# Contribution of the EU Health Forum to the future Public Health Programme - post 2013

## Contents

## Summary of key messages

**A robust, effective and fruitful Public Health Programme is a necessity:**

- to respect, apply and implement the legal texts making it mandatory for the EU to protect, promote and enhance the well-being of its population whilst respecting principles of subsidiarity;
- to promote "health in all policies" and make the link between various initiatives, between several sectors and priorities;
- to allow an active, efficient and powerful participation of public health stakeholders into the drafting of public health policies and their implementation;
- to fund pan-European projects/actions/organisations that support better health outcomes and policies responding to the needs of patients and citizens;
- to ensure the continuity and effectiveness of existing projects/initiatives that have proved to be valuable and successful.

**The Public Health Programme must promote:**

- the mental and physical well-being of EU citizens, taking into account the policies that impact them, adopting a holistic approach and avoiding the "silo traps". This also entails promoting the importance of health as a cross-cutting value in other EU initiatives;
- health as value in its own right, as well as a contributor to economic growth and sustainability;
- prevention which inter alia supports a reduction of ill-health related costs on society;
- actions on determinants of health, be them environmental, social, economical or related to life-style;
- good practice and sharing/disseminating findings that improve public health;
- equality and measures to fight inequality in access to care;
- equitable, sustainable and good quality health systems supporting independent living and quality of life, of which health promotion is an integral part
- a patient-centred approach, for which Innovation is social and organisational as well as technological and valued for its potential to improve quality of services, quality of care, and the quality of life.

**The success of the future PHP will be indicated largely by:**

- the improvement of the well-being and of health-related lifestyles, a reduction of inequalities, an increase of healthy life-years – these will be among the indicators of the impact of the a positive European Public Health Programme;
- economic data - not the main means of measuring the efficacy of the Programme but the Programme will demonstrate that health can and does lead to smart, sustainable and inclusive growth.
- reaching the goals set in the initiatives supported by the PHP;
- the implementation of Programme initiatives recommended actions, at member state level;
- an adequate and wide dissemination and communication of the findings/results of the initiatives supported by the Programme.

The Programme **must be properly resourced** and funding balanced as to ensure effective civil dialogue.

The economic impact of not dealing with ill-health would be devastating to European economies and health care systems alike. Therefore, in order to achieve positive economic impact and growth in health as well as in a number of other policy areas, it is essential that the EU adjust the framework of the future Health Programme.

Below, the EU HPF is answering the questions the Commission asked which are in bold, either in the headings, or under the section headings.

1. THE EU Health Policy Forum (EU HPF) welcomes the opportunity to contribute its views on the future of the Public Health Programme (PHP) post 2013 taking into account the key lessons learned from the evaluation of the 2003-2008 PHP and of the mid-term evaluation of the 2008-2013 Health Programme together with the views of our on membership and their members throughout the European Union.

2. In addition to the main messages identified by both evaluations, we wish to highlight the fact that health makes a contribution to core economic, social, environmental (such as labour policy, economic policy, urban planning, agricultural policy, education, information society and technology etc.) and cohesion competences of the EU and should be acknowledged as such. It is vital that health supports other sectoral aims as well as being a value in itself. The Forum believes that this aspect is key to the framework of the new PHP post 2013.

## 1) Why the need for a Public Health Programme?

**Does the structure for the new programme as presented to you (briefly above+ slides during the meeting) seem reasonable/satisfactory*?***

3. The presentation of the future Public Health Programme (PHP) had several strong points – the fact that the European Commission and the Executive Agency for Health and Consumers (EAHC) seek to improve the impact of the PHP and are looking for new indicators is a positive development. This will also, inter alia, increase the awareness on the benefits of the PHP. The evaluation picked up on several positive points of the PHP, that were even recognised by the European Court of Auditors such as the promotion of best practices and the strengthening of networks, which are two key achievements of the PHP.

4. The PHP is a vital mechanism for promoting public health in the EU and a crucial tool to support and further encourage cooperation between member states (MS) in the field of health.

5. We believe that the future programme needs to build and continue work of successful projects started under the current PHP as well as create coherence as to priority areas where suitable.

6. We feel that the critical "health in all policies" aspect and more generally the link and the coherence with the other EU policies and initiatives (including ones on pharmaceuticals and medical devices). To fully benefit from its potential we support a commitment to guarantee its correlation and relevance to topical health and health-related policies both on European (such as the EIP on Active and Healthy Ageing) and national level. We would welcome this to be reflected in the structure of the programme, for example through creating assessment indicators for the evaluation of the PHP which take this into account.

### 1.1 Legal base and obligations of the EU under various texts

7. The Article 3 of the Lisbon Treaty states: "*the objective of the EU shall be to promote peace, its values and the wellbeing of its peoples*." The definition of health in the Charter for the World Health Organisation is that it is "*not merely the absence of disease but a complete state of physical, social and mental wellbeing.*" The two are intrinsically entwined and the obligation of the EU/EC to promote wellbeing, including health, is clear and enforceable.

8. Furthermore, Article 8 makes the promotion of equity a new objective of the EU, which states "in all its activities, the Union shall aim to eliminate inequalities, and to promote equality, between men and women." The reduction of inequalities, and in particular health inequalities and the promotion of social cohesion are objectives of the European Union, and the Public Health Programme helps to meet these aims.

