Study supporting the final Evaluation of the 3rd Health Programme 2014-2020

Final report

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List of abbreviations

1HP	First Health Programme
2HP	Second Health Programme
3HP	Third Health Programme
AIR	Annual Implementation Report
AMR	Antimicrobial resistance
AWP	Annual Work Plan
Best-ReMaP	Joint Action on Implementation of Validated Best Practices in Nutrition
CARE	Common Approach for Refugees and other migrants' health
CHAFEA	Consumers, Health, Agriculture and Food Executive Agency
CHRODIS+	Joint Action on Chronic Diseases
CPMS	Clinical Patient Management System
DG	Directorate-General of the European Commission
DG-SANTE	Directorate-General for Health and Food Safety
DGA	Direct Grant Agreement
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
EHaction	Joint Action supporting the eHealth network
ERDF	European Regional Development Fund
ERN PaedCan	European Reference Network on Paediatric Cancer
ERNs	European Reference Networks for rare and complex diseases
ERWS	Early Warning and Response System
ESF	European Social Fund
ESI Funds	European Structural and Investment Funds
EU-JAV	Joint Action on Vaccination
EUnetHTA	European Network for Health Technology Assessment
GAPP	Joint Action on Good Practice Guidelines to authorisation and preparation process in blood, tissues and cells
GDP	Gross domestic product
GNI	Gross national income
HaDEA	The European Health and Digital Executive Agency
HCAIs	Healthcare-Associated Infections
HTA	Health Technology Assessment
ImmuHubs	Innovative Immunisation Hubs (Project)

IOM	International Organisation for Migration
iPAAC	Innovative Partnership for Action Against Cancer
JAHEE	Joint Action Health Equity Europe
JAMRAI	Joint Action on Antimicrobial Resistance and Healthcare-Associated Infections
JANPA	Joint Action on Nutrition and Physical Activity
MFF	Multiannual Financial Framework
Mig-HealthCare	Strengthen Community Based Care to minimize health inequalities and improve the integration of vulnerable migrants and refugees into local communities (Project)
MS	Member State
MyHealth	Models to engage Vulnerable Migrants and Refugees in their health, through Community Empowerment and Learning Alliance (Project)
NCA	National Competent Authority
NFP	National Focal Point
NGO	Non-governmental Organisation
OPC	Open Public Consultation
ORAMMA	Operational Refugee and Migrant Maternal Approach (Project)
RAHRA	Joint Action on Reducing Alcohol Related Harm
SCIROCCO	Scaling Integrated Care in Context (Project)
SGA	Specific Grant Agreement
SH-CAPAC	Supporting Health Coordination, Assessments, Planning, Access to Healthcare and Capacity Building in Member States under particular migratory pressure
TFEU	Treaty on the Functioning of the European Union
VISTART	Joint Action on Vigilance and Inspection for the safety of transfusion, assisted reproduction and transplantation
WHO	World Health Organisation
WP	Work Package

Abstract

This report supports the final evaluation of the third Programme for the Union's action in the field of health (2014-2020) (the Programme) and aims to assess its results and identify challenges and solutions with regard to its implementation.

The study found that the 3HP was largely relevant to the main health needs and responded to the needs of EU citizens. Furthermore, the 3HP proved to be flexible and adaptable to changes in health needs over time. Moreover, the 3HP was effective in achieving its objectives. In fact, it facilitated a more comprehensive and uniform approach to health issues across the EU while also contributing to improvements in health and healthcare policy developments.

The Programme was found to be cost-effective considering changes in the health landscape occurred over time. Over the implementation period, important efforts were made to improve its efficiency through simplifying and streamlining its procedures. The 3HP exhibited internal and external coherence, in particular with other financial instruments, such as Horizon 2020, and contributed to EU wider policies and priorities. Furthermore, it enabled mutual learning, knowledge exchanges and provided EU added value in different areas.

Four areas were identified to strengthen future health funding programmes and EU health action more broadly: building on relevant recommendations from the 3HP mid-term evaluation; improving the design of funding structures; facilitating and strengthening participation of all countries; ensuring sustainability. A set of recommendations is proposed.

Executive Summary

Purpose and scope of study

The Health Programme is the European Commission's main vehicle for funding collaborative actions to support public health in Europe. Its third iteration (The Third Health Programme, herewith the 3HP) ran for seven years from 2014 until 2020 and had a budget of EUR 449.4 million. The 3HP pursued objectives aimed at improving the health of Europeans and reducing inequalities by promoting health, encouraging innovation, boosting the sustainability of health systems and protecting Europeans from serious cross-border health threats. Funding was distributed to a variety of beneficiaries via the different funding mechanisms notably, Project Grants, Operating Grants, Direct Grants to international organisations, Joint Actions, Conferences, Health Award/Health Prize and Procurement contracts.

This report supports the final evaluation of the 3HP and has as its purpose to assess the main outcomes and results achieved and identify the main problems and solutions with regard to implementation, including regarding recommendations from previous evaluations. The research focused on five main evaluation criteria, namely the relevance, effectiveness, efficiency, coherence and EU-added value of the Programme.

Following the outbreak, in the first quarter 2020, of the COVID-19 pandemic in the EU territory, relevant actions funded by the Programme (2014-2020) were switched to their emergency mode and geared towards combatting the pandemic.

These actions are not included in the scope of the present study supporting the evaluation, since some of them were in early stage or in the middle of implementation at the time when this study was launched.

Methodology

The study used a mixed methodology comprised of three main aspects to assess the 3HP from different angles. These consisted of: (1) an assessment of the publicly accessible Programme database[1] as well as documents related to the Programme in order to build an understanding of the functioning of the 3HP; (2) consultations with stakeholders through interviews, focus groups, a targeted survey, an Open Public Consultation and through social media listening to understand their views of the Programme; and (3) an in-depth analysis of a sub-set of funded actions within six areas of the Programme (nutrition, alcohol, health inequalities, Anti-Microbial Resistance, Health Technology Assessments and vaccinations) presented in the form of case studies.

The study faced a number of challenges in accessing key sources of data which limited the extent of the assessment possible. Further, the number and variety of thematic priorities and individual funded actions precluded an in-depth study of them all. The study therefore sought to provide an update to the key findings of the mid-term evaluation, which functions as a baseline assessment, whilst investigating new issues arising after the mid-point of the Programme.

Key findings

Relevance

During the implementation of the 3HP, the main health needs identified across the EU related to health promotion and better and safer healthcare. However, there were also key

[1] Projects & Results (europa.eu)

needs related to health systems and health and social inequalities. Further, some health needs did change over time due to anticipated, and unexpected, developments.

The evidence examined in the present study indicates that the 3HP was largely relevant in that it addressed these health needs, particularly under objectives 1 (promote health, prevent diseases, and foster supportive environments for healthy lifestyles) and 4 (facilitate access to better and safer healthcare for Union citizens). This was a view largely held by consulted stakeholders and confirmed by an analysis of participating countries' priorities in their action plans. The involvement of participating countries in designing parts of 3HP was instrumental in ensuring the Programme was relevant.

The 3HP has for the most part remained relevant to changes in health needs over time and it was flexible enough to respond to the emerging health needs such as the migrant/refugee crisis in 2015 and the COVID-19 pandemic in 2020.

However, there were some factors which limited the relevance of the 3HP. For example, participating countries were not always engaged with shaping the programme, and stakeholders felt higher budgets could have helped address problems better. This may have led to some health problems not being adequately addressed. For example, some stakeholders felt it did not fully address problems around health inequalities, mental health, healthy environment, and child and infant health. However, it needs to be noted that there were several actions funded under the topics of mental health and health inequalities, nonetheless these were not always perceived to be adequately addressed, likely because they were not named as specific thematic priorities, so they did not receive proper emphasis.

The Programme was also relevant in that there was clear alignment between funded actions and the specific thematic priorities set out by the Programme, particularly for objective 1. Importantly, the funded actions were aligned with the Commission's wider priorities, which meant that actions funded under the Programme were directly relevant and responded to the needs of EU citizens, in particular in topic areas such as alcohol, and rare diseases.

Effectiveness

The 3HP has produced an array of positive effects during its implementation. This study found that the Programme has overall contributed to a more comprehensive and uniform approach to health issues across the EU in different policy areas (e.g., antimicrobial resistance, vaccination, health inequalities affecting vulnerable groups). However, some limitations exist, mostly due to national differences in terms of organisation of health systems and national priorities.

Moreover, the knowledge produced by the 3HP was used in policy making and the 3HP contributed to improvements in health and healthcare policy developments across the EU. The evidence gathered suggests that actions funded under the 3HP, including through Joint Actions and projects, influenced national strategies, helped establish national plans and led to the creation of national legislation in the area of health. This was especially the case in the fields of cancer, antimicrobial resistance (AMR), health technology assessments (HTA), mental health and alcohol. Some of the Programme's achievements also contributed to improvements in health and healthcare in the EU and at Member State level, in terms of implementation of best practices, coordination of efforts across Member States and changes to policy and practice at EU level. As an example, Joint Actions as a funding mechanism enabled important collaboration, fostered coordination efforts amongst Member States, facilitated the sharing of existing good practices and development of cross-collaboration on a number of pertinent topics. Similarly, the establishment of 24 European Reference Networks (ERNs) allowed for a high level of coordination between healthcare providers across Europe to tackle complex or rare medical diseases or conditions.

Funded actions contributed to achieving the 3HP objectives to a very good extent, in particular for objective 1 (promote health, prevent diseases, and foster supportive

environments for healthy lifestyles) and objective 4 (facilitate access to better and safer healthcare for Union citizens), although there were a few areas which were less addressed than others, including health security and socioeconomic determinants of health. The available data shows that the most effective funding mechanisms were Joint Actions and Project Grants. That being said, there were some factors which hindered the achievement of the 3HP objectives, and these have been found to limit the 3HP contribution to improvements in health across Europe. These factors were, however, mostly related to limitations at the national and beneficiary level (thus not directly attributable to the 3HP), including limited resources, capacity, political will and difficulties in engaging with stakeholders. Nevertheless, there is room for strengthened and more effective EU action to address those limitations and support Member States.

The exceptional utility criteria intended to facilitate higher participation of low-GNI countries in the Programme, and stakeholders did perceive the criteria as having a positive impact. However, low-GNI countries had a lower overall participation rate in 3HP actions as coordinators and partners when compared with high-GNI countries. Further, programme participation by low-GNI countries did not increase over time, and programme participation by low-GNI countries did not increase as compared to the 2nd HP (in fact, low-GNI countries coordinated fewer actions in 3HP compared to 2HP).

An important measure of effectiveness related to sharing and dissemination of Programme results. Our study suggests that 3HP results have, to varying extents, been published by the Commission services and by other stakeholders in scientific journals, and publications resulting from the 3HP have been used by stakeholders. It emerges that 3HP beneficiaries faced difficulties in publishing and disseminating the results of funded actions. While the observed limitations to the dissemination of 3HP results cannot be considered a shortcoming of the Programme itself, rather a responsibility of Programme beneficiaries, there is scope for the Commission to provide support to the dissemination of 3HP results by way of organising knowledge transfer activities.

