL			No national health strategy found
PL	Overall goal: Participatory and inclusive approach to reduce inequalities and improve the health and quality of life of Polish people. Strategic objectives: 1: Reduce morbidity and premature mortality due to cardiovascular diseases, including stroke; 2 Reduce morbidity and premature mortality rates; 3. Reduce the incidence of injuries caused by accidents; 4. Prevention of mental disorders by prevention and promotion actions; 5. Reduce the morbidity and limiting early negative effects of chronic diseases of the osteoarticular system; 6. Reduce morbidity and premature mortality due to chronic respiratory diseases; 7. Enhance the effectiveness of the prevention of infectious diseases; 8. Reduce inequalities in access to healthcare (in particular rural / urban divide)		National Health Programme for 2007-2015

PT	<p>4 strategic axes: citizenship in health; equity and adequate access to healthcare; quality in health; and healthy policies.</p> <p>4 Health System Goals: obtaining health gains; promoting supportive environments for health throughout the life cycle; strengthening economic and social support in health and disease; and strengthening Portugal's participation in global health</p>		<p>Portuguese Health Profile National Health Plan 2012-2016</p>
RO	<p>The overall objective of the health sector is to facilitate access to better and safer healthcare for the general population, with particular emphasis on vulnerable groups.</p> <p>Four specific priorities and areas of intervention have been identified, namely: 1) Development of the Healthcare Infrastructure: Developing public health infrastructure (i.e. monitoring environment hazards, etc.) and extending the population's access to new, modern health services such as new modern hospital buildings, integrated emergency services, long-term care and community care services, new diagnostic and therapeutic procedures, etc. 2) Research and Development in the Health Sector: The directions for research & development focus on: fundamental research ; health services research (poorly developed at present, with a lack of appropriate decision-making in the health policy area); and research on the state of the population's health. Particular emphasis is on the development of the Health Technology Assessment (HTA) field. 3) Access to e-Health: a dedicated e-Health network and cooperation among electronic patient registries. 4) Strengthening of Public Healthcare and Medical Assistance: a strong focus on prevention and health service reorganization. Measures in this area include: strengthening health program management and effectiveness with regard to both infectious diseases (TB, HIV/AIDS, etc.) and non-communicable diseases; and organizing screening programs for cervical cancer, breast cancer, and colo-rectal cancer. Service reorganization aims to decrease the use of hospital services and enhance the role of alternative types of care such as community care, community mental health services, primary health care, etc. Other actions aim to increase the quality of healthcare services and enhance institutional and professional capacity and performance across the system.</p>		<p>National Health Strategy 2014-2020</p>

SK	<p>Priorities: 1. Public health: improve administration, implementation and build up the system to better care for vulnerable groups and improve preparedness for biol/chemical threats and improve the level of non-medical determinants of health as well as strengthen citizens' interest and responsibility of citizens for their own health; 2. Improve and integrate better medical care; 3.Improve institutional healthcare provided through hospitals or other medical facilities</p>		<p>Strategický rámec starostlivosti o zdravie pre roky 2014 - 2030</p>
SI	<p>The overarching objectives of the strategy are: • improve monitoring of population's health status and the effects of health and other actions and policies that affect health; • Establish an effective system for identifying health hazards, risk assessment and responding to health threats; • Ensure an effective monitoring system for the study and control of communicable diseases, environmental risks and occupational diseases; • Reduce key risk factors for chronic diseases and conditions of the population such as smoking, risky and harmful use of alcohol, lack of exercise, obesity and unbalanced diet, use of illicit drugs, stress; • Establish an effective model of prevention and early detection of chronic non-communicable diseases and conditions and mental disorders; • Redirect health system from treatment in health promotion and disease prevention; • Strengthen management and enhance the efficiency of the organizational structure to consolidate a comprehensive quality system and ensure the financial sustainability of public health activities; • Ensure sufficient number of trained and competent staff in all areas of public health; • Develop health-in-all approach and strengthen interdepartmental cooperation; • Strengthen advocacy and improve communication in the field of public health; • Strengthen research in the field of public health.</p>		<p>STRATEGIJA RAZVOJA DEJAVNOSTI JAVNEGA ZDRAVJA 2013 - 2023</p>

<p>ES</p>	<p>Strategic lines: • Enhancing public health: Develop policies, strategies, plans and public health regulations, strengthen advocacy and governance in public health, develop and optimize information systems and public health assessment and as applied research in this field. • Coordination and territorial governance: Coordinate and integrate the actions of health promotion, prevention disease and disability across territorial / organisational levels to work towards complementarities and avoid duplication. Enhance coordination between public health services and care services, with visible and recognized leadership in the allocation of tasks and responsibilities of each actor involved in the procurement, implementation and evaluation • Health Equality: Reduce social inequalities in health due to geographical, ethnic, cultural, gender, social factors or other health determinants, as well as situations of disability. • Reorienting health services: Promote the organizational changes necessary to reorient health services towards health promotion and disease and disability prevention. Enhance the role of health promotion and disease prevention in the health care model. • Intersectoral health: Incorporate health in all public policies and foster coordination at all levels of government. • Empowerment health: Strengthen the skills and capacities of people and communities to improve and maintain their health and functional capacity throughout their life, and develop healthy lifestyles and insurance. • Create healthy and safe environments: Create environments that protect and promote health in all areas of life (family, community, education, health, labor, institutional settings, media, etc.). • Participation and community action: Strengthen community action and enhance community participation in setting priorities, decision-making and development and implementation of strategies to protect and promote health.</p>	<p>1) Strategy on chronic diseases of the Spanish NHS (Estrategia en EPOC del Sistema Nacional de Salud): http://www.msssi.gob.es/organizacion/sns/planCalidadSNS/docs/EstrategiaEPOCSNS.pdf 2) National Strategy on Sexual and Reproductive Health (Estrategia Nacional de Salud Sexual y Reproductiva): http://www.msssi.gob.es/organizacion/sns/planCalidadSNS/pdf/equidad/ENSSR.pdf 3) Strategy for Rare Diseases of the Spanish NHS (Estrategia en Enfermedades Raras del Sistema Nacional de Salud): http://www.msssi.gob.es/organizacion/sns/planCalidadSNS/pdf/Estrategia_Enfermedades_Raras_SNS_2014.pdf</p>	<p>Estrategia de promoción de la salud y prevención en el SNS</p>
<p>SE</p>	<p>1. Develop and provide health promotion and disease prevention tools to individuals. 2. National collaboration on health promotion. 3. Health promotion and disease prevention with regard to communicable diseases and serious health threats. 4. Reduce the negative effects and use of alcohol and tobacco to promote health and welfare. 5. Create opportunities for physical activity and good eating habits. 6. Create conditions for improving mental health and the prevention of mental ill health. 7. Strengthen knowledge management national, regional and local levels should seek support in both research and practical experience.</p>	<p>National Strategy to Combat HIV/AIDS and Certain Other Communicable Diseases; Mental Health Plan</p>	<p>Government Communication 2011/12 : 166 A public health policy with people in mind</p>

UK (England)	Tackling obesity Reducing smoking Reducing harmful drinking Ensuring every child has the best start in life Reducing dementia risk Tackling antimicrobial resistance Reducing tuberculosis	United Kingdom National Strategy for Sexual Health and HIV. Implementation Action Plan (2002)	From Evidence into action: Opportunities to protect and improve the nations health (Public Health England)
UK (Scotland)		(1) Autism, (2) Cancer, (3) Coronary heart disease and stroke, (4) Dementia, (5) Hepatitis C, (6) Tuberculosis	as of March 2016 a new public health strategy is under development. A 2015 Review of Public Health in Scotland: Strengthening the Function and re-focusing action for a healthier Scotland, available here: http://www.gov.scot/Resource/0049/00493925.pdf
UK (Wales)	(1) Adopting and implementing a multi agency systems approach to achieving significant improvements in the population's health; (2) Working across sectors to improve the health of children in their early years; (3) Developing and supporting primary care services to improve the public's health; (4) Supporting the NHS to improve healthcare outcomes for patients; (5) Influencing policy to protect and improve health and reduce inequalities; (6) Protecting the public and continuously improving the quality, safety and effectiveness of the services delivered; (7) Developing the organisation - Public Health Wales		The Public Health Wales strategic plan 2015-18
UK (Northern Ireland)	6 Strategic Themes: 1. Giving Every Child the Best Start; 2. Equipped Throughout Life; 3. Empowering Healthy Living; 4. Creating the Conditions; 5. Empowering Communities; 6. Developing Collaboration		Making Life Better' strategic framework for public health

5. INTERVIEW OVERVIEW

Over the course of the evaluation, we conducted interviews with 15 EU officials from DG SANTE staff members and representatives of Chafea (not including those interviews with EU officials for the case studies). The purpose of these interviews was to shed light on all aspects of the design and implementation of the 3HP, particularly regarding new features such as the thematic priorities and multi-annual planning. The subsections below give a brief overview of the findings from the interviews, structured in terms of relevance, effectiveness, efficiency and coherence.

Note that the following text presents a summary of the views recorded, rather than the evaluation team's assessment or judgements. The interview findings necessarily include subjective points of view that will be held up alongside other sources of evidences and triangulated in order to inform our answers to the evaluation questions during the last phase of the evaluation.

5.1. DG SANTE and Chafea officials interviewed

Table 13: List of EU Officials contacted for interview

Name	Role / thematic area
1. Athanassoudis, Irène	Policy officer, Health programmes and chronic diseases – DG SANTE
2. Buecherl, Wolfgang	Policy Coordinator, Performance of national health systems, DG SANTE
3. De La Mata, Isabel	Principal Adviser for Health and Crisis management - DG SANTE
4. Giraud, Sylvain	Head of Unit, Performance of national health systems – DG SANTE
5. Huebel, Michael	Head of Unit, Radiation protection and nuclear safety – DG SANTE
6. Keller, Ingrid	Policy Officer, Health programme and chronic diseases (formally Team Leader, Health Programme, DG SANTE) – DG SANTE
7. Pinto Antunes, Jorge	Deputy head of unit, Unit on healthy ageing – DG SANTE
8. Pletschette, Michel	Adviser Health science – DG SANTE
9. Schreck, Stefan	Health programmes and chronic diseases – DG SANTE
10. Dargent, Guy	Project officer – Chafea
11. de Maximy, Alice	Dissemination officer - Chafea
12. Menel Lemos, Cinthia	Project officer – Chafea
13. Meusel, Dirk	Project officer – Chafea
14. Remacle, Jacques	Head of Public Health division - Chafea
15. Zazvonov, Vera	Health Programme coordinator - Chafea

5.1.1. Main findings - Relevance

EU health needs

- The 3HP provides coordination support through its convening power and influence:** The main purpose of the 3HP is seen to provide a vehicle to **facilitate coordinated action** in areas of identified need which means that in each case, the intervention can be more powerful than if the individual actors worked in silo. This support to cooperation is seen as necessary because of the nature of the health challenges / needs which are seen to be common across MS. Therefore, it is regarded that it is better to act together rather than in isolation, in order to find common solutions under the EU umbrella. Countries can then **learn from each other in terms of best practices**.

- The EU is also seen to **provide a large “convening power”** and is therefore able to get actions off the ground relatively quickly, whilst getting everyone on board and streamlining activities. The EU also provides a link to the internal market, and can overcome issues which only tend to be heard if they’re taking place at the EU level. It is believed that for the health sector, there is an interest to have a health policy at the EU level in order to have more precision. The EU can also intervene in the political debate at the right moment. However, one of criticisms made in this respect was that the programme is quite small and therefore does not offer much leverage.
- **Lack of new ideas generated:** an overarching issue raised about the HP and its design is that it is still very “traditional”, in that it encourages and generates few new ideas. It was suggested that this therefore requires a more experimental instrument. A potential reason given for this is that the Commission has been facing increasing Euroscepticism, for example with the EU referendum in the UK and the Eurozone crisis, and is therefore facing pressure to deliver results quickly. As a result, they wish to deliver more immediate results, leaving less capacity to focus less on long-term goals and / or developing new ideas over time.
- **Focus on policy and not direct health delivery:** one of the key distinctions made by interviewees is that the HP is not intended to address stakeholders’ needs directly, but is instead meant to generate cooperation between MS (as previously mentioned). Its overall objective is not about providing structural support and directly affecting the way health is delivered at the national level, but more to support MS with developing national policies in the health field. Direct impact on health needs is therefore seen as a “second step” from the HP.

Thematic priorities

- The thematic priorities were welcome in principle and seen as a way of defining more precisely what the 3HP sets out to achieve. However, they were seen as too ambitious and diverse, which creates a risk of dispersion. For example, where the action is based more around scientific research, this should be funded by DG RTD.
- In addition, some interviewees expressed concern that the list of thematic priorities was simply too long and unfocused. The reasoning for this being that it is always easier to add thematic priorities than take them away, especially when different interest groups wish to have their area of interest specifically covered.
- A criticism made vis-à-vis DG SANTE’s priority setting is that at the moment, this seems to be done on the basis of discussion in DG SANTE, or even with MS within the Project Committee or with expert groups. However, it was suggested that it might be interesting to take more evidence-based approach that could help determine needs and priorities. It was mentioned that things are moving more in that direction and that this would be a very good move.
- Chafea programme officers noted gradual improvements how early yearly the yearly financial decision was published. While the delay in years 1 and 2 only allowed Chafea six months to prepare and publish calls for proposals, for year 3 it was published earlier, giving them more time to plan.
- Sometimes Chafea face difficulties with managing some of the tenders that have a high policy implication and are policy sensitive, as these request a lot of involvement of DG SANTE in their implementation of the tender. This can cause problems because in these cases there is no full delegation to the executive agency. This can also cause tensions between Chafea and the beneficiaries, as they want to progress quicker but Chafea must fulfil compliance with the

respective rules. Nevertheless, it was mentioned that this is only the case with a few actions (2-3% of contracts).

Actions

- **Lack of intervention logic:** an issue raised regarding the actions is that they are lacking an intervention logic (particularly under health promotion), or where they do have an intervention logic, this is not specific enough (e.g. refugee health). This also makes it difficult to evaluate the actions / projects themselves, as well as to communicate on what the project is about.
- Another issue raised was in regards to **matching actions to the priorities defined in the AWP**. It was stated that the actions chosen depend on the description in the AWP, which is sometimes very broad and not specific enough. This means that it is not easy to define calls and therefore there is a risk that actions may not be fully aligned with the thematic priorities and projects do not always deliver what is expected. Joint actions and service contracts can overcome these issues as their respective descriptions in the AWP are well-defined and, in the case of joint actions, based on negotiated procedures between DG SANTE and MS health authorities.

5.1.2. Main findings - Effectiveness

Defining and prioritising actions through the AWP

- **Politicisation of support:** irrespective of the strengths of the design, there was concern about the politicisation of support, and that the process of defining and prioritising actions through the AWP serves policy makers and not stakeholders.
- **Shift from a bottom-up to a top-down approach:** related to this issue, it was noted that there has been a clear shift towards joint actions; MS highly support these as they are very policy relevant. With joint actions, it is clearer what is expected from the actions, whereas with open calls for proposals, the project never fully addresses the goals which DG SANTE would like to achieve. Therefore, there has been a clear move from a bottom-up approach to procurement, to a more top-down one. It is believed that it will continue shifting in this direction, with an increasing elimination of open calls. It is recognised that this approach can achieve more policy-implementable results, but it is feared that developing best practices and new ideas and experimentation will be lost.

It was mentioned that with the AWP, at the end of the year policies had not been developed yet which had slowed Chafea down. Delays in legislation have led to actions which have had to be cancelled / withdrawn.

Effectiveness of MAP

- **Improved flexibility:** the MAP process is seen to require a certain amount of flexibility which it does provide, in order to accommodate for different unforeseen elements. For example, last year money was allocated to countries directly affected by the influx of migrants, and this was something which had not been originally included in the MAP.
- **Allows better planning and allocation / mobilisation of resources:** it is understood that with the resources available it is not possible to fund all of the priorities in a year. Therefore the MAP process allows DG SANTE to spread the priorities over a number years, in order to focus on just a segment of them in one year and therefore plan resource allocation accordingly. Overall, it was

considered that the MAP has significantly improved the decision-making process for defining and prioritising actions in the AWP.

- The MAP also allows for a **good sync between policy developments and implementation**, which was not the case before. This is extremely instrumental at the moment because the better regulation guidelines place an emphasis on this.

Effectiveness of 'exceptional utility' criteria

- **Resource intensive process:** one of the most important barriers to potential applicants / beneficiaries is the low success rate of receiving funding. Drafting a proposal is particularly resource-intensive, which provides little incentive for organisations to apply. The application process is still considered to be very long and requires a lot of admin work. A suggestion was made based on the model of what many other organisations do, which is to introduce a 2-stage application process. The first pre-selection stage would be based on a short 2-3 page application presenting the planned action, and then pre-selected applicants would be asked to submit a full proposal. It is recognised that this would require a change in the IT system used.
- **Low admin capacity of low GNI countries:** one of the main barriers for low GNI countries is their admin capacity. As mentioned above, the application process is particularly resource-intensive, and organisations / authorities from low GNI countries do not have the required staff and resources to put into the application and management process. Such resource constraints lower the capacity of countries such as Cyprus to apply for funding, as they have fewer health authorities and fewer organisations working in these fields. In terms of joint actions, it is not easy for beneficiaries from low GNI countries to lead these actions, due to the mentioned resource constraints and low capacity. However, it was mentioned that they could instead lead work packages.

5.1.3. Main findings - Efficiency

Design of efficient allocation of resources

- **Difficulty matching ambitions and amount of funding available:** a number of interviewees stated that the allocation of funds is taken from historical references and is therefore not accurate / realistic anymore. As a result, most actions are seen to be either under or over funded. Additionally, the budget was seen to be too limited in terms of what the Health Programme is trying to achieve. It was questioned how the programme can change the health of the EU health population with such a small budget, and therefore the programme's objectives were seen to be too ambitious given the resources available. It was suggested that the money should be concentrated on fewer actions. However, it was stated that you can only make a change in health if you go for long term actions, which require more consensus than there is at the moment, as well as fewer resources allocated to ad-hoc actions which have no sustainability.

Allocation of resources and efficient implementation of 3HP

- It was recognised that the costs of implementation and monitoring of programmes are quite low and reasonable. However, a common issue raised by interviewees was that **the more participants / partners** there are involved in an action, **the more unmanageable and labour- / resource-intensive** it is to implement.

- **Administrative burden:** it was recognised that the move to the new IT system has reduced costs and simplified both the application process for beneficiaries, and the management process for Chafea. In terms of monitoring, it was believed that efficiency will increase through this system as it is becoming more and more paperless. Nevertheless, it was mentioned that these costs and admin burden could be reduced further. The admin phase for the beneficiaries to register in the system remains high and is still difficult and time-consuming (particularly for joint actions where a large amount of organisations need to be registered). For example, in the public health sector, some beneficiaries are still not used to this type of system and therefore a suggestion was made to better train them on this.

Chafea are consulted by DG SANTE on whether the right funding mechanism is used, or whether the right budget has been allocated.

- In comparison to the 2HP, the 3HP is seen to have simplified the negotiations to commence, as well as the procedures for amendments. There was an overarching consensus that the **switch to the new IT system had simplified both application and evaluation processes**, but it was noted that there are still some bugs in its implementation. However, it was recognised that it may take another year to clear these bugs once the reporting for 2014 actions is complete. It was considered that each Health Programme has been more successful than the previous one.

Suggestions for improvements

- **More focused action:** a common suggestion made by interviewees is the need to make the objectives / priorities of the 3HP more focused by having fewer actions.
- **More consensus-building:** a number of suggestions were made to have more consensus building in the programme. There was seen to be a lack of consensus at the moment at both the political and operational level. It is seen that health problems are not restricted to the EU and that in order to change things and have an impact, long-term actions are required. This in turn requires more consensus building and a coordination of actions with other interventions and existing research. However, it is seen that coordination with other interventions is currently limited and that such coordination needs to be made more concrete.
- **Better evaluation of action:** interviewees also called for better evaluations of actions themselves. They highlighted how despite evaluations of the HP itself being conducted, evaluation of the projects (and of the policy) is missing. This goes back to the issue previously mentioned regarding the lack of / vague intervention logic for actions.

Monitoring processes and resources

- **Monitoring processes were seen to have improved** since shifting all actions onto an online grant management system, which provides online monitoring tools. This also provides automatically updated project information. While this has been time and resource-intensive, it is seen as an important step forward in modernising management of the 3HP.
- **Lack of standardised and clear indicators at action level:** the key issue raised in regards to monitoring processes is the lack of clear indicators defined centrally. Currently, there is no objective way to monitor progress, and the quality of monitoring very much depends on the type of action and / or the beneficiaries themselves and their respective admin capacity / experience of the HP. Chafea requests indicators from beneficiaries per action / grant, but there is

no standardisation of this, which leads to a very variable quality of indicators, as well as a potential bias of monitoring by what the desired outcome is. It was mentioned that currently Chafea are discussing with DG SANTE the setting up of indicators at the level of priorities, but there needs to be an improvement in the drafting of indicators. Additionally, most often than not, the objectives of the actions are not clear and smart, which means that evaluators need to ask DG SANTE what they expect and define indicators for the evaluation on the basis of their answer.

- **Need for intermediate indicators:** following on from the issue of lack of action-level indicators, it was also noted that because the HP does not have a direct effect on the health of the population, there need to be intermediate indicators in place which look at the policy process. It was mentioned that in the past, too much effort has been put into demonstrating the effects on the health of the population.
- **Need for more detailed planning processes:** related to the need for clear indicators, an issue was raised surrounding the need for more detailed planning processes in order to be able to carefully monitor actions. It was mentioned that currently work programmes, milestones and deliverables are used, but that the most important factors for monitoring are interim and final reports, where you can see what has been done. Additionally, with the current workload which Chafea have, it is not easy for them to be able to follow each action very closely. As a result, they keep an eye on the actions which are expected to be more difficult and / or are not seen to be going in the right direction. Building off this, it was suggested that there needs to be a more detailed and easier to follow plan, as well as have more standardised indicators in order to identify which actions are on the right track or not.

It was stated that there are no resources for evaluating and monitoring at the MS level.

- **Dissemination:** the need for a clear dissemination strategy was highlighted and the upcoming dissemination strategy is a solution to address this need. The strategy is currently still being drafted, and a new dissemination officer has been brought in to oversee dissemination at Chafea. The dissemination strategy will aim to provide different activities to reach different stakeholders. In addition, there are now fewer actions per project officer at Chafea, meaning that they have more capacity for dissemination. However, the issue of funding was raised, highlighting the difficulty in providing a clear dissemination strategy with little money left over for this.

5.1.4. Main findings - Coherence

- **Synergies:** Some examples of synergies between the funded actions were provided. One of these relates to infectious diseases and the need to try and complement this (by avoiding duplication) with what is done by the ECDC. As a result, the ECDC is involved in advisory groups to complement and build synergies with these actions.
- Overall, there is seen to be clear external coherence between the 3HP and Article 168 of the Treaty, as well as with other ESIFs, where the 3HP identifies ideas and then structural support is provided through these funds. However, going back to the issue surrounding lack of coordination / consensus-building, it was mentioned that there is **not enough synergy between research and public health** (nevertheless, this was an issue recognised to be true at all levels, i.e. MS and EU levels).

5.2. Interviews with EU officials (coherence)

Table 14: List of EU Officials contacted for interview

Name	Role / thematic area
16. Castro Fernandez, Esteban	Migration management support - DG HOME
17. Glowacka-Rochebonne, Katarzyna	Policy officer, Performance of national health systems - DG SANTE
18. Kersteins, Barbara	Deputy Head of Unit, Fighting infectious diseases and advancing public health - DG RESEARCH
19. Matthews, Maya	Deputy Head of Unit, Strategy and Coordination - DG SANTE
20. McCarthy, Kevin	International Aid and Cooperation Officer, Education, Health, Research, Culture; Human Development and Migration - DG DEVCO
21. Peetso, Terje	Head of Sector "eHealth and ageing policy", DG CONNECT
22. Peiro, Maria-Jose	Policy officer, Performance of national health systems - DG SANTE

5.2.1. Main findings – Coherence

Note that the main findings from these interviews are included under coherence Chapter 7 of the main report. The summary below reflects

- The scope for synergies / overlap between the 3HP and different policy areas is wide-ranging and substantial: from support for migration-related health concerns to e-Health, to access to medicine and anti-microbial resistance. It spans from the local to the global.
- It was noted that the HP is not particularly visible outside of the EU, i.e. on the global stage but that there was scope for supportive and complementary action in relation to the EU and global health agenda, as demonstrated by the migrant crisis.
- In order to capture these synergies, there are formal procedures for consultation and coordination, for instance through the inter-service group, working groups etc. exist which allow for systematic assessments of the policy coherence at the design stage. Once actions are underway, there is a lot of collaboration is ad hoc and based on relations / personal knowledge across DGs and in some areas there are well-established on-going discussions and relations.
- The 3HP is typically the less-well funded programme (compared to structural funds, HORIZON 2020, and even DEVCO and ECHO funds) meaning the incentive for other DGs to work with SANTE is not the same as if it were to have vastly greater funds.
- Nevertheless, the 3HP is perceived as a leaner, more responsive and exploratory programme which can address emerging challenges more rapidly than some other programmes (as illustrated by the response to the migrant crisis). This is an aspect which interviewees stressed the HP should exploit and leverage to incubate actions which can scaled up with other funds.
- Finally, a comparison was drawn between the types of beneficiaries which the HP is able to fund (which are wide-ranging, from MS authorities to NGOs and academic institutions), which again marks it out from other funding programmes which typically have more restricted beneficiaries.

5.3. Interviews with external experts (evaluators, international organisations)

Table 15: List of interviewees

Name	Role / thematic area
23. Halmanová, Mariana	Independent expert (evaluator of proposals under 3HP)
24. Meulenbergs, Leen	Executive Manager, Strategic Partnerships, WHO/Europe, and WHO Representative to the European Union (EU)
25. Watson, Jonathon	Independent expert (evaluator of proposals under 3HP)

5.3.1. Main findings - independent experts to 3HP

- The experts highlighted divergences between the needs of the MS but the common challenges which unite them include much of the scope of the 3HP (i.e. prevention of diseases in particular)
- Nevertheless, in terms of “gaps”, the following was noted: procurement practices which are out of step with developments in better care, technology transfer (especially in EU 13) and affordability (through better industry – clinic collaboration to provide cheaper drugs, for instance).
- There is a lack of understanding regarding EU added value which can lead to generic descriptions in proposals, despite the importance of quality description and the weight given to this in assessments.
- In terms of the rationale for EU action, the experts cited the need to address transnational problems and the importance of having a vehicle to engage partners and bring them together to identify solutions. And yet, while the HP operates at the EU level, it is important that engagement and dialogue occurs at the lower level. Ultimately the follow-through is in communities and local contexts which means that these actors need to be engaged.

5.3.2. Main findings - WHO

The WHO works in close collaboration with the EU institutions, including the Commission, as a partner.

There is a shared vision on a range of thematic areas, including on those agreed upon in the 2015 declaration of collaboration at the Regional Committee in Vilnius: antimicrobial resistance, non-communicable diseases, cross border health threats, health information, health inequalities and health systems. On these, and other issues, the WHO works closely with different Directorate Generals of the EC and has a strong collaboration.

When it comes to the Health Programme specifically, the WHO made the following comments:

- There is significant scope for collaboration on a range of topics and health challenges as outlined in the Vilnius paper which is not fully exploited. Still **more systematic collaboration** would lead to further avoiding duplication between the Organisations which would be mutually beneficial, including for the Member States
- While the HP and the WHO share the same broad objectives, the entry point is sometimes different. **More collaboration and discussion prior to the**

development of the annual work plans to look for synergies would be helpful

- There is a **lack of transparency** in the decision-making process for the **design of the HP and its annual work plans** (i.e. to determine what the HP should focus on in the broader sense)
- This **lack of transparency** is also present in the decisions regarding what will be **funded** (e.g. Decisions regarding direct grant agreements with the WHO is not the clear result of a consultation and mutual discussion). This sometimes leads to further elaboration and long discussions on the actual project that will be supported. A more transparent discussion prior to the publication of the work plan would be helpful.

6. ONLINE SURVEY FINDINGS

This section provides a **summary of the perspectives gathered through an online survey**. The online survey is one of several research tools used to consult key stakeholders (ranging from face-to-face interviews to online focus groups and thematic case studies and the online public consultation) on the relevance, effectiveness, and efficiency of the 3HP. The survey was distributed by email to all National Focal Points (NFPs) and Programme Committee members (PCs) of the Third Health Programme on 20 July, 2016. The survey sought to collect information on perceptions of these key stakeholders in terms of the following issues:

- **Suitability of the four objectives** of the 3HP and ability to address (emerging) health needs
- Existence of **health needs which have not been addressed** by the 3HP and whether they should be covered by action at the EU level
- **Implementation of the 3HP**: barriers to the participation of interested organisations; sufficiency of support and guidance provided by DG SANTE / Chafea (NFPs only); and actions to be supported in the Annual Working Programme (AWP) (PCs only).

The majority of the questions included in the survey were closed, multiple choice questions. In the cases where spontaneous written responses were invited this has been made clear in the report. This purpose of this design was to maximise responses by ensuring a manageable length for respondents and allow for systematic analysis of replies. At the same time, it is important to minimise the risk associated with ambiguous / unclear written answers. In the cases where the open replies were provided there were a number of insufficiently clear or detailed replies. In these instances, the evaluation team contacted the relevant stakeholders to ask for clarification. Where possible we have incorporated the findings from such follow-up discussions into the report.

The survey report starts with an overview of respondent profiles, followed by a summary of key findings in several areas. With a view to assessing the relevance of the 3HP, a substantial proportion of the survey was devoted to the programme's objectives and their relationship to perceived health needs. This led to a discussion of views on participation in the programme, particularly potential barriers that could be faced among certain groups and countries. This was followed by a section on programme management in terms of the guidance and support provided by DG SANTE and Chafea. A final section looks at implementation so far in terms of the Annual Work Programmes.

6.1. Profile of respondents

Responses were provided by 45 NFPs and PCs, covering the countries listed in the table below. Following the launch of the survey, three follow up emails were sent to respondents in order to encourage participation, with the survey closing on 19 August 2016.

Table 16: Survey respondents

	EU-15 Member States	EU-13 Member States	Other participating countries
Respondents	Austria	Bulgaria	Norway
	Belgium	Croatia	Republic of Serbia
	Denmark	Cyprus	
	Finland	Czech Republic	
	France	Hungary	
	Germany	Latvia	
	Greece	Lithuania	
	Ireland	Malta	
	Italy	Poland	
	Luxembourg	Romania	
	Netherlands	Slovakia	
	Portugal	Slovenia	
	Spain		
	Sweden		
United Kingdom			
No response		Estonia	

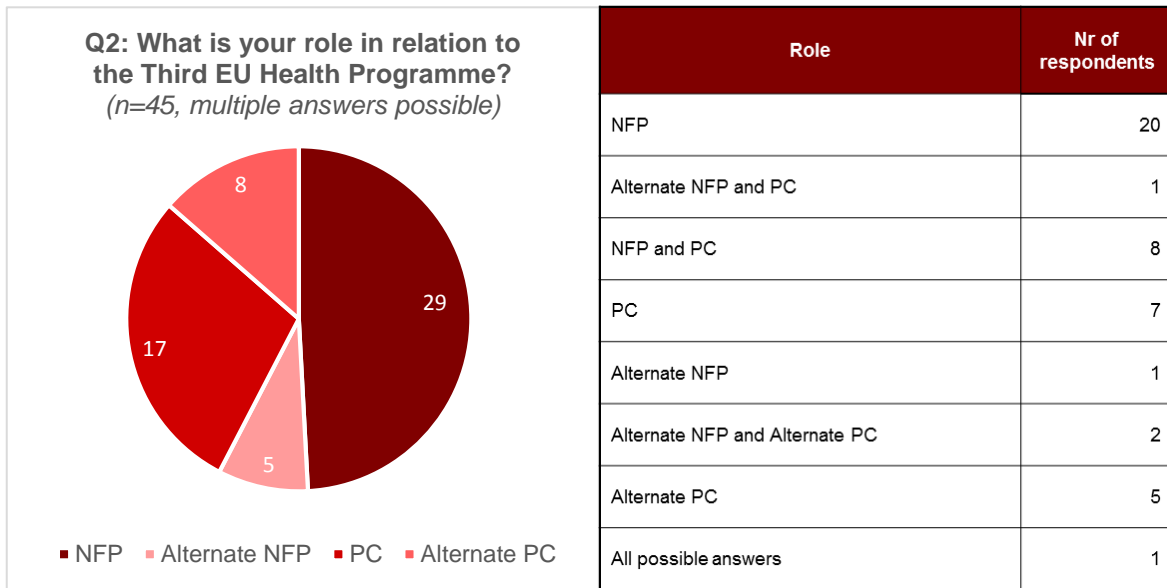
Source: Coffey e-survey

As shown in Table 16 above, the survey achieved a **satisfactory geographical balance across all Member States**, registering at least one response from all except Estonia. Representatives from Norway and the Republic of Serbia also completed the survey.