9. It follows that not to invest in public health and the promotion and protection of the physical and mental health of its citizens would be an abrogation of one of the EU's fundamental purposes.

10. Furthermore, Article 168 (TEU) has seven clauses that need to be implemented, bearing in mind subsidiarity:
    11. In the first clause, it is required that Union action […] shall be directed towards improving public health […] as well as health information and education […]. The second clause requires encouragement of cooperation, including in the organisation of exchange of best practice.

    12. Clause 5 states that the institutions "may also adopt incentive measures designed to protect and improve human health".

13. A human rights approach and the reduction of discriminations as discriminations will impact on the lives of vulnerable citizens and hinder their access to necessary prevention, treatment, care and support services must also be promoted in the design of a new Programme.

14. We support EU involvement in public health on the basis that it has the potential to contribute to the goal of health for all, using the clauses above.

**1.2 Participation in the economic growth of the EU**

15. We acknowledge the Commission support to the sustainability of health systems and encourage the European Commission to ensure universality, quality, equity and solidarity. These fundamental European values need to be re-emphasised, particularly given the current economic situation which has led to cuts in health and social budgets in many member states that are likely to have long-term impacts on health and social cohesion. In the context of an ageing society, specifically, "active and healthy ageing" rests on the cornerstone of equitable access to good quality healthcare – including preventive services, acute medical treatment, chronic disease management, and the necessary support and social services. In order to achieve equitable access and quality healthcare, a strategy for an adequate supply of healthcare professionals should be envisaged.

16. There is now a growing body of evidence to support the hypothesis that a healthy population is one of the most essential prerequisites for sustained economic growth, and some of this evidence indicates that well directed investment designed to improve the health of a population is one of the most cost-effective means of stimulating gross domestic product (GDP) growth. Hence a PHP planned to support the 2020 Strategy should seek to address the main health challenges in Europe.

17. Health is an important sector accounting for 10% of the total of EU workforce, which together with pharmaceutical products, medical devices, and daily living aids significantly contribute to the economic growth of the EU. The existence of a CAM workforce of 300-400,000 in the EU that is currently predominantly working outside state health care provision. In a Europe threatened by a future health workforce shortage, the potential integration of these CAM health workers is an important factor to consider.

18. The commonality of the challenges and the opportunities for growth through better health make a strong PHP increasingly important. The PHP has particular value as a unique bridge between health research, policy and practice, and offer an important complement to the research orientation of programmes such as FP7. In particular, the PHP offers significant scope for connecting research to policy, practice and implementation and developing innovative knowledge transfer and dissemination initiatives.

19. The Council of the EU have recognised that there is significant evidence that a high-level of mental health of the population is an important factor for the economy and that mental disorders lead to economic loss. In this regard specific action should be taken to address the people that are most affected by mental health issues, in particular younger and older generations.

20. To meet the goals of the EU 2020 strategy, we need to improve the well-being of all people, so that it can actively participate in the societal and economical world. We wish to reinforce promoting the value of healthcare to the wider economy.

21. Three areas of ill-health (cardiovascular diseases, cancer, and neuropsychiatric disorders) are the cause of 74% of deaths in Europe, and contribute 54% of the overall disease burden in Europe, as calculated in Disability Adjusted Life Years [1](DALYs). Accordingly, a PHP designed to support the EU 2020 Strategy must effectively address these three major health challenges. The most effective way to make improvements in these three areas would be to focus on the underlying determinates of health.

22. Fortunately, there is considerable coincidence between the risk factors for these conditions which need to be influenced and improved if the disease burden they create is to be reduced; in particular, common requirements for all four are:
    - major improvements in nutrition within European diets; these could be stimulated to a great degree by Common Agriculture Policy (CAP) reform designed to improve nutrition;
    - improving the rates of physical activity for children and adults;
    - reduction in exposure of all European populations to tobacco smoke; full implementation and enforcement of all existing legislation is required, as is further legislation to reduce even further the risks of passive smoking, etc;
    - reducing and preventing alcohol related harm which can be done by raising awareness and political commitment at all levels, drink driving actions, focusing on the availability of alcohol, the affordability, the marketing of alcohol towards especially young people, drinking environments and illegal and informal alcohol.

23. The future PHP must avoid a “silo trap”: we must return to a cross cutting approach which has worked in the past. While it is essential to encourage member state ownership of the Programme together with civil society and other stakeholders, the predominance of Joint Actions without sufficient interconnecting mechanisms will be counter-productive. We would also welcome greater direct alignment between the PHP and SANCO initiatives such as the Active and Healthy Aging Innovation Partnership or the forthcoming antibiotic resistance strategy

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[1] DALYs are a time-based measure combining data on premature mortality and morbidity within a population. DALYs are used to compare the health impact from various (groups of) diseases or major risk factors. At the urban level, it is probably feasible to make comparisons for a limited number of large diseases. DALYs are based on an ideal scenario where everyone in the population reaches maximum life expectancy (usually the Japanese life expectancy, which is 82.5 years for females and 80 years for males) in perfect health. The DALY measures the difference between this ideal health state and the estimated current status of the population. The data needed for this include age- and cause-specific mortality data and accurate estimates on the prevalence of the selected disease groups. The weighting factors for the diseases selected can be taken from international sources, although the applicability of weights derived from different populations has to be considered. In this way, the burden from a few major disease groups (cardiovascular, cancer, injuries/accidents, mental/behavioral) can be estimated and the differences between cities assessed.