An important milestone in the implementation of the Programme were the results of the mid-term evaluation. DG SANTE and its executive agency, HaDEA, have taken steps to address the 10 recommendations included in the 3HP mid-term evaluation. Evidence suggests that some of the recommendations have been addressed successfully. These include maintaining a focus on thematic areas of strong EU added value and strengthening and building links between the 3HP and wider Commission & EU policy agenda to maximise impact. Conversely, some recommendations were not sufficiently taken up, including spelling out how actions targeting health promotion and health systems should generate EU added value and investing in the resources necessary to improve systems for monitoring Programme implementation. The latter recommendations, alongside with those which were only partially met, should be followed upon in the context of the new EU4Health Programme (and beyond).

Lastly, the results of the 3HP were found to be sustainable overall, and examples of areas with high sustainability included HTAs, the Joint Action on AMR and the ERNs. Sustainability was aided by some elements of the Programme, such as the addition of an obligatory work package on sustainability in Joint Actions. From 2014, the sustainability work package was compulsory for all joint actions. Sustainability was also promoted through strong connections built between key stakeholders at the co-design stage of actions and throughout their implementation period. However, challenges to sustainability were also identified, such as a lack of political will in participating countries.

Efficiency

The assessment on the efficiency of the 3HP is primarily based on findings emerging from this study's consultation activities and evidence gathered to address other evaluation criteria. Data assessed in this study shows that the Programme was relatively cost-effective considering changes in the health landscape over its implementation period, and the size

and scope of funded actions undertaken. There was not significant deviation from planned resource budgets, and stakeholders consulted confirmed this, highlighting the positive impacts of work achieved with the resources allocated, even in cases where funding was not deemed to be wholly sufficient. Flexibility of funding allocation was particularly efficient and underlines a strong success factor of the Programme as a whole.

In some cases, the efficiency of the Programme was not as strong as it could have been due to elements of the Programme's design. Whilst operational and management costs were reasonable, administrative costs were sometimes disproportionately heavy, increasing workload of those involved in actions and potentially putting countries with low GDP or smaller organisations off becoming involved, or being involved in future work.

Further, the distribution of Programme credits among the four thematic priorities was efficient in that it addressed the key health needs identified during the implementation period, with funding allocation deemed critical to achieve expected results. A particular strength of the Programme was the flexibility of funding allocation, which for example allowed the Programme to respond to key health threats which emerged.

There were significant differences in costs and benefits between participating countries, as countries with lower GDP were less able to participate in the Programme (especially in coordinating roles) and Western European countries lead the most actions and received the most funding for actions. Accordingly, countries with less capacity and funding consequently did not feel the same benefits as other countries. Although the exceptional utility criteria increased participation of low GDP countries, differences in capacity still prevented these countries' fuller participation and they thus required further support from the 3HP.

Over the implementation period, important efforts were made to improve the efficiency of the 3HP through simplifying and streamlining Programme procedures including the introduction of electronic monitoring and reporting mechanisms. On the whole, these measures (particularly the digitalisation of the process/online platforms) did increase efficiency of the Programme and alleviate some administrative burden on applicants. However, there was some scope to simplify processes, especially in relation to applications for funding.

There was also some room for further improvement related to monitoring processes. Cost-effectiveness of actions could have been improved if there were a more centralised information system (either using existing systems in place within the Programme portal; or a new addition) dedicated to disseminating information about different funding to ensure synergies across projects, to better disseminate implemented actions, to coordinate projects, and to allow communication with project officers. Similarly, although there were benefits to the electronic reporting system, administrative burden associated with reporting was still high.

Coherence

3HP funded actions were aligned with the Programme's objectives and coherent with each other. Funded actions were found to be focused in relation to thematic priorities while also exhibiting useful synergies with one another, demonstrating high internal coherence. Further, the identified barriers to the effectiveness of the 3HP (i.e., lack of resources and lack of political will in Member States) do not relate to the internal and external coherence of the 3HP.

The 3HP overall encouraged cooperation and was aligned with other instruments financing health-related activities, in particular the European Structural and Investment Funds and Horizon 2020.[2] Moreover, 3HP funded actions systematically contributed to EU wider policies and priorities (i.e., the Europe 2020 strategy for smart, sustainable and inclusive growth in 2014-2015; the Juncker Commission's priorities in 2016-2019; and the Von der

[2] EU Framework Programme for Research and Innovation 2014-2020

Leyen Commission' priorities in 2020), and were aligned with wider international obligations, in particular the WHO common policy framework Health 2020 and the European Action Plan for Strengthening Public Health Capacities and Services. Lastly, the 3HP was coherent with other health-related EU policies and it has been aligned with Member States' strategies and initiatives in the field of health.

EU-Added Value

The 3HP provided added value compared to what could have been achieved by the EU in absence of the Programme and by Member States acting alone. In particular, the 3HP funded multiple actions which demonstrated strong EU added value by encouraging Member States to exchange best practices, cooperate and coordinate with each other on pertinent policy issues. Furthermore, the 3HP enabled mutual learning, knowledge exchanges and provided EU added value in different areas, especially in areas such as health promotion, health technology assessment, rare diseases and alcohol policy.

The seven added value criteria were well-defined and used in funding proposals to some extent. A significant proportion of stakeholders were not aware of the extent to which the criteria were well-defined or used, suggesting that there is scope to making the process of integrating the EU added value criteria in proposals clearer and more systematic. The criteria which were considered the most important comprised sharing of best practices and supporting networks for mutual learning, which corresponds to some of the areas where the 3HP funded actions provided stronger EU added value. Finally, the EU added value criteria remained relevant throughout the 3HP implementation period and are considered useful in the context of developing future health programmes and defining priorities most suited (and needed) in health policy at the EU-level.

Conclusions and Recommendations

The 3HP has been the European Commission's main vehicle for funding collaborative actions to support public health in Europe over the period 2014-2020. It ran for seven years and concluded at a time when the European and global health landscape was shaken by the COVID-19 pandemic. This evaluation assessed the 3HP relevance, effectiveness, efficiency, EU added value and coherence, in view of learning from the evaluation results and preparing for future EU action in health. The 3HP has largely been relevant in addressing the health needs expressed by European countries and citizens over the period of its implementation and it has adapted to changes in health needs over time, being flexible enough to respond to the emerging health needs such as, the migrant/refugee crisis and the COVID-19 pandemic. It has been effective in that it contributed to more cooperation and coordination amongst Member States and overall improvements in health policy developments across the EU. Its funded actions demonstrated added value and it created synergies with other national, EU and international policies addressing health. Despite the success achieved, there have been limitations to what the 3HP could have achieved, as described in the above synthesis. To address those limitations and ensure that EU action in health is fit for the complex and ever-evolving health landscape, this evaluation identifies a set of recommendations for EU action structured around four dimensions, summarised below.

Further building on the mid-term evaluation recommendations

Building on the mid-term recommendations, there should be a continued focus on areas of EU added value as they clearly emerged from the present analysis.

- Future EU action in the field of health should continue encouraging cooperation and coordination amongst Member States in areas such as rare diseases, HTA and eHealth, while also fostering exchange and implementation of best practices in the field of health promotion and disease prevention, in particular sub-themes which have emerged in importance.

Design of Programme and funding frameworks

Improving the outcomes and impacts of funding actions begin at design stage. A number of important findings across the main evaluation criteria pointed towards the design of funding structures and suggestions for improvement.

- Re-thinking of how cross-cutting policy issues can be integrated within the priority areas of the Programme. If there are key topics which represent important health needs, these should be given explicit attention and funding, rather than being included as a "cross-cutting issue". For example, in the 3HP, there were actions funded under the topics of mental health and health inequalities, however stakeholders did not always perceive these to be adequately addressed, likely because they were not named as specific thematic priorities- even if at certain moments during the Programme's implementation, funding and emphasis was provided.
- The flexibility and adaptability of the 3HP was one of its key strengths, and this should continue, which would pave the way for more flexibility in cases of sudden onset emergencies or changes in health needs. The Commission could consider some sort of formalised mechanism to protect such flexibility and ensure its sustainability in future Programmes.

Facilitating and strengthening participation of all countries

The participation of all EU countries in the Programme can only strengthen the outputs, outcomes and impacts. Full participation also has an impact on the added value of funded actions, and should remain an important factor for improvement.

- Structures should be put in place to remove barriers for countries with less resources. For example, increased resources at EU level dedicated to health issues would contribute to address the national difficulties in participating in the EU Health Programme. Further, an even stronger role of the Commission in brokering the existing knowledge and pooling the existing data would contribute to closing the knowledge gaps where needed while also steering national action. For example, the Commission could provide support to the dissemination of 3HP results by way of organising knowledge transfer activities (e.g., communities of practice, policy dialogues and other events).

Ensuring sustainability

The sustainability of funded actions can have a profoundly positive effect on EU and national health policies and systems. Guiding and actively supporting beneficiaries in conceptualising and implementing actions to foster sustainability is a key element of consideration for future planning.

- Mechanisms and support should be provided to ensure sustainability measures are planned or negotiated at the start of funded actions, so that the full responsibility of sustainability measures does not fall to Member States. Joint Actions have been particularly successful in this, due to certain focus and obligations on the sustainability aspects of the work and could be considered as good practice.

1. Introduction

This is the final report for the "Study supporting the final evaluation of the 3rd Health Programme (3HP)". The report provides a brief background to the 3HP, followed by an overview of the methodology used in this study before presenting an assessment of the relevance, effectiveness, efficiency, coherence and EU-added value of 3HP during its implementation period of 2014-2020. Annexes to this report contain supporting evidence alongside the research tools used for key evaluation activities.

1.1. Background to the Third Health Programme

1.1.1 Role of the Health Programme in the EU

The EU and its Member States face profound challenges in the field of health. This includes ongoing discussions related to the future of EU health, its role within the Multiannual Financial Framework (MFF) and more broadly health challenges related to increasing health inequalities, climate change, and access to universal health care coverage. All of these issues test the resilience of EU health systems and political structures. Further, the COVID-19 pandemic has highlighted the importance of a harmonised and collective response to cross-border health threats across EU Member States. Post-pandemic there will be a need to address longstanding challenges to health including the rising burden of chronic disease, harmful use of tobacco and alcohol, physical inactivity, cancers and communicable diseases, and the need for healthcare workforce planning, healthy ageing and the prevention of antimicrobial resistance. Tackling these challenges is key to ensuring the highest attainable standards of health as a fundamental right[3] for all people in the EU. Investment in the field of health also contributes to attaining EU goals including promoting the well-being of citizens, contributing to economic growth and exchange through the internal market, combatting social exclusion, promoting scientific and technological progress and enhancing cohesion and solidarity among EU countries.

In this context, the Health Programme is the European Commission's main vehicle for funding collaborative actions to support public health in Europe. Its third iteration (3HP) ran for seven years, under the MFF 2014 to 2020, and had a budget of EUR 449.4 million. The 3HP pursued objectives aimed at improving the health of Europeans and reducing inequalities by promoting health, encouraging innovation, boosting the sustainability of health systems, and protecting Europeans from serious cross-border health threats.

1.1.2. Legal basis for the Third Health Programme

The EU institutions can adopt legislation on those policy areas that have been mentioned in one of the EU treaties. The **Treaty on the Functioning of the European Union (TFEU)** provides the legal basis for the EU to act on the areas of interest of the 3HP, such as health protection, research, environmental protections or sustainability.

In 2014, **EU Regulation No 282/2014** of the European Parliament and of the Council repealing **Decision No 1350/2007/EC** established the legal basis and general objectives for the 3HP**. Article 3** of the regulation established specific objectives and indicators. The specific objectives of the Programme were to be achieved through actions that were established in line with the thematic priorities (listed in Annex I of the regulation). The programme, its evaluation and its results should be promoted with the help of Member States.