In terms of their roles, the stakeholders were invited to select all answers applicable to the position they currently hold, and could choose from NCP, alternate NCP, PC or alternate PC. The responses given are summarised in Figure 11, and included **29 NFPs and 17 PCs**. Fewer than 10 respondents stated they were “alternates”. It is important to note here that officials may be fulfilling both the primary position of NFP or PC, and the alternate position.

In order to avoid confusion, note that for some questions we focused the analysis on the responses provided by stakeholders stating they solely fulfil the role of NFP (20), PC (7) or both functions (8). When questions were submitted exclusively to one or the other category, this is explicitly stated.

Figure 11: Role of respondents in the 3HP



The respondents were then asked about **the length of service in their present role** (Figure 12). The majority of NFPs who completed the survey had been working in this capacity for one to four years. The PCs appeared to have been in position for a shorter period of time as a large majority reported that they had been a PC for less than two years. Half of the respondents indicating that they fulfil both roles had been carrying out their duties for more than four years, which suggests they have extensive experience of the policy context for the 3HP.

Figure 12: Length of service in present capacity

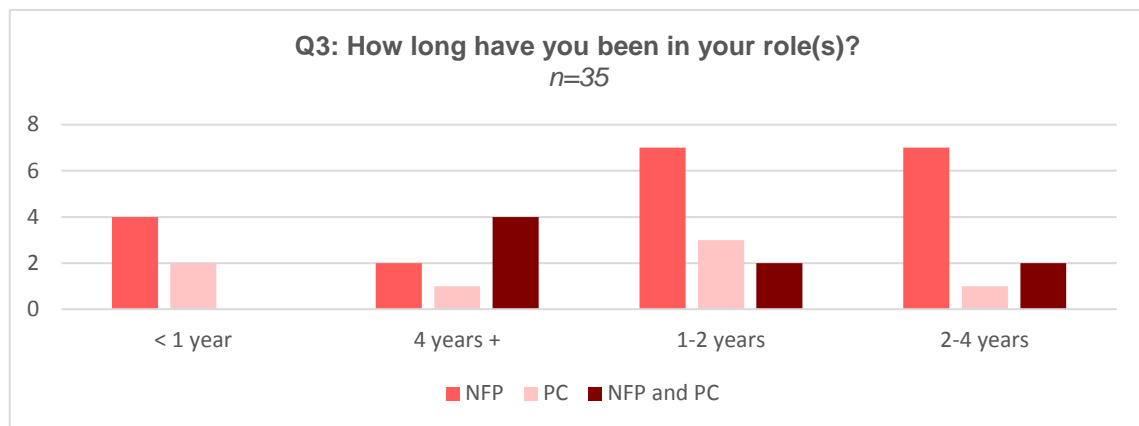
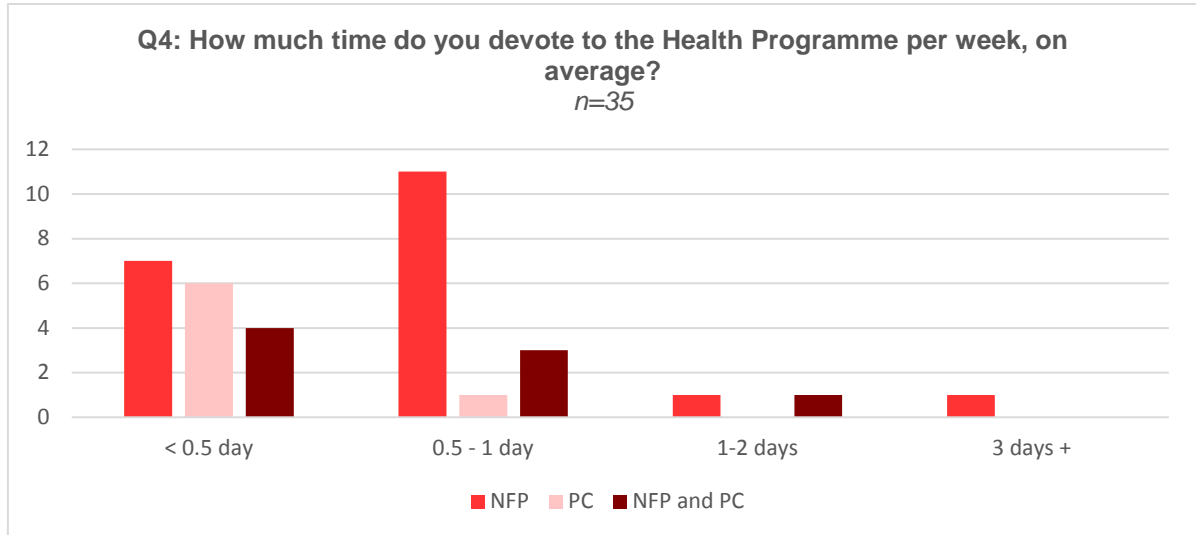


Figure 13 indicates that a majority of respondents across all the stakeholder categories reported devoting up to one day per week to activities related to the Health Programme. However, as you would expect NFPs report devoting relatively more time to the 3HP, with the majority spending between 0.5 and 1 day on it, while PCs in many cases spent less than 0.5 days per week. Only two NFPs and one stakeholder fulfilling both roles reported working on the Health Programme more than one day per week.

Figure 13: Average time per week spent working on the Health Programme



6.2. Objectives of the Third Health Programme

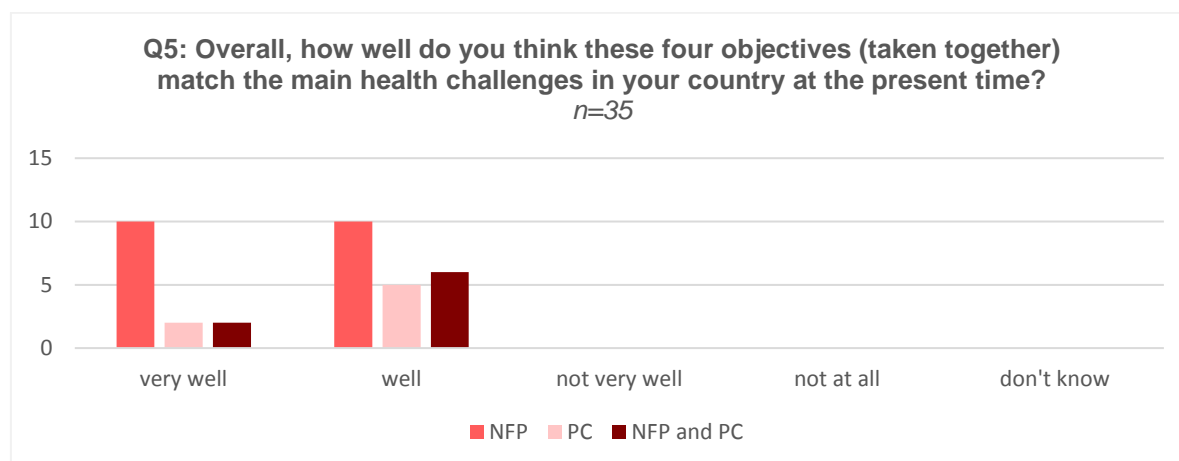
At the outset of the survey NFPs and PC were reminded of **the four main objectives of the 3HP**:

- to promote health, prevent diseases and foster supportive environments for healthy lifestyles;
- to protect citizens from serious cross-border health threats;
- to contribute to innovative, efficient and sustainable health systems; and
- to facilitate access to better and safer healthcare for Union citizens.

The respondents were then invited to select from multiple choices the option which best reflected their views on these objectives, and the extent to which they match the contemporary health challenges in their country (

Figure 14). Overall, the respondents across the different programme stakeholder groups appeared confident in the suitability of the programme's objectives to the health context in their country, as they all stated that the objectives matched the health needs in their country either well or very well. The NFPs appeared most convinced as they selected those answers in equal numbers. Two out of three PCs and similar numbers of representatives fulfilling both roles stated that the 3HP's objectives were well suited to their country's health needs, but did not go as far as saying that they were "very well" matched.

Figure 14: Suitability of the 3HP's objectives to national health needs



The survey continued with **specific questions about each of the four objectives**. For each of these, the NFPs and PCs were asked to consider the following aspects:

- the importance of the issues grouped under the objective (multiple choice question);
- whether dealing with them at EU level adds value compared to action by the Member States (multiple choice question); and
- whether any issues important in their country are missing (open-ended written responses invited on this question).

6.2.1. Objective 1: Promote health, prevent diseases and foster supportive environments for healthy lifestyles

As explained above, the survey respondents were asked to comment on the extent to which they consider the issues grouped under this objective as relevant in their country. presents the responses of the NFPs and PCs for each issue falling under this objective. Overall, the issues covered by this objective were considered as **very relevant** by the surveyed stakeholders. For each of the six aspects, hardly any respondents thought that it was *important to a very small extent*, and no respondents qualified an issue as *not important at all*. NFPs and PCs all had a view on the topic (no respondents declined to provide an answer in this question).

Chronic diseases (including cancer, age-related diseases & neurodegenerative diseases) appeared to be the **issue of highest perceived relevance**, whereas issues relating to **HIV / AIDS, tuberculosis and hepatitis** were considered as **important, but less so**.

Risk factors (such as tobacco and passive smoking, alcohol, unhealthy dietary habits and physical inactivity) were considered as very important, with only six respondents in total qualifying them as only important to a small extent.

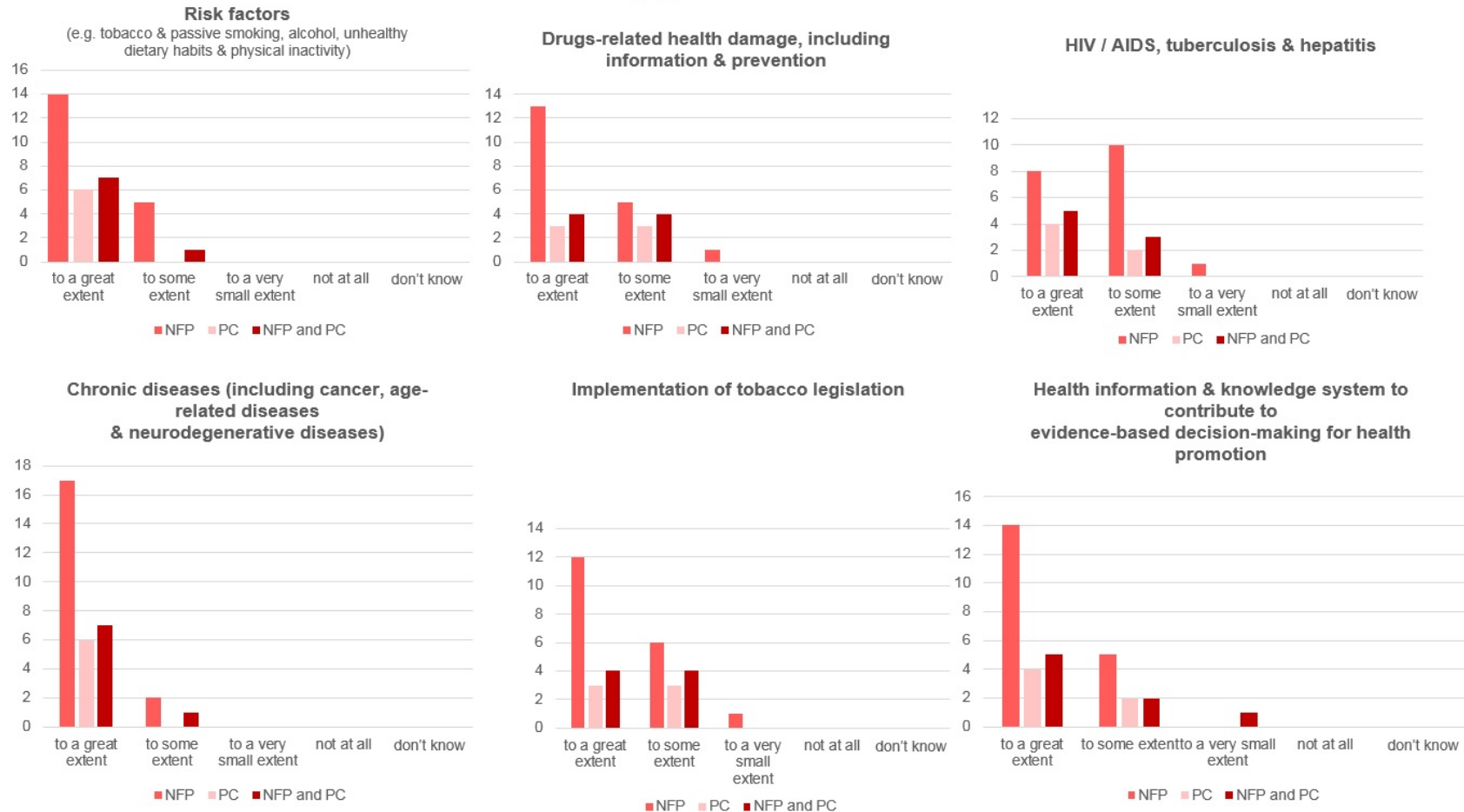
Drugs-related health damage, including information and prevention, the implementation of tobacco legislation and health information and knowledge system to contribute to evidence-based decision-making for health promotion were also all noted as somewhat less important issues in comparison to *chronic diseases*.

NFPs and PCs generally seemed to be **in agreement over the importance** of the issues covered by objective 1 of the 3HP.

Figure 15 : Importance of issues covered in objective 1 of the Health Programme

Q6: In your opinion, to what extent are the following issues important in your country?

n=33



The survey respondents were then asked to **consider the importance of dealing with these issues at EU level**, as opposed to Member State level only. Some stakeholders appeared less certain about this topic and were unsure how to answer. Across the two groups of stakeholders, the responses indicate they consider that it is **important for the issues of objective 1 to be addressed at EU level rather than by national action only**. This was particularly true for the problems relating to *risk factors, HIV / AIDS, tuberculosis and hepatitis*, as well as *chronic diseases*. The stakeholders considered EU action somewhat less important for *drugs-related health damage* and the development of a *health information and knowledge system*.

Figure 16 overleaf presents a detailed **breakdown of the responses** given by NFPs and PCs on each aspect of objective 1. NFPs and PCs had similar opinions on a majority of topics. On the issue of the *implementation of tobacco legislation*, some PCs were uncertain and were also more inclined to consider EU action as less important for the development of a *health information and knowledge system to contribute to evidence-based decision-making for health promotion*.

The stakeholders were then provided with the opportunity to raise **“other issues”** which, in their opinion, could be addressed by the 3HP under objective 1. Stakeholders were invited to submit any suggestions in an open text field.

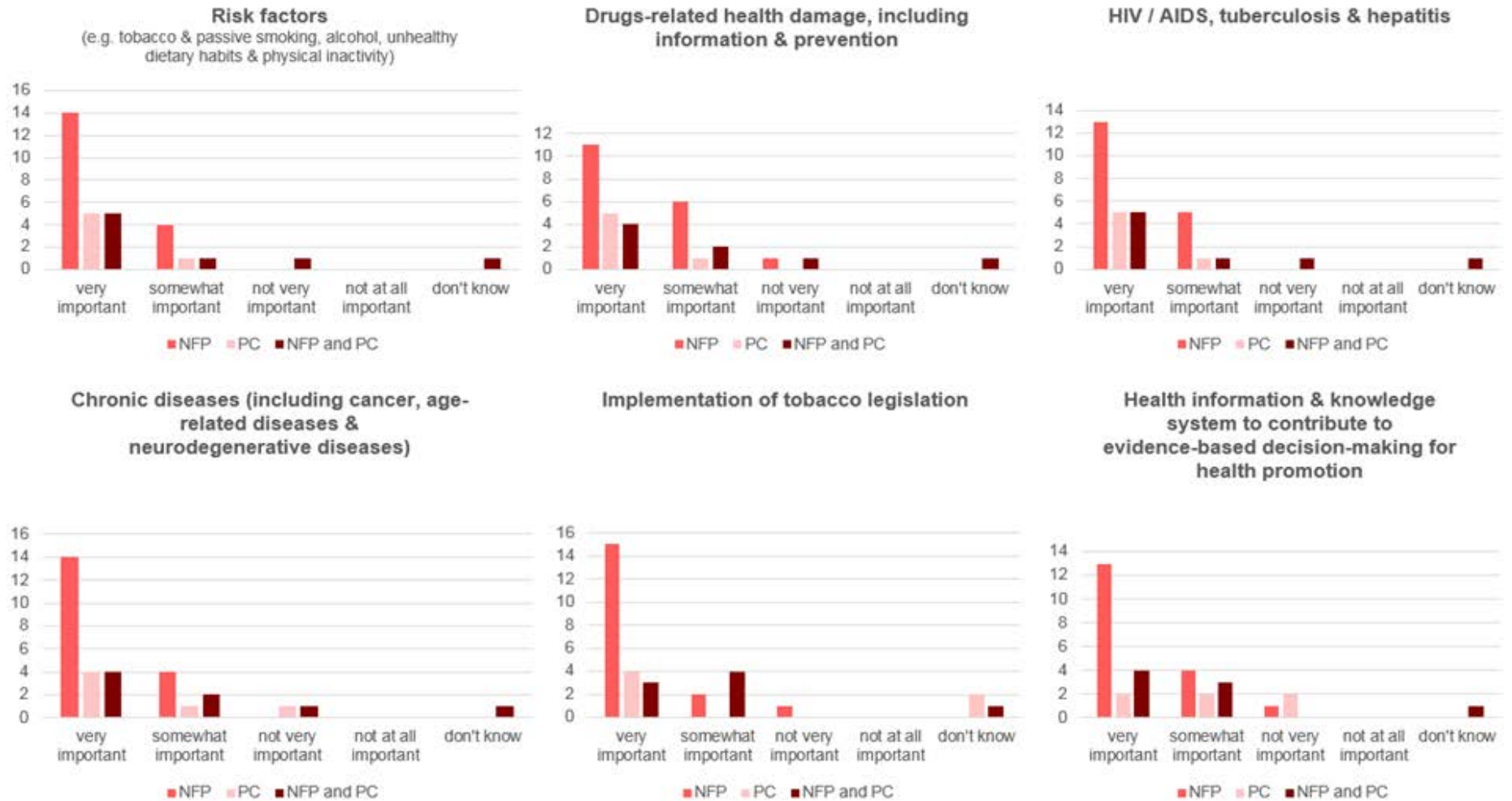
Six NFPs and PCs **provided spontaneous responses and (in some cases) corresponding justifications as to why these issues require action at the level of the EU**. The information provided below reflects the spontaneous opinions and views shared by the respondents and should not be read as factual statements, for example they may not be “new” issues per se but rather areas where the respondent felt more or a different emphasis would be beneficial.

- Giving consideration to health inequalities and social inclusion, as well as health **in all policies** and the role of other sectors **besides health** in objective 1 could be used to support the sharing of experiences and strengthen national policy making⁶⁴. **Dealing with these issues differently** (for example through increased dialogue with other sectors besides the health sector) can build relations between the Member States and bring more equality in health for citizens across the EU.
- Further **developing communication** in the context of health through specialist organisations both with patients and with state institutions.
- Enhancing **monitoring** in the context of health to improve comparability through the management of European Core Health Indicators (ECHI)
- Issues relating to the **empowerment** of citizens regarding their health choices.

⁶⁴ We note that Health inequalities is a transversal issue related to all four of the HP specific objectives and thematic priorities. It also appears in the HP’s legal basis as one of the general objectives and corresponds to inclusive growth imperative of Europe 2020 Strategy.

Figure 16: Importance of EU action for issues under objective 1 of the 3HP

Q7: How important do you think it is to deal with these issues at EU level (as opposed to only at Member State level)? n=32



6.2.2. Objective 2: Protect citizens from serious cross-border health threats

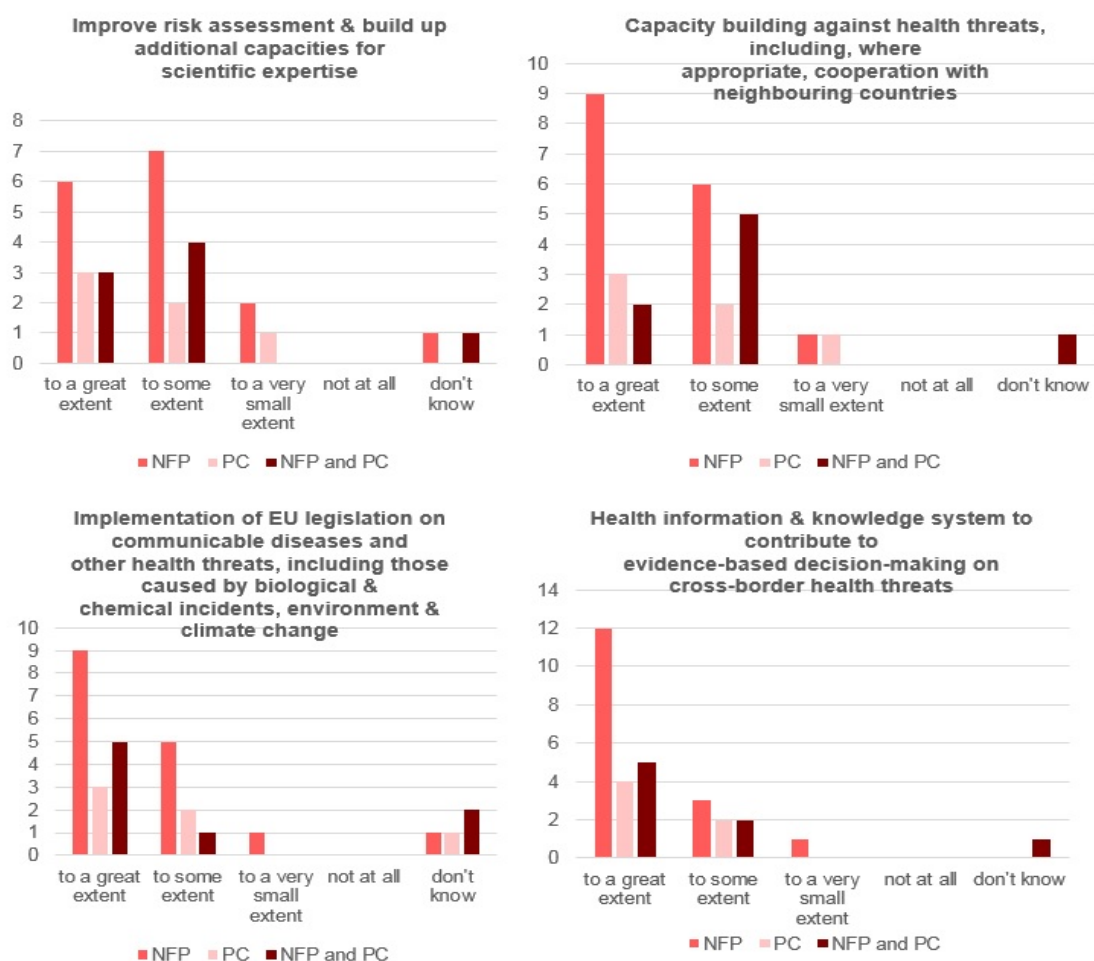
The survey respondents were asked to comment on the extent to which they consider the issues grouped under this objective as relevant in their country. The thematic priorities of objective 2 are the following:

- Improve risk assessment and build up additional capacities for scientific expertise
- Capacity building against health threats, including, where appropriate, cooperation with neighbouring countries
- Implementation of EU legislation on communicable diseases and other health threats, including those caused by biological and chemical incidents, environment and climate change
- Health information and knowledge system to contribute to evidence-based decision-making on cross-border health threats

Figure 17 presents the responses of the NFPs and PCs for each issue falling under this objective.

Figure 17: Importance of issues covered in objective 2 of the Health Programme

Q11: In your opinion, to what extent are the following issues important in your country? *n*=30

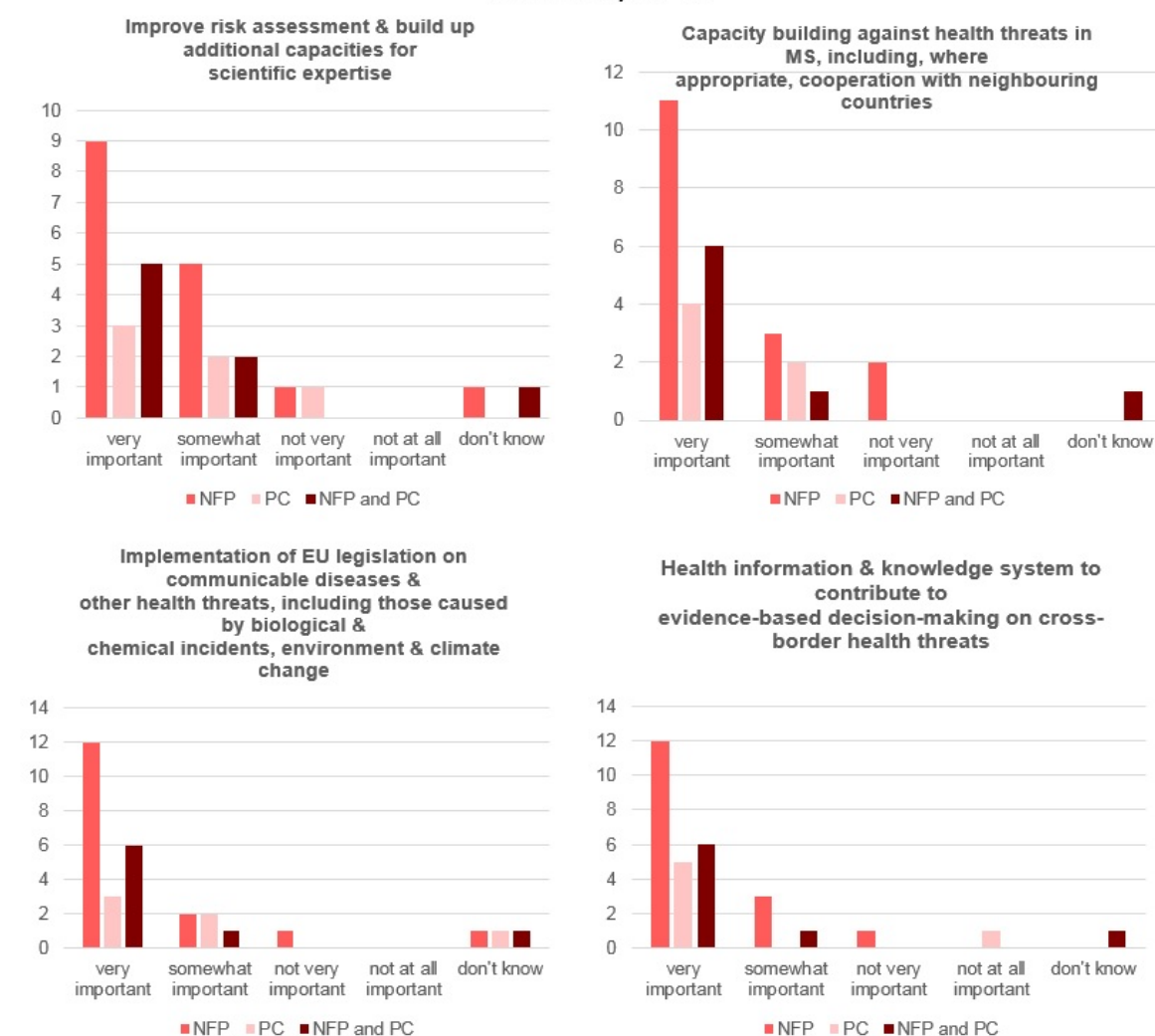


NFPs and PCs were generally in agreement about the importance of issues covered by this objective in their country. The *implementation of EU legislation on communicable diseases* and the development of a *health information and knowledge system* were considered as important to a great extent, and the two remaining priorities appeared slightly less relevant according to the survey respondents, especially in the eyes of the respondents who are acting as both NFP and PC.

The survey respondents were then asked to consider the importance of dealing with these issues at EU level, as opposed to Member State level only. Across the two groups of stakeholders, there was a consensus that it is important for the issues of objective 2 to be addressed at EU level rather than by national action only. The respondents felt strongly that the development of a *health information and knowledge system* should be tackled at EU level. *Capacity building* and the *implementation of EU legislation on communicable diseases* were also considered as priorities that should be addressed by EU action. Figure 18 presents a detailed breakdown of the responses given by NFPs and PCs on each aspect of objective 2.

Figure 18: Importance of EU action for issues under objective 2 of the 3HP

Q12: How important do you think it is to deal with these issues at EU level (as opposed to only at Member State level)? n=30



The stakeholders were then asked whether they thought there are “**other issues**” which could be addressed by the 3HP under objective 2 and invited to submit any suggestions for topics. As with all the open-text fields, the responses received reflect the views of respondents.

In the open responses to this question, NFPs and PCs provided the following answers corresponding justifications as to why they require action at the level of the EU:

- Explicitly introducing the topic of **Migration Health** (also in relation to other Pillars of the Programme)⁶⁵, as there is a need for cross-border cooperation; and
- The need for the **development of procedures or guidelines at EU level**, as they do not exist at the moment.

6.2.3. Objective 3: Contribute to innovative, efficient and sustainable health systems

The survey respondents were asked to comment on the extent to which they consider the issues grouped under this objective as relevant in their country. The thematic priorities of objective 3 are the following:

- Support voluntary cooperation on health technology assessment and uptake of results
- Promote voluntary uptake of innovation and e-health (including patient registries)
- Support development of health workforce forecasting and planning
- Setting up a mechanism for pooling expertise (for health system reform) at EU level
- Actions which support the European Innovation Partnership on Active and Healthy Ageing
- Implementation of EU legislation in the field of medical devices, medicinal products and cross-border healthcare

Figure 19 overleaf presents the responses of the NFPs and PCs for each issue falling under this objective. The thematic priorities under this objective were generally **considered as important issues** by the survey respondents, albeit **to a relatively lesser extent than the priorities of objectives 1 and 2**.

The support to the development of health workforce forecasting and planning, the promotion of voluntary uptake of innovation and e-health (including patient registries) and the implementation of EU legislation in the field of medical devices, medicinal products and cross-border healthcare were considered of utmost importance by a majority of stakeholders.

NFPs and PCs were convinced to a lesser extent of the importance of the support voluntary cooperation on health technology assessment and uptake of results and the development of actions to support the European Innovation Partnership on Active and

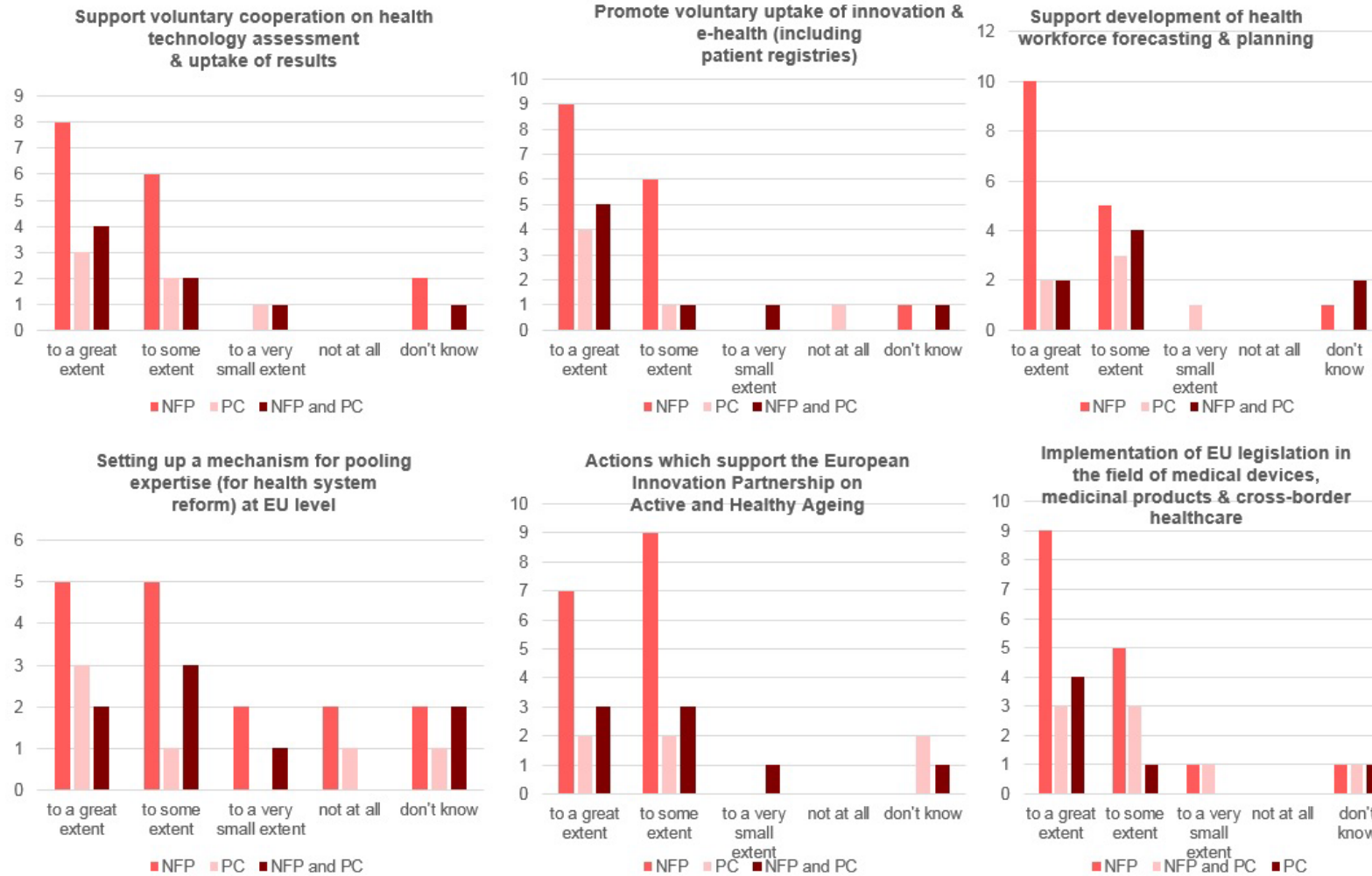
⁶⁵ The context surrounding the status of migrant health topics in the 3HP warrants clarification. The 3HP has not explicitly introduced migrant health as a topic, as discussed elsewhere in the background to the 3HP. However, the 2015 amendment to the annual work programme did introduce actions which responded to the health needs of migrants. In these cases, the projects relating to migrant health was introduced through objective 1. With respect to Objective 2, the Commission have considered the need to migrant health and have incorporated reference under thematic priority 2.2 was amended to include: “address the increasing health threats resulting from global population movements”.