How can DALYs be used?
DALYs can be used on populations of different sizes and be used for several purposes. DALYs can be calculated for all disease and injury conditions for each urban area. Using URHIS existing data, it would be possible to calculate the total number of years of life lost for all of the cause of death data.

## 2) Setting priorities

**In your views, what should be the objectives and priority areas, smart and with real EU added value, of the next health Programme be?**

### 2.1 The EU Health Policy Forum's suggestions

24. The Programme should support health policies that are based on evidence and provide a stimulus with which to implement recommendations and policies to improve and promote citizens health, prevent diseases and address entrenched health inequalities, which, as an outcome, will ultimately lead to sustainable health systems.

25. We support a concentrated prioritisation approach. In the past the Programme Committee has been insufficiently transparent and there has been duplication of efforts without proper evaluation. The choices of priority need re-appraisal.

26. Priority should be given to tackling the social gradient in health across Europe; health security planning; and the prevention of the greatest burdens of diseases and ill health, notably mental and physical health and wellbeing promotion to ensure that Europe will have an active and healthy ageing population - reinforcing core European values as well as creating economic benefits.

27. The Programme should focus on increasing healthy life years (HLY) in people with lower educational and socio-economic status. This is where we can make most progress, and it is also where health gain has most potential to contribute to a sustainable society and economic progress. It could establish measurable indicators of changes in HLY which would provide an invaluable tool for other fields of work of the PHP.

28. We wish that the Programme supports equitable, sustainable and good quality health systems supporting independent living and quality of life, of which health promotion is an integral part. It should:
    - protect health by identifying and acting on health threats across the EU;
    - continue to develop and improve the European Health Information System in order to improve data collection to enable county by county comparison;
    - develop and successfully implement Health Impact Assessment (HIA). We strongly encourage the use of HIA when developing policies that recognise the effect of social determinants on health, such as income inequality, education and housing.

29. The current focus of the presented structure for the future Programme does not take into account sufficiently the economic burden of health inequalities. Health inequalities have been estimated to cost the EU around €141 billion in 2004 or 1.4% of GDP, when taking into account labour productivity lost and costs to social security[2]. While the average level of health in the European Union has increased in the past decades, differences in life expectancy at birth between the lowest and highest socio-economic groups reaches ten years for men and six years for women in the EU[3]. In other words, the health gains are not evenly distributed across countries, or across socio-economic groups within the same country. Therefore, addressing this imbalance through projects to combat health inequalities, potential discriminating legislation and attitudes, to raise awareness and improve data collection should be a strong priority of the Programme. Furthermore, by tackling the economic burden of diseases and

[2] Mackenbach JP, Meerding WJ, Kunst AE. Economic implications of socioeconomic inequalities in health in the European Union. Luxembourg: European Commission; 2007.

[3] COM 14848/09. available from: http://register.consilium.europa.eu/pdf/en/09/st14/st14848.en09.pdf (accessed 25 August 2010).

health inequalities, the PHP could accomplish much towards achieving the goal of ensuring sustainable health systems in the EU.

30. Most of this burden of disease is eminently preventable, given the will and resources to do so; the means to address the relevant risk factors is known: what is needed is more innovation in the application of these means to populations. Improving the health status of the people of Europe is very largely a challenge to health promotion (which includes health education, health protection, and disease prevention), and health inequalities need to be addressed also in the context of improved systems of health promotion: here is further scope for innovation.

31. The aim of public health workers, organisations and services is to protect health, prevent disease and promote the health and well-being of the whole community. And yet, statistics from the European Commission show that, by 2020, the EU will be facing a shortage of 590,000 nurses, 230,000 doctors and 150,000 allied health professionals (pharmacists, physiotherapists, etc.). This will mean that 15% of care will not be delivered, due to lack of resources. Assisting with the development of a strategy to ensure an adequate supply of health professionals by supporting proper working conditions, is one way that the PHP can support the "New Skills for New Jobs" initiative and facilitate the implementation of the Active and Healthy Ageing Innovation Partnership.

32. Differences in life expectancy at birth between the lowest and highest socio-economic groups reaches ten years for men and six years for women. Although women tend to live longer than men, they also spend a longer proportion of their life in ill health. This means that, although all vulnerable groups should be targeted, early intervention on children and babies and maternal health should be particularly targeted as a cross-cutting group in society. The provision of a comprehensive package of policies targeting children, mothers and caregivers is seen as instrumental in laying the foundations for health through the life course. This should be prioritised in the Public Health Programme and the issue needs to be addressed politically and lead the European Union to devise a EU strategy for children's health. This could reinforce the EU Flagship Initiative on "Youth on the Move" and the European Platform against Poverty and Social Exclusion.