The 3HP Regulation enabled the EU to adopt health legislation in accordance with the **Treaty on the Functioning of the European Union (TFEU)** through **Article 6** which gives competences to the EU to carry out actions to support, coordinate or supplement actions of

[3] Article 35, Charter of Fundamental Rights of the European Union

the Member States, as well as Articles **114** (approximation of laws), **153 (**social policy), **168** (protection of public health), **179** (research and innovation) and **191** (environment).[3]

As stated in **Article 168 of the TFEU**, EU action must complement national policies and encourage cooperation between Member States. Therefore, the 3HP should contribute only where Member States cannot act individually or where coordination is the best way to move forward and achieve the stated results. Whilst Member States are responsible for the functioning of their health systems, there are specific areas where the EU can legislate, and others where the European Commission can support Member States' efforts.

EU added value criteria were integrated in the legal basis of the regulation and were expected to be used when establishing the Annual Work Programmes as well as in the procedure to evaluate proposals. Annex II of the regulation defines the specific criteria for establishing annual work programmes which adhere to an opinion of the Programme Committee. Hence, the Programme puts forward actions in areas where there is evidence of EU added-value on the basis of the following criteria: fostering best practice exchange between Member States; supporting networks for knowledge sharing or mutual learning; addressing cross-border threats to reduce risks and mitigate their consequences; addressing certain issues relating to the internal market where the EU has substantial legitimacy to ensure high-quality solutions across Member States; unlocking the potential of innovation in health; actions that could lead to a system for benchmarking; improving economies of scale by avoiding waste due to duplication and optimising the use of financial resources. Hence, the Programme puts forward actions in areas where there is evidence of EU added value on the basis of those established criteria.

1.1.3. Implementation of the Third Health Programme

Management of the Programme

The 3HP was implemented by the Directorate-General for Health and Food Safety (DG SANTE) and by the Consumers, Health, Agriculture and Food Executive Agency (Chafea), based in Luxembourg.

Every year, Annual Work Plans (AWPs) set out the priority actions and propose an indicative allocation of financial resources. AWPs are developed by the European Commission and adopted through consultation with the Programme Committee which is made up of a representative from each Member State. On the basis of the priorities in the AWP, DG SANTE and Chafea issued calls for proposals for the different funding instruments.

Chafea was closed on 31 March 2021 and further to this closure, the newly created European Health and Digital Executive Agency (HaDEA) is in charge of managing the legacy of the 3HP and new EU4Health programme (2021-2027) which succeeded the 3HP.

Another aspect of the implementation of the Programme is the National Focal Points (NFPs) which are national experts for the Health Programme in participating countries. NFP representatives are appointed by their national health ministries. NFPs assist in implementing the health programme at national level, disseminating the results of the Programme and assisting with informing about the impact of the Programme at national level.

Distribution of funding

Through 3HP, funding was distributed to a variety of beneficiaries via seven different instruments (including Project Grants, Joint Actions, Presidency Conferences, Operating Grants, Direct Grants to international organisations, Health Award/Health Prize and Procurement contracts). Actions undertaken through the 3HP were organised under 4 Specific Objectives and 23 thematic priorities as shown below.

Table 1. Specific Objectives and Thematic Priorities of the 3HP[4]

Specific Objectives	Thematic priorities
1. Promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle	1.1. Risk factors such as use of tobacco and passive smoking, harmful use of alcohol, unhealthy 1.2. Dietary habits and physical inactivity 1.3. Drugs-related health damage, including information and prevention 1.4. HIV/AIDS, tuberculosis and hepatitis 1.5. Chronic diseases including cancer, age-related diseases and neurodegenerative diseases 1.6. Tobacco legislation 1.7. Health information and knowledge system to contribute to evidence-based decision-making
2. Protect Union citizens from serious cross-border health threats	2.1. Additional capacities of scientific expertise for risk assessment 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
3. Contribute to innovative, efficient and sustainable health systems	3.1. Health Technology Assessment 3.2. Innovation and e-health 3.3. Health workforce forecasting and planning 3.4. Setting up a mechanism for pooling expertise at Union level 3.5. European Innovation Partnership on Active and Healthy Ageing 3.6. Implementation of Union legislation in the field of medical devices, medicinal products and cross-border healthcare 3.7. Health information and knowledge system including support to the Scientific Committees set up in accordance with Commission Decision 2008/721/EC
4. Facilitate access to better and safer healthcare for Union citizens	4.1. European Reference Networks 4.2. Rare diseases 4.3. Patient safety and quality of healthcare 4.4. Measures to prevent antimicrobial resistance and control healthcare-associated infections 4.5. Implementation of Union legislation in the fields of tissues and cells, blood, organs 4.6. Health information and knowledge system to contribute to evidence-based decision-making

Funding was issued under 3HP via seven **financial mechanisms** as shown below in Table 2.

Table 2. Financial mechanisms

Financial mechanisms	Description

[4] European Commission (2020) Health Programme Factsheet. Accessible: https://ec.europa.eu/chafea/health/programme/documents/factsheet-hp_en.pdf

Project Grants	Grants for organisations responding to calls for proposals to research, develop or explore a public health issue.
Joint Actions	Partnerships between key Member State authorities and other designated beneficiaries to develop/share/refine/test tools, methods and approaches to specific issues or activities, and engage in capacity building in key areas of interest.
Operating Grants	Financial contributions to non-governmental organisations that pursue one or more of the specific objectives of the 3rd Health Programme. Recipients are expected to assist the European Commission with information and advice necessary for developing health policies and implementing 3HP objectives and priorities. They are also expected to work towards increased health literacy and promotion of healthy lifestyles, and also on organising science policy conferences and contributing in the optimisation of healthcare activities and practices by providing patients' feedback and facilitating communication with patients, therefore empowering them.
Presidency Conferences	Thematic conferences to mark the rotating Presidency of the EU by Member States, held on particular health-related topics.
Direct Grants	Direct grants are signed with international organisations active in the area of health.
Procurement contracts	Cover specific needs related to the support of EU health policies including studies and evaluations and the development and maintenance of IT systems.
Health Award/Health Prize	The Health Award/Health prize was launched to recognise and encourage innovative initiatives that promote public health.

1.1.4. Scope of the study

This study supports the final evaluation of the 3HP and has as its purpose to assess the main outcomes and results achieved and identify the main problems and solutions with regard to implementation, including regarding recommendations from previous evaluations. The study aims to provide evidence, appraise progress made in attaining the actions within the 3HP and establish whether the expected benefits materialised. The study builds on previous evaluations of the EU Health Programmes including the mid-term evaluation of 3HP[5], the mid-term and ex-post evaluation of the 2HP and 1HP. The scope of the study is summarised in Table 3 below.

Following the outbreak, in the first quarter 2020, of the COVID-19 pandemic in the EU territory, relevant actions funded by the Programme (2014-2020) were switched to their emergency mode and geared towards combatting the pandemic.

These actions are not included in the scope of the present study supporting the evaluation, since some of them were in early stage or in the middle of implementation at the time when the study was launched. The emergency actions to combat the COVID-19 pandemic were mostly launched in the early stages of the pandemic, before the adoption of the EU4Health Programme (2021-2027)[6], which succeeded the Third Health Programme 2014-2020.

The comprehensive EU response to COVID-19 was evaluated through a continuous process of assessment of actions and measures and lessons learnt, which have been the subject of several Commission communications, including the Communication on drawing the early lessons from the COVID-19 pandemic[7], the Communication on short-term EU health

[5] European Commission (2017b) Mid-term Evaluation of the 3rd Health 2014-2020 under Regulation (EU) No 282/2014 on the establishment of a third programme of Union action in the field of health (2014-2020) Available at: https://ec.europa.eu/health/sites/health/files/programme/docs/2014-2020_evaluation_midtermreport_en.pdf

[6] Regulation (EU) 2021/522 of the European Parliament and of the Council of 24 March 2021 establishing a Programme for the Union's action in the field of health ('EU4Health Programme') for the period 2021-2027, and repealing Regulation (EU) No 282/2014 (*OJ L 107, 26.3.2021, p. 1–29*)
EUR-Lex - 32021R0522 - EN - EUR-Lex (europa.eu).

[7] European Commission, (2021), Communication on drawing the early lessons from the COVID-19 pandemic.

preparedness for COVID-19 outbreaks[8], the Communication on EU Strategy for COVID-19 vaccines[9], the Communication on Preparedness for COVID-19 vaccination strategies and vaccine deployment[10], the Communication on EU Strategy on COVID-19 therapeutics[11], and the Communication on EU Global Health Strategy[12].

Table 3. Scope of the study

	Scope
Thematic	23 thematic priorities across 4 specific objectives that aimed to promote health, prevent disease, and foster healthy lifestyles; protect citizens from serious cross-border health threats; contribute to innovative, efficient and sustainable health systems; and facilitate access to better and safer healthcare
Geographic	All EU Member States, two EEA countries (Norway and Iceland), and third countries Serbia, Bosnia Herzegovina and Moldova
Temporal	Programme implementation period 2014-2020 (the response to the COVID-19 crisis is out of scope)
Financial	7 funding mechanisms and a total budget of €449,5 million
Legal	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/EC

[8] European Commission, (2020), Communication on short-term EU health preparedness for COVID-19 outbreaks.
[9] COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE EUROPEAN COUNCIL, THE COUNCIL AND THE EUROPEAN INVESTMENT BANK EU Strategy for COVID-19 vaccines, COM (2020) 245 final, https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52020DC0245

[10] COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL Preparedness for COVID-19 vaccination strategies and vaccine deployment, COM (2020) 680 final https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52020DC0680
[11] COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE COUNCIL, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS EU STRATEGY ON COVID-19 THERAPEUTICS COM/2021/355/final
[12] COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE COUNCIL, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS on EU Global Health Strategy COM/2022/675 final.

2. Methodology

In order to assess the Programme according to the 22 evaluation criteria detailed in Annex 2, a three-phase approach was devised as illustrated in Figure 1.

Figure 1. Three-phase approach to the study

2.1. Building an understanding of the Programme

The first phase of the study involved gathering contextual information on the background, structure, functioning and implementation of the 3HP. The steps taken under this phase are outlined below.

- Firstly, **discussions with DG SANTE and HaDEA** on the scope of the study, data availability and overview of the functioning of 3HP were held during the early stages of the study.
- Then, the study team **identified relevant stakeholders** within seven stakeholder groups,[13] to be consulted with in latter phases of the study. Relevant stakeholder groups were identified for this study to ensure a varied and robust response to the evaluation questions and full understanding of the programme. The study team prepared a stakeholder engagement strategy to detail how stakeholders were to be involved in the study.
- An **analysis of the Programme database** was carried out. Web scraping of the publicly available HaDEA database[14] on funded actions was conducted, with the aim of developing a single output database containing relevant collated information and to inform the study team of the main funded actions, participating entities, and the geographical and temporal scope of actions falling within this evaluation study. The output of the web scraper contained all publicly available information about all funded actions in the database (as of 22/07/2021).
- **In-depth review of 61 preliminary documents**[15] relating the context, legal and financial basis of 3HP.
- **Main document review** covering documents that confirm the implementation status of 3HP activities, and strategic documents which shed light on the evolution of the 3HP to evolving needs and priorities. Through this review, the national health strategies and plans, as well as specific health strategies such as HIV/AIDS action plans, of all countries in the scope of the present study were reviewed and the priorities were extracted and mapped to the objectives of the 3HP.