Healthy Ageing in the context of health in their respective countries. *The setting up a mechanism for pooling expertise (for health system reform) at EU level* was markedly considered the least important priority under objective 3, with 6 stakeholders stating that they considered it important to a very small extent or not important at all. Understandably, this was the priority of which the most stakeholders were unsure which could highlight an issue with its wording.

Figure 19: Importance of issues covered in objective 3 of the Health Programme

Q16: In your opinion, to what extent are the following issues important in your country?

n=30



The survey respondents were then asked to consider the importance of dealing with these issues at EU level, as opposed to Member State level only. Across the two groups of stakeholders, there was a **consensus that it is important for the issues of objective 3 to be addressed at EU level** rather than by national action only, but to a lesser extent than objectives 1 and 2.

Unsurprisingly, the NFPs and PCs were **most convinced that the *implementation of EU legislation in the field of medical devices, medicinal products and cross-border healthcare should be addressed by action on EU level***. The stakeholders also considered that it is important that priorities relating to the *support of voluntary cooperation on health technology assessment and uptake of results*, the *promotion of voluntary uptake of innovation and e-health (including patient registries)* and the *support to the development of health workforce forecasting and planning* are addressed at EU level. However, it was less evident than for the first priority and the number of stakeholders considering EU action as somewhat important rather than crucial was slightly higher. Finally, in line with their statements in the preceding question about the importance of priorities in objective 3 of 3HP, the NFPs and PCs considered that *actions to support the European Innovation Partnership on Active and Healthy Ageing* and the *setting up a mechanism for pooling expertise (for health system reform) at EU level* are less suitable to be tackled through EU initiatives. For the latter priority, this could be symptomatic of the relative absence of interest of stakeholders in this priority as seen in the previous question.

Figure 20 overleaf presents a detailed breakdown of the responses given by NFPs and PCs on each aspect of objective 3.

The stakeholders were then asked whether they thought there are “**other issues**” which could be addressed by the 3HP under objective 3 and invited to submit any suggestions for topics. As ever, the replies reflect the views of stakeholders and may not necessarily be considered “new” but rather areas where respondents felt emphasis was important (and should either be continued or improved).

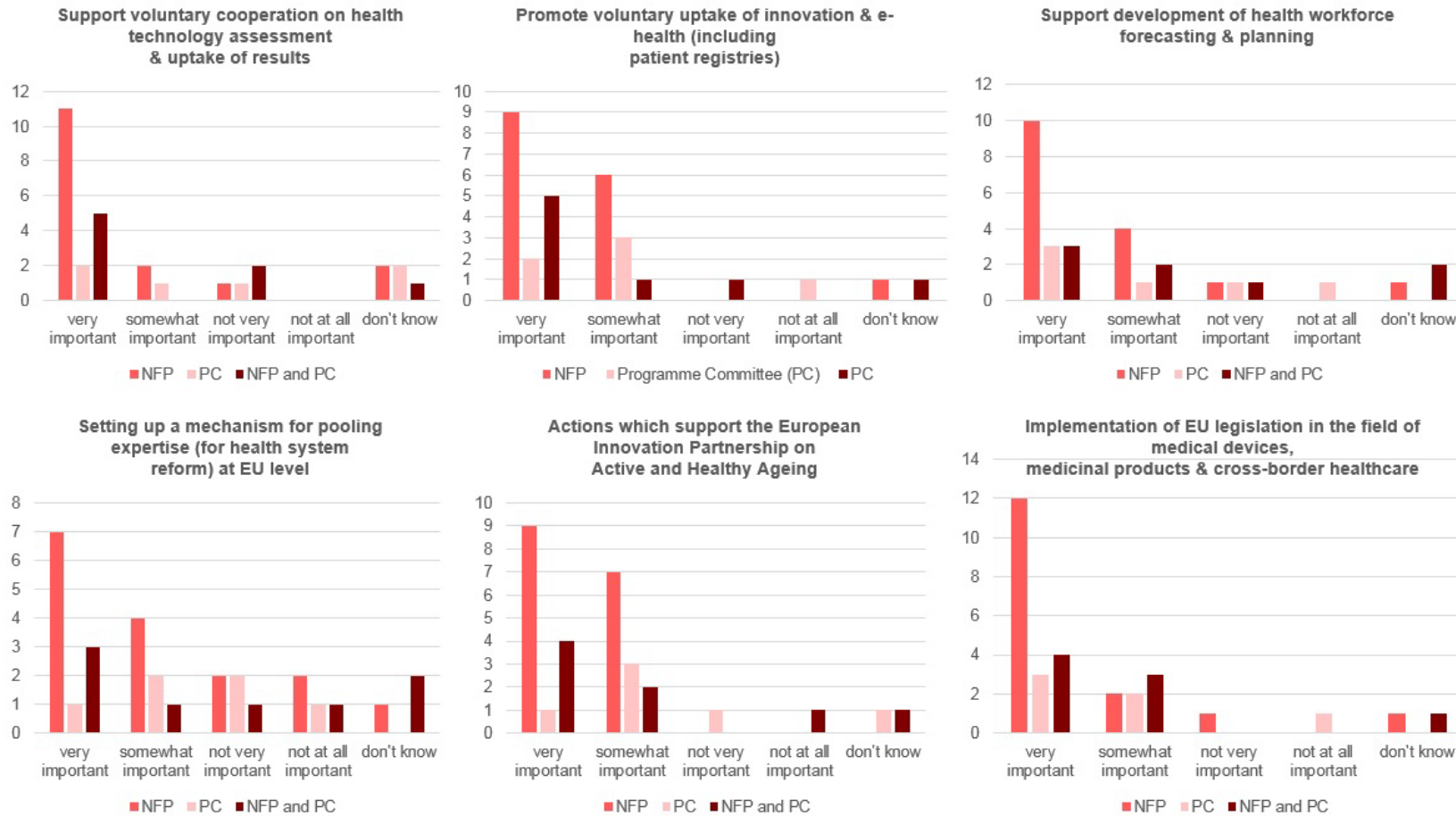
In the open responses to this question, NFPs and PCs listed the following issues / areas and provided corresponding justifications as to why they require action at the level of the EU (when such explanation was provided):

- The need to improve the communication between specialists; and
- The need to maintain valid and reliable indicators, to ensure comparability of health data at the EU level continues to progress, for example in new areas and at the same time is maintained in areas where indicators already exist.

Figure 20: Importance of EU action for issues under objective 3 of the 3HP

Q17: How important do you think it is to deal with these issues at EU level (as opposed to only at Member State level)?

n=30



6.2.4. Objective 4: Facilitate access to better and safer healthcare for Union citizens

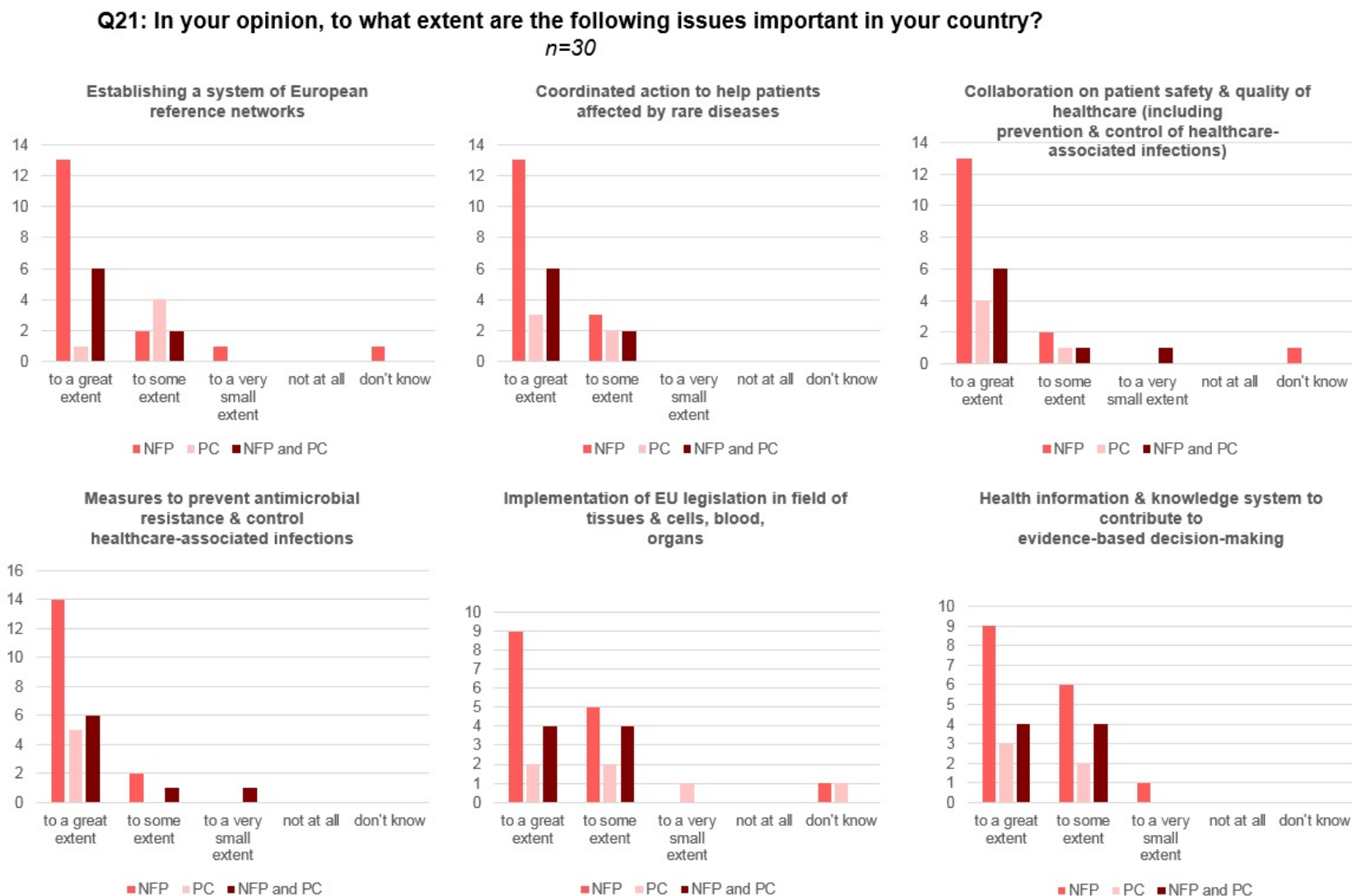
The survey respondents were asked to comment on the extent to which they consider the issues grouped under this objective as relevant in their country. The thematic priorities of objective 4 are the following:

- Establishing a system of European reference networks
- Coordinated action to help patients affected by rare diseases
- Collaboration on patient safety and quality of healthcare (including prevention and control of healthcare-associated infections)
- Measures to prevent antimicrobial resistance and control healthcare-associated infections
- Implementation of EU legislation in field of tissues and cells, blood, organs
- Health information and knowledge system to contribute to evidence-based decision-making

Figure 21 overleaf presents the responses of the NFPs and PCs for each issue falling under this objective.

Overall, the survey respondents considered **the thematic priorities of objective 4 as important to a great extent** in the context of health in their respective countries. As a whole, the NFPs and PCs **felt more strongly about this objective than objective 3**. The taking of *measures to prevent antimicrobial resistance and control healthcare-associated infections* and the *coordinated action to help patients affected by rare diseases* were the priorities highlighted as most important by the survey participants. The *collaboration on patient safety and quality of healthcare (including prevention and control of healthcare-associated infections)* and *establishing a system of European reference networks* were also considered as important but to a lesser extent. Finally, NFPs and PCs were less certain of the relevance of remaining priorities, in particular the development of a *health information and knowledge system to contribute to evidence-based decision-making*.

Figure 21: Importance of issues covered in objective 4 of the Health Programme



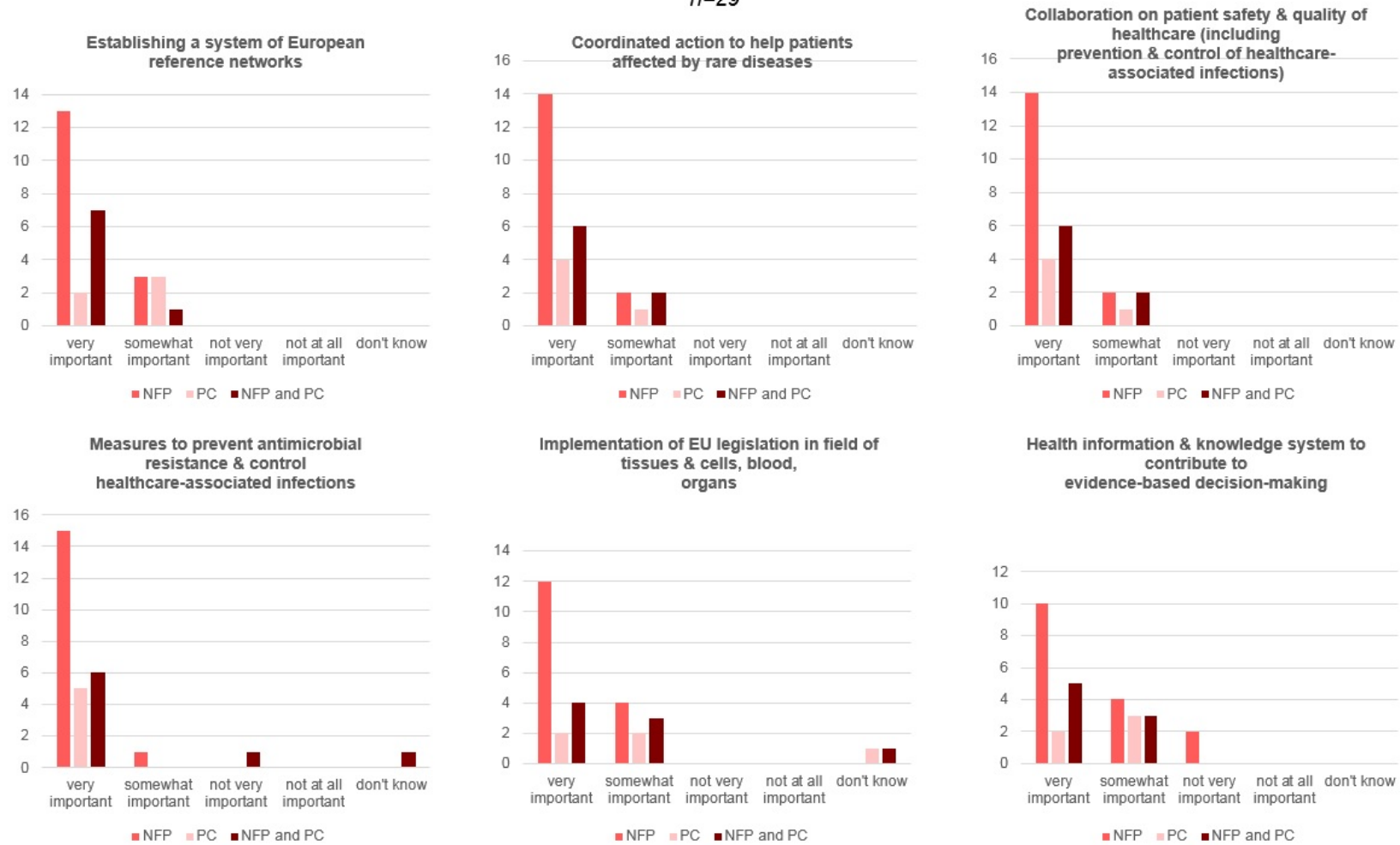
The survey respondents were then asked to consider the importance of dealing with these issues at EU level, as opposed to Member State level only. Across the two groups of stakeholders, there was a **consensus that it is very important for the issues of objective 4 to be addressed at EU level** rather than by national action only, to a **higher extent than objective 3**. Figure 22 overleaf presents a detailed breakdown of the responses given by NFPs and PCs on each aspect of objective 4.

Stakeholders highlighted the importance of EU action in relation to the taking of *measures to prevent antimicrobial resistance and control healthcare-associated infections* and the *establishing a system of European reference networks*. NFPs and PCs also thought that there is scope to address the *coordinated action to help patients affected by rare diseases* and the *collaboration on patient safety and quality of healthcare (including prevention and control of healthcare-associated infections)* at EU level, but to a lesser extent. Finally, the stakeholders appeared less convinced of the importance of the EU's involvement in the development of a *health information and knowledge system to contribute to evidence-based decision-making* and the *implementation of EU legislation in field of tissues and cells, blood, organs*.

The stakeholders were then asked whether they thought there are additional issues which could be addressed by the 3HP under objective 4 and invited to submit any suggestions for topics. There were no responses on behalf of respondents.

Figure 22: Importance of EU action for issues under objective 4 of the 3HP

Q22: How important do you think it is to deal with these issues at EU level (as opposed to only at Member State level)?
n=29



6.2.5. Barriers to participation in the Third Health Programme

The NFPs were asked to consider the **barriers that could prevent potentially interested organisations from participating in 3HP** and comment on the extent to which the following examples of barriers affect potential applicants in their country:

- Availability of information about HP support (calls for tender)
- Securing co-financing for actions
- Complexity of application process
- Administrative burden (once project is up and running)
- Challenges in coordination between MS (e.g. identifying partners, agreeing on roles, language barriers)

Figure 24 overleaf and all the remaining replies provides a detailed breakdown of the responses given according to whether the respondent represents a country which is “low GNI” (i.e. with lower than 90% of the EU average GNI per participant) or “high GNI”. **All of the examples were considered by the stakeholders as having an effect** on potential applicants at least to some extent. **Securing co-financing for actions and the complexity of the application process** were thought having the **greatest impact** on organisations interested in participating in the 3HP irrespective of whether they were based in low or high GNI countries (although the complexity of the application process was considered more troubling by respondents from high GNI countries). NFPs thought that potential applicants are less affected by the challenges arising from the coordination between MS (e.g. identifying partners, agreeing on roles, language barriers) and there were no meaningful differences between high GNI and low GNI respondents. According to the survey respondents, the availability of information about HP support and the perceived **administrative burden of running** a project could also have an effect on applicants, and here again, those in high GNI countries were more likely to rate the potential barriers more highly.

The NFPs were also asked whether they think the barriers mentioned above affect potential applicants in their country in a disproportionate manner (

Figure 23). More than half of the NFPs from high GNI countries responded that they **did not consider applicants in their country as excessively affected by barriers to participation** in the 3HP. By contrast, more than half of the NFPs from low GNI countries reported the reverse situation. Only one respondent expressed the view that applicants in their country are consistently facing more barriers than those from other countries and this was a respondent from a low GNI country.

Figure 23: Effects of barriers on potential applicants in home country

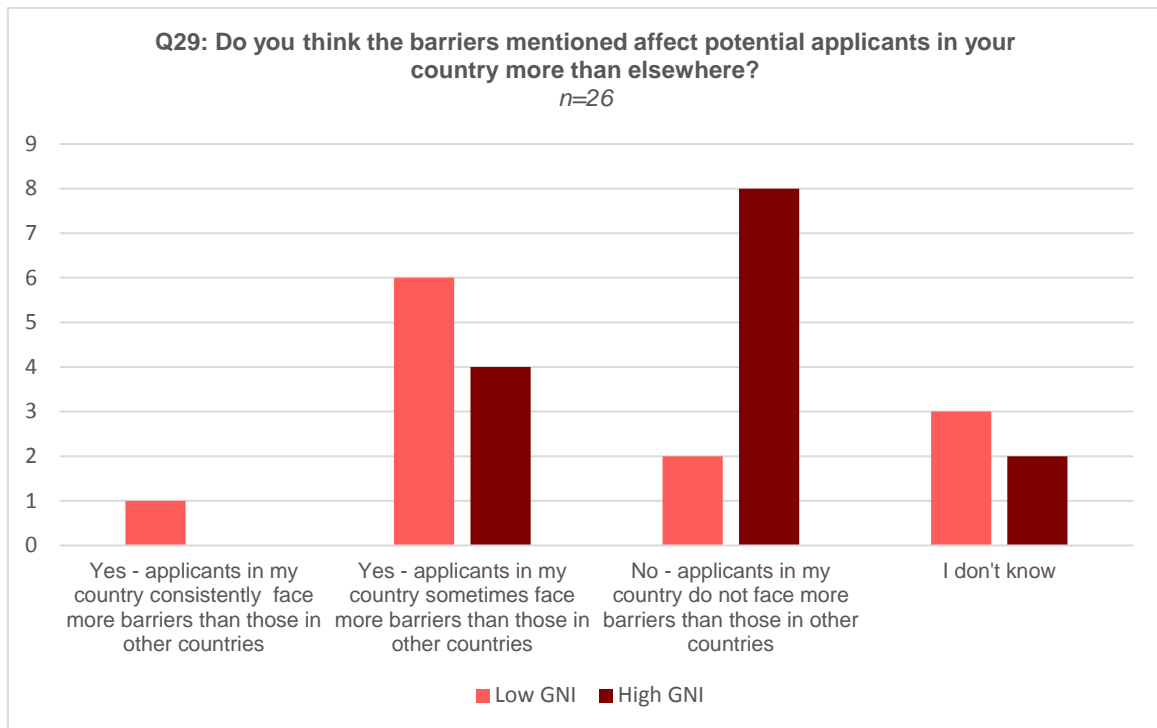
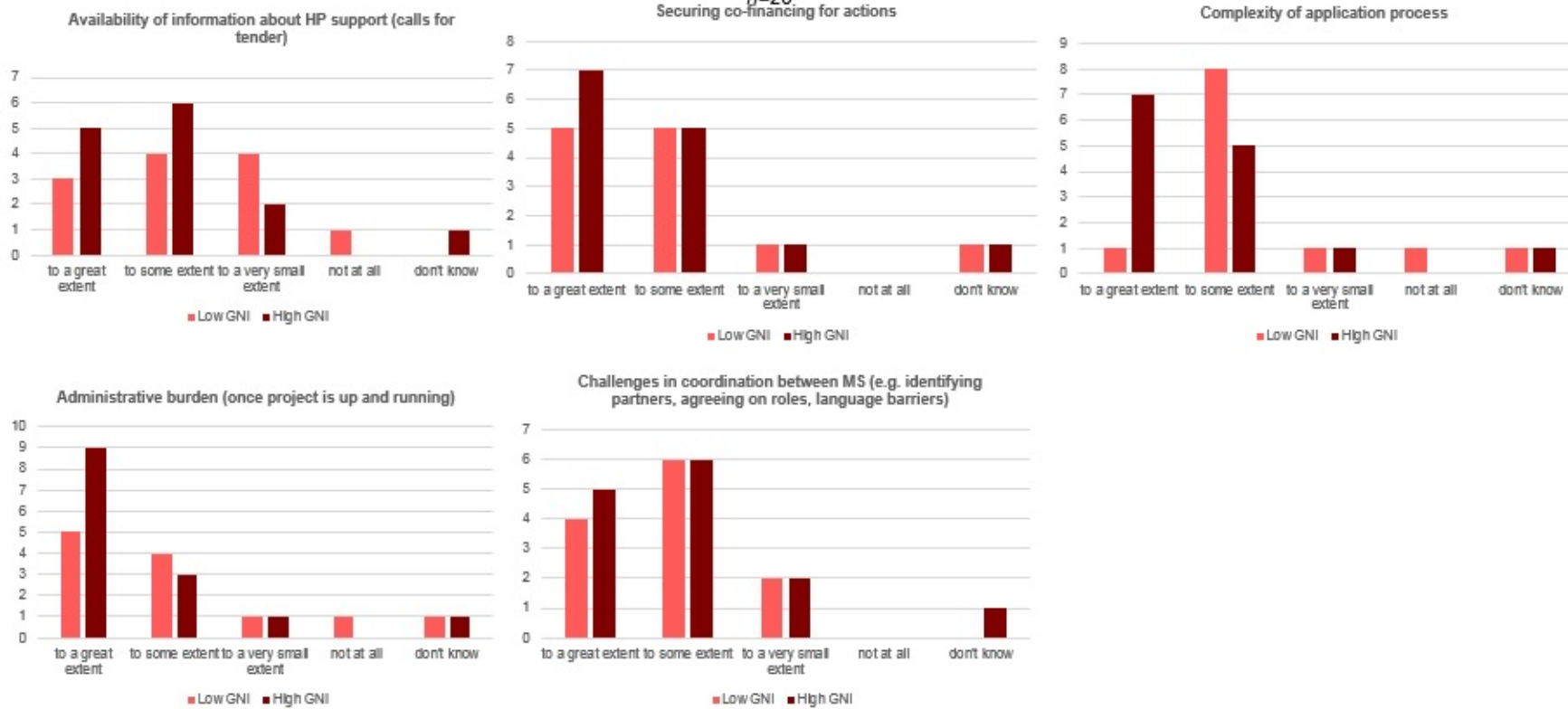


Figure 24: Barriers to participation in 3HP

Q27: There are several barriers that could prevent potentially interested organisations from participating in the Health Programme. To what extent do you think the following ones affect potential applicants in your country?

n=26



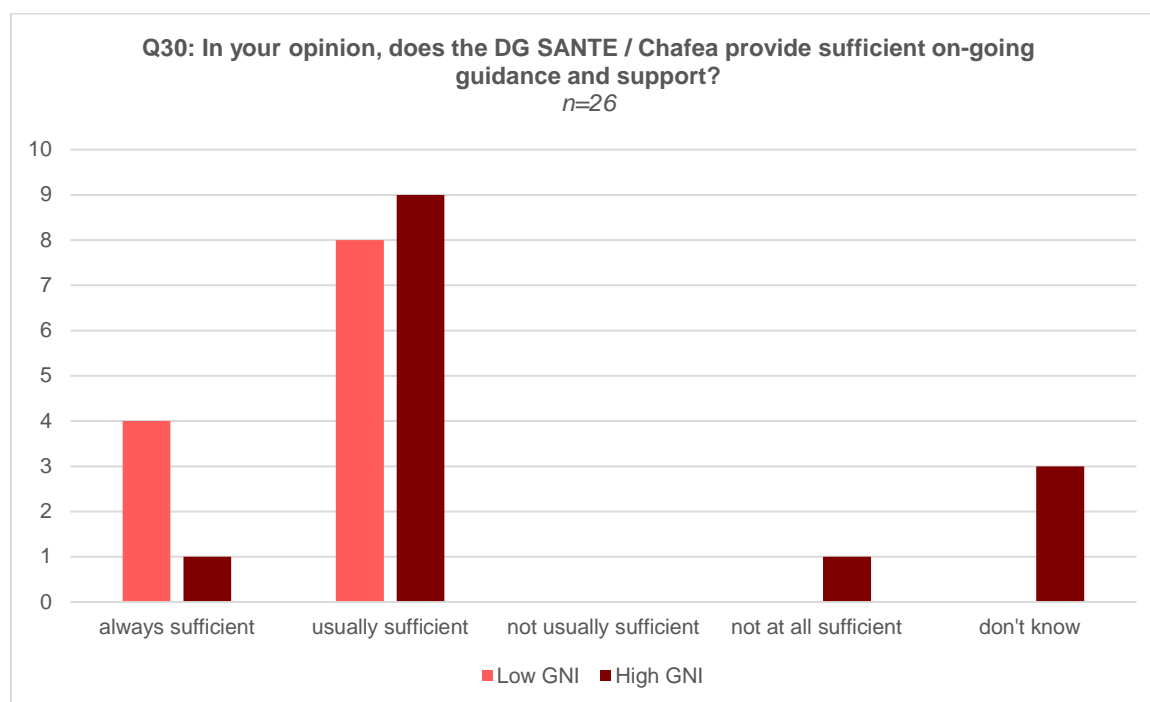
The NFPs were invited to consider and list any **additional barriers to participation** in the 3HP. The following suggestions were made by respondents and reflect their views:

- Having the **competence to apply** for a Health Programme project, as it can be hard to get someone that knows how to correctly submit an application for EU funding given the complexity of application process.
- Organisations from the public sector have **less capacity to participate** in Joint actions to a greater extent.
- **The differences in salaries** for experts between countries has been raised as an issue for participating experts (who may be less willing to participate).
- **Fewer opportunities** (low level of funding compared to Horizon 2020 and fewer project grants than in the 2HP).
- **Language barriers**.
- **More support** in the application process needed, either from **Chafea** (enhancement of helpdesk; more contact persons) or through greater support from national administrations supported by the Health Programme (for example, in Horizon 2020 national institutions receive an allocation of funding in order to support organisations apply for funding).

6.2.6. Sufficiency of the guidance and support by DG SANTE and Chafea

NFPs were also invited to share their opinion on the on-going support and guidance provided by DG SANTE / Chafea. Their responses are summarised in Figure 25. The NFPs were generally **very positive** with a large majority stating that the **guidance and support provided by DG SANTE and Chafea are sufficient**. Just one respondent from a high GNI country believes the support is not at all sufficient.

Figure 25: Opinion on guidance and support by DG SANTE and Chafea

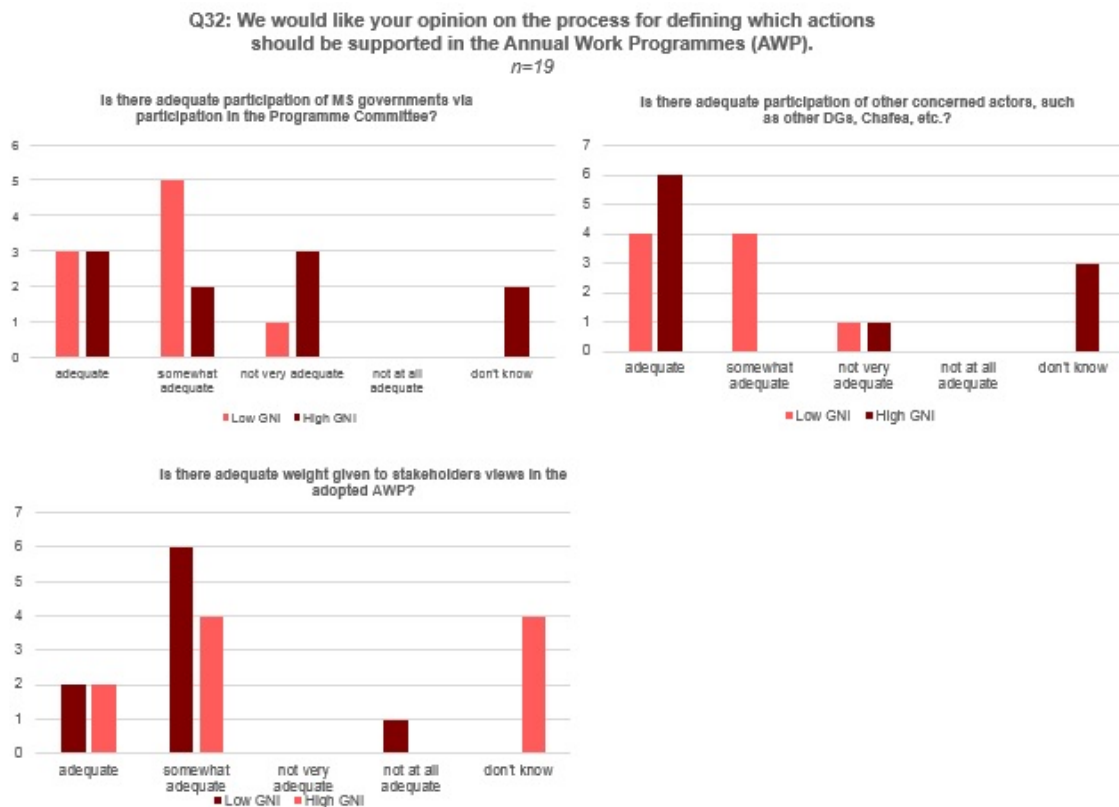


6.2.7. Actions in the Annual Work Programmes

The PCs were then invited to give their opinion on the **process for defining which actions should be supported in the Annual Work Programmes (AWPs)**. Their views are summarised in the figure below.