33. Another priority should be Non Communicable Diseases (NCD): they are responsible for the majority of disability adjusted life years lost and therefore threaten the economic viability of the European Union. The World Economic Forum has identified NCDs as the second most severe threat to the global economy in terms of likelihood and potential economic loss. An improved management of NCDs would render the biggest positive impact in terms of increased well-being of the EU's people, economic growth and in a reduction of the economic burden of non-communicable disease. The most cost effective solution to reduce NCDs are through public health interventions that take a health promotion approach, which address the determinates of health (nutrition, alcohol, tobacco, physical activity and the social determinants of health.).

34. A suggestion is to identify a "paradigm of care", which would account for the need for sustainable, equitable and good quality systems, as well as for 'smart' and 'inclusive' growth. Priority areas could then be aligned to the paradigm. This paradigm could be used to select the priority areas for the Programme based on a continuum of care and the needs of individuals, professionals and other stakeholders at each level in the provision of care. For example, the different priority areas could be prevention (public health initiatives), self-care (including lifestyle, self-medication, self-management of chronic disease) and primary secondary and tertiary care.

35. We also recommend a holistic approach to health and ill-health: from an increased understanding of what determines health and what determines ill-health, citizens can be encouraged and supported to lead healthy lives by pursuing the former and avoiding the latter. This builds resilience and resistance in citizens so they can remain healthy, resist stressors

that could potentially make them unwell and thus enable them live longer productive and independent lives. Furthermore, when they become ill, they are then better able to respond to secondary prevention measures. The gradual introduction of “whole systems” into general health system delivery can be deemed to be innovative and has the potential to act as a catalyst for change towards establishing more sustainable healthcare systems that are truly focused on health, its maintenance and its care.

**2.2 Comments on proposals made by EC**

2.2.1 Innovation

36. The concept of “innovation” needs to be defined and it should be clear that it is social and organisational as well as technological. In order to underline implementation and local change, the definition could be expanded: “to provide policy makers *and practitioners* with innovative solutions”. Adding “building capacity for implementation”, may also strengthen the definition.

37. Innovation should be valued for its potential to improve quality of services, quality of care, and the quality of life: it should be people-focused rather than technology-focused to ensure it brings genuine benefits and is cost effective. It must be clear that innovation is not only economy driven but aims at providing better quality care for all.

38. The focus on innovation in bridging health and social systems should be stressed; this is particularly crucial in effectively tackling the challenge of prevention and management of chronic diseases. The importance of meaningful user involvement in the identification of needs and throughout the process of development, implementation and evaluation of innovative solutions must not be overseen when reflecting on innovation.

39. The innovation response to the sustainability challenge facing health systems is both to foster completely novel solutions to unmet needs, but also to deploy more efficiently what we already have and to set the right conditions for future innovation.

40. Innovation must encompass whole health system initiatives including promotion of improved health and social equity.

41. The EC should adopt a truly innovative approach: integrated and creative ways of service delivery. The concept of integrated care needs to be supported as the way forward – i.e. more coordination between the different strands of the EU social models for more cost-effective, equitable, sustainable and universal services. Nevertheless, it is crucial to make sure that a balance is achieved between demand and supply (market) in any future developments. In addition, we think that there could be a stronger focus on patients as well as on systems which deliver healthcare to patients, given the increasing personalisation of medicines and the stronger patient voice in treatment choices. Future health systems will have to be evidence-driven to a much greater extent than is the case today, for purposes of analysis and real-time treatment and this might deserve greater emphasis.

42. We feel that the proposed structure for the new programme risks duplicating the focus of other EU funding Programmes through its emphasis on supporting innovative solutions in health funding, care and research. The structure of the new Programme should be designed to clearly demonstrate coherence with health policy at local, national and EU level, and make efforts to facilitate co-operation amongst these tiers through funded actions in the programme. Furthermore, to avoid stagnation of successful initiatives, we support the continuation of current successful projects which have proven to deliver valuable outcomes and have the potential to create innovation in health policy.

43. The new Programme should make efforts to promote social innovation through measures and initiatives aimed at promoting good health in the context of an ageing society. However, it is important that the reflection on the ageing demography of the EU incorporates the notion that

ageing is something which occurs across the whole life-cycle and should not be compartmentalised as something concerning those of or approaching pensionable age.

44. Efforts should be made to ensure that this prioritisation does not come at the expense of crucial health concerns, shared across the EU, such as chronic diseases, communicable diseases, anti-microbial resistance, tobacco control, alcohol-related harm etc. In short, we would welcome efforts to use the new Programme as a tool to promote the wellbeing of EU citizens.

2.2.2 Prevention of diseases

45. This pillar must include both primary and secondary prevention of diseases, focusing on the social determinants of health, to tackle inequalities, so an alternative title could be "*Prevention of diseases and addressing the determinants of health*".

46. Another suggestion would be to name this strand "*Promotion of health and prevention of diseases*" so that the promotion of health among EU citizens is recognised as an important objective in itself rather than this being an area that is only focused on preventing specified diseases.

47. We support a more progressive approach to action on health determinants, especially the EU dimension of determinants where WHO Action Plans are supported by member states.

48. This is entirely consistent with the approach for social determinants of health as recognised by EU member states signatory to the 2009 World Health Assembly Resolution on the Recommendations of the Commission on Social Determinants of Health, in turn recognised by the EC in the Communication "Solidarity in Health". We urge that Ministerial statements are honoured.