[13] Public authorities (central government/ministries of health, and public health authorities or agencies); Academic/research organisations; Non-governmental organisations; EU citizens; Patients and service users and organisations representing them; Consumer organisations; Company/business organisations; Other (international organisations e.g. WHO, OECD; Healthcare service providers; Organisations presenting healthcare service providers; Healthcare professionals' associations; Independent experts)

[14] Projects & Results (europa.eu)

[15] Consisting of previous evaluations of the European Commissions' health programmes, as well as relevant EU health strategy documents and legal texts on the functioning of the health programmes

- Five **scoping interviews** were carried out with representatives from DG SANTE and Programme Committee members, to better understand differing perspectives of 3HP, including successes and gaps, administrative issues, and the varied funding mechanisms
- An **in-depth analysis of a sample of 18 funded actions** relating to the case study topics[16] was carried out. Relevant documents were reviewed, and discussions were held with key stakeholders within DG SANTE and HaDEA to inform the development of the case studies.

2.2. Consulting with stakeholders

In-depth stakeholder consultations were carried out over the course of the study: an Open Public Consultation, a targeted survey, interviews, focus groups and social media listening as elaborated below.

- The **Open Public Consultation** (10 March – 10 June 2022) provided the general public, and all interested parties, with the opportunity to provide information and opinions on the matters to be addressed in this study. The OPC was targeted at all those who have an interest in the 3rd Health Programme but who had not necessarily been directly involved in the Programme design or implementation. Questions were therefore relatively high-level, exploring the overall perception of the Programme, and its relevance to broader health needs and objectives. A total of 69 responses were received.[17]
- The **targeted stakeholder survey** (10 March - 13 May 2022) collected further evidence on the views and perceptions of those with direct experience of the Programme regarding its relevance, implementation and performance. The survey was targeted at all those who have been directly involved in the Programme design and/or implementation (including those having received funding from the Programme) and who were therefore able to answer relatively specific and more detailed questions on the implementation and performance of the Programme.
- 34 **Stakeholder interviews** were carried out from April to July 2022 to help the study team to understand in more depth the design and implementation of the 3HP. They were also used to cross-check and triangulate with findings drawn from other data collection tasks and to fill gaps in evidence collected through other tasks.
- Five online focus groups were conducted (May to June 2022) to gain further insights into the main funding mechanisms of the 3HP[18]. Between three and 10 stakeholders took part in each focus group, which lasted for up to 4 hours.
- **Social media listening[19]** was conducted to extract data from Twitter between July 2020 – July 2022 to understand coverage and trends of discussions on the six case study topics of the study.[20]

2.3. Analysis and synthesis

Once all data from desk research and consultations with stakeholders was gathered, in-depth analysis and synthesis was undertaken, as detailed below.

[16] Alcohol, Antimicrobial resistance (AMR), health inequalities, nutrition, Health Technology Assessment (HTA), and vaccinations

[17] Three responses were identical (including responses to open-ended questions), and so they have been considered as one response. The analysis therefore focused on 67 responses.

[18] Project Grants, Operating Grants, Joint Actions, Procurement contracts, and a final focus group on all funding mechanisms. Due to a lack of participation and availability of DG-SANTE and HaDEA staff, the fifth focus group was ended early, and follow-up interviews were scheduled instead.

[19] Social media listening is the process of tracking social media platforms for mentions and conversations related to a topic, then analysing these for insights.

[20] Alcohol, Antimicrobial resistance (AMR), health inequalities, nutrition, Health Technology Assessment (HTA), and vaccinations

Analysis and synthesis

The purpose of the analysis and synthesis phase was to draw together the data sources generated from the study, to allow for the identification of patterns, divergences and convergences in findings per evaluation criteria. Data sources were analysed separately to identify key findings per evaluation question. The findings were compared per evaluation question across the study activities, noting divergence and convergence of evidence and accounting for differences in views per stakeholder group. In preparation for analysis, data was organised into useable formats, e.g., writing up interview notes and focus group notes, cleaning and organising OPC and targeted survey data files. Then, data was analysed as below.

Qualitative data analysis

The following steps were carried out to utilise qualitative data gathered through the document review and stakeholder consultations:

- The study team drew out key findings from the document review to provide documentary evidence relating to each relevant evaluation question.
- Relating to the funded actions database, qualitative information including abstract, priority area, and coordinator, was analysed related to each relevant evaluation question.
- Open-ended questions from the OPC and targeted stakeholder survey were manually reviewed and coded for key themes.
- The notes from the focus groups were reviewed and key findings were summarised by evaluation criteria.
- The notes from the interviews were reviewed and coded into a master file showing key issues by stakeholder group. This was then reviewed by evaluation criteria and trends were summarised into the final report.

Quantitative data analysis

The following steps were carried out to utilise quantitative data gathered through the document review and stakeholder consultations:

- Responses to close-ended questions within the OPC and targeted stakeholder survey were processed using univariate analysis (proportions, averages), disaggregated by question and key variables. Responses were also processed using bivariate analysis, including cross-tabulations.
- Tables and graphs of key points were created for the social media listening and further explanatory text was drafted to provide insights into these findings.

Case studies

The case studies provide a deep dive on a specific theme within 3HP. The study team used the approach of contribution analysis[21] to enable the identification of concrete links between thematic objectives and their specific outcomes and impacts. The level of contribution from the 3HP at each of these steps was considered based on a thorough review of the evidence; as well as other contributing factors in influencing the outcomes.

[21] Contribution analysis involves unpacking the intervention logic for specific activities of 3HP, isolating the hypothesis (or hypotheses) underpinning the various steps involved – e.g., from outputs to outcomes, or from outcomes to impacts – and exploring to which extent the evidence available supports the hypothesis.

The case studies were used to provide evidence to answer evaluation questions Q4a[22], 4b[23], 4c[24], 5[25] and 9a[26], related to the effectiveness of the Programme. Additionally, findings from the case studies were used to provide evidence to answer other evaluation questions as needed. As an example, please see Q4 (on page 35) for the case study on European response to the challenges related to vaccination, and Q5 (on page 40) for the case study on alcohol.

2.3.1. Limitations and robustness of study findings

Key strengths of the study include the identification of links between inputs, outcomes and impacts of specific actions of the Programme, which was achieved through the use of contribution analysis and presented in the case studies of the Programme (see Annex 3). Furthermore, despite challenges in engaging stakeholders as outlined below, the study engaged with a rank of stakeholders from across the main groups identified through the study. Engagement with those involved in the management and design of the Programme was particularly high through the interview and focus group consultations. The study team was therefore able to corroborate insights from such relevant stakeholder groups across the multiple consultations to yield reliable evidence and data to produce a thorough assessment underpinning this study. Additionally, the extensive document review provided a solid basis for the study and generated key line of enquiry to be investigated through the stakeholder consultations.

However, a number of limitations apply to this study relating to unavailability of data relating to the 3HP including elements regarding financial information, and varying degrees of stakeholder engagement potentially due to the timing of the study (being undertaken after the commencement of the EU4Health Programme) and the number of other public-health priorities being faced by all relevant stakeholder groups during the study period (COVID-19, war in Ukraine).

The study team had access to the *public-facing* database for the Programme. This database only includes partial information about projects (the public information does not include all funding mechanisms, nor all types of outputs)[27]. Thus, the analysis of the database may be limited or may not be representative due to the types of funded actions which are included. As not all of the actions of the Programme are included in the publicly accessible database, this means the analysis conducted on the basis of this information alone may be limited.. To mitigate this risk, complementary data were provided to the study team, providing additional information.

Moreover, through the consultations undertaken as part of this study, stakeholders were able to provide feedback on all ongoing actions as well as completed actions, regardless of their implementation maturity, as long as they fell under 3HP funding.

Due to the limitations of the public-facing database, specific data requests were made to DG SANTE throughout the evaluation to fill these gaps. For example, DG SANTE provided the study team with a comprehensive list (in excel format[28]) of the procurement contracts concluded under the Programme. Additionally, information on procurement contracts was

[22] To what extent has the Programme contributed to a more comprehensive and uniform approach to health and healthcare in the EU

[23] To what extent has the Programme contributed to improvements in health and healthcare in the EU and at Member State level?

[24] To what extent has the Programme contributed to the EU's influence on health and healthcare standards, policies and practices at international level?

[25] Case study on HTAs also answered EQ5 "To what extent have the Programme's objectives (general and specific) been met?"

[26] To what extent are the Programme results and effects likely to be sustainable?

[27] The publicly accessible database contain information on actions funded through grants agreements (344 for the whole Programme) but does not contain information on the procurement contracts concluded over the Programme implementation period

28 Extracted from DG SANTE's financial data warehouse

provided in the staff working documents of the Commission, accompanying the annual reports on the implementation of the Programme from 2014 to 2020.

Relating to the exceptional utility criteria, comprehensive information (e.g. on the success rates of applicants seeking to benefit from the exceptional utility criterion; resources allocated to increasing participation from low GDP countries over the Programme period; a sample of funding proposals to assess the extent to which each of the exceptional utility criteria were applied in funding proposals) was not available, which limited the depth of analysis possible when assessing the effectiveness of the exceptional utility criteria. To mitigate the consequences of this data gap, the list of grants successfully awarded under the exceptional utility criteria (i.e., 80% of EU co-funding) was extracted from the Commission Sygma/Compass database and made available to the study team in the last phase of the evaluation study.

Regarding the stakeholder consultations, a full list of stakeholders who participated in the Programme and their contact details was not available to the study team. The study team mitigated the consequences of this issue and overcame the difficulty by defining a list of specific organisations within each group based on the public facing database of the 3HP which listed ‘coordinator’ and ‘partner’ organisations. Through desk research, the study team collated a stakeholder contacts database. This included names and organisations to be consulted for each stakeholder group and contact details where publicly available. Occasionally, interviewees recommended relevant stakeholders who were approached to fill gaps in the study. This limited the comprehensiveness of the consultations as not all stakeholders were contacted to participate in the study. Further, the specific named persons involved in the Programme may not have been contacted. Both of these factors may have affected the number of responses received to the consultations.

An overview of the strengths and limitations of our approach to each aspect of the study can be found in Table 4 overleaf.

Table 4. Overview of strengths and limitations of the study

Research tools	Description	Strength of the collected evidence
Secondary data collection tools		
Document review	• 3HP Implementation documentation: 37 • Strategic Documents (policies/reports) to support assessment of the relevance of the 3HP: 32 documents + Member State Strategies from 33 countries • EU-level collected data on health indicators to support assessment of the relevance of the 3HP: 16 Eurobarometer databases and 16 Eurostat databases for a total of 32 databases.	• **Mixed quality:** The documents specifically about the 3HP provided a lot of useful information about its implementation. However, many of the documents did not refer specifically to the 3HP and therefore their usefulness was limited. Further, many of the documents did not provide information about the outcomes of the programme's funded actions. • **Limitations**: The study team reviewed documents in English only. Relevant documents in other languages were not assessed, however gaps in evaluation questions were assessed throughout and gaps were filled through targeted document searches or through consultation data.
Mapping of the public-facing HaDEA database on funded actions	• A web scraper was built using the open-source programming language Python. • All publicly available information on the funded actions listed in the HaDEA database was extracted and compiled. • Funded actions details were aggregated to form a single searchable dataset.	• **Medium quality:** The study team undertook all of the analysis that was possible from the public-facing database. Details were captured on the characteristics of the funded actions. • **Limitations**: This approach was limited to the funded actions that are available on the database, and the level of detail that the database provides. This approach did not capture any funded action details that are not contained on the public-facing HaDEA database of funded actions including relating to procurement contracts. To mitigate this, DG SANTE shared information on certain funded actions (for example procurement contracts) with the study team.
Primary data collection tools		
Open public consultation	• OPC was launched on EUSurvey and ran from 10 March – 10 June 2022. • OPC targeted all those who had an interest in the 3rd Health Programme but who had not necessarily been	• **Medium quality:** All interested stakeholders were able to take part in the OPC within the consultation period. 67 unique responses were received to the OPC.