PCs were **generally positive on the process**, in particular with regards to the participation of other concerned actors. Half of the respondents stated that this aspect of the process for defining which actions should be supported in the AWPs was adequate (and all but one of the respondents from a low GNI country). The participants also appeared **satisfied with the weight given to stakeholders' views in the adopted AWP**, deemed *somewhat adequate* by half of the respondents and *adequate* by one in five. Four of the ten low GNI respondents reported they did not know if there was sufficient weight given to stakeholders' views.

The respondents were **slightly less complementary on the participation of national governments in the process for defining actions in AWPs** through their involvement in the 3HP Programme Committee; one in five thought it was *not very adequate*. One interpretation of this would be that some PCs consider national governments (not necessarily their own) could be more engaged in the process for defining actions. We note that most of the respondents who expressed this view were from high GNI countries.



7. FOLLOW UP MINI SURVEY FINDINGS

An online survey was distributed by email to all National Focal Points (NFPs) and Programme Committee members (PCs) of the Third Health Programme (3HP) on 20 July 2016 and was one of several research tools used to consult key stakeholders on the relevance, effectiveness, and efficiency of the 3HP. The survey sought to collect information on perceptions of these key stakeholders regarding the suitability of the four objectives of the 3HP and its ability to address (emerging) health needs; the existence of health needs which have not been addressed by the 3HP and whether they should be covered by action at the EU level; as well as the implementation of the 3HP. Responses to the original survey were provided by 45 NFPs and PCs, representing all Member States except Estonia but including respondents from Norway and the Republic of Serbia. The detailed findings of the online survey were presented in the Annex to the Interim Report, dated 23 November 2016.

In December 2016, a mini survey was developed with the purpose of obtaining additional feedback on specific issues from the respondents to the original survey. The three questions of the mini-survey aimed to build on the feedback provided and focussed on public health needs in the Member States and the programme's objectives and thematic priorities, in addition to the possible barriers organisations could face to participating in the programme.

The paragraphs below summarise the findings of the mini survey on the basis of the responses collected and analysed by the evaluation team.

7.1. Introduction

By 4 January 2017, 25 responses to the mini-survey had been received, covering the countries listed in the table below.

Table 17: Mini survey respondents

	EU-15 Member States	EU-13 Member States	Other participating countries
Respondents	Austria	Bulgaria	Norway (2)
	Belgium (2)	Hungary	Republic of Serbia
	Germany (2)	Latvia	
	Greece	Lithuania	
	Ireland	Malta	
	Netherlands	Poland	
	Portugal	Romania	
	Spain	Slovakia	
	Sweden (2)		
	United Kingdom (2)		
TOTAL	14	8	3

The mini survey was completed by eight PCs (or alternates), nine NFPs (or alternates) and nine respondents who stated that they fulfil both a Programme Committee Member and a National Focal Point roles (or their alternates).⁶⁶

Representatives from 11 low-GNI Member States participated⁶⁷, whereas the NFPs and PCs from high-GNI Member States to respond were 14.

7.2. Reasons for EU action by Objective

The survey participants were first asked to elaborate on the responses provided in the initial survey as to whether or not action is needed at EU level rather than only national / regional / local levels. The participants were invited to describe the single most important reason which justifies EU action for each specific objective of the 3HP. Their responses are summarised below.

- *Objective 1: Promote health, prevent diseases and foster supportive environments for healthy lifestyles*

All but two participants⁶⁸ to the mini survey cited a reason for EU action in the context of this Specific Objective of the 3HP. Most frequently, the justification for EU action was linked to the exchange of best practices and expertise, as well as the potential for mutual learning between Member States facing similar public health concerns. It was also noted that action at EU level promotes activities and engagements that would not otherwise be a priority for national governments, but also that this type of action supports the creation of sustainable health systems empowering individuals and communities to take action for their health and public health, thus leading to positive health outcomes for all citizens in a country. Finally, the benefits of action at EU level were cited such as pooling resources to achieve innovation in health promotion or the fact that coordinated action at EU level is more effective.

- *Objective 2: Protect citizens from serious cross-border health threats*

There appears to be a broad consensus from the participants regarding the need for EU action in relation to this particular objective of the 3HP: one in two respondents stated that coordination between Member States is essential as communicable diseases are transboundary in nature. Some respondents mentioned the need to develop early warning systems

- *Objective 3: Contribute to innovative, efficient and sustainable health systems*

The relevance of action at EU level was identified by respondents to relate to the development of best practices and innovation in the field of public health. Here, EU action was mainly seen by respondents as a support to national governments in the development of sustainable health systems. The development of eHealth (which refers to healthcare practice supported by electronic processes and communication) and

⁶⁶ The Programme Committee member and NFP from Ireland answered in conjunction with one another and their response was counted as one.

⁶⁷ Low GNI countries as defined in the 3HP refers to countries whose gross national income (GNI) is less than 90% of the Union average. High GNI countries have higher than 90% Union average GNI. The precise list of eligible countries can vary by year but has so far in the first three years of the HP consistently included all those MS who joined the EU after or on July 1st, 2004 (i.e. BG, CZ, CY, EE, LV, LT, HU, HR, MT, PL, RO, SI, SK) as well as EL and PT. From 2015, ES has also been classified as "low GNI". Eurostat provides the data for the classification here : http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=nama_inc_c&lang=en

⁶⁸ Lithuania and Romania.

support for the EIP on active and healthy ageing were also cited by several respondents as providing rationale for EU action under this objective of the 3HP. While respondents did not elaborate how these aspects link to the need for EU action, we can assume that the need for EU action relates to the common challenges facing health systems and the possibility for eHealth and innovation to create more sustainable systems irrespective of their starting point.

- *Objective 4: Facilitate access to better and safer healthcare for Union citizens*

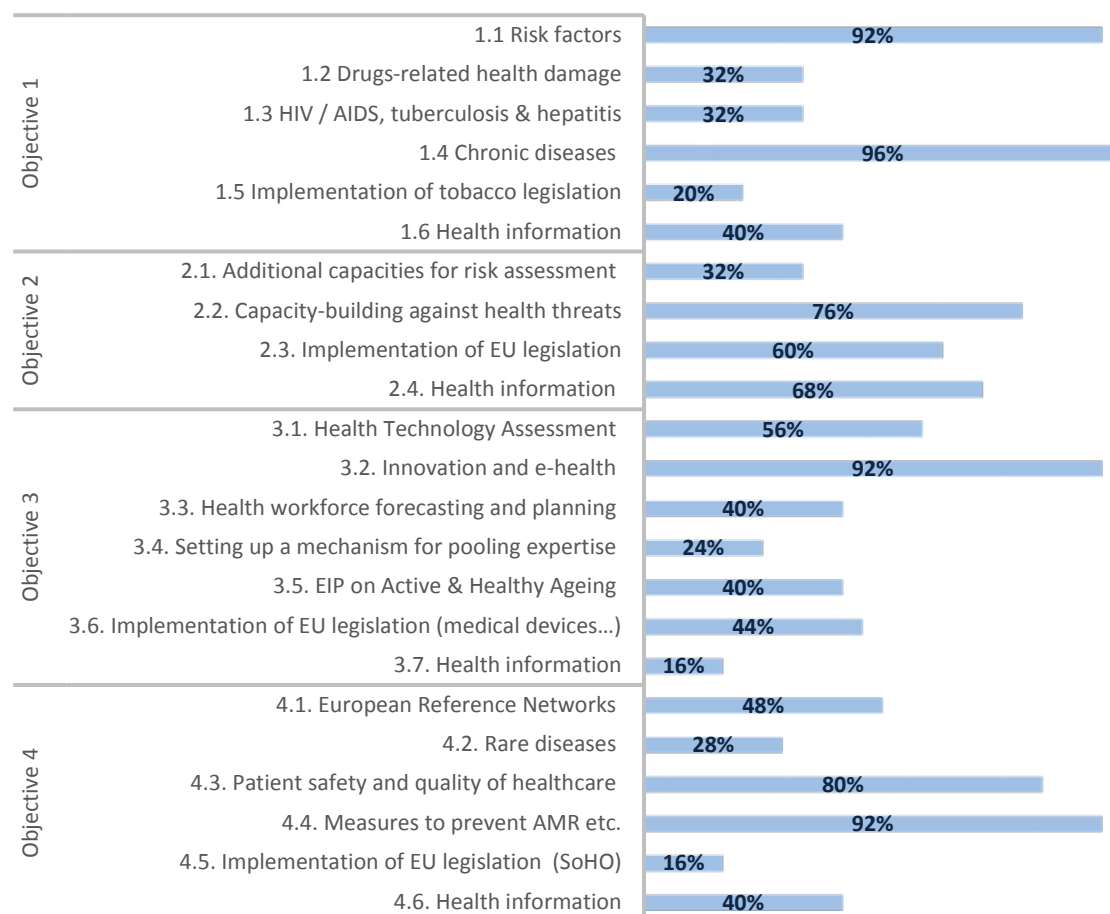
The responses provided by the NFPs and PCs illustrate less clarity regarding the need for EU action (as shown by the lower number of responses: 17 out of 25 participants provided a response). Among the reasons cited were the fact that the sum of actions in this field contributes to improve the overall excellence of health care in terms of safety and quality, as well as to promote innovation in health in the EU, but also that action is needed in the interest of preventing disease and ensuring equal treatment for all EU citizens. The effects of EU action here were mainly considered as contributing to the establishment of a common set of health standards, which will ultimately consolidate the cohesion among all EU Member States. Respondents also specifically mentioned the suitability of European Reference Networks (ERNs) to achieve economies of scale. Others cited the need for EU action in light of the challenges posed by antimicrobial resistance, which is a threat on both European and international levels.

7.3. Importance of thematic priorities for the Member States' public health policies

The mini survey respondents were then asked to outline the three thematic priorities that are **most** important for public health in their country in relation to each objective of the 3HP. Figure 26 presents an overview of the responses received (with the percentages of respondents who have chosen each option).

- *Risk factors (1.1)* and *chronic diseases (1.4)* were overwhelmingly cited as most important in the context of Objective 1.
- *Capacity-building against health threats in Member States (2.2)* was the most "popular" thematic priority under Objective 2. However, the contribution of *Health information and knowledge system to evidence-based decision-making (2.4)* and the *Implementation of EU legislation on communicable diseases (2.3)* were also cited as important by more than 60% of respondents.
- Regarding Objective 3, almost every NFP and PC who responded considered that *Innovation and eHealth (3.2)* are the most important thematic priority in this context. In contrast, the contribution of *Health information and knowledge system to evidence-based decision-making (3.7)* was chosen as a priority by less than one fifth of respondents, as was the *Setting up of a mechanism for pooling expertise at EU level (3.4)*.
- For Objective 4, the respondents were fairly unanimous that the leading thematic priorities are the development of *Measures to prevent AMR and control healthcare-associated infections (4.4)*, as well as *Patient safety and quality of healthcare (4.3)*.

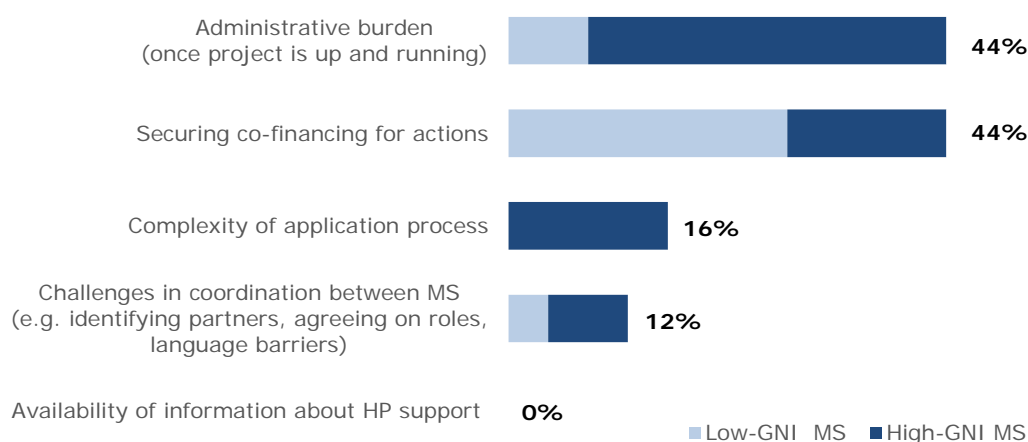
This was in line with the respondents' answers on the main reasons for EU actions in the context of each Objective provided above. However, the *Implementation of EU legislation in the fields of tissues and cells, blood, organs* and action in the context of *rare diseases* were seldom chosen as key priorities.

Figure 26: Importance of thematic priorities for public health in Member States


7.4. Potential barriers to participation in the 3HP

The initial survey mentioned several potential barriers that could prevent interested organisations from participating in the 3HP in their country. Respondents to the mini survey were invited to select the potential barrier that they consider most important in their country. It is important to note that (despite these instructions) some participants chose to provide more than one answer. All answers are reported below.

Figure 27 presents the findings from the mini survey on the importance of potential barriers to participation. The analysis is presented with a breakdown of the responses from low and high-GNI Member State representatives, as well as the percentage of respondents from all participating who chose each answer.

Figure 27: Relative importance of potential barriers to participation (low and high-GNI Member States)

We note there was no single barrier to participation in the 3HP cited by a majority of participants. However, overall, respondents consider the administrative burden and securing co-financing to be the most problematic aspects (cited by almost half of the respondents).

Participants from high-GNI Member States were many to highlight the barriers posed by the administrative burden of project management and the complexity of the application the leveraging of co-financing for actions. Challenges arising from the coordination between Member States were highlighted by a limited number of participants from both groups, but overall less than 12% of all respondents thought this aspect was problematic. No respondents deemed the availability of information about 3HP support as a potential barrier to the participation of interested organisations in their country.

The respondents to the mini survey were then asked to provide a short explanation for their answer. We provide a summary of the explanations collected from respondents below, by type of barrier to participation.

- Administrative burden (once projects are up and running) and complexity of application process:** A few respondents noted that the administrative burden is particularly heavy on smaller organisations⁶⁹ and that beneficiaries would appreciate more support from Chafea.⁷⁰ Also, the respondent from Portugal highlighted that, in a context of scarce financial and human resources, the additional burden of heavy administrative requirements is seen as a weight rather than a benefit and suggested that simplification of the procedural aspects could be helpful⁷¹. A respondent from the UK summarised this as follows:

“The EC administration process (both application and management) is more complicated than the national processes and can be a hurdle for newcomers to European funding.”

⁶⁹ Austria, Belgium., Sweden.

⁷⁰ Germany.

⁷¹ The evaluation team note that simplification measures have been put in place but that nonetheless the respondent commented that more measures could be taken. Unfortunately specific suggestions were not made.

- **Securing co-financing for actions:** The majority of respondents (seven out of 11) who chose this as the main barrier to participation to the 3HP in their country were representatives from low-GNI Member States.⁷² It was noted that small NGO and other institutions often lack the necessary financial means to run a project or take part in a project.⁷³ This is also exacerbated by the continuous cut-down of non-essential expenditure by national governments in a general climate of austerity and thus they also struggle to contribute to actions. This type of comment was made by several respondents⁷⁴, for instance the representative from Austria:

“Due to the continuous cut-down of non-obligatory expenditure, our Ministry cannot contribute to secure the 40% of the overall eligible budget.”

- **Challenges in coordination between Member States:** These potential challenges were mentioned mainly in connection to applications, where a collaboration based on equality and trust in between the different partners should be established. For example, the following comment was made by the respondent from Spain:

“As the alternate for the Programme Committee I can refer mainly to barriers for the Joint Actions applications. In this regard one barrier is challenges in coordination between MS, in the sense of having a balance and trustful collaboration in between different partners and along the whole Joint Action.”

Language barriers were pointed out by the Slovak respondent as a limit to the involvement of experts that could be a contribution to projects, Joint Actions or other financial interventions under the 3HP.

⁷² Bulgaria, Greece, Hungary, Latvia, Poland, Romania and Republic of Serbia. The high-GNI Member States who chose this answer were Austria, Ireland, the Netherlands and the UK.

⁷³ Comments to this effect were made by respondents from Austria, Ireland, the Netherlands and the UK.

⁷⁴ Austria, Greece, Hungary, Latvia.

8. FOCUS GROUP FINDINGS

We conducted a series of three focus groups in order to engage relevant public health experts in discussions on a variety of topics. The purpose of the focus groups was to gain insight into such issues as the relevance of the 3HP and its specific objectives and thematic priorities in relation to health needs, EU added value and synergies with other actions at EU and other levels. We conducted three groups, one each for specific objectives 1 (Health promotion), 3 (Innovative, efficient and sustainable health systems) and 4 (Access to better and safer healthcare) of the 3HP.⁷⁵

In practical terms, the focus groups brought together experts with specialised knowledge and experience from around Europe. Since such experts are dispersed geographically, we conducted the focus groups online, using chat software. Each group was moderated by one of the evaluation team's sector experts, based on a discussion paper prepared and circulated in advance. The groups were carried out on 17-18 August 2016 and each lasted from 1.5 to 2 hours.

The ensuing subsections present the findings from each focus group, in individual reports that are structured as follows:

- Introduction: gives an overview of the methodology and practicalities of the focus group;
- EU health needs
- Perceived relevance of the specific objective
- Perceived relevance of the thematic priorities falling under the specific objective
- EU added value and utility
- Best practices and lessons learnt
- Conclusions

8.1. *Specific objective 1: Health Promotion*

8.1.1. Introduction

The online focus group on objective Health Promotion took place on 17.08.2016. The discussion lasted one hour and a half, and finally involved 4 participants; one planned participant dropped out due to a car accident on the day of the focus group.

Recruitment: Based on the lists of experts provided by the EC, a review of appropriate experts from Scientific Committees and professional networks by the recruiter, herself health promotion expert, 22 health promotion experts were contacted. 5 experts agreed to participate, 11 were not available and 6 did not respond. A reminder was sent after one week to the ones who had not responded yet. The experts approached included mainly academics, politicians and representatives of international organizations with comprehensive knowledge on Health Promotion, the 3HP and the current developments. The experts approached were from Estonia, Slovenia, UK, Austria, Germany, Finland, Norway, Portugal, US, Belgium and Spain, as well as experts from EU Office of WHO.

⁷⁵ Given the political sensitivity of specific objective 2 (Cross-border health threats), the originally foreseen focus group was replaced with interviews with members of the Health Security Committee, which are still being carried out.

Expertise: The participating experts have a strong expertise in Health Promotion, Primary Health Care and Preventive services, risk factors and chronic diseases. The participants were from Finland, Belgium, Spain and the United Kingdom.

The full breakdown of participants' profiles is described in the table below.

	Background / area of expertise
Participant 1	Musculoskeletal health and conditions that affect it
Participant 2	Evidence-informed health promotion and policy development
Participant 3	Health promotion and behavioural change
Participant 4	Policy maker, at regional and national level (regional ministry of health, deputy minister, etc. Health care management. Now working at Regional health services

A professional moderator led the focus group and the participants engaged in a healthy debate, responding to points raised by each other, as well as to our questions. The discussions reflected the main objectives of the focus groups, which were to:

- Generate evidence for DG SANTE on suitability of 3HP objectives to address EU / Member States needs
- Better understand how thematic priorities and actions contribute to HP objectives
- Analyse the coherence and consistency of the health action at different levels
- Generate evidence on the strengths and weaknesses of EU health action and the best context for EU action
- Identify best practices from other actors' health action transferable to the EU

The analysis of the focus group results is based on Qualitative Content Analysis and used a summarizing and structuring categorization approach as the qualitative analysis principle.

This report summarises experts' contributions and presents the findings of the online discussion.

8.1.2. Health needs in the EU

The experts named a number of key challenges representing the current and evolving needs of the EU and for EU health action. Those can be categorised into different blocks:

- **Demographic change and ageing:** The experts named demographic change, ageing and related health and social needs as a crucial challenge. Demographic change leads to more elderly needing care and home support, while fewer young people have jobs to bring income and tax money. The increasing burden from long-term conditions with high morbidity but low mortality (i.e. musculoskeletal, vision, hearing, dementia) is a central challenge. Prolonged life expectancy is leading to increased chronic diseases, multiple comorbidities and their related economic costs. Especially increasing inequalities in health, related to ageing and chronic diseases were named as a key challenge.
- **Chronic Diseases:** Chronic diseases (e.g. diabetes) are still rising and related to lifestyle factors such as healthy diet or physical activity. The experts concluded

that efforts need to be continued and more effective methods (not only targeting individuals but also reinforcing health enhancing environments) need to be strengthened. This includes measurement tools for CDs and their systematic and EU-wide application. For those living with chronic diseases, a person-centred holistic approach is needed.

- **Mental health:** The experts were in agreement that mental health is a currently underestimated key challenge, not reflected in the EU Health programme. Mental health, suicides and factors affecting mental health (such as stress, social support, etc.) were explicitly mentioned as important problems to tackle. In their opinion, mental health problems, especially burnout and depression, are still increasing, and call for a strong investment of the EU.
- **Healthy Lifestyles and NCDs:** The experts felt that health related lifestyles, both in terms of health-threatening behaviours (substance abuse, risk behaviour) and health-enhancing behaviours (physical activity, healthy diet including fruit and vegetable consumption but also sleep) are still relevant challenges. Even though there was some improvement (or at least less dramatic negative trends than expected) in many countries' lifestyles (e.g. on adolescent's drinking and smoking), especially physical inactivity and sedentary lifestyle leading to overweight and obesity remain a challenge. One expert pointed out that "approaches to deal with it are still rather individual oriented and lack collaborative and cross sector research and action to deal with the needs". Health information was identified as a key challenge as health literacy remains poor and people's expectations of what health care can and should deliver is high.
- **Health supporting environments** (e.g., social capital, community participation, healthy physical environment) were emphasized as important area for enabling health in the EU. The experts stated that collaboration across sectors had insufficiently improved, with different stakeholder groups or policy target groups and participation of population and sub groups remaining too low.
- **Migrant health:** The influx of refugees was named as a new challenge related to EU health needs.
- **Over-medicalization and adverse drug reactions** were also identified as a challenge. Experts were in agreement that this key challenge needs better monitoring, analysis of causes and effective measures to tackle this problem including the role of self-management.
- **Musculoskeletal disorders and low back pain** were also named as challenges due to rising numbers.
- **Immunization:** Evolving problems related to vaccination (shortages, lower coverage, anti-vaccines groups, financial barriers, etc.) were named as an area requiring more consideration from the EU.
- **Limitation in availability and systematic use of monitoring instruments:** The experts agreed that there is a concentration on prevalence and mortality in monitoring of MS and in general a lack of systematic monitoring. This includes a lack of good instruments to measure change at EU level or at national/regional level using EU-wide indicators. While the monitoring of prevalence of diseases and conditions, and in most cases behaviour, is possible, there is no monitoring of determining factors and are more directly influenced by measures, such as health literacy or policy changes. Instruments to measure some of these factors are available but not systematically implemented. For example, there are no good measures available for disability, and monitoring is often limited to mortality.

- **Need for evidence-based policy making:** The experts identified chronic diseases and reducing their impact as well as how to change people's health behaviour as an increasingly relevant topic to be covered by the EU health action. They discussed that the core issue was how to integrate research evidence and real life policy making with its priorities and values. "For policy makers, research is only one opinion". The experts called for studies on evidence-based policy making in different MS and contexts and pointed out that health policy should not only build on research focused on diseases and end points, but also on determinants and mechanisms.

8.1.3. Differences between MS

In general the experts agreed that there are considerable differences between and within MS in terms of burden of diseases and in the factors that influence them. For instance, health literacy differs hugely between countries, ranging from 25% of people with limited or insufficient health literacy in the Netherlands, to almost 60% in Bulgaria.

Differences between countries are related to political and health systems. **Health systems** range from central planning systems such as in Eastern Europe to locally oriented systems such as in the Nordic countries. This goes along with differences with regard to the **financing of the health system** and differing **Public Health capacities** in MS. There are also differences in **evidence-based policy-making**: the experts agreed there are big differences in the uptake of research evidence for policymaking between MS. As the political systems differ, countries are at different stage of "development" in using evidence and "there is not enough information about these local contexts to really learn from each other between countries". In some countries, guidance available at national level is "copied" at local level, in an automatic fashion without really adjustment.

The experts agreed that those differences are largely related to income and education, and other social health determinants. E.g. the economic and financial crisis and the austerity measures that followed were seen as the typical example of a macro-social health determinant.

The experts' discussion of the economic conditions for health promotion in Europe proved intense:

- **Limited investment in health**

The experts were in agreement that, in most EU MS, health is insufficiently considered as an investment in the current political climate **and health-related spending is seen as a cost, not as an investment** in the health and productivity of the population.

As many MS are under economic pressure, **health expenditures have often been reduced and co-payments increased while coverage has been reduced, leading to less and unequal access to health care**. At the same time, prices of new medicines and new technologies are consuming a large proportion of resources. Investments in social policies and social support programs have also been reduced.

- **Economic pressure leads to more consideration of cost-efficiency**

The experts thought that, due to the economic pressure in some countries, healthcare expenditure is being looked at more closely and new ways of working are considered to ensure the right care at the right time and at the right cost, and improve cost-efficiency.

- **Emergencies and crisis situations shadow public health and health promotion**

When there are financial and budgetary constraints, emergencies and crisis situations shadow important, longer-term health issues. However, public health and health promotion intervention are the most cost-effective. The experts felt that there is a **need to show the economic benefit** of improving health and reducing disability and improved ability to work and live independently.

The experts were also concerned about the effects of economic pressure to reconsider health needs and priorities (at least on local level and health), having the effect that especially **long term needs are no longer priorities**.

- **Economic pressure may lead to more marginalisation**

Politicians and policymakers need to cut costs due to the current economic crisis, while new crises such as the migrant crisis in the EU have created an urgent need to build new services and capacities; this situation also leads to "fights", media campaigns and also **collision of population groups, especially among marginalized people** afraid of losing even more benefits.

- **Economic pressure may lead to negative public health effects**

There are huge differences between MS as to how changes have happened. In some countries, most noticeably Greece, austerity measures have led to a less well-performing health system, a situation has already translated into higher prevalence (for instance suicide). For other countries, the consequences of investing less in public health will be noticeable only in the longer term, 3-5 years is not long enough to note the health effects of capacity reduction in health promotion organisational structure and budgets.

8.1.4. Thematic priorities

8.1.4.1. Thematic priority 1.1: Risk factors such as use of tobacco and passive smoking, harmful use of alcohol, unhealthy dietary habits and physical inactivity

The experts felt that the topic is still relevant in regard to the influence of risk factors on major health problems, disability and mortality. They mentioned that even though the definition includes other risk factors it would have been beneficial to include other health relevant behaviours such as e.g. sleep.

In general, the experts also identified several limitations: they agreed that there is still **too much concentration on risk factors**. A more comprehensive view is required, looking at multiple levels, including social determinants and structures such as policies (like e.g. transport for physical activity) and their interactions. Sustainable changes have to include supporting environment - interventions for efficacy, effectiveness and ways of implementation and applicability in different settings and their evaluation. For risk factors such as unhealthy diet, they mentioned nutrition as an example of the need for a more comprehensive approach as food and nutrition in the EU are influenced e.g. by varying nutrition and food legislations, and industry interests.

8.1.4.2. Thematic priority 1.2: 'Drugs-related health damage, including information and prevention'

The experts discussed the need for an extra priority area on drugs. It was not clear to the experts why drugs were not included in the first thematic objective as they felt drugs constitute a risk factor such as smoking etc. They thought that there should be more emphasis on the appropriate use of drugs, including over-the-counter-drugs. It was pointed out that the "climate" around drugs changed in Europe with an increased consumption and acceptance of specific drugs, leading to a higher demand for adequate information about health effects, especially for young people.

The experts mentioned that illegal drug-abuse is still a problem calling for a discussion about strategies.

Over-medicalization was mentioned as another relevant field for this priority.

8.1.4.3. Thematic priority 1.3: 'HIV/AIDS, tuberculosis and hepatitis'

While the experts found the thematic priority clear in its aim, they were not convinced about its relatively **narrow scope** and discussed the relevance of the named diseases. Other infectious diseases e.g. STIs such as chlamydia and herpes should be included. The experts felt that there is still a need to focus on HIV especially taking into account the rise of HIV in some countries and the spread through increased travelling. The experts mentioned that specific conditions of the spread of these diseases should be taken into account e.g. by more targeted approaches. Similarly, they pointed out that tuberculosis was almost eradicated but is again on the rise due to immigration.

8.1.4.4. Thematic priority 1.4: 'Chronic diseases including cancer, age-related diseases and neurodegenerative diseases'

This priority on chronic diseases is **still relevant, but there are substantial overlaps with the priority 1 on risk factors**, especially taking into account the relevance of healthy life-styles in chronic conditions. The disease-orientation in the thematic priority was discussed as not being fully adequate.

It was strongly suggested to include under this priority **mental health** e.g. depression and musculoskeletal conditions as conditions with high relevance for burden of disease and disability as well as diabetes. The experts also felt that "age-related diseases" are not clear in scope and multi-morbidities, especially relevant for ageing, should be included. Also the scope of the objective was not clear to the experts, especially in regard to what actions the priority aims on (e.g. on prevention or self-management).

8.1.4.5. Thematic priority 1.5: 'Tobacco legislation'

The experts were in agreement that this area **should be mentioned under objective 1 on risk factors**. It was not clear to them, why a thematic area is dedicated only to legislation for tobacco, while neglecting other legislations e.g. on food and alcohol. This priority with a very narrow scope was believed to **over-emphasize** the importance of tobacco legislation.

8.1.4.6. Thematic priority 1.6: 'Health information and knowledge system to contribute to evidence-based decision-making'

This priority is very important as a key tool for the evaluation and design of policies, and relevant for all thematic priorities. However, they found it was formulated too vaguely without defining e.g. contents or target-groups (public to enable informed / shared decision making, health professionals, policy-makers).

According to the experts this priority should go beyond informing the public and should be more targeted at national and regional governments in the MS, so as to offer possibilities for identifying problems, benchmarking, giving direction and guidance. Surveillance as a component was found to be also very important but needs to be less fragmented (which e.g. hinders the transfer of e.g. health record data) and should meet current needs.

The experts suggested that the thematic area should cover different levels, ranging from statistics, surveys, health records etc. to measures at the level of the determinants of lifestyles, health literacy, policies, and health supporting environments to information on the impact of health conditions i.e. disability.

The experts also pointed out that such information system should include other contextual factors that influence policy-making. The participation of target-groups in policy development and decision-making was named as being beneficial to create real-life know-how about factors of evidence-based decision-making.

8.1.4.7. Conclusive remarks on thematic priorities

In general the experts rated the thematic priorities of the 3HP as not well balanced. The different thematic priorities were assessed as not comprehensively covering the relevant health topics and overall the systematic organization of the contents of priorities including the distinction between some priorities is not clear; e.g. why two thematic areas cover smoking while other topics were left out. They also stated that the programme's intervention logic is missing.

The experts identified a number of topics that they felt were absent in the priorities from the Programme:

Mental health: The experts mentioned several times and agreed that mental health is missing as a specific thematic area, especially taking into account that there are a number of societal factors increasing the health risk such as a "highly competitive world, with increasing individualism, lack of social and family support, isolation, etc."

Traffic and accidents: The experts also expressed that they felt that traffic related health topics such as traffic accidents and road deaths should be included in the health topic, which should include structural factors influencing behaviours such as organizing traffic/transportation such as safe bicycle lanes, lights on jogging routes etc. Also sports and occupational accidents were mentioned as a missing area.

Musculoskeletal and oral health: Other areas as musculoskeletal and oral health were also mentioned to be absent even though they are already included e.g. in the WHO strategy draft on NCDs.