49. It should specifically include promotion and improvement of health equity, and literacy – the real underlying factors behind disease. To affect sustainable change that will improve the health of the EU population while also addressing affordability, a stronger emphasis must be placed on health equity measures in health systems and a horizontal approach to the contribution health improvement can make to public policies and societal practices, including for private sectors.

50. The Programme should contain key strategies for increasing patient empowerment and enabling meaningful patient participation in healthcare and effective self-care. Such empowerment will be an essential element of future healthcare as it is predicted to shift increasingly towards a home and community environment and towards using eHealth and ICT based solutions for patient-centred chronic disease management.

51. The previous PHPs have not been developed by life cycles when it should maximise health and health promotion throughout the life course (from early years to healthy ageing). In respect of prevention, children are the best investment in the future. Therefore, it has great importance to include programmes targeting settings and life cycles in the PHP.

52. Strong focus on mental health should be given and, investments in (primary and secondary) prevention and treatment services promoted. The treatment gap for mental, neurological and substance use disorders is formidable especially in poor resource countries and the PHP should address it.

2.2.3 Implementation of legislation

53. As a general comment, there are overlaps between the first (innovation) and this area. We think that what is missing is a broader perspective approach so that the health relevant

components and impacts of other implemented policies such as the CAP, chemicals, the recognition of professional qualifications etc. are also monitored and responded to.

54. Legislative measures and policy studies should include support for the strategy of *health in all EU policies*, not just isolated measures for health systems. That particularly applies to the contribution of health to the flagship targets for EU 2020, as the inclusive and sustainable objectives matter to health as much as innovation (which health promotion does naturally being a relatively new concept and science).

55. The examples given under the heading of "implementation of health legislation" focus on hard law. Normally speaking we would expect that member states reflect on implementation as part of the legislative process. There is a potential "gap" which the PHP could address where the legislation in question contains measures which involve action at EU level or involve the strengthening of the role of non-governmental actors (examples might be the centres of excellence and national contact points proposed in the cross-border healthcare directive). EU health policy is also advanced through "soft" law and through institutional restructuring. It would be useful if the PHP could support these areas as well.

56. When supporting member states in the implementation of EU health legislation, consideration should be given also to appropriate stakeholder involvement, in accordance with Article 11 of the Lisbon Treaty that ensures civil dialogue takes place, which helps bring the EU policy process closer to people living in Europe. .

57. There are cross-cutting areas of action that are relevant to all three areas and which have particular potential to strengthen the impact of the PHP. These include dissemination, knowledge transfer and capacity building. The added value of the PHP to support networks that disseminate information, transfer knowledge and build capacity was recognised by the European Court of Auditors.

58. Some of the real value of the Programme is not being communicated appropriately. In the design of the new Programme, further support for this purpose should be incorporated, which would help improve some of the perceptions of the Programme's impact and value. We note that the results of individual projects do not appear to be very visible outside the community which is directly involved. The PHP would be significantly more efficient if dissemination and promotion of the initiatives were further promoted. The Commission could strengthen communication and dissemination for instance by making mandatory in the application form to one of the Programme tools to indicate which way applicants plan to disseminate and share with the adequate interested parties the findings of their work.

59. Much can be done to improve scaling up: impact assessment applications, avoidance of duplication, evaluation, programme management and integration with policy agendas and cycles, more effective engagement of regional (sub national) and civil society stakeholders, and transparency of decision making, including better involvement of targets and inclusion of communities most affected by decisions in design and implementation.

## 3) EU added value

**Do you agree that the EU added value would be an exclusive criterion for the ranking of priorities? Could other criteria be used?**

### 3.1 Notion of "added value"

60. The notion of EU added value should be defined prior to being considered as a measurement of usefulness and potential success, since addressing the issues of one member state solely would not qualify the added value of the EU but if this action has an impact on neighbouring countries, that action would bring added value to more than one member and therefore the notion should not necessarily be defined by the number of member states directly concerned and involved in the programme but by considering the impact is has on additional indirect beneficiaries of the action.

61. It is very difficult to propose broad-based measures of added-value that would be applicable across the three areas of the programme. The metrics applicable to implementation of legislation will be relatively concrete. In relation to innovation, the criteria should in some way reflect adoption of innovation, which is an acknowledged issue within European health systems. The Commission may also wish to examine whether some metrics involving the frequency with which projects outputs are accessed or referenced could be useful where the project output is in the form of guidelines.

62. The Commission should also define expectations on the number of added value criteria initiatives under the Programme should fulfil and their relative weight (e.g. whether there are added value criteria that all programmes should fulfil and others that may be related to specific types of activity).

**3.2 Which criteria could be used for measuring the EU added value?**

63. The ranking of priorities should be based on the values and obligations outlined in the Lisbon Treaty and contribute to achieving the Treaty aims and objectives, such as equity, social justice and well-being for people and society, as well as civil dialogue.

64. Further consideration should also be given to the importance of multi-level governance, in that multiple public actors have the opportunity to significantly input into the agenda setting and prioritisation process, and also participate in the programme. Recognition of the essential nature of multi-level governance to the programme's efficacy will require explicit commitment to involve sub-national authorities with competency for public health and health care delivery, and given that health is a decentralised competence is most member states.