Table 4. Overview of strengths and limitations of the study

Research tools	Description	Strength of the collected evidence
	directly involved in the Programme design or implementation. • Questions were therefore relatively high-level, exploring the overall perception of the Programme, and its relevance to broader health needs and objectives.	• **Limitations**: Ten respondents had only very basic knowledge of the Programme (15%), and eight said they had no knowledge of it at all (12%).
Targeted stakeholder surveys	• Survey was launched on Qualtrics and ran from 10 March to 13 May 2022. • The survey targeted those who had been involved in the design or implementation of the Programme. • The questions asked in the survey covered the following themes: effectiveness, efficiency, relevance, coherence, and EU added value.	• **Medium-low quality:** 32 responses were received to the survey. • **Limitations**: Due to the small sample size, it was not possible to report on whether differences between stakeholder groups were statistically significant. Further, no responses were received from stakeholders directly involved in the evaluation of the Programme, limiting the evidence base for the study on this topic.
Stakeholder interviews	• Virtual / telephone interviews were conducted from 21 April to 29 July 2022 • Interviewees were selected based on their field of knowledge and expertise, their level of involvement with the Programme and on their likely ability to provide information on various key issues of the evaluation. Topic guides were tailored to explore points in the areas the interviewees were knowledgeable about	• **Medium-high Quality:** 34 interviews were completed with a good coverage across stakeholder groups. • **Limitations**: Targets were not met for some stakeholder groups but despite this, there was good coverage across the areas of the study. Further interviews with government policy makers including members of the Programme Committee and National Focal Points may have deepened the level of analysis possible for some evaluation criteria.
Focus groups	• Five online focus groups with key stakeholders were conducted to gain further insight into the main funding mechanisms of the 3HP, as well as cross-cutting issues emerging from previous desk and field research. • Each focus group covered a different funding mechanism of the Programme	• **Medium quality:** There were between seven and ten participants in the first four focus groups. The final focus group consisted of three participants (see below). Participants were generally engaged in the discussions and there was sufficient time allocated to discuss the topics in question. • **Limitations**: Focus groups were not representative of all thematic areas of the Programme. The last focus group on all funding mechanisms was ended early due to a lack of

Table 4. Overview of strengths and limitations of the study

Research tools	Description	Strength of the collected evidence
		availability of participants and follow-up interviews were arranged instead.
Social media listening	• Social media listening was used to extract data from Twitter between July 2020 – July 2022 to understand coverage and trends of discussions on the six case study topics of the study (alcohol, nutrition, health inequalities, anti-microbial resistance, health technology assessments and vaccinations)	• **Medium quality:** • Due to the large volume of data that the search garnered, a sample of 20,000 tweets was used. 67% of the tweets were from users located in the UK, followed by 10% in Ireland. • **Limitations**: Limitations in accessing historical data for Twitter using TalkWalker meant that the exercise did not cover the entirety of the Programme, but rather the last 2 years. • Whilst hashtags are often not translated and tweets were extracted in multiple languages, the search terms being in English likely resulted in an English language bias.

3. Findings of the study

Section 3 provides the main findings gathered as part of this study, structured per evaluation criteria. Each sub-section begins with an assessment of the baseline situation preceding this evaluation: both at the start of the 3HP (in 2014; this is mainly based on the ex-post evaluation of the 2HP[29]) and at the midpoint (in 2017; this is mainly based on the mid-term report[30]).

3.1. Relevance

This criterion seeks to assess the relevance of the 3HP, including whether its objectives and priorities have been relevant to health needs across the EU, if thematic priorities were sufficiently covered by the funded actions to achieve the Programme's objectives and Commission's wider priorities, and the relevance of the Programme to EU citizens and their needs.

3.1.1. Q1. To what extent have the Programme's scope, including its objectives and priorities been relevant to health needs across the EU, considering their evolution over the evaluation period?

This section assesses the extent to which the objectives and priorities of the Programme, its actions and other activities, address health and healthcare needs and problems at EU-level over the evaluation period (over time and up until 2020). The assessment draws together the evidence collected through desk research including a detailed mapping of participating countries' priorities, consultation activities, as well as case study findings on health inequalities.

The study's results demonstrate that the main health needs in the EU during the 3HP programming period related to health promotion and better and safer healthcare, and that the 3HP has been largely relevant to these needs; therefore, the 3HP was relevant across the four objectives and addressed key health needs. Further, the 3HP, for the most part remained relevant to changes in health needs and a rapidly shifting health landscape over time, such as increased migration (including migrant/refugee crisis of 2015) and cross-border health threats (namely the COVID-19 pandemic). However, there were a few limiting factors to relevance, and there were a few key health needs which were not addressed adequately by the Programme. The following subsections presents the evidence base/findings that substantiate this assessment.

Main health needs in the EU during 3HP (Q1a)

The mid-term evaluation of the 3HP identified a set of public health and healthcare needs and problems at the time when the Programme was established in 2014.[31] These needs have remained relevant throughout the full implementation of the Programme (2014-2020), as reflected in their identification as priority areas for participating countries and as highlighted by all consulted stakeholders.

- During the implementation of the 3HP, the main health needs identified across the EU related to health promotion and better and safer healthcare. A mapping undertaken

[29] Coffey International Development., 2015. Ex-post Evaluation of the Health Programme (2008-2013) Final report [online]. Available from: https://ec.europa.eu/health/system/files/2016-11/ex-post_ev-hp-2008-13_final-report_0.pdf [Accessed November 2020].

[30] Coffey International Development., 2017. Mid-term Evaluation of the third Health Programme (2014 – 2020) Final Report [online]. Available from: https://ec.europa.eu/health/sites/health/files/programme/docs/2014-2020_evaluation_study_en.pdf [Accessed November 2020].

[31] An ageing population, threatening the financial sustainability of health systems and causing health workforce shortages; A fragile economic recovery, limiting the availability of resources to invest in healthcare; An increase in health inequalities between and within Member States; An increase in the prevalence of chronic disease; Pandemics and emerging cross-border health threats; The rapid development of health technologies; Increase in mental health problems (particularly among the young); Other specific emergency situations which expose EU health professionals to unprecedented challenges (for example, dealing with the repercussions of the large increase in refugees); and Threats to environmental health such as air quality and pollution monitoring.

during this study of the national health strategies in the participating countries[32] revealed that the most common priority area reflected in country-level health strategies analysed was objective 4. Better and safer healthcare (72 priorities; 40%). Key health needs which relate to this objective included the visibility of rare diseases and patient safety and quality of healthcare.

- The second most common priority area was objective 1. Health promotion (65 priorities; 36%), also confirmed by multiple consultees (academia/research stakeholder and numerous NGOs). who reported that the promotion of healthy behaviours (objective 1) was a key health need in the EU. Published data also shows the main health needs among participating countries have been related to risk factors including drug-related damage and chronic diseases. In the EU between 2014 and 2017 deaths from mental and behavioural diseases increased by 31.2%.[33] This included deaths from dementia, mental and behavioural disorder due to drug dependence, harmful alcohol use, and other behavioural and mental health disorders.[34] Note that many of these conditions were covered by objective 1 (promote health, prevent diseases, and foster supportive environments for healthy lifestyles) in the 3HP, however, mental health is not included in the thematic priorities of the Programme. This has been identified as a gap in the Programme and is discussed in the sub-section below on the needs which the 3HP did not address.
- Health and social inequalities also represented a key health need in the EU as there are important health differences across regions and socio-economic groups, which was reported by several interviewed stakeholders.[35] Some of the priorities of participating countries also related to health and social inequalities (12 priorities; 7%). Stakeholders mentioned specific groups or specific inequalities within the EU which needed to be addressed, including women and children (specifically migrant women) (academic/research stakeholder, as well as OPC respondents), children with cancer and survivors across Europe (there are big health inequalities, for example survival rates differ largely between Eastern and Western Europe and there are large variations in access to healthcare) (healthcare professionals' organisation), and populations such as homeless people, sex workers, and migrants, which require intersectional approaches (NGO).
- Some of the priorities of participating countries also related to objective 3. Health systems (24 priorities; 13%); further specific needs under objectives 1, 4, and 3 are given in A5.1 in Annex 5.
- Health threats (objective 2) was not a major identified need during Programme implementation. Furthermore, this objective was not identified by stakeholders as being a key health need, and this was not a topic which was included in many countries' priorities (only 7 Member State priorities related to this need; 4%). This may be due to a perception that health threats are a topic to be addressed at the EU and/or international level due to its cross-border nature, but also given the dynamic and fast changing nature of health threats. Similarly, rare diseases may have been seen by participating countries to be addressed at EU level and were therefore not prioritised in national strategies.

The key health needs as reported above have not been entirely constant, rather health needs have changed over the period of the 3HP's implementation. This was further supported by stakeholders consulted[36] who reported that health needs evolved over time, and an analysis of trends at particular moments in time indicated that a focus on health promotion has remained relatively stable over the implementation period, whereas better and safer healthcare has

[32] See Section 0 for information on the methodology of this task.

[33] Data is only available from 2014 until 2017. Data found for the years 2018 and 2019 is incomplete and cannot be used to compare information across the 27 Member States; see A5.1 in Annex 5

[34] Eurostat, [online data code: HLTH_CD_ARO]. *Causes of death - deaths by country of residence and occurrence.* Available from: Statistics | Eurostat (europa.eu) [Accessed October 2021]

[35] Including an academic / research stakeholder, a governmental public health organisation, and an organisation representing patients and services users.

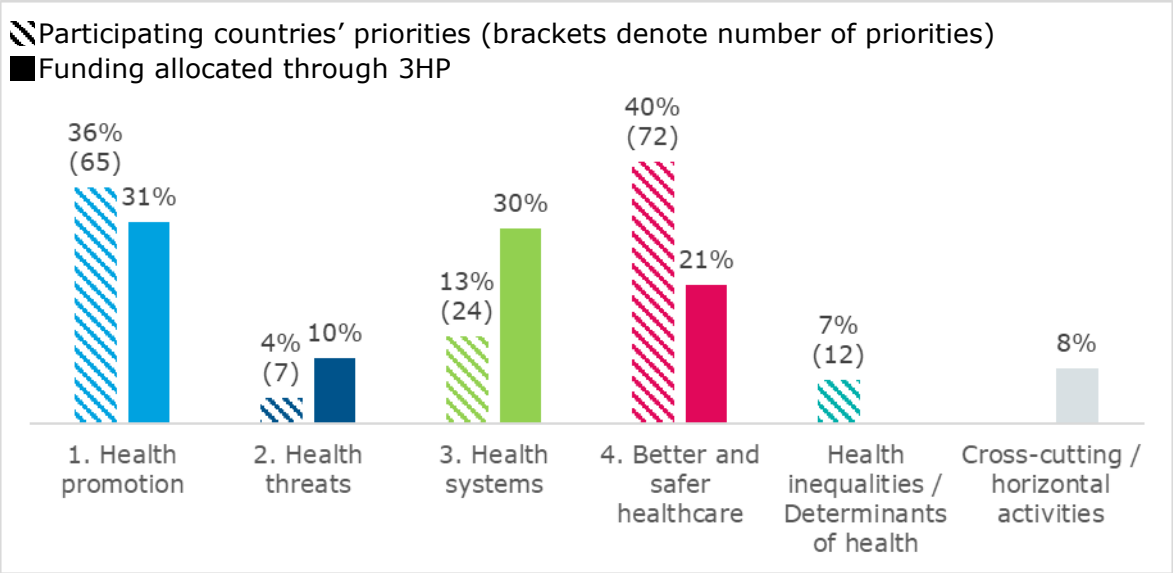
[36] Government and policy maker (in the focus group on procurement mechanisms); interviewed NGO.

peaked in certain years. See A5.1 in Annex 5 for detailed information, including information about how trends in priorities over time correlate to EU-level plans or strategies.