Immunisation coverage: The experts also mentioned immunization as a missing area in the priorities, especially to ensure an appropriate priority setting of research, manufacturing and pricing according to health needs of EU and world population.

Over-medicalization and the role of the pharmaceutical sector: Over-medicalization was mentioned several times by the experts, including the role of the pharmaceutical sector and the role of self-management.

The experts did not consider that any priority should be removed from this specific objective.

8.1.5. Objective Health Promotion

The experts were in agreement that in general the objective is well formulated, especially appreciating the inclusion of “supportive environments” even though it was also suggested to complement “supportive environments” with **“building structures, environment and policies enabling and encouraging healthy life”**. It was also suggested to have a broader formulation by adding to **“preventing disease ‘and its impact”**. The experts agreed that emphasizing **“to overcome health inequalities”** would be important for the health promotion objective.

The experts rated the objective as **“very relevant”**, but pointed out that the **“specification via the thematic priorities could be improved, made more logical, and complemented by a more social determinant-based approach”**. It was suggested to add a **“multi-sector or multi-level approach”**. The programme needs a more systematic and comprehensive approach instead of disease- or risk factor-specific approach to create interventions which enable healthy living in a sustainable way, requiring longer term research than what exists now, including especially implementation research in different settings instead of neutral RCTs for efficacy.

The experts had a number of suggestions on how to improve the 3HP:

The programme should **focus more on determinants**. It remains very individually focused while health promotion is not only about enabling individuals, but also about strengthening communities and policies and making environments healthier. The current programme **does not give much space to interesting approaches such as health promoting schools, workplaces, hospitals, sports clubs, cities, etc.**

There is also a **need for more evidence on how to implement health policies and change behaviours** of citizens and also health care providers. More linkage of data between health and social topics is needed so that the true impact / costs / benefits can be better understood (such as for example in Sweden). The programme needs to emphasise how to enable citizens to be more active participants for the sake of their health.

The experts also stated that the **ecological theme was completely absent** in the entire programme. They expressed that they believe that public health and sustainable development are interrelated and measures could reinforce each other.

8.1.6. EU added value and utility

The experts agreed that the EU has an important role in regard to **data collection and collation** e.g. through harmonized data collection methods and data banks, **providing resources, and providing examples of best practice**. This enables it to have a key role in the **development of standards, and of information systems**. Due to the great variety of MS health systems, political structures, cultures, histories, etc., the EU is well placed to benefit from learning from different contexts.

With regard to policy-making, the experts considered the EU was adding value in the definition of **economic, social and health policies and the formulation of country-specific recommendations** (e.g. through the European Semester, the EU's annual cycle of economic policy guidance and surveillance).

Experts also identified **legislation** (like on tobacco or food, fiscal fraud, pharmaceuticals, patents, safety of products, etc.) and **recommendations** (e.g. on nutrition, genomics etc.) as another very relevant area of EU intervention.

Key barriers / structural difficulties towards EU health action

As a key barrier for EU action for health policies the experts identified the difficult structure of the EU due to the political responsibilities of national or regional structures of the MS for health policies, in contrast to an increasing need for European strategies and policies.

The experts found the EU funding system favouring 'old' ideas instead of taking risks to create innovation, and being too short-term oriented to create sustainable impact.

Another barrier identified was the limited scope of the health programme and the fact that the Health programme only represents a relatively small instrument compared to other programmes. They also felt that the proportion of already very limited funding is going to joint actions while there is not enough funding available for projects to generate new practices.

The HP priority setting was found to be slow and not responsive enough to evolving needs.

Experts suggested to include more social science and questioned the often-obligatory involvement of SMEs as a good way to improve collaboration.

Added value of EU health action

The experts found that there are positive outcomes of the HP e.g. to stimulate development towards better quality through collaboration, e.g. in the area on personalized medicine. But they also noted that there was an implementation gap, meaning an insufficient transfer of results of EU health action into policy-making and in the practice of MS, which the experts mainly related to the different level of responsibilities for practice in the MS (local/regional/national vs. EU-wide). In experts' views, continuity of thematic actions should also be improved, including long-term instead of short-term actions. They suggested improving collaboration e.g. complementing it with a stronger interaction with the regional health authorities to improve dissemination and impact; especially as many health actions are decentralized while the current interactions are on national level. A stronger involvement of regional and national decision-makers and actors was suggested to link projects and improve the dissemination of good practice.

A stronger leadership of the HP and more sustainability were identified as necessities for an enhanced EU added value. It was suggested that similar to the ECDC, an organisation with a broader scope than just infectious diseases could be a way to improve a multi-disciplinary and multi-country knowledge generation.

8.1.7. Best practices and lessons learnt

EU examples of good practice

The experts identified several examples of good practice implemented in/by the EU such as:

- European Reference Networks
- European HTA Network
- Patient Safety Package
- Expert Panel on Effective Ways of investing in health
- eHealth network
- WHO-EU Observatory on health policies
- Policies in public health genomics
- Tobacco legislation, and other related interventions such as smoking prohibition in pubs
- Healthystadia (creating health promoting sports clubs and stadia)
- Health Literacy Survey
- Several projects on tackling health inequalities
- Repopa project (Research into policies project for evidence-informed policy making)

International examples of good practice and lessons learnt

The experts reported that many countries have programs but explicitly mentioned Australia as a good example for health actions. They mentioned a programme to de-medicalize back pain and the skin cancer prevention campaigns in Australia and New Zealand. In general, Australia was named as an example of good practice e.g. how to use whole community approaches with citizens involved in deciding what to fund in the first place.

The experts concluded that societal impact of EU research could be more clearly required, shown and evaluated. Australia has also developed very good models for scaling up and disseminating good practices, whereas the EU Health Programme does not use them sufficiently.

8.1.8. Conclusions

The experts discussed strengths and weaknesses of EU health action:

Strengths

The experts named as **strengths** of the 3HP its capacity to compare, learn, and plan jointly, which helps MS and regions to focus. They agreed that the programme focuses on important issues, gathers information, best practices, and creates networks.

Weaknesses

The insufficient involvement of people responsible to apply policies at different levels was one weakness identified. Experts suggested the 3HP slogan should be "Think EU-wide, act locally".

The experts felt that implementation gaps should be tackled, meaning more involvement and interaction with people responsible to design / implement policies, less actions, more continuity, better coordination with other programs and structures of EU.

The intervention logic and theory of change of the Health Programme was considered not clear enough especially for meeting the key challenges listed by the programme. Better priority-setting (to ensure notably that priorities do not overlap), stronger emphasis on multiple determinants, additional resources for projects and less for joint actions were suggested. The experts stated a lack of definition of objectives of actions to be able to track changes, which should be a part of the intervention logic. More focus should be given to long-term (as opposed to short-term) actions, including effective multiannual programming instead of annual work plans.

In terms of topics and priorities, it was suggested to focus on major determinants and large and growing burdens of diseases. The Health Programme should encourage more integrated approaches and put the emphasis on scaling up and dissemination across MS.

Experts felt that health action is somewhat scattered and suggested the programme should be more focused on specific topics with more systematic consideration of the available evidence and experience from other projects or actions, on the basis of which a refocused list of topic could be established.

Capacity building efforts should focus on mapping existing capacities and addressing the weaknesses.

The experts concluded to put more emphasis on evidence of economic benefits of any action as they felt that the lack of resources is the biggest threat to health prevention and care. In that course standardised indicators to measure outcomes of different models of delivering care were suggested.

8.2. *Specific objective 3: Contribute to innovative, efficient and sustainable health systems*

8.2.1. Introduction

The online focus group on specific objective 3 took place on 17th August 2016. The discussion lasted one hour and a half, and involved seven participants. The participants were recruited from among the members of the EU Expert Panels, expert evaluators of the 3HP and Horizon 2020 who demonstrate special interest in health systems, the organisation and provision of health services, health workforce and innovation. 20 experts were contacted. The invitation letter explained the goals of the evaluation, format of the online focus group discussion and objectives of this consultation. 6 health experts agreed to participate in the online discussion. Prior to the focus group discussion the experts received a Discussion Paper providing background information on the 3HP, its objectives and thematic priorities in general, as well as on the specific objective which was to be discussed by the participants, in this case **Contributing to innovative, efficient and sustainable health systems**. At the end of the discussion, a transcript was generated and used to draft the write-up of each focus group. The transcript was used by the evaluators only and the report made completely anonymous.

The participants represented various fields such as academia, policy, research, business (medical publishing and health care services organisations) and practice. Their professional interests in health policies ranged from a special focus on health workforce policies and planning, training and education for health care professionals, methodology and evaluation including health economic evaluation, impact assessment analysis, epidemiology, ageing and health, health systems management, to CEE health systems, leadership in healthcare, women leadership in healthcare and nursing. The experts have extensive experience in collaborating with such organisations as WHO and the European Public Health Association. Some had taken part in the evaluation of 2HP already and Horizon 2020 of the EC on the topics of eHealth, health systems innovation, SMEs, as well as gender issues. One participant took part in evaluation study on behalf of the European Brain Council. The participants represented several EU countries: Belgium, Greece, Hungary, Malta, Poland, Portugal and the United Kingdom.

The full breakdown of participants' profiles is described in the table below.

	Background / area of expertise
Participant 1	Academia/ Epidemiology, health policy
Participant 2	Academia/Practice/ Ageing, health service management and leadership with focus on CEE
Participant 3	Policy/health workforce policy and planning
Participant 4	Business/ medical publishing/ SME, organisation of health care services
Participant 5	Academia/Policy/Practice/ nursing and health workforce policy and planning
Participant 6	Practice/ Medicine/ Public health/ Epidemiology,/ Innovation/ healthcare management
Participant 7	Practice/research /national and international health policy/ planning and financing from prevention and screening to access to care and treatment

Two professional moderators (including one health expert) led the focus group and the participants engaged in a healthy and vigorous debate, responding to points raised by each other, as well as to our questions. The discussion reflected the main objectives of the focus groups, which were to:

- Generate evidence for DG SANTE on suitability of 3HP objectives to address EU / Member States needs
- Better understand how thematic priorities and actions contribute to HP objectives
- Analyse the coherence and consistency of the health action at different levels
- Generate evidence on the strengths and weaknesses of EU health action and the best context for EU action
- Identify best practices from other actors' health action transferable to the EU

This report summarises experts' contributions and presents the findings of the online discussion.

8.2.2. Health needs in the EU

The major problems affecting health identified by the experts were: ageing, health of vulnerable populations (elderly, migrants, minorities, etc.), and related cultural challenges, multi-comorbidities, non-communicable and rare diseases, the spread of infectious diseases – especially HIV, tuberculosis and Hepatitis, antimicrobial resistance and healthcare-associated infections –, a growing burden of mental health problems, a range of unmet health needs of the European populations, as well as addressing specific issues which contribute to the (un-)sustainability of healthcare systems such as capacity building in healthcare staff, inequality in and across countries and more efficient spending of the available resources.

Key challenges, i.e. lifestyle and related risk factors for chronic diseases, are fully aligned with the 3rd Health Programme priorities for 2014-2020. Other additional policy challenges, either directly or indirectly related to the EU public health policy agenda, include the use of illicit drugs, cross-border healthcare, eHealth practices and solutions, and new technologies, therapies and treatments.

The experts agreed that while there are highly advanced public health and medical solutions, a large share of certain population groups has very limited or no access to them. The participants agreed that the needs of an ageing population and needs of migrants will require an adaptation of services and personnel, notably including the acquisition of cultural skills and the provision of support for the mental health of health care professionals and in general. Interventions such as: screening, prevention and care for the disadvantaged populations (e.g. the Roma population in CEE or rural communities where there is no access to primary care, where GP posts are left vacant due to the unattractive living /social and economic conditions) should be assured. In order to reverse the negative trend regarding obesity, diabetes, and the metabolic syndromes and the corresponding increasing number of patients, attention should be paid to improving diet and nutrition habits, also including alcohol consumption. The downward trend in the incidence of lifestyle-related conditions is worsening every year as the economic gains of the food and alcohol industry do not offset the costs in the health sector incurred by these conditions.

8.2.2.1. Addressing the needs

In order to adequately and effectively address health needs in Europe, the EU and MS should "think globally and act locally". Despite the fact that some MS such as the UK have a highly advanced health system with extensive resources as compared to the CEE countries, the issues are the same and include: fragmented systems, silo mentality, no provision for the specific needs of a highly diverse population with diverse demands and a disease-/deficit-focus on health as opposed to asset-based approaches and proper engagement with the community.

Although it seems that similar problems affect all European countries to a greater or lesser degree, there are also different challenges and needs between Member States. The north-south divide notably remains relevant. Northern and southern countries enjoy different health structures and health cultures for example. Northern countries (e.g. Scandinavian countries) have developed infrastructures related to school nutrition; southern countries (e.g. Greece) typically do not. The nutrition and/or exercise habits are totally different in Finland compared to Italy; therefore, we can see that i.a. obesity, diabetes and heart attack percentages vary. Paradoxically, life expectancy remains higher in Italy and Spain than in Finland and Sweden.

The experts unanimously agreed that efforts should focus on enhancing the quality of primary, secondary and tertiary health care. The trend is for the private sector to improve but the state systems are lagging behind and health gains cannot be made with incomplete care offer and incompetent caretakers. The main aspects mentioned by the experts related to the assessment of health needs include: 1) poor diagnosis of certain conditions, 2) insufficient research and evidence-base, and 3) policy development influenced by interest groups.

There is poor diagnosis of certain conditions, especially the autoimmune diseases which nowadays affect so many people, and are characterised by poor treatment and great difficulty in patient coping. The increasing burden of diseases and treatment costs in the particular area of mental disorders (including delayed diagnosis and care for patients) is combined with considerable differences between patients and between countries. Many mild to moderate mental disorders are under-diagnosed and untreated, especially in youth. It will be essential to better identify health needs, to assess those needs, monitor their evolution and disseminate best practice more effectively. There are different ways of identifying health needs. For instance, prevalence studies are increasingly rare nowadays but the use of smart phones is increasingly common and considering ways of using these to identify needs is an imperative. Without a reliable evidence base, policy development is more influenced by the various interest groups who have a stake in the health sector and are less guided by facts. The experts strongly believe that the issue of how to ensure that research evidence is taken into account by policy-makers is a critical one which – unfortunately – only few countries address. Best practice includes the UK and Canada which have invested seriously in research and in mechanisms to link evidence with policy-making.

Lastly, experts recommended to work towards value-based healthcare interventions, the correction of inefficiencies in every aspect of health care and the phasing out of care with little or no benefit to patients by implementing evidence-based best practice. More and more research demonstrates that cost containment is ineffective and even counterproductive. Cost reduction without regard to the health outcomes achieved is dangerous and self-defeating, leading to false savings and potentially limiting effective care.

8.2.2.2. *Emerging health needs which require action*

The participants agreed that youth and children mental health needs had been consistently overlooked and were re-emerging as an essential need to address. There is a shocking prevalence of mental health problems in young people even in higher education and health systems and communities/families are struggling to cope with this phenomenon. Mental health needs are still 'under the carpet' and not addressed adequately. This boils down to better diagnosis of certain health needs which tend to get forgotten and not letting the pharma industry dictate to us what is and is not important. It is important to set up European Reference Networks (e.g. as it is in the case of cancer or rare diseases) for an optimized management of brain diseases (mental and neurological disorders) and to develop the supporting infrastructures (databases and registries).

There are also health challenges related to new epidemics such as *zika* and a strong come back of old diseases such as tuberculosis. At this stage of the discussion, expert participants did not identify the migrant crisis or new patterns of diseases linked to climate change as newly emerging concerns.

They focused more on the chronic conditions which 77% of the total burden of disease in Europe, the multiplicity of determining factors (health, socio-economic, genetic, environmental and behavioural), the long-term nature of care and treatment have all served to confound hospital traditional, fragmented and top-down led responses towards more integrated care.

A new emphasis is put on the challenges, for sustainable health systems, related to population ageing. This implies keeping people healthy, but also keeping them active longer (e.g. Pathways project, addresses the challenge of bringing people back to workplace). Generally, policy makers have some ideas but they are too far removed from real health needs and are more concerned with health demands rather than health needs. More than 35% of obese patients are in need of special care for this disease, therefore it is the area where the EU can come in and investigate real health needs that politicians who are too busy with their votes cannot really be bothered with. Finally, specialists' movements (depending on salaries, better privileges, etc.) along with the new diseases and the movement of populations as well as a lack of competent health workforce pose serious challenges to the health systems. Therefore there is a strong need for the EU to take action in this respect.

8.2.3. Thematic priorities

The discussion then turned to each of the thematic priorities covered by specific objective 3. The objective was to gather experts' views on the definition and scope of each priority, and its relevance.

8.2.3.1. HTA

HTA has a two-tier system in Europe; in some countries, it is characterised by a strong research base and a highly advanced system related to its development and application, and the CEE countries where neither is particularly advanced (with some exceptions though). HTA is a very important tool in the hands of informed decision/policymakers. The commissioning, development and use of HTA is a part of the working routine within the health sector and in other sectors, e.g. environment or economy. Different governments and agencies on all administrative levels as well as the WHO and the

European Commission use HTA because it is expected to support knowledge transfer and evidence-based governance. Unfortunately, it is a vague and alien term for many people. It is so diverse that it needs consideration across health care systems and not in isolation. HTA for public health/social innovation interventions is not highly developed. It needs to cover soft technologies, such as organizational reforms with regard to structures and mechanisms, as well as medicines, equipment, etc. It is an obvious priority in the process of making care delivery more efficient as a scientific method and an essential tool for informing decision-makers and assessing the value of specific actions or technologies, thereby reducing the risk of implementing measures that negatively affect patient outcomes. It supports evidence-based recommendations on the financing of all healthcare services with public funds. One of the examples can be the rethinking of the drug reimbursement list. However, people usually associate HTA with pharma innovation which is not helpful. While on one hand, HTA should act as a bridge between the worlds of research and decision making, it is hardly ever the case today due to the fact that the concept and scope of HTA is not clear.

8.2.3.2. E-health

The participants agreed that both terms - innovation and e-health - are more familiar although a definition of innovation and e-health is missing at the EU level. It is a very broad area which can and should include more topics. Similarly to HTA, e-health has many definitions and is used as a blanket term for many things that involve IT systems. This presents some challenges for both the decision makers and the public. It is clearer but not yet fully understood. The experts stated that the cost- effective profile of innovation + eHealth are quite important. In addition, health self-management is also critical and seems to be adequately supported. However, there is a lot of room for further development in this area. Digital health is so vast (e.g. health apps, lifestyle apps or remote diagnosis of COPD). Such things need to be further explained and their potential presented in a better way. Innovation is a buzzword which some do not find very useful. Here more specificity is needed, even when we use e-health (why not "m-health" perhaps to refer to migrants' health needs?). Some participants felt that this priority should be combined with the first one - HTA. Often, innovation is perceived as only relating to technology. Looking from the perspective of health care systems, changes in management or in education of health workers are certainly important and relevant to innovation, and they are implemented on an on-going basis. Calling it innovation always attracts some to look out for the new and puts off others who consider it too avant-garde. The experts experienced many challenges in evaluation work related to e-health. Technological innovations are often times presented as research projects given the vagueness of the definitions of both innovation and e-health.

8.2.3.3. Health workforce planning and forecasting

The Focus Group participants stated that health workforce planning and forecasting is a major issue and constitutes a more specific priority; it is less vague but not everyone's cup of tea. Unfortunately, it is not yet generally well understood and still underutilized. There is no clear information, strategy and guidelines. Again, it is a vaguely expressed priority and the corresponding action – support by a network of experts – is very limited. It was suggested that the priority should be called "health workforce governance" instead, to be more comprehensive and cover planning. Planning and forecasting sounds like a statisticians' role. The assessment of healthcare workforce needs, their priorities (e.g. better work/life balance, flexible working hours, equal opportunities for academic/management/clinical career, etc.) would help in better planning of the health

workforce / healthcare personnel per specialty or country. The needs of women health workforce should also be better taken into consideration as women do worse in environments which are at risk of increasing inequality and impacted by mental health services, conflict areas.

The health workforce is the most critical resource on which health systems depend. Politicians do not like to engage in reforming that area because of the political risks in challenging vested interests. An example in many countries is the reluctance to review the definition of scopes of practice, for instance to expand the functions of nurses or pharmacists is a huge issue for CEE countries but not only. There needs to be more EU level planning and activity before the outmigration of qualified workforce gets to a point where the source countries' health systems collapse. The project Health Prometheus financed by the EU FP7 has investigated the push and pull factors related to the mobility and related policies in Member States.⁷⁶

The EU should do more with regard to this priority, for example: provide better incentive and generate and develop all possible human resources for health. In addition, female healthcare workforce has been neglected and not properly activated in meeting the European needs in healthcare delivery. There needs to be a fair mechanism that compensates the source countries for their loss of qualified health workforce or support new research into innovative solutions in the area of training and professional development. Motivation and incentives are key to this issue. Timely research and early action are important here to ensure a cost-effective training of the workforce, the acquisition of flexible skills. The experts strongly agree that the EU needs to do more in this respect. It has been active in that area only since late 2008. It has supported studies on the mobility of health workers (Health Prometheus financed by FP7), and on continuing professional development of health professionals (Study concerning the review and mapping of continuous professional development and lifelong learning for health professionals in the EU)⁷⁷. It has supported a Joint Action on planning and forecasting which has just ended. This is only a first step. The EU can continue to support research and information gathering on the health workforce at EU/EFTA level, develop a database on needs and trends, disseminate good practices, in summary develop actions which are beyond the capacity and responsibility of single countries.

8.2.3.4. Pooling expertise at Union level

Setting up a mechanism for pooling expertise at Union level is certainly a valuable and essential objective in the eyes of the experts but a top-down approach to this priority is not appropriate. The EU's role is to promote initiatives in the fields which it considers relevant and let experts join forces. The experts pointed out that there are good efforts around thematic research networks that are helpful in determining research priorities and agendas at the EU level. In smaller MS, research is in its infancy and will always remain very limited. It is very rare for smaller MS to be involved in cross country EU research. Yet, such countries can learn a lot from other health systems and how they have responded to the financial crisis and pick up lessons for resilience building in their systems. There is a new ERA-net around health services research priority setting that has a pan European focus and small countries are welcome to join and contribute. The

⁷⁶ M. Wismar, C. Maier, I. A. Glinos, G. Dussault (eds.), Health professional mobility and health systems: evidence from 17 European countries European Observatory Series 2011 available at:

<http://www.euro.who.int/en/home> and <http://www.euro.who.int/en/home/projects/observatory/news/news/2012/10/new-book-on-professional-mobility>

⁷⁷http://ec.europa.eu/health/workforce/key_documents/continuous_professional_development/index_en.htm

participants agreed that comparative overview of policy responses to the crisis is a very important aspect. For example, the comparison showed that where the number of nurses was critically cut, this undermined the infrastructure of the systems, the morale of those systems and the confidence that the public has in governments and civil unrest.

8.2.3.5. Active and healthy Ageing

The group stated that the priority related to promoting health and active ageing is clear. Active and healthy ageing is one of the major priorities in EU; a lot of projects and initiatives have been implemented already. It seems to be one of the most advanced priorities in terms of its scope, development and activities. The thematic groups within various European initiatives are active and developing strategic priorities of their own and there are many exciting innovations already. However, different partnerships have been dealing with a lot of cross-cutting issues such as: frailty, compliance, integrated care, elderly, etc.), even if consistency across projects has been lacking. Initiatives have been perceived to be implemented in silo.

It would be relevant to include quality improvement in the scope of this priority. With respect to ageing, the key and integrated issues include: income generation, health maintenance, early identification and effective care of new health. There is a broad open platform/marketplace for innovative ideas and anybody could join in. It is still not clear how wide we can cast the net of innovation e.g. housing policy and different ways of providing accommodation in the built environment should also be included. Experts also questioned the multi-use of innovation, for instance telecommunications and technology, which should not be limited to elderly but could be used across many health-related areas. The problem is that there seem to be no initiatives which reach the grass roots or permeate upwards from the Priorities.

8.2.4. Objective 3 “Contributing to innovative, efficient and sustainable health systems”

In the light of the needs identified earlier in the discussion, and taking into account the experts’ considerations on the component thematic priorities, the focus group moved on to the relevance, added value and utility of the specific objective 3.

The participants unanimously agreed that “Contributing to innovative, efficient and sustainable health systems” is a laudable goal which relies upon a strong infrastructure through a capable, well trained and flexible workforce and should be absolutely included as the objective in the 3HP of the EU. However, they propose that the objective should include, amongst others, healthcare staff governance and dissemination of innovation, health self-management and sharing of best practices. The EU can contribute by informing policy-makers on good practices that improve efficiency and sustainability and by helping countries to adapt and implement such practices. Money remains a good incentive to convince decision-makers to make the right choices and the EU should make the best of its financial capacity to influence policy-making in the right direction.

Concerning innovation, the EU gives a prize for that, we should know better or more what the most important EU innovation has been in terms of its impact on EU health and who or what would be the recipient.

8.2.5. EU added value and utility

Citizens' health is a core value of the EU (Art.168, TFEU). EU public health policy complements national policies, encourages cooperation across countries and facilitates coordination. Particularly, EU public health policy generates economies of scale by pooling resources to tackle common challenges, such as pandemics or the risk factors associated with chronic diseases. The EU brings added value in fostering research and improving health outcomes through frameworks such as Horizon 2020 and the 3HP. EU countries have faced major gains in population health in recent decades, resulting in an increased life expectancy and better access to care and quality of care. Mortality rates following, for example, a heart attack or a stroke, have sharply decreased. However, there is a transition from 'acute patients' to 'chronic patients'.

Pressure on health and social systems is therefore building up and is expected to further increase due to demographic changes, reforms of healthcare systems and the burden of chronic diseases. Moreover, new threats such as (re)emerging infectious diseases and antimicrobial resistance (such as resistance to antibiotics) pose additional challenges to Member States and the EU. In February 2013, the European Commission adopted the "Social Investment Package (SIP) for Growth and Cohesion" as a new policy framework to reform and strengthen EU social protection and health systems and, transversally, to mainstream health in policies affecting the social determinants of health through the development of integrated approaches: improving cost-efficiency through sound innovation, investing in human capital and reducing inequalities in health. The EU will support reforms through the European Semester process and through other funding instruments, e.g. Horizon 2020 Health Research and Innovation, complementing the 3HP.

Overall, considering where the EU adds the most value, the participants agreed that they have covered the priority areas where EU added value and utility was deemed important and action at the EU level necessary. However, there are other areas which bring added value; there are some regulatory inputs and standards the EU provides e.g. directives on free movement which are vital in setting professional standards e.g. in a post Brexit world. Some of these standards can be lost and for example nurses can be out back into hospital training schools. The experts believed that more emphasis should be put on communication to enhance the public understanding of what the EU competencies are and what the EU can do for individual countries. Unfortunately, the current climate is clouded by Brexit. In view of politicians' EU-bashing and citizen apathy, it is difficult to generate the motivation for and enthusiasm about it beyond a relatively small circle of already committed professionals working in this area.

The need for better and more communication about the benefits of EU level collaboration and knowledge transfer is right in promoting better public understanding of the EU competencies; the added value of EU action needs to be better promoted and felt by end users, namely healthcare stakeholders including European citizens because the impact of the EU financed projects is low. The EU has the responsibility of supporting actions that benefit all its member states e.g. intercountry collaboration in delivering highly complex services or highly specialized training, research on and treatment of rare diseases, health literacy. Change will not be developed by single states – it can be initiated by a single state but collaboration and dissemination of good practice is needed among MS to bring about a sustainable change. However, the EU can make governments do what is right but when the individual members of those governments will not have the capacity or motivation to act the actions will fail. It can also lead to developing more divergence as all the differences are ironed out across countries.

The experts stressed once again that the EU added value should be present in such areas as: autoimmune diseases which remain ill researched, ill diagnosed and generally

poorly treated, alcohol and tobacco for which we have great evidence of their harm, no individual country seems to have the courage to take the necessary next steps as too many of the countries are in the industry's pockets. Unfortunately, we are still letting the big industries (sponsor too many politicians and their campaigns) dictate what we do and do not do. Further, we still never take adequate action with respect to obesity and still mostly eat processed food which harms us and leads us to obesity, diabetes, CVD etc. Additionally, we should respond differently to drug trials and RCTs which have implications for research and therapeutic interventions. The experts strongly stated that we need the EU to do the essential but unpopular things – take on a leadership role in areas where there is limited political interest and/or a need for a concerted approach. They also stated that the EU added value stays is the achievable objectives which influence positively the daily life of millions of people.

8.2.6. Best practices and lessons learnt

The experts agreed that there is plenty to learn and that there are plenty of other instruments devoted to innovative, efficient and sustainable health systems which do not work in isolation. It is positive that the 3HP scope and objectives are linked to the Europe 2020 Strategy, the EU Health Strategy "Together for Health" and their shared principles and objectives, taking forward work already started under the 2HP; and supporting EU health policy and legislation including legislation on medical products and medical devices. It is important to mention the WHO health Strategy 2020 and Sustainable Development Goals are working towards similar targets.

There is also an opportunity to consider synergies from a range of related policies which generate health gains – not just directly but indirectly e.g. employment. One of the most important indicators for health is having a job! The World Health Assembly has just adopted a Global Strategy on the Health Workforce, and WHO is mandated to promote and help implement it. This is all very nice, but WHO has very limited capacity to do so, financially and in terms of human resources. Also, there is a UN Commission of Health employment and economic growth which is due to report in the fall. There are also innovative initiatives within start-ups developed both in the EU and the US.

In addition, many initiatives relate to asset based approaches to community health programmes by aligning these policy tools and ensuring they are working synergistically to upscale the gain. It is worth mentioning health initiatives developed by EUPHA and EPHA which seek to gather updated information on sustainable health systems and promote this via advocacy and promoting joint actions.

8.2.7. Conclusions

The EU health action is a powerful tool which provides incentives and supports the development of innovation in various priority areas but not with equal effectiveness and clarity due to the lack of targeted communication to the public, policy-makers and industry. The added value of the EU action is in various regulations and policies, but the new deal created by Brexit is likely to raise obstacles. Therefore, the EU should focus more on helping increase the health gain of everyday lives of the people. The EU has the responsibility of supporting actions that benefit all its member states in delivering highly complex services or highly specialized training and research on the treatment of autoimmune, infectious and rare diseases, health literacy and mental health including mental health of youth and health workforce. Cost reduction strategy in health services cannot be implemented without considerations for its health outcomes as it could have a significant negative impact on the care provided. Since effective, satisfied and well

trained health workforce is the backbone of the sustainable health system, the action, attention and political will to support its governance, development and planning should be clearly reflected and addressed by the EU 3HP.

8.3. Specific Objective 4: Facilitating access to better and safer healthcare for Union citizens

8.3.1. Introduction

The online focus group on objective 4 took place on 18 August 2016. The discussion lasted more than two hours, and involved 4 participants⁷⁸. Focus group participants have been selected in accordance with the thematic priorities for objective 4. Experience with the European Reference Networks, rare diseases, patient safety and quality of healthcare, prevention of antimicrobial resistance and control of healthcare-associated infections, further to implementation of Union legislation, and of health information and knowledge systems in evidence-based decision-making were ensured (see table below). The participants were recruited from four different member states across the European Union (i.e. Finland, Greece, Italy, and Sweden).

The full breakdown of participants' profiles is described in the table below.

	Background / area of expertise
Participant 1	A sanitary engineer at the Ministry of Health, with 30 years of experience in the field of public health. Recently also national focal point for the 3HP.
Participant 2	A health economist and University professor, working primarily in the field of health services management. Recently at board level involved in cross-border health projects. Formerly evaluated community public health actions.
Participant 3	An anaesthesiology specialist and senior health policy adviser, working in the field of public health, involved mainly in highly specialised care and disaster medicine. Recently point of contact for European Reference Network and Rare Diseases.
Participant 4	A clinical pharmacologist in antimicrobial chemotherapy and researcher in EU legislation on data protection and medical research. Recently researcher in evidence-based patient safety practices and utilization of information technology in health care.

A professional moderator led the focus group and the participants engaged in a healthy debate, responding to points raised by each other, as well as to our questions. The discussions reflected the main objectives of the focus groups, which were to:

- Generate evidence for DG SANTE on suitability of 3HP objectives to address EU / Member States needs
- Better understand how thematic priorities and actions contribute to HP objectives

⁷⁸ 3 experts online, 1 expert sent answers by email

- Analyse the coherence and consistency of the health action at different levels
- Generate evidence on the strengths and weaknesses of EU health action and the best context for EU action
- Identify best practices from other actors' health action transferable to the EU

This report summarises experts' contributions and presents the findings of the online discussion.