65. These other criteria must also be considered as tools to measure the EU added value:
    - equity criteria, for example participation within and between states; geographic diversity;
    - potential (positive) impact on EU health priority;
    - effective pan-European dissemination (see above);
    - improvement in healthy life years;
    - solidarity among member states within the EU;
    - extent to which targets have been reached;
    - contributing to the attainment of the EU 2020 targets, especially in terms of the inclusivity, sustainability and innovation targets;
    - cost benefit and opportunity costs analysis;
    - economies of scale and sustainable economic growth;
    - update, exchange, adaptation and implementation of best practices – practices that have a demonstrable (i.e. measurable) impact;
    - implementation of EU legislation;
    - degree of implementation in the different member states of the "Strategic Implementation plan of the European Innovation Partnership on Active and Healthy Ageing" (as this is the pilot programme of the first EIP). It would accurately measure EU added-value as this would represent a case where a European partnership facilitated by the European Commission has an impact at member state level and achieves concrete results;

- transferability – from project to real-life policy or practice settings in a specific number of MS;
- patient/user satisfaction;
- degree of user involvement;
- languages used in the project;
- increased health literacy, later onset of chronic disease, decrease in the rate of use of conventional;
- improved health outcomes due to enhanced prevention, promotion, self-management and screening, combined with appropriate use of medication;
- absenteeism at work matched by a resulting increase in productivity and, additional years of healthy longevity e.g. as has been agreed in the HAIP initiative;
- ability to pro-actively face societal challenges, which is a criterion for other EU strategies, such as the "Innovation Union";
- ability to promote inclusive growth, which is one of the three objectives of the Europe 2020 Strategy.

66. In the past, the EU HPF already proposed in the four key criteria as they are based on the Treaty and are not the responsibility of individual member states:
    - sustainable economic growth
    - protection and promotion of public health
    - equality among people
    - solidarity among Member States

67. Using Disability Adjusted Life Years (DALYs) might also be an appropriate means; targets could be set for reductions in DALYs over the next PHP period for specific conditions. But to use only these would be to enforce total utilitarianism; reduction of health inequalities needs to be addressed for social inclusion purposes, as well as a contribution to improved health status and to a more effective economy.

68. The link to implementation needs to be integrated into the planning of the programme. Not all projects involve implementation on the ground, but some will and thought needs to be given to how the funding provided through the programme can be linked to funds for sustained implementation, whatever source these come from. If this could be done, it would contribute to the goal of demonstrating European added-value.

69. We recognise that this particular conception of EU added value is difficult to systematically measure with quantitative analysis. Therefore, we encourage a strengthening of the evaluation procedures used in funded projects to incorporate methodologies that allow for the discrete added value to be articulated. This point links to the need for greater communication and dissemination of the results and outcomes of funded projects.

70. We would also like to stress the heightened importance of the Programme to certain EU12 member states, for whom the Programme is a crucial and efficient tool to build capacity in their health services and address the inequities in health between and within EU12 and EU 15 member states. Consequently, we welcome any efforts the Commission will take to promote the new Programme as method to tackle the social gradient in health across EU member states, with a particular focus on increasing participation of EU12 member states. Ultimately, the success of this approach will be an essential measure of EU added value

## 4) Indicators

**What kind of indicators do you think could help measure the impact of the PHP?**

71. Indicators should be coherent with the aims of the EU 2020 strategy. By clearly integrating the Programme into the objectives of several of the EU2020 Strategy initiatives, the Programme can thus be measured through its participation in helping to meet targets of the specific initiatives.

72. Objectives should either be seeking to produce outcomes and recommendations that feed directly into future policy development (as this the case with ICT for Health in which the epSOS project links to the development of the future eHealth Action Plan) or be used to augment the implementation of health policies.

73. In order to ensure the effectiveness and efficiency of the Programme, the ability to measure the outcomes of actions should be a criterion of perhaps equal importance to EU Added value.

74. In light of the EU 2020 Strategy goals and objectives, we also believe that it is important that the Programme demonstrates that health can and does lead to smart, sustainable and inclusive growth. However, we would discourage economic indicators from being used as the primary source for measuring the efficacy of the programme. We would support a range of health and wellbeing indicators to measure the impact of the programme. As we believe that the Programme should be orientated towards improving the wellbeing of citizens and focussed in reducing inequalities in health across the EU, it is logical that the impact of Programme is measured by such criteria and welcome the mainstreaming of asset-based indicators in the Programme. The benefit of this approach is that its successful outcome will inevitably lead to an improvement of economic circumstances through less absenteeism of the workforce, lower demand on health systems and so on (see above, under “EU added value”).

75. Health impacts several economic outcomes important to Europe 2020: wages, hours worked, labour force participation, early retirement, labour participation of those caring for a ill member of the household, education outcomes (good health in childhood reduces school absenteeism and early drop-out rates, The EU already monitors several of these economic indicators. Improvements or reductions in these indicators could also be tied to measure the impact of the PHP.