Relevance of 3HP to main health needs (Q1a)

The 3HP has been largely relevant to the identified key health needs in the EU described above. Figure 2 demonstrates a comparison between the spread of participating countries' priorities and the allocation of funding in the Programme to these same priority areas.

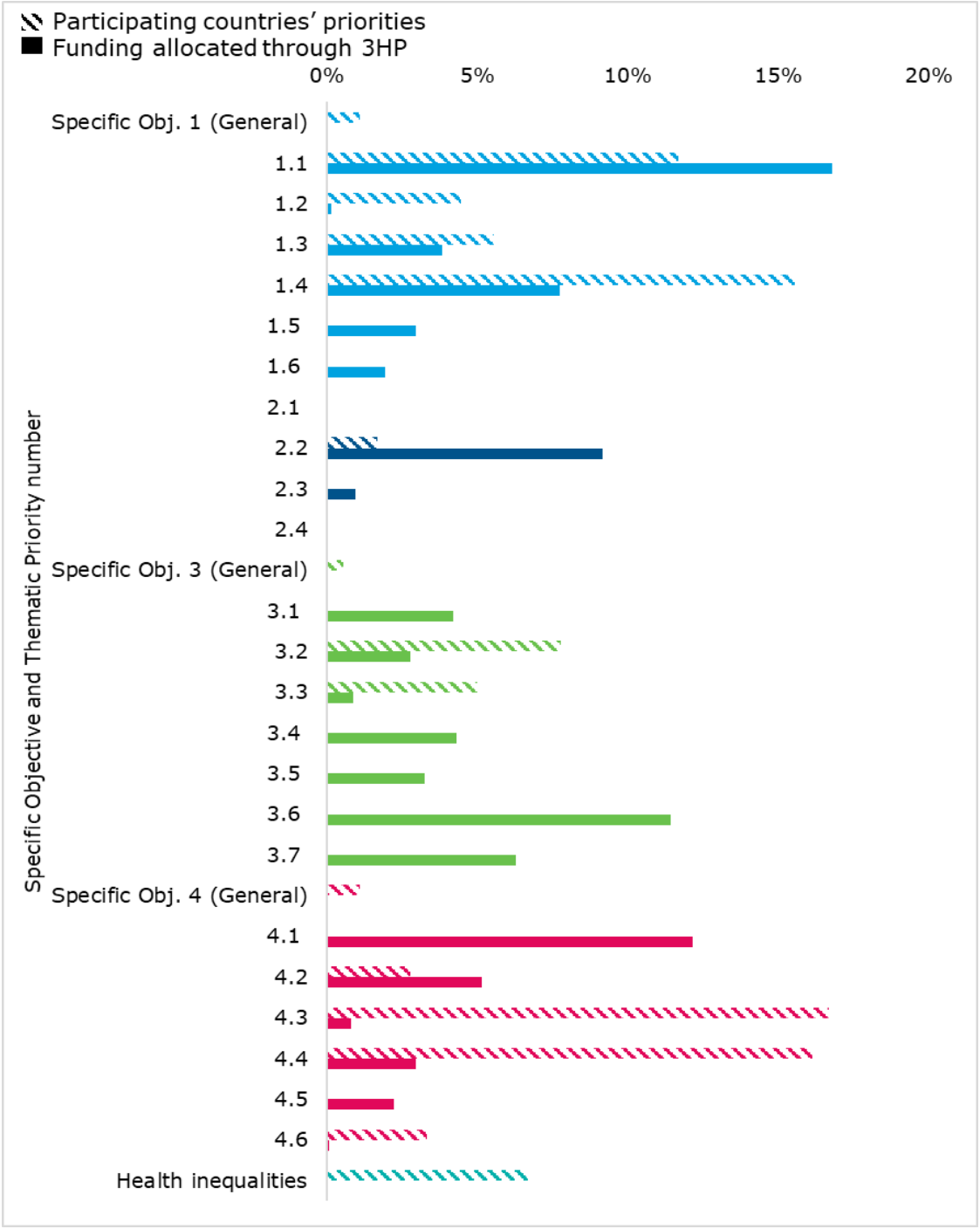
Figure 2. Percentage of participating countries' priorities in an objective area compared to funding allocated by the 3HP to that objective area



- *Source: Annual Implementation Reports; ICF analysis of participating countries' health strategies. Note that in Annual Implementation Reports, funded actions and funding are separated by priority areas, while funded actions relating to health inequalities/determinants of health are not identified in this way. There were 138 participating countries' priorities which did not map to the objective areas; these were not included in this graph.*

3HP funding allocations generally matched the priorities of participating countries, and the percentage of funding matches almost exactly for objective 1. Figure 3 illustrates a similar comparison, but at the level of the specific thematic priorities. The 3HP thematic priorities divided by specific objective are presented in Table 1 above.

Figure 3. Number of participating countries' priorities captured per specific thematic priority (all plans which started or ended during 3HP implementation)



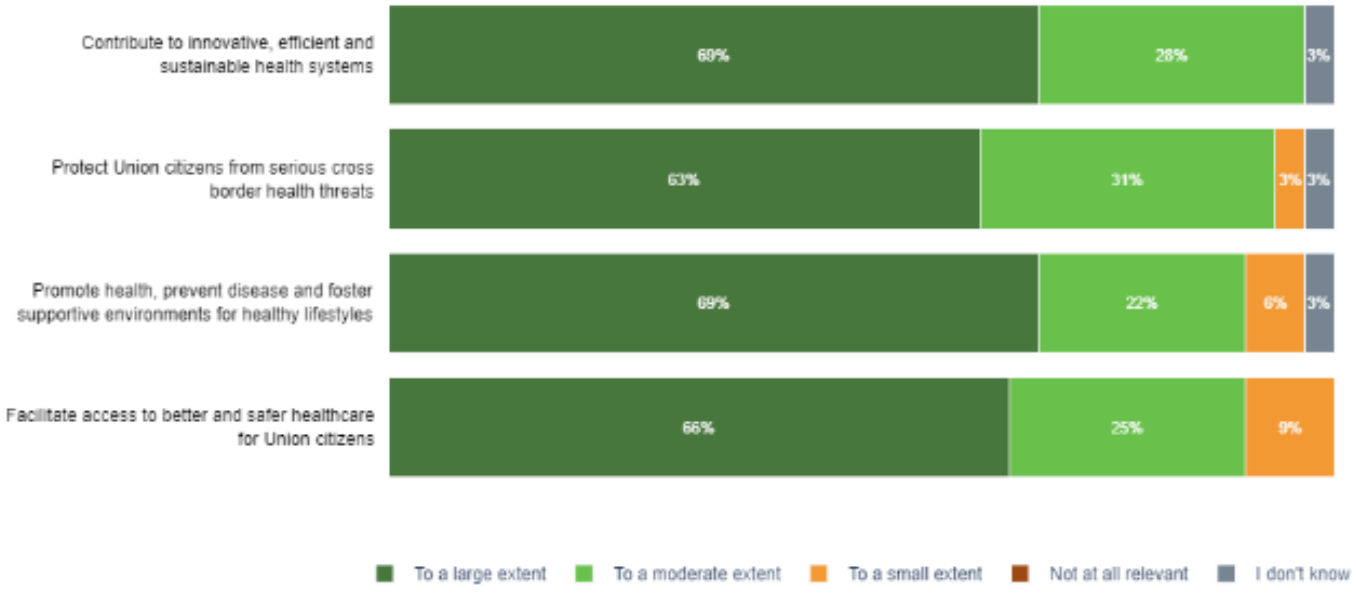
- *Source: ICF analysis of eligible countries' health strategies; analysis of Programme spending by thematic priority (from staff working documents). Total amount spent on the thematic priorities across the 3HP years = EUR 373,726,759. See Annex A5.1 in Annex 5 for more information.*

This graph indicates that some 3HP thematic priorities were aligned with national priorities, whereas this was only partially the case for other thematic priorities.

This data was corroborated by perceptions of stakeholders collected through consultations. Through the OPC, more than three quarters of respondents said that the 3HP correctly identified the EU health and healthcare needs and problems at the time of its development, to at least a moderate extent (52 responses, 77%; see Annex A5.1 in Annex 5). Similarly, a large

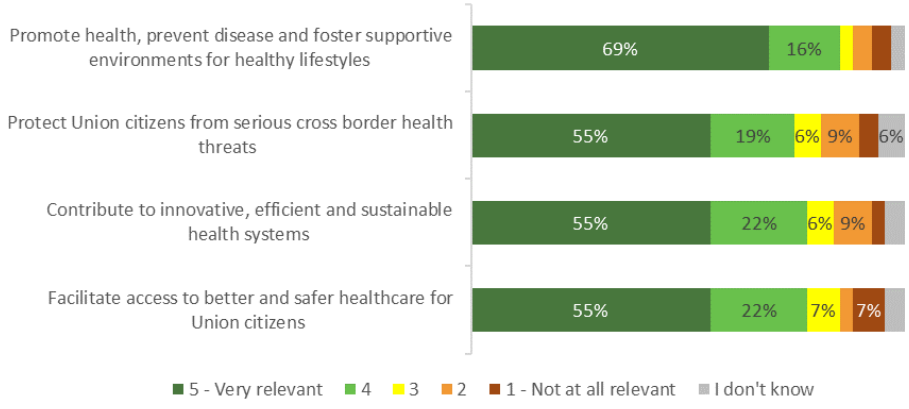
majority of targeted stakeholder survey respondents said that all four of the Programme's specific objectives were relevant in relation to EU health needs at the time of the Programme's development (Figure 4).

Figure 4. Targeted stakeholder survey: In your view, how relevant were the Programme's specific objectives in relation to EU health needs at the time of the Programme's development? (n=32)



OPC respondents believed that all four of the Programme's specific objectives were very relevant in relation to EU health needs, and in interviews, stakeholders[37] reported that the objectives of the 3HP were aligned with the main health needs in the EU. An academic/research organisation remarked in the OPC that the scope of each of the objectives is very broad and therefore very relevant to health needs in the EU. See Figure 5.

Figure 5. OPC: In your view, how relevant are the 3rd Health Programme's specific objectives in relation to EU health needs? (n=67)



The paragraphs below discuss perceptions of consulted stakeholders of the alignment of the 3HP with main health needs in the EU related to each of the four specific objectives.