8.3.2. Health needs in the EU

Health intervention is characterised by (very) long-term **trends** which make it a challenge to clearly identify health needs as well as assess the impact that any intervention has. Health situation and needs are quickly evolving, and new challenges emerge which make the context of health intervention ever more complex. In the light of the economic and financial crisis, and the increasing burden on Member States health systems, cuts in welfare benefits in crisis-stricken countries obviously worsen the position of the categories of the population which are already worse off (e.g. poor pensioners, areas in industrial decline, immigrants).

According to the experts, the **key health needs in the European Union** are as follows: growing burden of life-style diseases (e.g. obesity) and mental disorders, non-communicable disease prevention, health of the elderly, in particular (e.g. cancer, dementia); citizens' information and mistrust (e.g. in immunization); sufficiently trained workforce; equity issues and health inequalities; equal quality and availability of care across member states; and financial burden on health care systems. Novel approach to cancer care and targeted therapies was identified as another need. Cancer will come more prevalent as the population grows older, even if research is making progress.

Experts think there is awareness of, and agreement on, many priorities across the EU, but particular (political) interests and pragmatism create a gap between the theory and the practice of health action. Health and environmental are the most affected areas during a financial crisis, because of their weak representation at policy level. People do not value their own health and environment during crisis either. Further, in democratic systems, consensus is required, so policy makers often must choose what makes political sense, which conflicts with the relevance of public health interventions. Due to underrepresentation of patients' interest by patient organizations at policy level, patients' need are often overlooked.

Experts also agreed that socioeconomic factors were key determinants in health. These differences in the access to health care are also aggravated by the unequal quality of the health care between Member States. In addition, there are profound differences in addressing health consequences of demographics; for instance, elderly care is considered with different degrees of priority depending on the Member States.

Experts mentioned the health of immigrants as an example for **new, emerging health needs**. In terms of public health it makes sense to prioritize this issue. Immigration will bring new problems (and re-activate some old problems, e.g. related to prevention and management of infectious diseases, such as tuberculosis). However, seeking consensus among the Member States is still problematic, as their attitude towards migration and the corresponding plans and actions vary from one country to another. EU funds addressing more technical issues and challenges in the field of (public) health could help Member States tackle the issue without raising political questions, though, as experts pointed out.

8.3.3. Thematic priorities

Under specific objective 4, the priorities are the following:

- European Reference Networks
- Rare diseases
- Patient safety and quality of healthcare
- Measures to prevent antimicrobial resistance and control healthcare-associated infections
- Implementation of Union legislation in the fields of tissues and cells, blood, organs
- Health information and knowledge system to contribute to evidence-based decision-making

8.3.3.1. *European Reference Networks*

Experts agreed that the **European Reference Networks** (ERN) are relevant and important, especially for smaller Member States. ERN foster cooperation between professionals and centres of expertise in different countries, allowing smaller countries (which do not reach a critical number of cases above which research would be sustainable) in particular to benefit from the research, knowledge transfer, as well as ensuring the availability of treatment facilities where necessary. Cooperation between centres through ERN should be further facilitated at the Community level, as there is much potential gain (e.g. knowledge exchange, shared registry data, research coordination for increased quality and cost effectiveness). Communication and health information technology are very important and should also be developed in order to be able to support the collaboration through ERN. As the ERN have so far generated a lot of interest from the researcher community, they could optimally be used to support collaborative research and information exchange, the development of highly specialised care and the availability of treatment facilities across the EU.

8.3.3.2. *Rare disease*

Regarding the second priority, experts pointed out that the definition of **rare disease** is becoming very broad and there are problems in many MS to provide adequate care for rare disease patients. Rare diseases in accordance with the definition of the EU, including those of genetic origin, are life-threatening or chronically debilitating diseases which are of such low prevalence that special combined efforts are needed to address them. As a guide, low prevalence is taken as prevalence of less than 1 per 2,000 in the Community. Further, because of their low prevalence, rare diseases are often subject to exchange of information on them only through the European Reference Networks. Therefore, as experts added exchange of knowledge through ERN is ultimately needed.

8.3.3.3. *Patient safety and quality of healthcare*

Experts shared the view that **quality** means appropriateness. Appropriateness⁷⁹ – in different definitions – has a number of key requirements such as: care is effective (based on valid evidence); efficient (cost-effectiveness); and consistent with the ethical principles and preferences of the relevant individual, community or society. To average citizens it means high technology and maybe short waiting lists or compassionate health professionals (“the expected health benefit exceeds the expected negative consequences by a sufficiently wide margin that the procedure is worth doing” as Rand Corporation defined). Regarding **safety** experts stated that in order to build their trust on that patients’ interest is to have EU-wide minimum requirements for the accreditation of health services providers. However, as noted, attempts to improve the availability of information to patients on safety and quality might only be relevant for the better educated. In addition, , both quality and safety should ideally represent baseline inputs, but unfortunately all the basics of care are now under threat with the current lack of staff and funding. Given the change in circumstances, priorities at policy level need to be reconsidered. Perhaps, guidance developed at EU level could support priority-setting. Ethics of healthcare systems and incentives should also be considered.

8.3.3.4. *Measures to prevent antimicrobial resistance and control healthcare-associated infections*

Experts underlined that more education and awareness in **antimicrobial resistance** is needed, both for health professionals and the public. It was added that national Ministries of Health and/or national accreditation agencies need to make sure that these practices are adhered to. As mentioned above, infectious diseases may be emerging again due to immigration. Treatment and care services should be adapted to the needs of migrants, including those for XDR/MDR-TB and TB/HIV management, as the 67th World Health Assembly (WHA) on 19 May 2014 rearticulated in its new post-2015 global TB strategy. The problem also reaches far beyond healthcare for humans. Initiatives will not be sufficiently effective if not involving also non-human usage of drugs and regulations made mandatory

8.3.3.5. *Implementation of Union legislation in the fields of tissues and cells, blood, organs*

Experts warned that the donation and transplantation of **human tissues and cells, blood, organs** are too big an issue for most countries to handle nationally. Regarding cooperation between Member States, however, different traditions and cultures result in very different donor organ/tissue/cell availability which creates an obstacle to cross-border healthcare within this field. In addition, the related topics of the implementation of Union legislation in the fields of high quality medical devices and medicinal products, and the directive on patients' rights in cross-border healthcare shall be considered as well. Regarding the former, experts mentioned, that a stronger EU-wide convergence in the regulation of medicinal products and medical devices would be appropriate, both for the functioning of the Single Market and in the interest of users and health professionals.

⁷⁹ Appropriateness In Health Care Services, Report on a WHO Workshop Koblenz, Germany 23–25 March 2000 at http://www.euro.who.int/__data/assets/pdf_file/0011/119936/E70446.pdf

8.3.3.6. Health information and knowledge system to contribute to evidence-based decision-making

As the experts agreed, **health information and knowledge systems** are the basis for all health care services, such as health prevention, promotion and care. Information Technology has a lot of potential to improve both the quality and efficiency of healthcare. Health systems need data and user friendly information systems to raise awareness, to promote education, or to support decision making and to improve services. This is a horizontal area of intervention for the health programme, and “de facto” money is required to ensure the functioning and management of the information exchange and benchmarking mechanisms established in the past. It is definitely a relevant area where to invest and EU-wide initiatives are necessary to create portals and shared databases. Experts also suggested, that computer-assisted diagnostic support systems should be developed with equal access to all EU Member States as part of making care equally available and at a harmonised level. Perhaps the only concern is, as mentioned, that according to this approach some fund must be earmarked to support cooperation between national authorities.

8.3.3.7. Conclusive remarks on thematic priorities

Regarding the main health needs identified at the beginning of the focus group discussion, as a **conclusion** of the discussion on the thematic priorities, experts stated that the numbers, distribution and level of training of health workforce will need more attention. In relation to elderly health and mental problems it was concluded, that they are not only about high-tech care but perhaps are more related to disturbed sensory perception and loneliness in the increasingly urbanised society. As regards access to health care, experts thought that a lot was missing, especially on the demand side in terms of the existence of equitable access to health care. They added that it might be extremely difficult to find a balance among the priorities and constraints of 28 different Member States. Objective 4 did not seem to provide much help in securing more impact for the directive on patients' rights in cross-border healthcare. At the same time, experts recognised that this might have not been what the Member States really expected from the Commission, as the balance between imposed (new) priorities and a reasonable associated financial burden might be delicate to find.

Experts **concluded** that “*Facilitating access to better and safer healthcare for Union citizens*” should be one of the core objectives of the EU’s health programme (specific objective 4 of the 3rd Health Programme). However, the Health Programme should go far beyond the very generic WHO and UN policy documents, and focus on the above mentioned specific needs where substantive results can be realistically achieved.

8.3.4. Objective 4 “Facilitate access to better and safer healthcare for Union citizens”

Objective 4 “Facilitate access to better and safer healthcare for Union citizens” would be achieved through increasing access to medical expertise and information for specific conditions, also beyond national borders. It would also entail helping to apply research results and developing tools for the improvement of healthcare quality and patient safety through, inter alia, actions contributing to improve health literacy.

8.3.5. EU added value and utility

Talking about **added value and utility** experts agreed that it makes sense for the EU to focus on topics which have a clear supra-national dimension. Overall, an increasing number of issues are supranational by nature as people become more and more mobile and economies integrate. Therefore, data gathering and sharing, the identification of best practices, and the support to some specific patient groups (e.g. rare disease) who do not have access to adequate health, care need to be given priority. Greater emphasis should be put on lesson learning, the definition of guidelines and constitution of a strong evidence base, and the dissemination of these best practices in all MS – rather than leaving national stakeholders responsible for the implementation without much guidance. To some extent this is already happening, but we need robust descriptions of best practices also on broader healthcare areas.

Weak legal mandate (and the specific nature of the EU's health competence) was considered as a **key barrier** towards EU health action. The Member States can object that many topics linked to healthcare do not fall under Article 168 of the Treaty. The EU always assumes, as experts said, Member States would object, but there were high expectations from the professions for common guidance to help to address quality issues.

In light of the performance so far, despite the constraints of the legal mandate, funding and staffing levels, the EU is **performing** reasonably well, experts agreed. However, quality assurance and cost effectiveness objectives will not be met and harmonisation will not be achieved as long as Member States can choose whether to comply or not.

8.3.6. Best practices and lessons learnt

Regarding **best practices in health actions** already implemented by / in the EU, experts referred to cooperative programmes at regional level, such as the Interreg Programmes, that often have bigger budget than the Health Programme. The EU was advised to follow closely the results of these programmes as there might be some duplication between those and the priorities of the Health Programme. Besides, programmes run by other international organisations need to be monitored, too. The scope of objective 4 is described as rather narrow, and very much focused on the supply-side. Although this interest is legitimate, it may not be the most effective and efficient use of EU funds, experts warned. EU would be able to work more cost-effectively by scrutinising and utilising already existing materials, such as guidelines and HTAs, in order to provide Member States with quality-checked / evidence-based and endorsed best practice guidance, they added.

8.3.7. Conclusions

Improving access and monitoring quality and safety are important goals of the EU health action. Even if goals (partly political) are clear, they are not credible if sufficient resources are not allocated for implementation. In addition, goals must be more specific. In addition to the key health needs discussed above, experts suggested to put the emphasis on monitoring efficiency and effectiveness to ensure the sustainability of healthcare systems. In this regard, instead of very specific targets which affect (the health of) a small proportion of EU citizens, those issues need to be addressed which are more prevalent and in the interest of a wider population. Needs like smoking, sexually-transmissible diseases, infant mortality rates, rare diseases, migrants' health

or medical tourism could be domains where funds can be spent more effectively. Too many priorities implies a fragmented budget, which cannot translate into any meaningful impact. An enhanced focus of health action should be one of the best practices in health policy (including prioritising and ethics), supported by robust implementation mechanisms.

9. FOCUSED INTERVIEW FINDINGS

9.1. *Specific Objective 2: Health threats*

The evaluation included a series of online focus groups of public health experts who were engaged in discussions on the relevance of the 3HP and its specific objectives and thematic priorities in relation to health needs, EU added value and synergies with other actions at EU and other levels. Given the political sensitivity of specific objective 2 (Protect citizens against cross-border health threats), the originally foreseen focus group was replaced with a series of in-depth interviews with members of the Health Security Committee (HSC). The interviews were conducted during November and December 2016 and included members of France, Malta and Spain. An additional interview with a representative from Croatia took place in early January (see table below)

The subsections below give a brief overview of the findings from the interviews structured in terms of EU health needs, relevance of the specific objective and the thematic priorities under it, and conclusions.

Note that the following text presents a summary of the views recorded, rather than the evaluation team's assessment or judgements. The interview findings necessarily include subjective points of view that were held up alongside other sources of evidences and triangulated in order to inform our answers to the evaluation questions presented in the main report.

Table 18 : List of members of the HSC involved in interviews

Contact	Role	Status
Antoine Schwoerer	Head of Defence and Health Security Projects, National Plans and International Affairs, Ministry of Social Affairs and Health (FR)	Interviewed on November 2016
Isabel Noguer Zambrano	Director, National Centre of Epidemiology, Health Institute Carlos III (ES)	Interviewed on December 2016
Rosa Cano	Manager, National Centre for Epidemiology, CIBERESP (ES)	Interviewed on December 2016
Tanya Melillo	Head of Infectious Disease Prevention and Control Unit, Health Promotion and Disease Prevention, Ministry of Health (MT)	Interviewed December 2016
Aleksandar Simunovic	National Institute of Public Health (HR)	Interviewed January 2017

9.2. *Profile of interviewees*

Based on initial contact made by the EC with members of the HSC, an initial list of six people was proposed for the interviews. All of them were contacted, five agreed to participate, although one of them is to be interviewed over the coming weeks. One did not accept because her specific area of expertise was not relevant to objective 2 of the 3HP.

The experts involved in the interviews were from France, Malta and Spain. They have a strong expertise in health security and all of them work at national health ministries or institutes. Most of them have participated in meetings of the HSC and one in particular has been involved in the Committee since 2004.

9.3. Main findings

This section summarises experts' contributions and presents the findings of the interviews.

Health needs in the EU

The experts named a number of key challenges representing the current and evolving needs of the EU and for EU health action which are detailed in turn below:

- **Integrated health information:** the need to better integrate health information systems owned by Member States (MS), the EC and international organisations (WHO, OECD) remains significant. This would benefit the reporting, transmission and use of information for policy making.
- **Cooperation for health security:** Another expert cited the need to strengthen cooperation between Member States (and with the EC) for effectively addressing serious cross-border health threats.
- **(Financial) sustainability of health services:** this was cited as becoming particularly important in the context of an ageing population which puts new and increased demands on health services.
- **Diseases related to life-style and behaviours:** According to one of the experts, this includes both communicable (e.g. AIDS which is related to sexual behaviour) and non-communicable diseases (e.g. chronic diseases related to smoking, eating, and alcohol).

There was also agreement that there are **no major differences between MS in terms of health challenges** as all face similar issues such as ageing, AIDS, chronic diseases related to life-styles, etc. In the area of health security in particular, one expert mentioned that differences are more significant between the EU (or its MS) and third countries e.g. United States. What is different between MS, according to the experts consulted, are the approaches to dealing with (common) health challenges and the resources they can invest.

In terms of **new or emerging health needs**, experts mentioned mental health, ageing and vector-borne diseases such as Ebola and Zika which are very difficult to eradicate. (New) infections brought by population movements was also mentioned as an emerging health need which is not being sufficiently addressed yet at EU and MS level. This was also true for diseases related to food security and to the environment.

Objective 2 "Protect citizens against serious cross-border health threats"

After examining expert's views on current and future EU health needs, we focused the discussion on objective 2 of the 3HP.

The experts generally felt that the objective should be one of the **core objectives** of the HP and that it is relevant to EU's health needs previously discussed. Two experts were of the opinion that the coordination and collaboration aspect, as well as team work and pooling of resources, were among the crucial elements related to the protection of

citizens against serious cross-border health threats. Another expert also said that the objective could be clearer in terms of *how* citizens are to be protected. These opinions may be indicating that there is room for **refining the phrasing of the objective** by, for example, stating the main ways in which the objective is supposed to be realised.

In relation to this, one of the experts mentioned that the absence of clearly defined goals means that the EU "*sometimes overdoes*" (i.e. over-stretches itself) and it would be better prioritising and focusing efforts where they can add the most value. The expert provided the example of the Commission-organised workshops on the Ebola outbreak in October 2015⁸⁰. Although these workshops were "*good and useful*", they engaged all MS despite the fact that risk of an Ebola outbreak was very low for some countries. The experts' view was that resources could have been better invested by focusing on those countries with a higher risk.

Thematic priorities

We then focused on examining the relevance and formulation of the four thematic priorities under objective 2, namely:

2.1 Risk assessment through providing additional capacities for scientific expertise

2.2 Capacity building against health threats in Member States, including, where appropriate, cooperation with neighbouring countries

2.3 Implementation of Union legislation on communicable diseases and other health threats, including those caused by biological, and chemical incidents, environment and climate change

2.4 Health information and knowledge system to contribute to evidence-based decision-making

In general, the experts agreed that it is relevant that EU action focuses on these thematic priorities and considered that they address the most important issues under objective 2. One expert also talked positively about the fact that all thematic priorities are inter-linked.

Regarding the individual priorities, the following comments were made:

- **Risk assessment:** Two experts considered that EU action on this front is very important and that the EU is "*doing a good job already*". One of the experts mentioned the risk evaluation during the Zika outbreak, where all MS were invited to participate. For the experts, the importance of having proper risk assessments is as a means to help early diagnosis and deployment of resources and expertise.
- **Capacity building, including cooperation with neighbouring countries:** Experts considered it to be very relevant that the EU have provided training activities to strengthen MS capacities for preparedness and response especially given Member States' limited resources and/or expertise for providing standardised and on-going training. One experts also highlighted two training programmes delivered by the ECDC⁸¹ which were considered to be very useful:

⁸⁰ The workshops were delivered as part of one of the actions funded under thematic priority 2.2 "Capacity building against health threats in Member States, including, where appropriate, cooperation with neighbouring countries". For more information on the workshops see, for example: http://ec.europa.eu/dgs/health_food-safety/dyna/enews/enews.cfm?al_id=1628

⁸¹ The European Centre of Disease Prevention and Control (ECDC) was established in 2005. It is an EU agency with aim to strengthen Europe's defences against infectious diseases. It is seated in Stockholm, Sweden. Our

namely the European Programme for Intervention Epidemiology Training and the European Programme for Public Health Microbiology Training⁸². The implementation of exercises for testing capacities and expertise already in place in the MS was also considered highly relevant, as well as actions aimed at transferring expertise and/or best practices between countries⁸³. In terms of where the EU could do more: one suggestion was that the EU could be more actively involved at international level by contributing to developing capacities in third countries too (e.g. African countries). Enhancing networking and cooperation between relevant stakeholders at MS, EU and international level was considered a key area for EU action too.

- **Implementation of EU legislation:** Only one expert commented on this, saying that *“a lot has been done already”*. In their view, the law and tools to implement legislation are in place already, although there are some Member States that may require additional support to implement those tools (e.g. International Health Regulations and joint procurement of medical countermeasures).
- **Health information:** This was considered a relevant area of focus by most interviewees. But no further comments / explanations were provided.

Regarding **areas not covered by the current thematic priorities**, the majority of experts considered that **communication was not sufficiently addressed**, especially in terms of communicating with the public during an outbreak, but also among relevant stakeholders such as national authorities, EC and EU agencies (ECDC, EFSA). The expert mentioned that the Network of Communications that had been created within the HSC was a very good start, but that further work and capacity building was needed. One expert in particular emphasised that health professionals do not have the expertise to use social media to their advantage during an outbreak⁸⁴.

Another expert mentioned **migration as an issue that may not be sufficiently addressed by the current thematic priorities**. This topic was considered also an emerging health need during the initial discussion. Food safety was mentioned too, and one of the experts explained that it has cross-border implications given that the food (animal and vegetable) we normally consume comes from different countries in the EU and other regions. Working with the food industry and the veterinary sector is key to building up security in this respect.

Summary

Stemming from what was discussed with the experts during the interviews, it is possible to identify some strengths and areas for improvement of how the 3HP addresses health security:

- **Strengths:** Objective 2 is clear and covers the most important aspects of the protection of citizens from serious cross-border health threats. Thematic priorities related to risk assessment, capacity building, and

Mission: According to the Article 3 of the founding Regulation, ECDC's mission is to identify, assess and communicate current and emerging threats to human health posed by infectious diseases. (See more at: <http://ecdc.europa.eu/en/aboutus/Pages/aboutus.aspx#sthash.pBXTK7bZ.dpuf>)

⁸² For more information on the training programmes see:

<http://ecdc.europa.eu/en/epiet/Pages/HomeEpiet.aspx>

⁸³ Particularly on the issue of transferring expertise between countries, one expert mentioned that the EU should support this by helping countries address cultural, language and legal issues that prevent health professionals from transferring their experience easily to health professionals in other countries.

⁸⁴ It is worth noting that this expert considered that the limited communication capacities/expertise affected not only action on health security but also on health promotion and information, particularly when disseminating messages/information that pretend to impact on people's life-styles and behaviours.

coordination/cooperation between relevant stakeholders were considered the most relevant for EU action. They are also the areas where the most remarkable achievements have been realised. In this respect, the EWRS was mentioned by one expert as an example of a tool developed by the EU that works very well and that is being used extensively by Member States. The creation of an EU network of reference laboratories was also cited as a very important initiative, as well as the joint procurement of MCM.

- **Areas for improvement:** The formulation of objective 2 could be improved by emphasising the ways in which the protection of citizens will be accomplished, and there was agreement that this related to enhancing coordination and networking between Member States, but also with the EC, international organisations and third countries. Moreover, developing Member States capacities to define and disseminate messages to the public during an outbreak was considered to be not sufficiently addressed by the current thematic priorities and a relevant area where the EU could play a more important role.

10. OPEN PUBLIC CONSULTATION FINDINGS

10.1. Introduction

An online open public consultation (OPC) took place from 23 November 2016 to 23 February 2017. The purpose of the consultation was to allow stakeholder to provide views on different aspects of the evaluation questions. It also fulfils the consultation requirement stipulated in the Better Regulation Guidelines published in May 2015. By definition, all citizens and organisations across the European Union (EU) were welcome to contribute to this consultation, however the OPC targeted those with an interest in health policy, public health, and/or healthcare in Europe. It was disseminated via the Chafea and SANTE websites, shared on the Health Policy Platform and distributed via stakeholder mailing lists and National Focal Points.

The OPC gave the possibility to interested parties to express their views and opinions on the Third Health Programme (3HP) and focussed on the following topics:

- *The objectives and priorities of the 3HP, and the extent to which these are appropriate and in line with health needs in the EU;*
- *The way the 3HP is implemented, and the extent to which this is effective and efficient; and*
- *The overall added value and usefulness of the 3HP.*

The participants were invited to complete the online questionnaire provided and available in English. In addition, the participants were able to submit contributions in any official EU language. The paragraphs below summarise the findings of the OPC survey on the basis of the responses collected and analysed by the evaluation team.

10.1. Profile of Respondents

In total, 133 responses to the OPC were received, covering the countries listed in below. We note that the vast majority of respondents listed a country in the EU-15 MS (which corresponds to the older MS of the EU and also MS which are typically more involved in the 3HP, see Chapter 2, Data analysis).

Table 19: Main country of residence / establishment of OPC respondents (as stated)

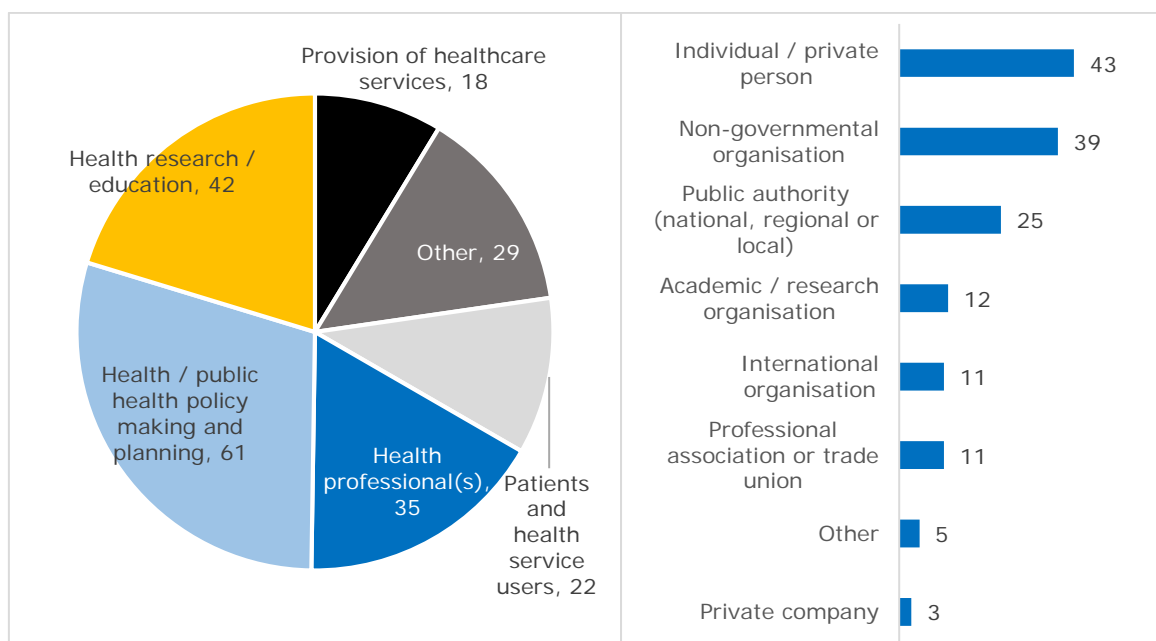
	EU-15 Member States	EU-13 Member States	Associated countries	Other
Respondents	Austria (5)	Bulgaria (3)	Norway	Global (offices in US, South Africa and representation in Brussels)
	Belgium (29)	Croatia	Switzerland	EU
	Denmark (2)	Cyprus (3)		Ukraine
	Finland (5)	Czech Republic		
	France (5)	Hungary		
	Germany (4)	Latvia		
	Greece	Lithuania (4)		
	Ireland (4)	Poland (2)		
	Italy (12)	Romania		
	Luxembourg	Slovakia (6)		
	Netherlands (10)	Slovenia (1)		
	Portugal (3)			
	Spain (13)			
	Sweden (3)			
	United Kingdom (7)			
TOTAL	104	24	2	3

The participants were asked to state whether they were responding to the OPC as an individual or on behalf of an organisation or institution, as well as their main field of professional activity. The respondents were able to select more than one answer to these two questions.

As shown in the right hand side of Figure 28, a majority of respondents were individuals, followed closely by representatives of non-governmental organisations. Almost one fifth of respondents were representatives of national, regional or local public authorities. Representatives from academia, international organisations and professional associations were less numerous to participate. Five participants did not fit in the proposed categories and included a coalition of NGOs and a Member of the Scientific Committee of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

The sectors in which respondents operate are shown in the left hand side of Figure 28. Almost half of the survey participants noted they are mainly active in the field of health / public health policy making and planning, followed by health professionals and health research / education specialists. Respondents working in the provision of healthcare services were the least numerous. Just under one in four participants noted they were mainly active in another field. Their open responses included the international monitoring of drugs and drug addiction, safety and security (as well as civil protection), medical technology and eHealth.

Figure 28 : Profile of respondents to OPC⁸⁵



As shown in Figure 29, half of the participants reported having some knowledge on EU health policy and the 3HP, the number of individuals aware of (general) EU health policy being slightly more important. About a third of participants appeared more confident and reported having detailed, in-depth knowledge of the policy areas. Overall, the level of knowledge of participants was lower for the 3HP, as 16% of respondents noted theirs was very basic. The percentage of survey respondents who stated that they have no knowledge at all was also higher for the 3HP, but this was only the case for a very small number of respondents.

Figure 29: Participants' extent of knowledge on EU health policy and 3HP, n= 133

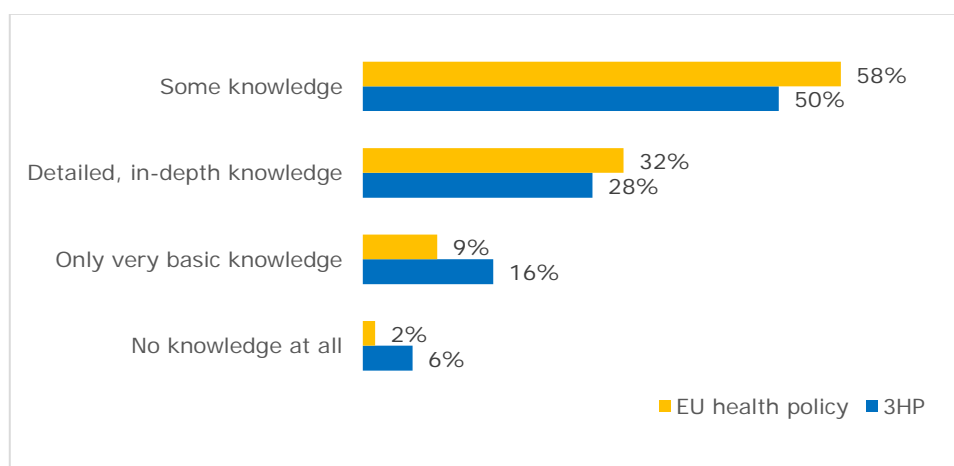
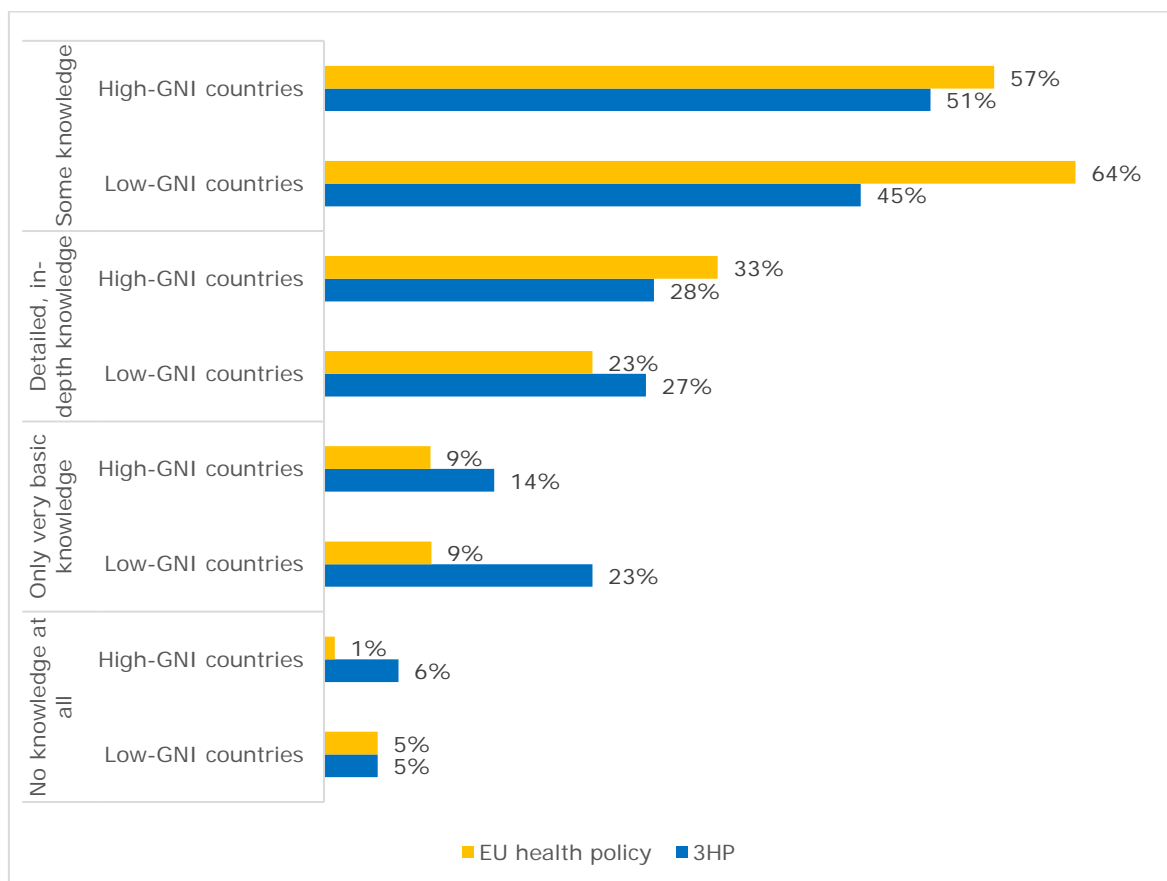


Figure 30 overleaf presents a breakdown of the responses collected by low-GNI (Bulgaria, Croatia, Czech Republic, Greece, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia, Romania and Ukraine) and high-GNI countries (Cyprus, EU-15

⁸⁵ As respondents were able to select more than one answer to describe the two profile questions, the total number of responses add up to more than 133.