76. Eurofound, the European Foundation for the Improvement of Living and Working Conditions (a European Union agency, that provides expertise in the planning and design of better living and working conditions in Europe) conducted a pan-European” Quality of Life Survey” in 2003 and 2007. The data cover issues relating to income inequalities and deprivation; families, work and social networks; life satisfaction, happiness and sense of belonging; social dimensions of housing; urban/rural differences; participation in civil society; quality of work and life satisfaction; time use and work–life options over the life course. The survey was compiled into an interactive database of statistical quality of life indicators, EurLIFE. The EU could continue to conduct European Quality of Life Surveys and compare the data to monitor improvements on a regular basis.

77. The European Health Information Survey (EHIS) and the European Health Examination Survey (EHES) are both expected to become live within the next few years, and these could contribute. The EUROBAROMETER surveys and the OECD Better Life Index[4] could well be useful in this context. Based on various available indicator systems, the indicators developed in

[4] http://www.oecdbetterlifeindex.org/

the North West of England for “Living Well across Local Communities” could probably be used to monitor the success of the new PHP.[5]

78. Health parameters are likely to include:
    - age-specific and disease-specific death rates;
    - disease prevalence rates;
    - DALYs;
    - Healthy Life Years (HLYs);
    - health status indicators (e.g. body mass index, mental wellbeing, etc.);
    - health-related lifestyle indicators (e.g. diet, tobacco exposure, exercise, etc.)

79. In order to measure health inequalities and impact of the Public Health Programme, these indicators could be applied between member states and within them to distinguish health inequalities among European regions.
    - life expectancy at the age of 40;
    - healthy life days expectancy;
    - Disability Free Life Expectancy;
    - infant mortality;
    - chronic illnesses;
    - cardio vascular diseases;
    - tobacco and alcohol consumption; child obesity in year 6;
    - overweight; underweight population
    - mental and behavioural disorders (disease of nervous system);
    - psychoactive substance use;
    - fruits and vegetables consumption;
    - distance from general practitioner; distance from general hospital
    - medical practitioners per inhabitant;
    - satisfaction with the national health care system;
    - quality of national health service;
    - health care expenditure as share of GDP;
    - expenses within the health sector;
    - self- reported absence from work due to illness;
    - compensation for absence from work due to illness;
    - percentage reporting positive mental wellbeing;
    - level of health literacy;
    - percentage of people in need accessing prevention and care services
    - percentage of budget allocations to prevention services in comparison to total health expenditure[6];
    - coverage through mandatory national health insurances;
    - percentage reporting recommended levels of recreational exercise.

## 5) Ideas to motivate inactive MS

80. Low participation levels from MS may result from a number of causes (lack of awareness of the programme, issues with co-financing, lack of capacity to participate), and potential solutions will need to take into account all these dimensions and the specific issues within different MS.

[5] More information: http://www.nwph.net/hawa/details.aspx?pid=103&type=rep&id=2227
[6] http://www.oecd.org/topic/0,3699,en_2649_33929_1_1_1_1_37407,00.html

81. It is particularly important that the PHP is based on a robust analysis of the key issues facing MS in order that the calls have the highest possible salience, and that views from MS with historically low levels of participation are particularly sought out, to avoid any high-GDP bias in the issues selected. Priorities for the Programme could be discussed with relevant Commission working groups (such as Patient Safety/Quality, Workforce) and these fora could be used to promote the PHP to MS.

82. Lowering the administrative burden to participate in a project must be considered a prime objective. Often overly complex administrative procedures can act as a barrier to partnerships, especially for small civil society organisations with limited resources to fall back on. An effort to harmonise the administrative procedure of the PHP and other EU mechanisms would be a significant simplification.

83. Possible approaches might include:
    - education of health and finance ministers of MS on the association between healthy populations and GDP growth, on the main health challenges in Europe preventing such good health, and on potential EU actions, and actions within MS, needed to remedy these;
    - financial incentives by EU, e.g. 50% EU funding to support specific developments in MS;
    - optimisation of Structural Funds information distribution and improvement of Structural Funds programme management;
    - introduction of a proactive EAHC support desk going towards inactive member states with attractive projects which could be of interest and applicable to;
    - involving the inactive MS in the design of the call for projects, the call for projects. Their participation will ensure that projects will meet health needs in their country, thus increasing the possibility that local stakeholders will apply for projects;
    - collaboration with DG Regional Policy to ensure that European Regional Development Fund (ERDF) support to health projects is conditional upon support to specific health promotion commitments / specific collaboration with DG SANCO;
    - assisting MS not involved to develop relevant capacity (especially public health capacity) where serious capacity deficiencies are identified; and specifically targeted towards low-GDP countries (for example leadership development in health, or change management courses) could increase the number of participants from low-GDP MS and awareness of the Programme and its activities. Coordination with other initiatives and funding programmes (see above), for example the Structural Funds, may also increase participation;
    - organising high-level conferences or technical consultations about PH topics in MS with low participation levels as an instrument to deliver impulses and mobilise MS representatives
    - tackling language barriers which occur in the comprehension of EU terminology and applying it in the national context;
    - lowering the administrative burden to participate in a project. Often time overly complex administrative procedures can act as a barrier to partnerships.
    - calls for tenders, proposals, and projects dedicated to regions or countries with higher levels of health inequalities both within countries and countries that have a lower health status and lower life expectancy than the EU average.
    - more involvement of essential stakeholders in MS, e.g. a special initiative to educate and to collaborate with academic institutions and civil society representatives in MS, at which EU plans and priorities could be publicised;
    - the Commission should identify the specific healthcare problems in the inactive member states and try to address these problems at European level specifying the concrete benefits of member state participation through active communication, advice and guidelines;
    - Members of the European Parliament who are active in the different health policy problems of inactive member states could be encouraged to lobby their national parliaments and governments to get more involved by outlining the opportunities for such involvement;

- European Stakeholders could appeal to their national members to lobby the respective national governments to become more involved by outlining the opportunities for such involvement.