- Specific Objective 1: the 3HP has largely been relevant to needs related to health promotion. In the OPC, objective 1 was rated as the most relevant to EU health needs

[37] Including some governmental policy makers and governmental public health organisations, a few stakeholders from organisations representing patients and services users, an academic / research stakeholder, a stakeholder from a healthcare professionals' organisation, and a stakeholder from an organisation representing healthcare service providers

(46 responses, 69%) and it was also deemed relevant by most targeted stakeholder survey respondents (29 out of 32 or 91%). The most relevant thematic priorities under objective 1, according to OPC respondents, were chronic diseases and risk factors. See A5.1 in Annex 5 for more detailed information. Further, alcohol and nutrition (topics examined as case studies) were areas of importance in the EU over the 3HP implementation period, which were addressed through a variety of 3HP actions such as Joint Actions. See Annex 3 for the full case study text.

- Specific Objective 2: overall, health threats was not a topic which was highly prioritised by participating countries, and when considering the programme overall objective 2 received the lowest amount of funding within the 3HP.[38] As seen in Figure 3, there were some thematic priorities for which there were no participating countries' priorities identified, and these areas also received very little or no 3HP funding.[39] However, topics related to health threats, including pandemic preparedness and increased migration, grew in importance over the period of programme implementation, and the 3HP did exercise flexibility to respond to these needs (see the following sub-section for more information). Most targeted stakeholder survey respondents found objective 2 to be relevant (30 out of 32 or 94%), and one interviewee from a governmental public health organisation reported that Joint Actions and direct grants helped increase capacity for communicable diseases, especially in the field of survey and the laboratory capacity information systems. In the OPC, objective 2 was deemed very relevant by just over half of respondents (37 respondents, 55%). The most relevant thematic priorities under objective 2, according to OPC respondents, were health information and knowledge system, and implementation of Union legislation on communicable diseases. See Annex A5.1 in Annex 5 for more detailed information.
- Specific Objective 3: there have been considerable health needs related to health systems across the participating countries, and the 3HP has largely been relevant to these needs. In the targeted stakeholder survey, objective 3 was seen as the most relevant out of the four objectives, with almost all respondents considering it was relevant to at least a moderate extent (31 out of 32, 97%). Fewer respondents to the OPC found this objective relevant (deemed very relevant by 37 respondents, 55%). The most relevant thematic priorities under objective 3, according to OPC respondents, were innovation and e-health, and health workforce forecasting and planning. See A5.1 in Annex 5 for more detailed information. Some consulted stakeholders, however, reported that the 3HP did not adequately address all health system needs. For example, an interviewed NGO felt that the 3HP did not adequately address the siloed nature of healthcare systems, while participants in the focus group on project grants reported that public health functions and strengthening public heath infrastructure were relevant needs which were not addressed by the 3HP.
- Specific Objective 4: the 3HP has largely been relevant to needs related to better and safer healthcare and addressed them proportionally. Objective 4 was deemed relevant by most targeted stakeholder survey respondents (29 out of 32, 91%), however fewer respondents to the OPC found this objective relevant (deemed very relevant by 37 respondents each, 55%). The most relevant thematic priorities under objective 4, according to OPC respondents, were patient safety and quality of healthcare, and measures to prevent antimicrobial resistance. See A5.1 in Annex 5 for more detailed information. A few respondents raised some concerns related to the 3HP's relevance to themes related to objective 4, for example that beneficial impacts could not be seen in a respondent's country (see A5.1 in Annex 5). However, competencies related to

[38] The comparatively lower amount of 3HP funding dedicated to objective 2 might be explained by the fact that themes related to health security and cross-border health threats were addressed also via other means and mechanisms not directly funded in the context of the 3HP. Examples include the 'Early Warning and Response System' (EWRS), the Health Security Committee, the EU Civil Protection Mechanism.

[39] 2.4 Health information and knowledge system to contribute to evidence-based decision making (no funding received); 2.1 Risk assessment additional capacities for scientific expertise (<1% of 3HP funding); and 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 (1%).

health services largely fall under Member State competence. It is worth noting that thematic priority 4.2 on rare diseases[40] received 5% of 3HP funding, indicating high alignment between the participating countries and the 3HP (this topic represented 3% of participating countries' priorities). Furthermore, an academic stakeholder reported that EU action on rare diseases (e.g., the establishment of the ERNs and the ORPHANET nomenclature codification system) was considered successful in helping Member States tackle inequalities, improve visibility and cross-border healthcare for rare disease patients.[41] However, the same stakeholder also reported that although EU action led to recommendations on integrated care, social care needs, and patient care needs, those recommendations have not been fully put into practice. Further action in this area is therefore needed, according to this stakeholder

The evidence presented above indicates that the 3HP was largely relevant to the health needs in the EU during the Programme implementation period. Furthermore, some factors have been identified through this study's consultation activities[42] which enabled the 3HP to address the most important health needs. Those factors include the involvement of participating countries in designing parts of Programme and a systematic collaborative approach bringing together all relevant policy units within DG SANTE to contribute to the definition of the 3HP priorities.

Relevance of 3HP over time (Q1b)

The 3HP mostly remained relevant to changes in health needs over time, such as increased migration (including refugee crisis of 2015) and cross-border health threats (namely the COVID-19 pandemic). It also presents a level of continuity with the previous Health Programme (2HP), taking into account the changing health landscape over time.

The analysis of Commission's documentation indicates that the 3HP has been flexible to ongoing and changing health needs. For example, in 2015, the EU was impacted by an influx of refugees entering Europe. In response, Chafea quickly launched direct grants and calls for proposals for actions addressing this issue and was able to sign the selected grant agreements within less than 3 months of the 2015 AWP amendment. According to the 2015 Annual Implementation Report[43], this was supported by simplified administrative procedures introduced in 2014 as well as the participant portal for online submissions and the online evaluation and electronic signature of grant agreements. Further, DG SANTE's 2020 Annual Activity Report[44] reported that in 2020, actions under the 3HP were reoriented to the greatest extent possible towards tackling the COVID-19 pandemic without having to terminate ongoing activities.

The flexibility and continued relevance of the 3HP over time was confirmed by stakeholders consulted as part of this study. More than two thirds of this study survey respondents (20 responses, 67%) said that objective 2 had become more relevant over time, mainly due to new and emerging cross-border health threats during the time of the Programme[45] and the severity of communicable diseases. To corroborate that, an interviewed stakeholder from a healthcare professionals' organisation felt that the 3HP became more relevant and the results became more practical in the second part of the Programme.

40 Support Member States, patient organisations and stakeholders by coordinated action at Union level in order to effectively help patients affected by rare diseases.

41 The effectiveness of EU action in the area of rare diseases is further discussed in the Effectiveness section of this study.

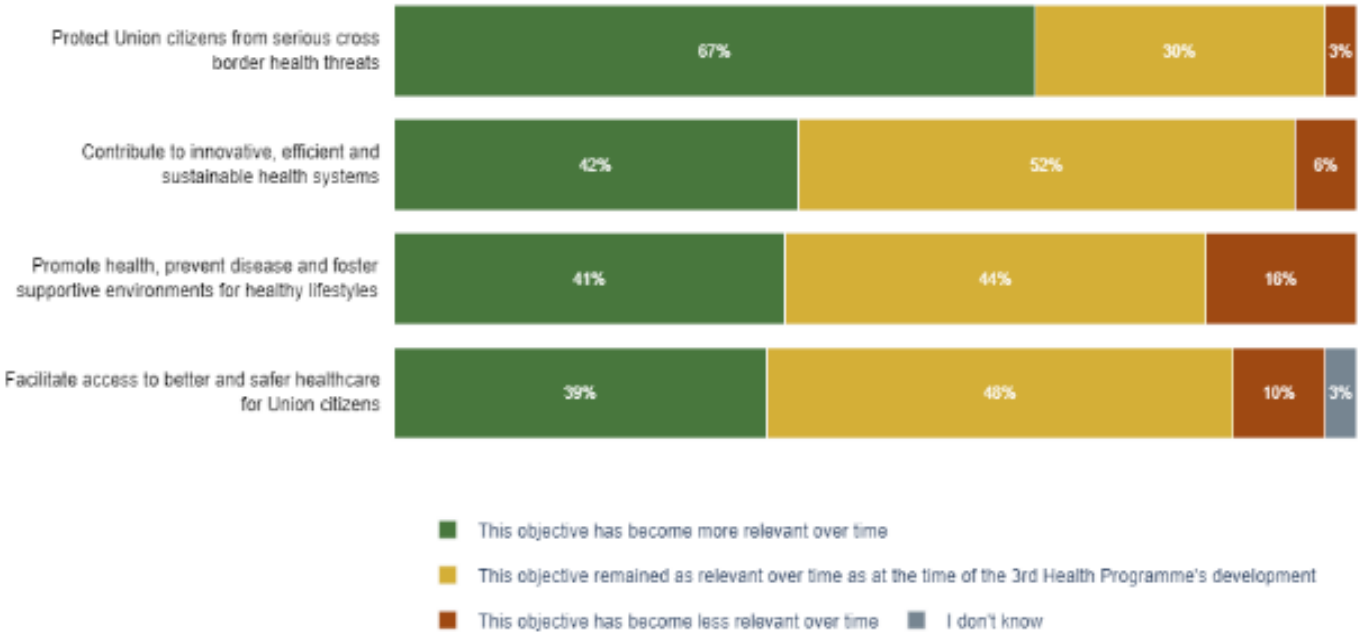
42 In particular, views on factors contributing to the 3HP relevance to health needs across the EU were provided by EU-level and national policy makers participating in this study's interview programme and the focus group on procurement mechanisms.

43 European Commission. (2018). REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL: Implementation of the third Programme of the Union's action in the field of health in 2015. Available from: https://ec.europa.eu/health/sites/default/files/funding/docs/implementation2015_en.pdf

44 European Commission. (2021). Annual Activity Report 2020: DG Health and Food Safety (SANTE). Available from: https://ec.europa.eu/info/system/files/annual-activity-report-2020-health-and-food-safety_en_0.pdf

45 A note in the survey indicated to respondents that COVID-19 was not in the scope of this study. However, respondents did mention COVID-19 as a factor explaining why this specific objective became more relevant over time. Other factors mentioned by respondents included cross-border movement/migrations, globalisation and environmental threats.

Figure 6. Targeted stakeholder survey: To what extent have the Programme's specific objectives (and associated actions) remained relevant? (n=32)



One specific change in health needs was that in 2015, the EU was impacted by increased migration. Migration was seen as a big challenge to health in the EU by the consulted stakeholders (including a governmental public health organisation). A stakeholder from an international public health organisation reported that although migration was not explicitly included within the four thematic areas, this was addressed well within the 3HP as a cross-cutting issue. This was further confirmed during the focus group on project grants, where an NGO reported that a funded action they worked on which related to vaccinations for migrants enabled better access to health services, especially in underserved areas, addressing a challenge posed by migration and its impact on health.

Specifically, there have been increased numbers of refugees and asylum-seekers in the EU during the period of Programme implementation. In the focus groups on project grants, a governmental public health organisation mentioned that in response to the migrant/refugee crisis, in 2015-2016 the European Commission quickly developed calls and issued grants and special instruments to accommodate this need. In a focus group, a government public health organisation reported that the objectives of their project were relevant to the health needs related to increased numbers of refugees. Therefore, the 3HP was flexible and adaptable to needs presented by increased migration of refugees and asylum-seekers.