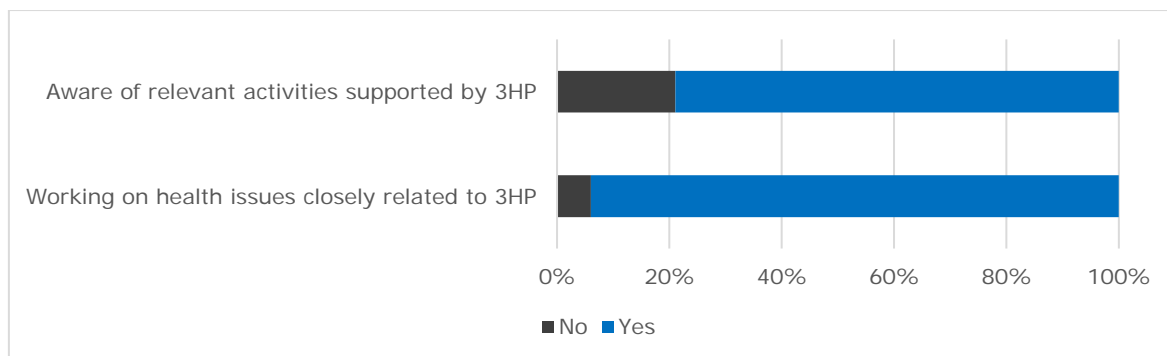
except Greece and associated countries Norway and Switzerland). The trends between the two categories of respondents are broadly similar. It is noteworthy that, across the two categories, respondents have stated they are better acquainted with EU health policy compared to the 3HP.

Figure 30: Participants' extent of knowledge on EU health policy and 3HP (Low-GNI countries, n=22 and High-GNI countries, n=111)



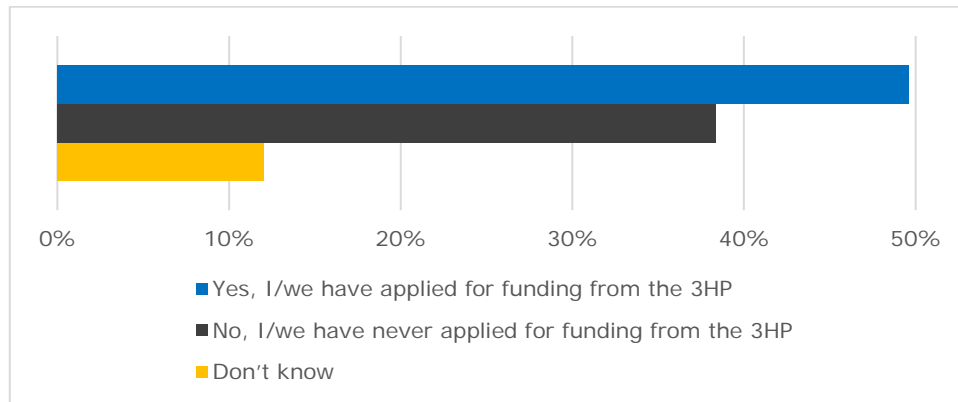
As shown in Figure 31, over 90% of all respondents reported working on health issues that are closely related to the ones supported by the 3HP and three in four were aware of activities funded by the 3HP relevant to their work.

Figure 31: Relevance of 3HP for participants' work and awareness on supported activities, n=133



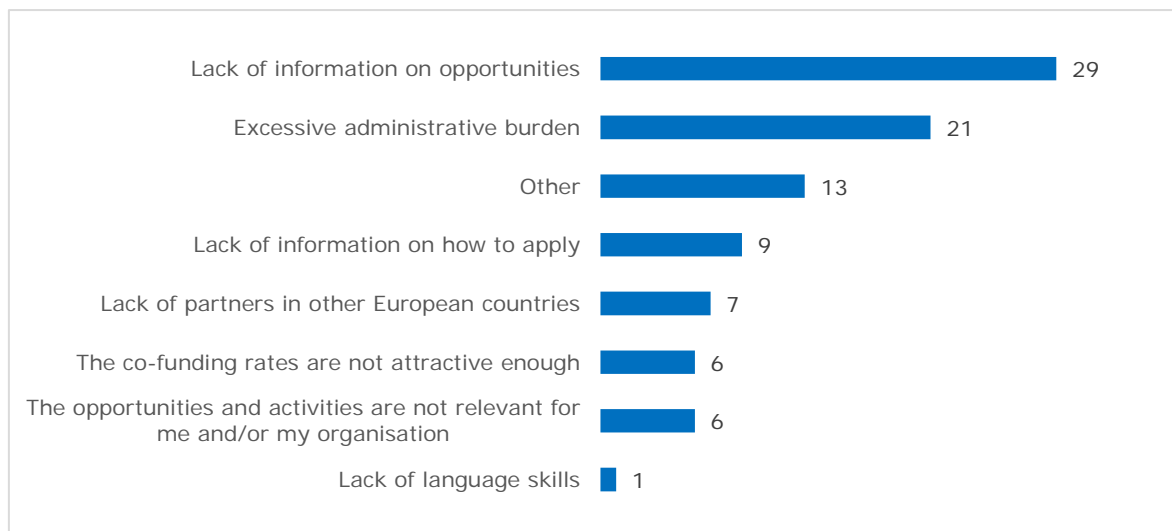
However, almost half of the respondents noted they have never applied for funding from the 3HP and one in 10 was unsure if they had applied (Figure 32).

Figure 32: Applying for funding under the 3HP and / or its predecessors, n=133



The respondents who had never applied for funding under the 3HP were given the possibility to provide details on their reasons not to do so. The participants were able to choose all answers that applied to their situation from a list. As indicated in Figure 33, among the reasons for not applying for funding, the respondents to the OPC mainly cited the lack of information on opportunities (more than half), followed by the excessive administrative burden (chosen by over a third of respondents). Just over one in 10 respondents stated that the co-funding rates were not attractive enough or that the activities supported by the 3HP were not relevant for their organisation. Only one participant cited their lack of language skills as a reason for not applying for funding under the 3HP.

Figure 33: Reasons for not applying for funding through 3HP, n= 51



The respondents to the OPC were also invited to give details on any other reasons for not applying for funding under the 3HP.

Two respondents cited the lack of human resources of their organisation as the main obstacle to applying for funding under the 3HP, whereas another two noted they had applied as partners.

The explanations provided by respondents also included the fact that the presentation on the opportunities had been too close to the application deadline or that their organisation had been created too recently.

Importantly a participant noted they believed that, unlike other EU programmes such as Horizon 2020, partner search platforms are not available for organisations / experts wishing to participate in the 3HP. The respondent made the following recommendation to address this issue:

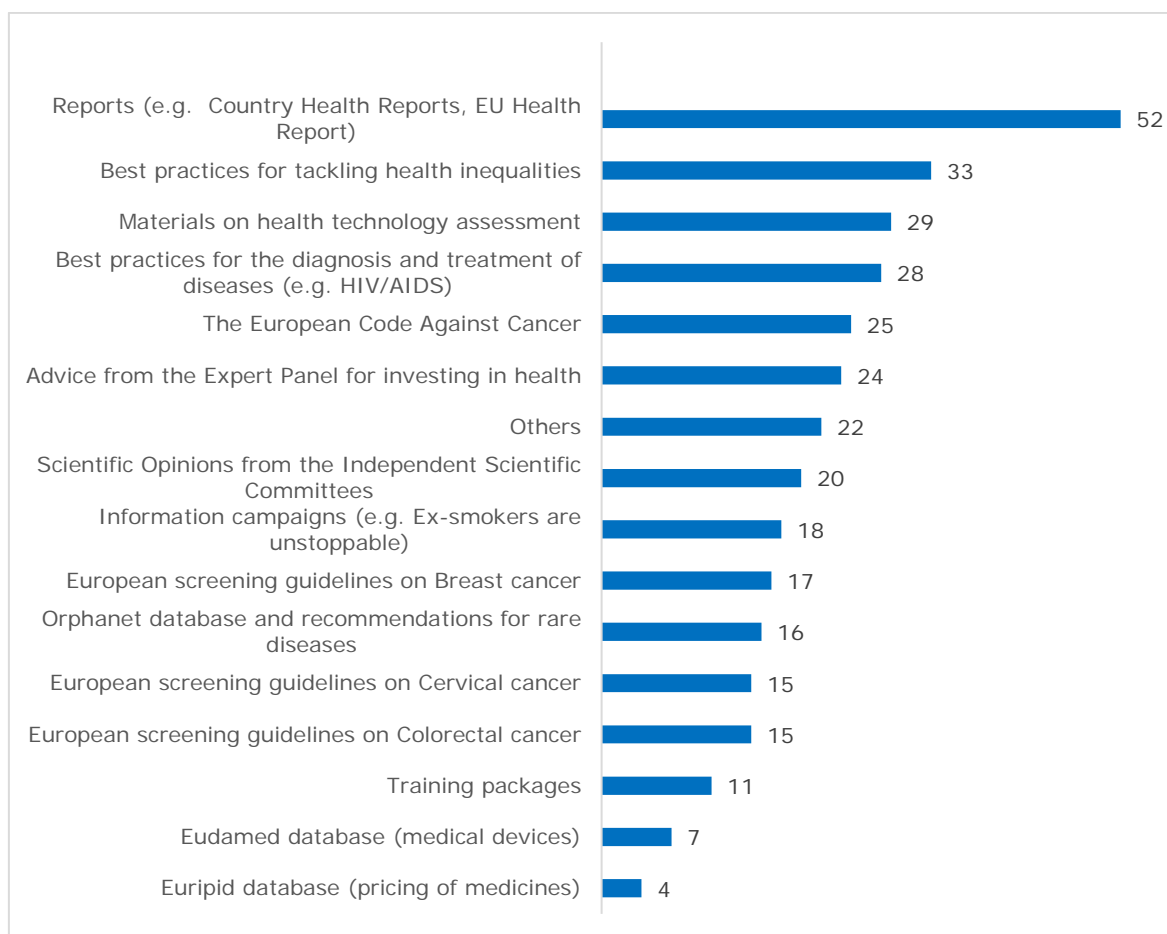
"[...] to develop or in some way support a database where all interested in 3HP institutions and organisations can register and see other profiles. In this way anyone interested in a topic can easily set up a partnership and invest more time in proposal development rather than in setting the partnership."⁸⁶

Regarding the suitability of the focus of calls for proposals under the 3HP, it was noted by one participant that the *"[t]opics are very specific, not generic enough to be looked at from a professional perspective; too disease-oriented."*

Respondents were also asked if they had ever consulted, used, or participated in any of the results, services or products stemming from activities supported by previous Health Programmes. A list of suggested activities was provided and the respondents could choose all that apply. Their responses are summarised in Figure 34 overleaf.

Almost half of the respondents reported experience with reports such as Country Health Reports and EU Health Reports. Best practices for tackling health inequalities and for the diagnosis / treatment of diseases, as well as materials on health technology assessment were familiar to a third of respondents. The least popular activities were the Euripid and Euramed databases, as well as training packages on specific topics (such as cancer screening, migrants' and refugees' health, capacity building in the preparation and response against health threats in air and sea travel).

⁸⁶ As mentioned above, this is the view of the respondent and is without prejudice to existing platforms such as the Health Policy Platform.

Figure 34: Experience with activities supported by previous Health Programmes, n=109

26 respondents to this question noted that they had experience with activities supported by previous Health Programmes which were not on the list. Their open responses included the following activities:

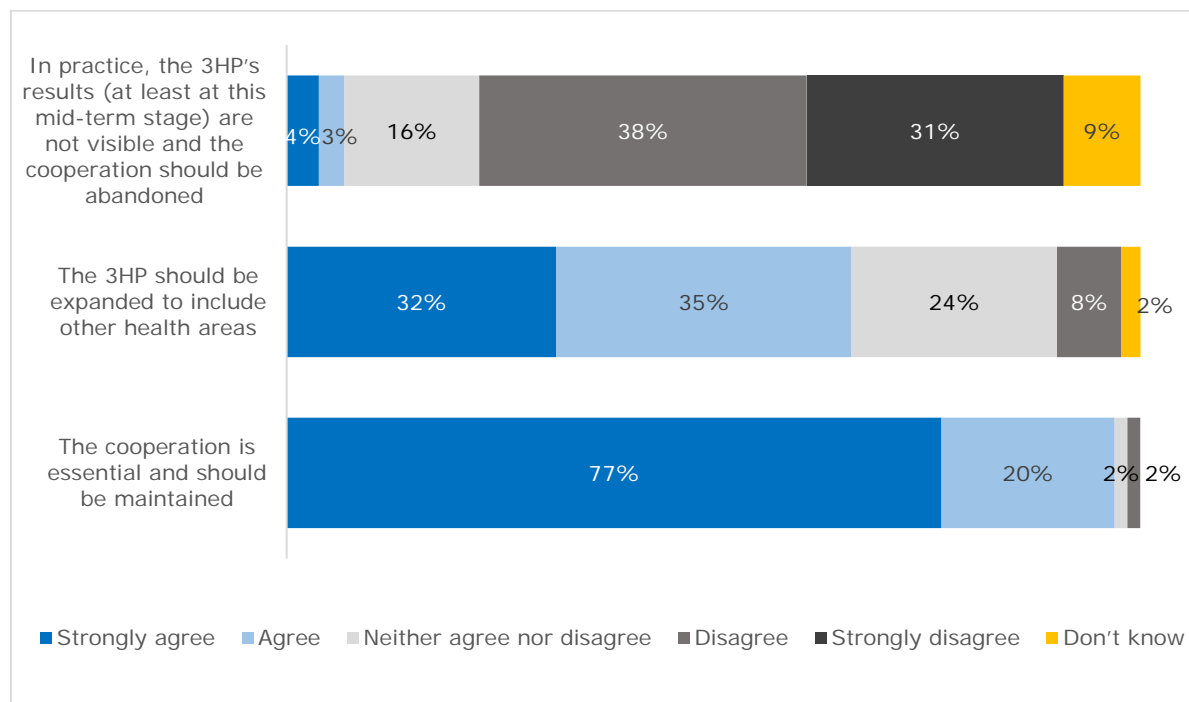
- European Centre of Disease Prevention and Control (ECDC) or EMCDDA-related materials (European Monitoring Centre for Drugs and Drug Addiction);
- infectious diseases and safety/security issues;
- EQADeBa (Establishment of Quality Assurances for the Detection of Highly Pathogenic Bacteria), QUANDHIP (Quality Assurance Exercises and Networking on the Detection of Highly Infectious Pathogens);
- European Partnership for Action Against Cancer Joint Action (EPAAC)
- Eubis (European Blood Inspection System): Common European Standards and Criteria for the Inspection of Blood Establishments & Audit/Inspection-Training Guide;
- RARHA Joint Action on alcohol related harm (Reducing Alcohol Related Harm).

10.2. Respondents' views on EU cooperation

The OPC respondents were asked to comment on the cooperation at EU level between relevant health organisations, national health authorities, academia and non-governmental bodies supported by the 3HP. Figure 35 presents the responses in relation

to the agreement or disagreement of participants to three statements about this type of cooperation. The respondents appeared largely supportive of the activities funded under the 3HP in the context of EU level cooperation between actors of the health sector, as over two thirds stated that the cooperation is essential and should be maintained. Respondents also appeared to share the view that the 3HP should be maintained as less than one in 10 agreed that it should be abandoned. The responses of survey participants were more nuanced on whether the scope of the 3HP should be expanded to include other health areas. Here, the number of neutral respondents and those who disagreed with this statement were higher.

Figure 35: Opinions on the support of cooperation at EU level, n=133



The respondents were then asked to reflect on what they consider to be the main way in which the 3HP is contributing (or could contribute) to addressing health-related challenges. Almost all respondents provided comments in their open replies. Often, the comments were very specific and it was difficult to identify trends or shared concerns. Below, we provide a snapshot (and relevant quotes) of the key aspects discussed in the open replies.

A significant number of respondents emphasised the role of the 3HP for the collection of best practices, dissemination of results and development of guidelines, all of which are beneficial:

"By collecting best practices, disseminating them and promoting meetings between stakeholders."

"Supporting inter-entity cooperation and encouraging the dissemination and implementation of project results."

"Promote the development of common good practices, foreseeing the harmonization, mutual recognition and equal access to health technologies/services within EU member States."

"Definition and common application of best practices, as well as the development of guidelines."

Furthermore, according to respondents, the 3HP has the potential to provide funding for campaigns and research:

"The programme can contribute to promote health by means of funding screening campaigns, patients and caregivers empowerment programs."

"Funding of research and communication programmes."

"The main ways in which the 3HP could contribute to addressing health-related challenges are the support to States and the promotion of cooperation through research programmes and funding institutions."

The importance of the 3HP's contribution (and potential contribution) to the support of cooperation / collaboration between all stakeholders in the health sector was highlighted by many respondents:

"The 3HP is contributing through supporting the collaboration between organizations, institutions and academia."

"Bridge building between countries and actors of health care (stakeholders)."

"Collaboration between involved institutes and partners of Member States enables exchanges of experiences and solutions."

"Cooperation of all stakeholders, including professional associations and patient organisations."

"Bringing relevant actors together (according to requirements to build partnerships for projects)."

In addition, it was noted that the 3HP presents an opportunity to address systemic challenges such as environmental health and health inequality:

"It should also contribute to addressing environmental health issues (endocrine disrupters, air pollution, soil pollution, etc.)."

"The Health Programme could (and should) address [health] inequalities with a strong human rights approach and with the goal of removing them within a few decades."

"[...] Trying to reduce health inequalities."

Finally, it was noted that the 3HP holds a significant potential in relation to cross-border / pan-European issues and transboundary cooperation, and should (continue to) be focussed on addressing such challenges, through:

"Cross border cooperation."

"Cooperative programmes should address issues that no single MS can tackle on its own."

"To promote activities to challenge cross-border health threats."

"More focus on cross-border health threats issues (communicable disease)."

The respondents were then asked to consider the main aspects (if any) of the 3HP, that need to be changed or improved. 88 respondents shared an opinion in their open replies. Often, the comments were very specific and it was difficult to identify trends or shared concerns. Below, we provide a brief overview (and relevant quotes) of a selection of aspects which were raised by multiple respondent in the open replies.

A significant number of respondents suggested that there is a need to enhance the promotion of the 3HP and its funding opportunities:

"[More] publicly available information."

"More translations of documents in national languages."

"More information about funding opportunities / [more efforts to achieve a] greater awareness of funding opportunities."

"More clarity and transparency about the actions, at least on the EC website."

Furthermore, it was noted that more efforts for the dissemination of results could be deployed:

"Greater dissemination of results to policy makers and practitioners."

"Better dissemination of the obtained results and impact on society."

"The implementation of recommendations and guidelines which have been produced with funding under the 3HP should be promoted, monitored and the impact on health evaluated."

"Dissemination of knowledge is in many cases still 'old fashioned', with conferences / meetings etc. that are targeted towards academia / experts. In order to increase impact, more attention should be paid to other means of dissemination, i.e. fact sheets, concrete policy proposals etc."

Comments were also made on the (future) programme's content and focus, with specific suggestions for a move towards a patient-centred approach and achieving value in healthcare:

"The programme is too fragmented: concentrate on a few areas to achieve more. A stronger focus should be put on prevention, targeting specific key populations. In general, prioritising the objective of empowerment of patients and ensuring that health services are more inclusive and patient-centred would also help achieving a greater impact."

"A health approach more based on patients and their emotional part. An affective-effective model in which the patient is at the centre of the health system and health is not only focused on the biomedical."

"Value-Based healthcare (VBHC) models are being implemented across the globe with interesting examples in EU countries. With the patient at the centre of care, VBHC aims to improve outcomes by defining a common set [of objectives] and require greater coordination by all healthcare players to achieve those results, with an additional aim of reducing costs through this process."

"Favour projects and models with focus on value in healthcare."

Other respondents suggested that the programme could be doing more to ensure uptake at the local level:

"[The 3HP could focus more on the] transfer to national and local policies aspect."

"We strongly believe that involvement of local authorities should become a standard."

Finally, a number of respondents highlighted the importance of achieving policy coherence and enhancing the synergies with other EU policies, in particular Horizon 2020:

"The 3HP should also build stronger synergies and coherence with other policies of the EU, such as the development and research policies of the EU."

"EU programmes in general need to bridge better with each other i.e. H2020 and the Third Health Programme."

"Ensure better alignment with H2020. The Programme should place a greater emphasis on encouraging engagement with other policy areas to ensure the conditions are in place for good health and to ensure it is more equitably spread across populations. It should provide greater support for capacity building to enhance leadership and advocacy skills for a "Health in all Policies" approach to strengthen health sector collaboration with the environment, economic and social policy sectors. There should also, in this context, be a greater emphasis in the Programme to contributing to the sustainable development agenda as an approach to improve health and health equity in the EU."

10.3. Respondents' views on the 3HP's objectives and priorities

The OPC sought to gather views on the appropriateness of the objectives pursued by the 3HP and, more generally, whether the EU should provide funding for actions necessary for the attainment of these objectives.

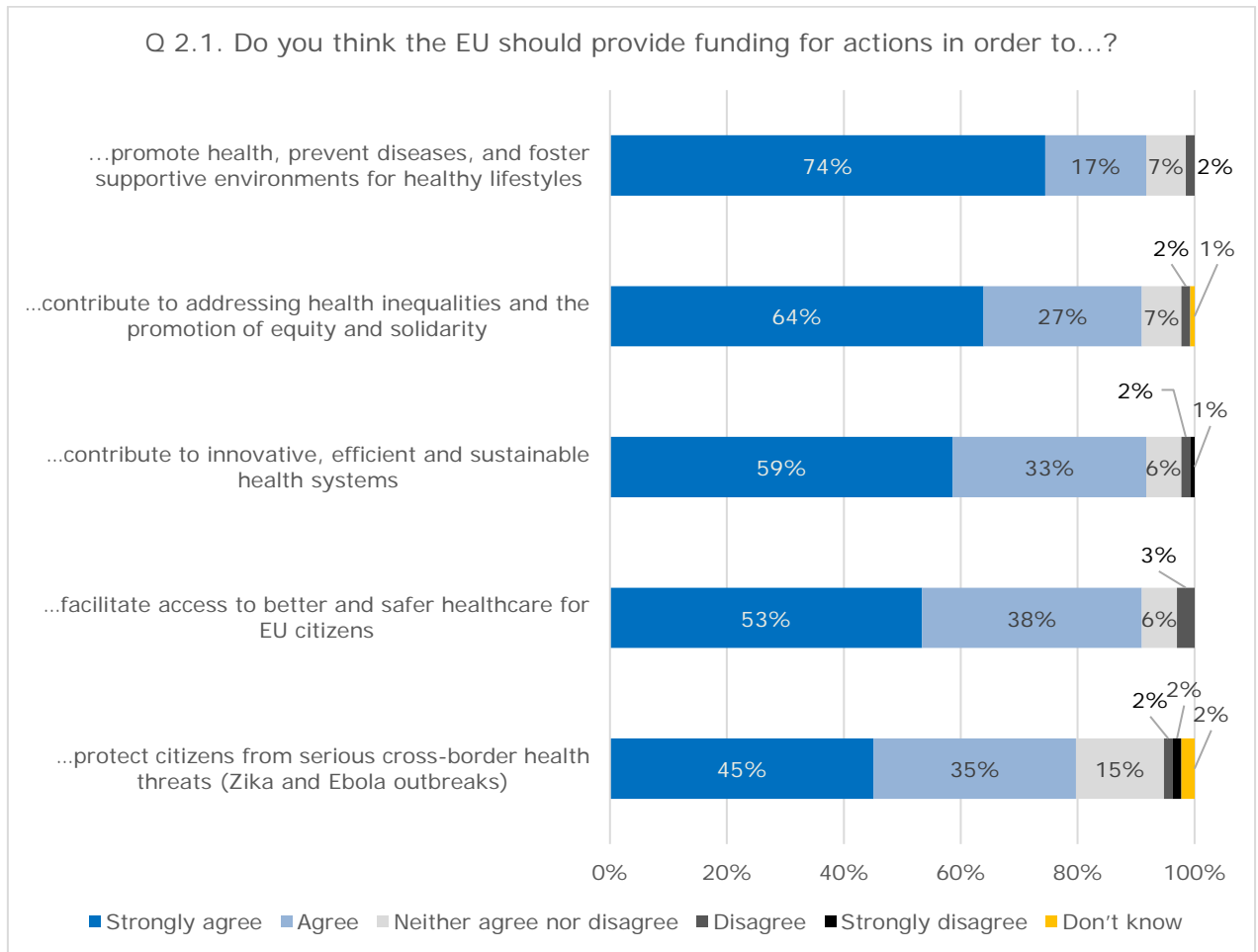
Figure 36 shows the responses collected through the OPC in relation to the relevance of the objectives of the 3HP. The OPC asked whether the EU should provide funding for actions in order to fulfil the four specific and general objectives of the 3HP. The respondents were overwhelmingly of the view that the EU should continue supporting the important health-related challenges facing EU citizens, governments and health systems reflected in the formulation of the 3HP's objectives. The areas considered as most important for EU action were to:

- promote health, prevent diseases, and foster supportive environments for healthy lifestyles (Specific Objective 1)
- contribute to innovative, efficient and sustainable health systems (Specific Objective 3), and
- contribute to addressing health inequalities and the promotion of equity and solidarity (General Objective).

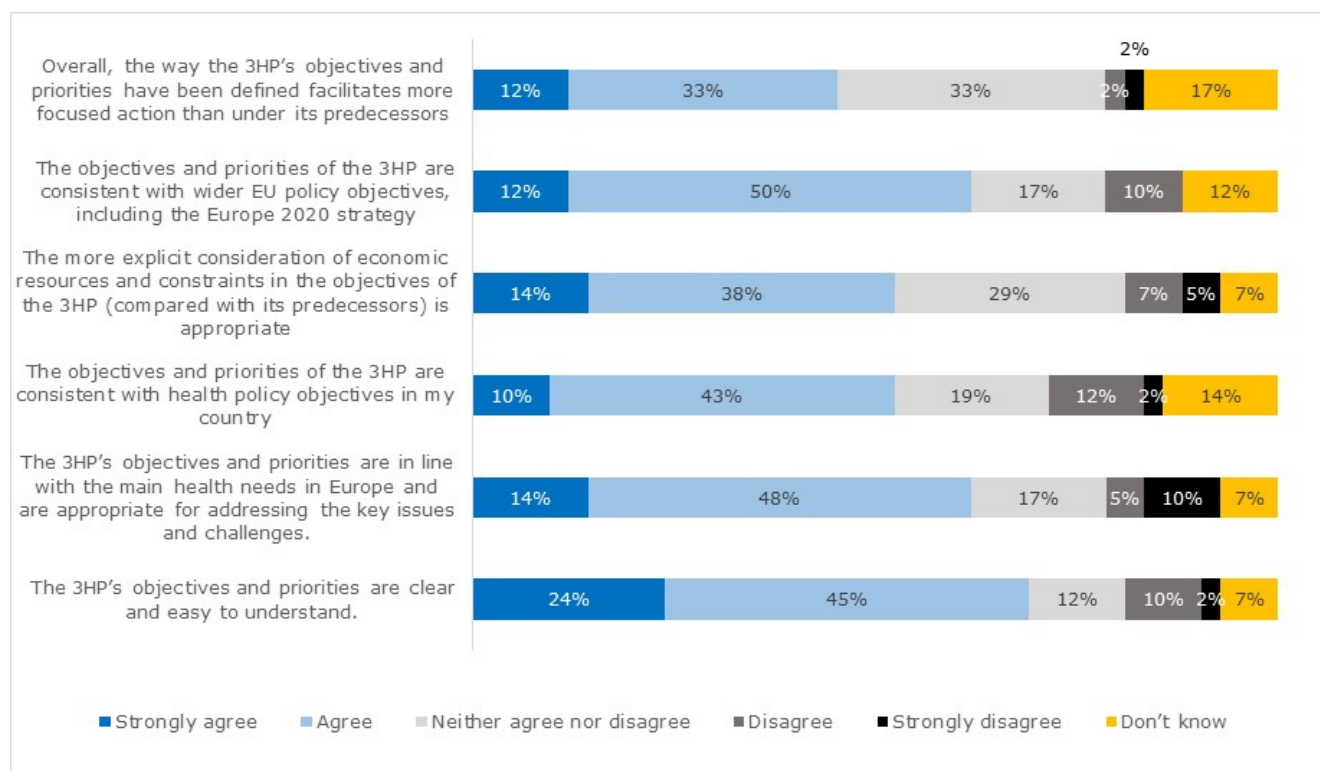
The respondents were slightly more uncertain on the relevance of EU support for the protection of citizens from serious cross-border health threats (Specific Objective 2) and

for the facilitation of access to better and safer healthcare for EU citizens (Specific Objective 4).

Figure 36: Relevance of 3HP objectives



The following Figure 37 presents the respondents' opinions on the objectives and priorities of the 3HP.

Figure 37: Opinions on the 3HP's objectives and priorities, n=133


The majority of respondents agreed that the 3HP's objectives and priorities are clear and easy to understand, as well as consistent with wider EU policy objectives (more than 60% agreed or strongly agreed with these statements). Similar numbers were also of the opinion that the 3HP's objectives and priorities are in line with the main health needs in Europe and are appropriate for addressing the key issues and challenges. Just over one in two respondents agreed or strongly agreed with the remaining statements. Overall, the outlook was slightly less positive when it came to the definition of the 3HP objectives and priorities and their consistency with national health policy objectives.

The OPC respondents were then invited to summarise any concerns about the relevance and coherence of the 3HP and its objectives. A total of 46 respondents opted to provide comments. Often, the comments were very specific and it was difficult to identify trends or shared concerns. Below, we provide some examples (and relevant quotes) of the key aspects discussed in the open replies.

A number of respondents noted the needs to address issues relating to healthy lifestyle:

"Nutrition and promotion of a healthy lifestyle, particularly focussing on children and youngsters should get more support."

"Diabetes, strokes, AIDS and junk food are strong risk. More vegetables are needed in food."

"To reflect the commitment to the implementation of the Framework Convention on Tobacco Control (FCTC)."

"The biggest challenges and threats to health in Europe lie in broader societal forces. It is important that the health sector engages more with these broader processes that are generating ill health and maintaining high levels of health"

inequalities. Yet the Health Programme is, more and more, implementing activities with a more narrow health-care, and bio-medical approach."

Others highlighted a need to bring the 3HP's objectives in line with contemporary challenges:

"Objectives need to be updated to be relevant to current and near-future health challenges, and to reflect the commitment to the SDGs."

"The description of the objectives should most notably be updated to include action on the cross-border (global) health threat posed by antimicrobial resistance (which cannot be accurately described as an epidemic or pandemic, but an even more pressing scale and urgency), as well as the cross-border health threats linked to the development of the internal market and EU trade policies, noting that e.g. diet is the top determinant in the development and prevalence of (preventable) chronic diseases in the EU."

"Since the 3HP was drafted, EU has seen new issues concerning the health of migrants and refugees, and implications for the receiving population, including mental health issues."

From a practical point of view, a respondent was concerned that there are *"too many objectives considering both resources and runtime of the program"*, whereas another cited language barriers and knowledge gaps of initiatives such as 3HP and other European and international strategies, especially at the community level.

Figure 38 presents the answers provided by the OPC respondents on the respective importance of the 3HP's 23 thematic priorities, which are gathered under its four specific objectives. The OPC respondents were invited to select up to five priorities that they consider to be the most important, and up to five that they consider to be not relevant.