84. There is a great need for the western member states to transfer their knowledge to and help building the human capacity in the eastern countries in order to promote the project management capabilities in eastern Europe. Due to the fact that the relationship of national policies and health promotion is diverse in the member states, the connection between EU and national policies is not clear in the current practice.

85. In EU co-financed projects, the poorer, more disadvantaged countries (e.g. in central or eastern Europe) cannot provide as "own contribution" more than their own workforce (i.e. no contribution in cash) therefore they have less chances for project leadership or to participate in a project. Therefore, they are less able to promote their own interests during project development and implementation. In order to prevent this to happen in the future, EU should differentiate between the member states, and contribute financially more to those projects which are participated or lead by a representative of a disadvantaged country.

## 6) Resources

86. The Commission should reflect on the potential linkages between the PHP and other sources of Commission funding. Most obviously, making links to Structural Funds could address the geographical imbalance in take-up of existing projects, but links to the Framework Programme should also be considered. Given that the overall size of the programme is unlikely to be increased, this linking and catalyzing role of PHP projects becomes more important.

87. Within the Programme, there should be an appropriate balance of resources allocated to Joint Actions, Operational Funding and Project funding. Future Joint Actions should include relevant stakeholders as associate partners – this should be a pre-requisite. At the moment, there is a rather ad hoc approach to their involvement. The Commission can ensure that stakeholder representatives to Joint Actions are balanced as to interests, both in role and in numbers. The Commission can also help to ensure that Joint Actions foresee an adequate compensation mechanism for stakeholder involvement, so as not to deter those civil society representatives with limited resources.

88. Operational funding is absolutely critical to ensure representative NGOs in public health can play an effective role in civil dialogue processes at EU level. This funding should be awarded over the entire Programme period and the European Commission should envisage the development of multiannual financial frameworks for operating grants, in order to allow continuity and longer term planning for the funded organisations.

89. Projects could also be seen as a "spring board" to other EU funding Programmes on health (FP8, Information Society and Structural Funds), either as an exploratory "pilot", a laboratory for large-scale research, innovation, societal/health cohesion projects, or at end of the pipeline to act as a catalyst of ensure the outcomes of projects funded elsewhere become embedded in policy, systems and practice. This will help to reinforce the relevance of the Programme in the context of the wider, larger scale programmes and initiatives also tackling health.

90. Attention should be paid to how to make the Programme accessible to smaller NGOs, for example through simplification of procedures and appropriate financial rules.

91. A very cost effective way of tackling the economic crisis is community development, strengthening the resilience, social capital and coherence of local communities. Since

behaviour change can be best achieved through positive community models, community development is an important element of health promotion. Therefore, health promotion can be a good contribution to tackling social and economic crises. Recognising this fact, by building the evidence for need and implementation, can motivate member states to participate.

## 7) Conclusion

92. Close collaboration with stakeholders throughout the design and implementation of the Health Programme is essential to ensure that it remains relevant to the needs and realities of the healthcare settings.

93. We suggest for an overall improvement, that an external evaluation of the Commission communication strategy is conducted. With real communication know-how, EU added value would increase dramatically and the outcome would comprise a positive overall impact of the future EU Health Programme. More efficient communication could also result in more effective and improved value added of EC policy making.

94. Combating health inequalities must be conducted bearing in mind that there are wider economic underpinnings that have to be tackled over and above access to care.

95. The economic impact of not dealing with ill-health would be devastating to European economies and health care systems alike. Therefore, in order to achieve positive economic impact and growth in health as well as in a number of other policy areas, it is essential that the EU adjust the framework of the future Health Programme.

***Specific comments on letter from the Commission:*** *The "Safety, quality ….. of pharmaceutical devices" should presumably read pharmaceutical treatments and therapies.*

END – 28 June 2011

## 8) ANNEX: Members of the EU HPF Working Group on the Future of the PHP – post 2013

Contributions were received from:

- AAE - Aids Action Europe
- AESGP - Association of the European Self-Medication Industry
- ASPHER - Association of Schools of Public Health in the European Region
- EFCAM - European Federation for Complementary and Alternative Medicine
- EFPIA - European Federation of Pharmaceutical Industries and Associations
- EHMA - European Health Management Association
- EPF – European Patient Forum
- EPHA – European Public Health Alliance
- ER WCPT - European Region of the World Confederation for Physical Therapy
- ESQH: European Society for Quality in Health care
- EUROCARE - The European Alcohol Policy Alliance
- EuroHealthNet
- HOPE - European Hospital and Healthcare Federation
- IDF Europe – International Diabetes Federation
- IUHPE - International Union for Health Promotion and Education
- YFJ: European Youth Forum