The top five priorities are shown in Figure 38 and were, in order of importance:

- 1.4. Chronic diseases
- 1.1. Risk factors
- 1.6. Health information and knowledge system to contribute to evidence-based decision-making in the context of Specific Objective 1 (Promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle)
- 4.3. Patient safety and quality of healthcare
- 4.4. Measures to prevent AMR

The five thematic priorities considered as least relevant by the respondents were the following:

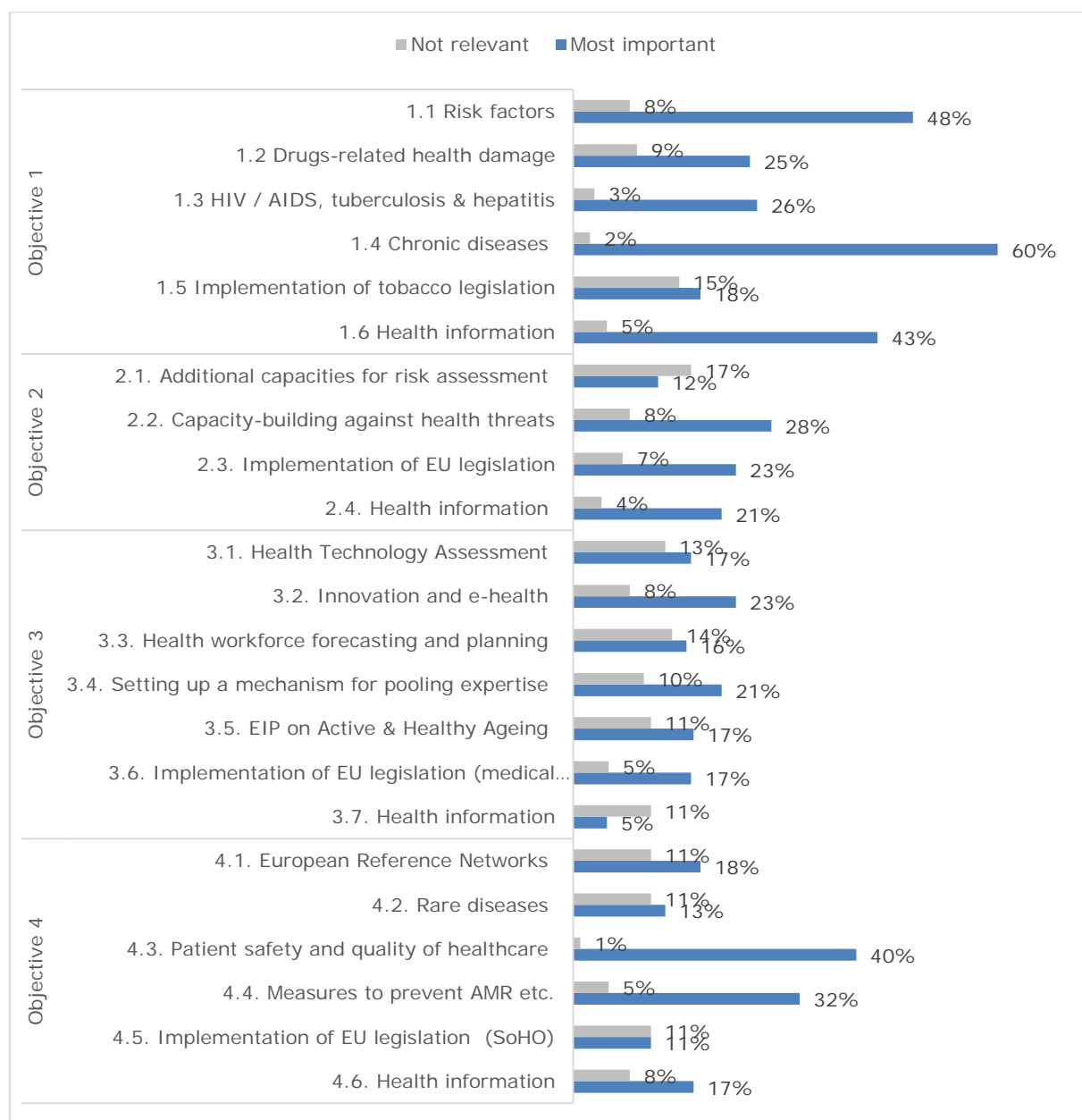
- 2.1. Additional capacities for risk assessment
- 1.5 Implementation of tobacco legislation
- 3.3. Health workforce forecasting and planning
- 3.1. Health Technology Assessment

- (ex aequo) 4.5. Implementation of EU legislation (SoHO), 4.2. Rare diseases, 4.1. European Reference Networks, 3.7. Health information and knowledge system including support to the Scientific Committees set up in accordance with Commission Decision 2008/721/EC, and 3.5. EIP on Active & Healthy Ageing.

The respondents were also asked to list any other important thematic priorities they believe the 3HP should support in the future, or to suggest amendments to the existing priorities.

As many as 51 open replies were given, but the responses were very diverse. They included areas such as diabetes, hepatitis C and cancer prevention were cited. In addition, endocrine disruptors in air, soil and water pollution.

Figure 38: Respective importance of the 3HP's 23 thematic priorities, n=133



10.4. Respondents' views on the implementation of the 3HP

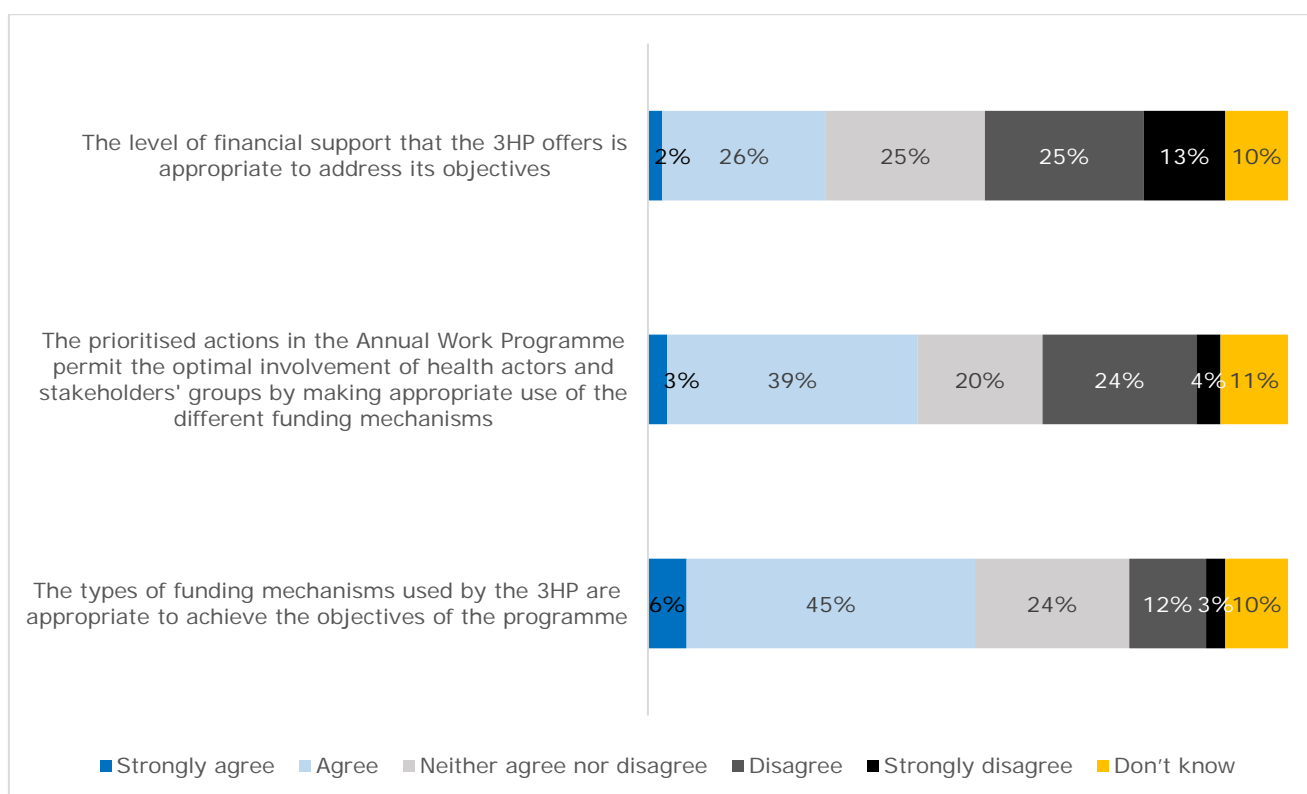
The OPC respondents were then asked to share their opinions in relation to statements about the implementation of the 3HP (2014 – 2020) to date (i.e. 2014 – 2016).

Opinions on the 3HP's funding mechanisms

Figure 39 summarises the respondents' level of agreement with three statements regarding the suitability of the 3HP's funding mechanisms. About a quarter of the OPC respondents were neutral on the three statements. Half of the respondents agreed that the types of funding mechanisms used by the 3HP are appropriate to achieve the objectives of the programme. They were slightly less numerous to think that prioritised actions in the Annual Work Programme permit the optimal involvement of health actors and stakeholders' groups by making appropriate use of the different funding mechanisms. Less than one in three respondents agreed that the level of financial support that the 3HP offers is appropriate to address its objectives and the respondents were more numerous to disagree with this statement.

One in 10 participants was unsure how to respond to the question.

Figure 39: Opinions on the funding mechanisms of the 3HP, n=133

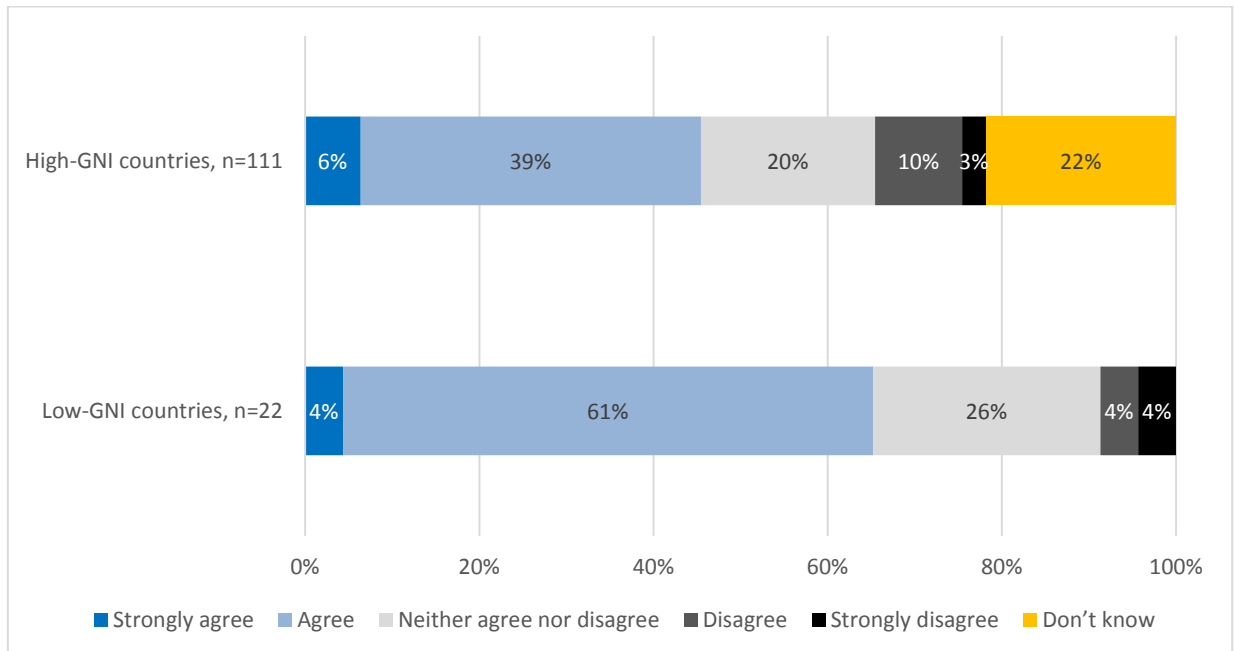


The participants were also asked whether they agreed or disagreed that the 3HP includes appropriate measures to involve all Member States, including those with lower incomes. Figure 40 summarises the responses of the participants, by low-GNI (Bulgaria, Croatia, Czech Republic, Greece, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia, Romania and Ukraine) and high-GNI countries (Cyprus, EU-15 except Greece and associated countries Norway and Switzerland).

The opinions of respondents from low- and high-GNI countries were broadly similar. A majority of respondents from low-GNI countries agreed with the statement, and one in four were neutral. Only less than 10% of low-GNI country respondents considered that

the 3HP does not include appropriate measures to involve lower income Member States. A quarter of the respondents from high-GNI countries were unsure how to answer the question, but almost half thought that the 3HP includes appropriate measures to involve all Member States, including those with lower incomes.

Figure 40: Suitability of 3HP measures to involve all MS, including those with lower incomes, n=133

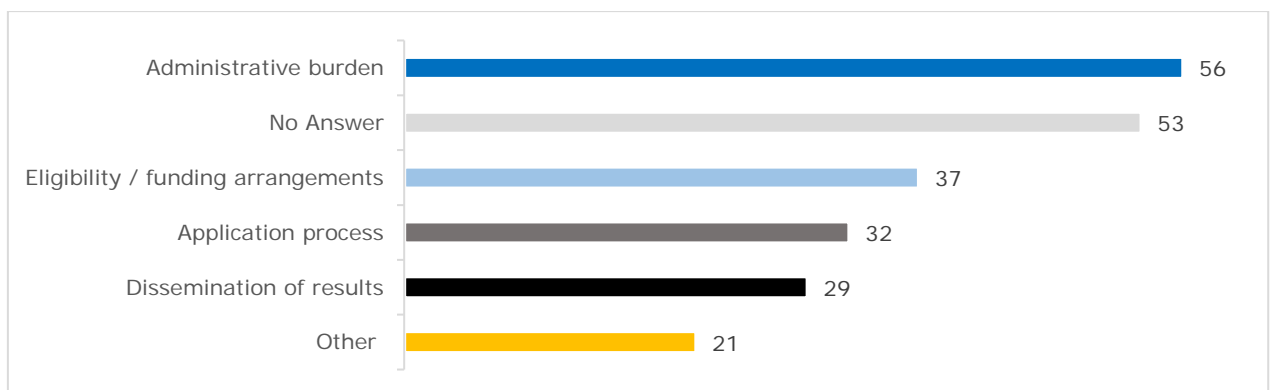


Additional concerns of respondents about the 3HP and its implementation

The participants were invited to share any additional concerns about the 3HP and the way in which it is implemented, in the areas suggested in Figure 41. The respondents were able to select all the areas of concern relevant to them. Over a third of the participants did not provide an answer.

The participants to the OPC answering this question appeared to be mainly concerned with the administrative burden, as well as the eligibility and funding arrangements.

Figure 41: Areas of additional concern on the implementation of the 3HP, n=133



The respondents were able to briefly summarise any concerns other than the suggested areas in an open response. A few examples of relevant quotes from the 21 open replies received are provided below:

“More specialised programmes are needed, mainly by disease and another, a general one for rare diseases.”

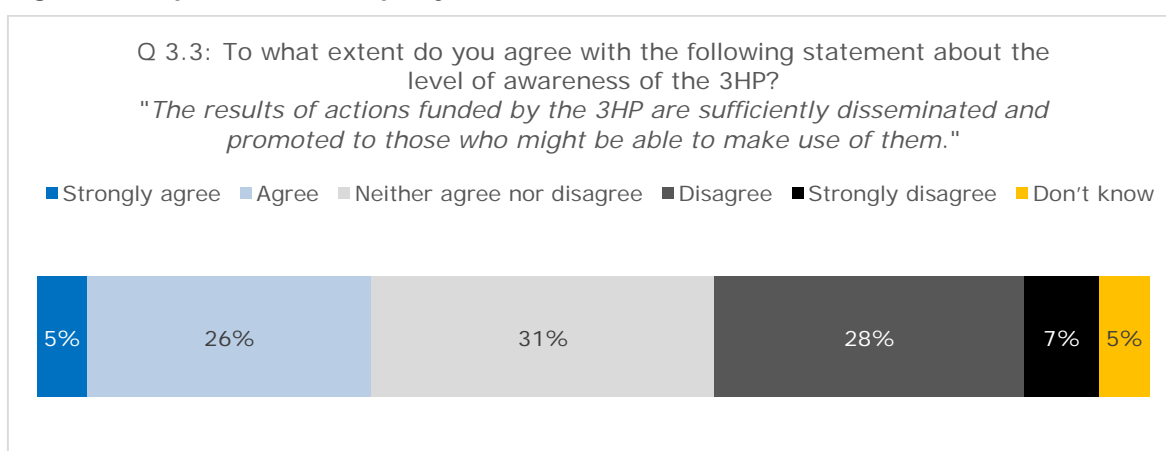
“Opportunities for young public health professionals”

“Civil society participation must be more explicit, even further - each member state should have one civil society organization working on national and international level included in the joint action. Only that will ensure greater performance and a greater added value for the EU citizens.”

Dissemination of results from actions funded by the 3HP

The respondents were also asked whether they agree that the results of actions funded by the 3HP are sufficiently disseminated and promoted to those who might be able to make use of them. Figure 42 presents a summary of the responses collected. The same proportion of respondents agreed and disagreed with the statement, which suggests that their views are ambivalent on the promotion of the 3HP to potential beneficiaries. This is also reflected in the fact that a third of the respondents remained neutral.

Figure 42: Opinions on adequacy of dissemination of results, n=133



Final comments

Finally, the respondents to the OPC were able to share views on issues they considered had not been covered by the consultation. 44 respondents provided further details in their open replies. Often, the comments were very specific and it was difficult to identify trends or shared concerns. Below, we provide a snapshot (and relevant quotes) of the key aspects discussed in the open replies.

The budget of the 3HP should at least remain at its current level, or be increased, in order to achieve the programme’s objectives:

“The Health Programme budget is much too low to achieve everything it aspires to. It should either be expanded significantly (By at least one order of magnitude) OR prioritised actions should be reduced similarly.”

"The EU HP must continue to be appropriately funded, possibly even with increasing level of funding, and selection of priorities should address the priorities of European patients and citizens, as well as having broad impact beyond one country or one disease-area."

While the Joint Actions are widely supported by beneficiaries, there are some doubts on the way they function currently:

"Joint Actions are in principle a good idea, but suffer from a few weaknesses. The selection of eligible partners is not working and a better process in-country should be devised to ensure that the partners match the objectives and that they are actually able to perform the tasks that are expected from them. There should be a preliminary vetting of proposals to enable a smoother negotiation process. A pre-application stage could be introduced where short outline proposals are examined and full proposals only invited from partnerships that fulfil both quality, implement ability and management criteria."

"Joint Actions are not a useful mechanism for health programme implementation and serve solely as a very expensive form of promoting networking."

"The current arrangement does not support EU stakeholder participation, this should be made a requirement and the whole process made more transparent."

Suggestions on the (future) scope of 3HP activities were made, including complementary and alternative medicine (CAM) and front-line health:

"The WHO have grasped the potential of CAM to play an important role in health systems and made clear recommendations for its integration into health systems. Wealthier, better educated European citizens are increasingly integrating CAM into their healthcare provision and led by the USA, a new movement called integrated health and medicine is gaining favour with healthcare professionals as they recognise the contribution many CAM modalities can make to more patient-centred holistic care. The EU needs to recognise these trends and take CAM more seriously in formulating future health policy and action."

"Front-line [frontline workers are those directly providing services where they are most needed, especially in remote and rural areas, such as community health workers and midwives, as well as local pharmacists, nurses and doctors who serve in community clinics] is excluded from the entire 3HP."

"The content of the annual work programmes and priorities setting is not transparent and does not sufficiently involve health related stakeholders."

Comments were also made on the most relevant areas for EU action:

"EU added value is clearest in a focus on internal market measures to tackle cross-border health threats, not only including communicable diseases and pandemics, and especially a stronger focus on AMR, but also recognising that all member states face the same threats from cross-border determinants including unhealthy dietary environments, alcohol, environmental health threats (including air quality, climate change), consumer safety, tobacco, sedentary work and mobility, and the impacts of employment and social precarity on (mental) health."

"The importance of prevention (of chronic diseases, communicable diseases and

AMR) in economic and health system sustainability should be highlighted in Health contributions to EU economic, budget, taxation, social and employment policies and programmes. Much closer coordination is needed to respect the Health in all Policies requirement”

Summary of main findings

Overall, the respondents to the open public consultation provided a positive feedback on the EU's Health Programme and appeared largely supportive of the activities funded under the 3HP. EU support is critical to EU level cooperation between actors of the health sector and respondents emphasised the role of the 3HP for:

- The collection of best practices, dissemination of results and development of guidelines
- The provision of the necessary funding for campaigns and research
- The support to address systemic challenges such as health inequality.

The Programme's objectives are broadly agreed, in line with the main health needs and consistent with wider EU policy objectives and other EU programmes. But respondents suggested to re-consider the scope of the programme – to include such issues as diabetes, hepatitis C and cancer, but also endocrine disruptors in air, soil and water pollution – as well as the coordination and coherence with national health policy objectives.

From an implementation perspective, respondents raised a number of issues which should be monitored and addressed to enhance the cost-effectiveness of the Programme:

1. Administrative burden appears to remain a concern, especially when co-funding rates are not systematically considered attractive enough for individual organisations;
2. Awareness and information on the Programme remain relatively limited, even amongst stakeholders: more emphasis should be put on the communication and dissemination on the 3HP, the opportunities created and its results, while the support to the networking of stakeholders could also be strengthened.

11. REFERENCE LIST

11.1. High-level HP documentation

Document	Date
Council Regulation (EC) No 58/2003 of 19 December 2002 laying down the statute for executive agencies to be entrusted with certain tasks in the management of Community programmes	2002
Commission decision of 15 December 2004 setting up an executive agency, the "Executive Agency for the Public Health Programme" for the management of Community action in the field of public health – pursuant to Council Regulation (EC) No 58/2003, 2004/858/EC	2004
Commission White Paper, Together for Health: A strategic approach for the EU 2008-2013, COM(2007)630	23.10.2007
Commission Staff Working Document accompanying document to the White Paper – Together for health: A strategic approach for the EU 2008-2013, Impact Assessment, SEC(2007)1374	23.10.2007
Decision 1350/2007/EC establishing a second programme of Community action in the field of health (2008-13)	23.10.2007
Commission decision of 20 June 2008 amending Decision 2004/858/EC in order to transform the "Executive Agency for the Public Health Programme" into the "Executive Agency for Health and Consumers", 2008/544/EC	2008
Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions, The EU role in Global Health, COM(2010)128	31.3.2010
Council conclusions on the EU role in global health, 3011 th Foreign Affairs Council meeting, Brussels	10.5.2010
Commission Proposal for a Regulation of the European Parliament and of the Council on establishing a Health for Growth Programme, the Third multi-annual programme of EU action in the field of health for the period 2014-2020, COM(2011)709	9.11.2011
Commission Staff Working Paper, Impact assessment accompanying the document: Proposal for a Regulation of the European Parliament and of the Council establishing a Health for Growth Programme, the third programme of EU action in the field of health for the period 2014-2020, SEC(2011)1322	9.11.2011
Public Health budget	2013
Commission Staff Working Document, Investing in Health, SWD(2013)43	20.2.2013
Commission Implementing Decision of 17 December 2013 establishing the Consumers, health and Food Executive Agency and repealing Decision 2004/858/EC, 2013/770/EU	2013
Commission, Communication from the Commission on effective, accessible and resilient health systems, COM(2014)215	2014
Regulation (EU) 282/2014 on the establishment of a third programme for the Union's action in the field of health (2014-2020)	11.3.2014
Health priorities 2015-2019	2014
Mission letter for the Commissioner for health and food safety	1.11.2014

Thematic priority fiches (21 documents)	2nd half of 2013 ⁸⁷
<ul style="list-style-type: none"> • Prevention Measures • Major chronic diseases • Capacity building • Legislation in communicable diseases and other health threats • Expert panel on health • Legislation on medicinal products • Legislation on medicinal products-Active pharmaceutical ingredients: system inspection • Legislation on medicinal products-Clinical trials database • Legislation on medicinal products-European pharmacopoeia/EDQM • Legislation on medicinal products-Clinical trials database IT • Legislation on medicinal products-VICH • Legislation on medicinal products-Inspections of third countries' regulatory systems for clinical trials • Legislation on medicinal products-Evaluation of transposition measures on falsified medicines directive • Legislation on medicinal products-MRL • Legislation on cross-border healthcare • European Reference Networks • Organs Blood Tissues • EMP database and IT systems • ICH reform and regulators forum initiative • Development of EU requirements for the placing on the market of medicinal products for human use through the international conference on harmonisation of technical requirements for registration of pharmaceuticals for human • Studies and impact assessment legislation on medicinal products) 	
Commission, Memorandum of Understanding between the Consumers, Health, Agriculture and Food Executive Agency and DG Health and Food Safety, DG Agriculture and Rural Development, DG Justice and Consumers, DG Internal market, Industry, Entrepreneurship and SMEs – Modalities and Procedures of Interaction	2016

11.2. HP implementation documentation

Document	Date ⁸⁸
The Health programme 2014-2020 & its implementation	10.12.2013
Note to the Director General SANCO on 3HP-MAP	2013
Multi Annual Planning for the Third Health programme	2014
Form MAP – legislation on medical devices	
Factsheet: The third health programme 2014-2020 funding health initiatives	2014
Consultation process with Programme Committee (9 documents)	
- Rules of procedure	
- Minutes of the Health Programme Committee Meeting of 3.3.2014	

⁸⁷ The thematic fiches are Commission's working documents on the planning of the implementation of the different priorities from 2014 onwards.

⁸⁸ Some documents, in particular Commission's internal documents, are not dated.

- EP Summary record of the meeting of the Health Programme Committee Meeting	
- Summary record of outcome of the written procedure on 2014 AWP	
- Minutes of the HPC Meeting of 6.3.2015 and corrigendum	
- EP Summary record of the HPC Meeting	
- Minutes of the HPC Meeting of 4.2.2016	
- EP Summary record of the HPC Meeting	
Multiannual Planning 2014-2016:	2014
- Financial allocations	
- Description of action, policy context and expected outcomes	
- Note for the attention of Programme Committee members	
The Third Health Programme 2014-2020	June 2014
Commission implementing decision and annexes concerning the work programme for 2014 in the framework of the third programme of the Union's action in the field of health (2014-2020) and the EU financial contribution to the WHO framework convention on tobacco control, serving as a financing decision, C(2014)3383	26.5.2014
List of 2014 Chafea health calls	2014
Award decisions on FPAs, joint actions, projects, public procurements, specific grant agreements (<i>5 documents</i>)	2014
Budget overview Public health and Risk assessment 2014	2015
Registration, validation of legal entities and financial capacity check	10.6.2014
3rd health programme 2014-2020: New online submission system	10.6.2014
3rd health programme 2014-2020: New procedures – Simplification	10.6.2014
Commission implementing decision (as amended) and annexes concerning the work programme for 2015 in the framework of the third programme of the Union's action in the field of health (2014-2020) and the EU financial contribution to the WHO framework convention on tobacco control, serving as a financing decision, C(2015)3594	2.6.2015
List of 2015 health calls	
Award decisions on grants to support actions on migratory pressure, specific grant agreements	2015
Financial allocations AWP 2014-2015-2016	2016
Consolidated data on joint actions 2014-2016	
Commission implementing decision and annexes concerning the work programme for 2016 in the framework of the third programme of the Union's action in the field of health (2014-2020) and the EU financial contribution to the WHO framework convention on tobacco control, serving as a financing decision, C(2016)1158	1.3.2016
European Semester thematic fiche, Health and Health systems	13.5.2016
3HP cofunding by MS	2016
Recurrent expenditures 2014-2017	

Commission, Monitoring projects, joint actions and direct grants concluded under the 3 rd Health Programme 2014-2020	
Commission, Implementation questionnaire on Health Programme indicators – Instruments: projects, joint actions and direct grants	
Commission, Questionnaire on reporting on Health Programme indicators – Instruments: HP-SGA-OG	2015
Multiannual planning exercise 2017-2020	2016
<ul style="list-style-type: none"> - Background - Note - Input MAP template Input MAP 2017-2020 template	
Annual Work Programme template 2017-2020	
Thematic priorities revision 1 (them prior – fin instr_rev1)	

11.3. Past reports, evaluations and audits

Document	Date
European Court of Auditors, The European Union's public health programme (2003-07): An effective way to improve health?, Special Report No 2	2009
Commission, First interim evaluation of the Public Health Executive Agency	2010
Ex post evaluation of the Public Health Programme 2003-2008	03.2011
Mid-term evaluation of the EU Health Strategy 2008-2013	09.2011
Mid-term evaluation of the Health Programme (2008-2013)	10.2011
Commission Staff Working Paper, Impact assessment accompanying the document: Proposal for a Regulation of the European Parliament and of the Council establishing a Health for Growth Programme, the third programme of EU action in the field of health for the period 2014-2020, SEC(2011)1322	9.11.2011
ICF/GHK, Cost benefit analysis for the delegation of certain tasks regarding the implementation of Union Programmes 2014-2020 to the Executive Agencies	2013
Ex post evaluation of the Health Programme (2008-2013)	2015
Chafea, National focal point dissemination activities (draft report)	2016
Commission, Action plan following the ex post final evaluation of the 2 nd Health Programme	March 2016

11.4. Documentation on public health problems and needs

Document	Date
Citizens' summary: Dealing with major public health threats – EU policy paper	
WHO, The European Health Report: Health and health systems	2009
Commission Staff Working Document, Health Security in the EU and internationally, SEC(2009)1622	23.11.2009
Marmot, M., Fair Society, Healthy Lives (The Marmot Review), Strategic review of health inequalities in England post-2010	2010

WHO, A framework for national health policies, strategies and plans	June 2010
Communication from the Commission to the European Parliament and the Council, Action plan against the rising threats from antimicrobial resistance, COM(2011)748	15.11.2011
WHO, Regional Office for Europe, Action plan for implementation of the European Strategy for the Prevention and Control of Non-communicable Diseases 2012-2016	2011
WHO, Review of public health capacities and services in the European Region	2012
WHO, Health 2020	2012
Aluttis CA, Chiotan C, Michelsen M, Costongs C, Brand H, on behalf of the public health capacity consortium (2013). Review of Public Health Capacity in the EU. Published by the European Commission Directorate General for Health and Consumers. Luxembourg	2013
Commission, DG Health and Consumers, Commission Staff Working Document: Investing in Health, SWD(2013)43	2013
Decision 1082/2013/EU on serious cross-border threats to health	22.10.2013
OECD, Health at a Glance: Europe 2014 (joint publication of the OECD and the European Commission)	2014
WHO IHR monitoring, Summary of states parties 2013 report on IHR core capacity implementation ⁸⁹	2014
Commission, Evaluation of the implementation of the Commission Communication:	2014
Combating HIV/AIDS in the European Union and the neighbouring countries, 2009–2013	
Communication from the Commission on effective, accessible and resilient health systems, COM(2014)215	2014
WHO, The European Health Report: Targets and beyond – reaching new frontiers in evidence	2015
Eurostat, Key figures on Europe, Quality of life: Facts and views, The EU in the world (3 documents)	2015
Council conclusions on “Lessons learned for Public Health from the Ebola outbreak in West Africa – Health Security in the European Union”, (2015/C 421/04)	2015
Report from the Commission to the European Parliament and the Council Report on the implementation of Decision No 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious cross-border threats to health and repealing Decision No 2119/98/EC	2015
Eurohealth, Securing health in Europe: balancing priorities, sharing responsibilities, 21(3)	2015
OECD, Health statistics	November 2015
Commission / Government of the Grand Duchy of Luxembourg, Conference: “Lessons learned for public health from the Ebola outbreak in West Africa – how to improve preparedness and response in the EU for future outbreaks”	October 2015
Council, Conclusions on lessons learned for public health from the Ebola outbreak in West Africa – Health security in the European Union (2015/C 421/04)	December 2015
Commission, Humanitarian aid and civil protection, EU response to the Ebola epidemic in West Africa: ECHO factsheet	March 2016

⁸⁹ See, http://apps.who.int/iris/bitstream/10665/145084/1/WHO_HSE_GCR_2014.10_eng.pdf?ua=1

Global Health Security Agenda	Last updated 7.3.2016
Commission, Health reporting systems at national level	Last updated 26.5.2016
The Economist Intelligence Unit, Healthcare markets in Europe: What would be the impact of Brexit?	2016
Commission Communication, Action Plan on the integration of third country nationals, COM(2016)377	2016
Commission, European Semester thematic fiche: Health and health systems	2016
Commission, Expert Panel on effective ways of investing in health, Access to health services in the EU	2016
European Centre for Disease Prevention and Control, EU laboratory capability monitoring system (EULabCap): Report on 2013 survey of EU/EEA country capabilities and capacities	2016
Commission, ECHO, EU response to the Ebola epidemic in West Africa, Factsheet	2016
Eurohealth, Special Issue on Health Systems Strengthening, 22(2)	2016
Commission, Expert Panel on effective ways of investing in Health (EXPH), Memorandum on Reflections on hospital reforms in the EU	2016
European Parliament, Health and social security, Briefing: Public expectations and EU policies	2016
Commission, DG SANTE, Programme Committee meetings: Minutes (3/03/2014, 6/03/2015, 4/02/2016)	2014-2016
OECD Health portal (online resource), http://www.oecd.org/health/	
OECD, Health by country (online resource), http://www.oecd.org/health/bycountry/	
OECD Health statistics 2015 (online resource), http://www.oecd.org/health/health-data.htm	
UNHCR, Health (online resource), http://www.unhcr.org/uk/health.html	
WHO, Regional Office for Europe (online resource), http://www.euro.who.int/en/home	
European Observatory on Health Systems and Policies (online resource), http://www.euro.who.int/en/about-us/partners/observatory	
Health and financial crisis monitor (online resource), http://www.hfcm.eu/	
The health systems and policy monitor (online resource), http://www.hspm.org/mainpage.aspx	
ECHI (European Core Health Indicators) data tool (online resource), http://ec.europa.eu/health/indicators/indicators/index_en.htm	