Although the 3HP's adaptability and flexibility was largely seen as a success, some stakeholders[46] reported that refugee and migrant health was not a topic adequately and consistently addressed by the 3HP. A stakeholder from an organisation representing patients and services users reported that the 3HP could have been more proactive, for example supporting healthcare access information in more languages in order to support access to health care. Specifically, an academic / research organisation reported that the MyHealth project[47] was an innovative project, yet some needs were not sufficiently addressed through it. These included the need to change how health professionals approach communities, and more broadly, overcoming language barriers and increasing awareness of cultural issues faced by migrants to improve cultural competency in primary healthcare.

[46] An interviewed academic stakeholder and participants in the focus group on project grants.

[47] The main aim of the MyHealth project was to improve the healthcare access of vulnerable immigrants and refugees newly arrived in Europe, by developing and implementing models based on the knowhow of a European multidisciplinary network.

Another major health challenge during the period of the 3HP was the COVID-19 pandemic. Although, the response to the COVID-19 pandemic is out of scope of this study, DG SANTE's 2020 Annual Activity Report[48] reported that in 2020, actions under the 3HP were reoriented to the greatest extent possible towards tackling the pandemic without having to terminate ongoing activities. Both an academic / research stakeholder and a stakeholder from an organisation representing patients and services users listed work on COVID-19 as an example of how the 3HP has remained relevant to public health changes in Europe. Specifically, in the focus groups on project grants, an NGO highlighted that a recent call was issued by DG SANTE on mental health as a consequence of the COVID-19 pandemic, demonstrating adaptability of the Programme. In the same focus group, an academic / research organisation reported that ERNs adapted quickly to the COVID-19 pandemic (and also to the conflict in Ukraine): this stakeholder reported that the ways of working of the ERNs could be used in other ventures. However, a few OPC respondents stated that too much focus was put on the COVID-19 crisis and vaccination, to the detriment of other health and healthcare needs and challenges during this time period, such as the need for other types of prevention initiatives (e.g., related to diet or physical activity).

In conclusion, this study found that the 3HP mostly remained relevant to changes in health needs and a rapidly shifting health landscape over time in Europe. This is demonstrated by the adaptability of the 3HP to main changes occurred during the Programme implementation period, such as increased migration (including migrant/refugee crisis of 2015) and cross-border health threats (namely the COVID-19 pandemic).

Limiting factors to relevance

There were, however, some limiting factors to the relevance of the 3HP overall. Although the sections above indicate the 3HP has been relevant to key health needs overall, some stakeholders (including a few governmental public health organisations, a few NGOs, and a few healthcare professionals' organisations) disagreed on the extent of such relevance and indicated that the overall objectives of the 3HP were not always as aligned to key health needs as they could have been. In the OPC, a few respondents said that the Programme did not correctly identify the health and healthcare needs and problems at the time of its development (7 responses, 10%). Interviewees described some factors which hindered the 3HP from fully meeting the health needs of the EU, including insufficient funding, broadness of thematic priorities, and eligibility criteria for Joint Actions. These are discussed in more detail in A5.1 in Annex 5.

Topics or needs not addressed by the Programme

There were a few notable topics or needs which the 3HP did not adequately address. In the OPC, a large proportion of respondents said that some relevant problems or needs were not identified by the Programme at the time of its development (30 responses, 45%). One public authority noted that the Programme was too small in size and could therefore not address all issues. In addition to the gaps discussed in the sections above related to specific thematic priorities, there were some other topics which may have been given less attention by the 3HP.

There have been substantial health needs related to health inequalities, and while health inequalities was not an objective area of the 3HP, it was, initially and according to Programme documentation, to be addressed in a horizontal way across the thematic priorities. The box below presents the relevant findings of the case study on this topic.

Relevant findings from Case study on health inequalities affecting vulnerable groups

The EU has acted through the 3HP to address health inequalities affecting vulnerable groups. Specifically, there have been six main actions through the 3HP:

[48] European Commission. (2021). Annual Activity Report 2020: DG Health and Food Safety (SANTE). Available from: https://ec.europa.eu/info/system/files/annual-activity-report-2020-health-and-food-safety_en_0.pdf

- the **Joint Action Health Equity Europe**, which aimed to improve health and well-being of EU citizens, achieve greater equity in health outcomes across all groups in society and reduce inter-country heterogeneity in tackling health inequalities. The Joint Action also included a specific focus on migrants and vulnerable groups;
- the project **Mig-HealthCare**, which aimed to promote effective community-based care models to improve physical and mental health care services, support the inclusion and participation of migrants and refugees in Europe and reduce health inequalities;
- the project **MyHealth**, which aimed to improve the healthcare access of vulnerable immigrants and refugees newly arrived in Europe and focused on women and unaccompanied minors;
- the **SH-CAPAC**, which aimed to support Member States in coordinating, assessing and planning their public health response to the challenges posed by migratory pressure;
- the project **AHEAD** which aims to address the challenge of medical deserts and medical desertification in Europe to help reduce health inequalities;
- the **European network to reduce vulnerabilities in health** which aimed to bring together NGOs and academic partners from different European countries and contribute to the reduction of EU-wide health inequalities and better equipped health systems to deal with vulnerability factors.

The examined actions have produced a wealth of outputs for the benefit of policy makers, health and social care professionals and beneficiaries (e.g., vulnerable individuals and communities) which have contributed to enhancing cooperation and coordination among actors involved in reducing health inequalities and improved knowledge and best practice exchanges.

Despite these positive results and the significant resources invested by the 3HP on this policy area, overall, the theme of health inequalities is not perceived by consulted stakeholders as sufficiently addressed by the 3HP. In fact, almost a third of this study's survey respondents reported that the 3HP contribution in this area was little (7 out of 32 respondents 23%, said that the 3HP contributed to a small extent while 2 out of 32 respondents, 7%, said it did not contribute at all).This might be partly explained by the fact that reducing health inequalities was a general objective of the 3HP and represented a cross-cutting issue addressed by the Programme, rather than being explicitly integrated in the 3HP specific objectives and thematic priorities. Therefore, stakeholders might be less aware of the role of the 3HP in addressing health inequalities.

The positive results of the funded actions in terms of increased cooperation and coordination between different actors, improved knowledge and exchange, can reasonably contribute in the long-term to build capacity and create infrastructures able to address health inequalities and the social determinants of health.

The full case study can be found in Annex 3.

There were some topics which were common among participating countries' priorities, but which received relatively small amounts of 3HP funding. This was the case for 4.3 (Safety and quality of healthcare) and 4.4 (Preventing AMR and healthcare-associated infections). The reverse was also true: there were topics which were not highly prioritised by participating countries, but which received relatively large amounts of 3HP funding. This was the case for priorities 3.6 (legislation on medical devices, medicinal products and cross-border healthcare) and 4.1 (ERNs).

Figure 7 illustrates some other priorities among participating countries which were not prioritised by the 3HP.

Figure 7. Number of participating countries' priorities which were not included in the 3HP priorities (all plans which started or ended during 3HP implementation)

- *Source: ICF analysis of eligible countries' health strategies*

The most common of these omitted specific priorities was mental health (e.g., "Prevention of mental disorders by prevention and promotion actions" in PL). Between 2014 and 2019, the percentage of citizens from the 27 Member States that were identified as having depressive symptoms slightly increased.[49] Moreover, the number of deaths for mental and behavioural disorders increased by 31.2%.[50] The mid-term evaluation also noted the exclusion of mental health in the 3HP[51], with a number of stakeholders consulted underlining the importance of Mental health as an ongoing key health need, and such stakeholders[52] reported the 3HP did not adequately address mental health or wellbeing. OPC respondents said that although the Programme acknowledged the high prevalence of mental health problems, they felt that the issue was not extensively included as a key thematic priority in and of itself, which could have strengthened the relevance of the Programme as a key tool in integrating a psychosocial

[49] Eurostat, [online data code: HLTH_EHIS_MH1E]. Current depressive symptoms by sex, age and educational attainment level. Available from: https://ec.europa.eu/eurostat/databrowser/view/hlth_ehis_mh1e/default/table?lang=en [Accessed October 2021].

[50] Eurostat, [online data code: HLTH_CD_ARO]. *Causes of death - deaths by country of residence and occurrence.* Available from: Statistics | Eurostat (europa.eu) [Accessed October 2021].

[51] European Commission, 2019. Marketplace workshop on mental health best practices and implementable research results. Available from: https://ec.europa.eu/health/non_communicable_diseases/events/ev_20190514_en [Accessed December 2021].

[52] An interviewed academic / research stakeholder and participants in the focus group on project grants.

approach to mental wellbeing, taking into account and linking to the social and environmental factors that play a role in community positive mental health.

Note that although this evaluation study relates only to 3HP, extensive actions on mental health were carried out under 2HP, for example leading to the creation of the "EU-Compass for Action on Mental Health and Well-being"[53], which carried on into the programming period of the 3HP. Further, a national governmental policy maker reported that several Member States requested the inclusion of a mental health-focused Joint Action. Although this was not undertaken in 3HP, this stakeholder did report that this was addressed in EU4Health in 2021. Other actions on mental health may have also been funded or undertaken by DG SANTE outside the 3HP, however this is outside the scope of the present evaluation.

Another common priority was healthy environment, lifestyle, or culture (e.g., "Promote healthy and safe living and an equally safe working environment and decrease trauma and mortality from external causes of death" in LV). A few interviewees (academic / research stakeholder and a governmental public health organisation) mentioned environmental issues including interplays between the climate and health to be key health needs in the EU. A governmental public health organisation reported that the Joint Action on Health Equity Europe (JAHEE) included environmental inequalities and migration, but speaking about the 3HP more broadly, addressing these key health concerns depended on the Joint Action and the consortia. Other topics which may not have been adequately covered by the 3HP include child health and infant health; these topics and others are discussed more in A5.1 in Annex 5.

Q1 Conclusions

During the implementation of the 3HP, the main health needs identified across the EU related to health promotion and better and safer healthcare, although some health needs did change over time due to anticipated, and unexpected, developments. The 3HP was largely relevant in that it addressed these health needs, for example health promotion (objective 1) was highly prioritised by participating countries and accordingly received a large amount of funding. Health threats (objective 2) was not an area which was highly prioritised by participating countries (at the start of the Programming period), and when considering the 3HP as a whole, objective 2 received the lowest amount of funding within the 3HP. Under objective 4, rare diseases were identified as a specific key health need in the EU which was addressed appropriately by actions within the 3HP.

Moreover, factors which facilitated the relevance of the Programme include the active and inclusive participation of 3HP participating countries in the design of the Programme, and that by design the Programme was adaptable and flexible to ongoing developments and changes in health or policy areas influencing health. Accordingly, the 3HP mostly remained relevant to changes in health needs over time, such as increased (and sudden) migration and pandemics (notably COVID-19), and it was flexible enough to respond to the emerging health needs in these areas.

Despite the overall relevance of the 3HP to main health needs across the EU, there were a few notable health topics which were deemed relevant at national level but were not perceived as adequately addressed by the 3HP at EU level (e.g., healthy environments, mental health, maternal and child health). Such misalignment between national and 3HP priorities might be explained by different factors, some of which are not necessarily linked to the 3HP, including general health trends which differ from one country to the other, different national resources and capabilities influencing the setting of national priorities, as well as the fact that EU-level priorities often represent a synthesis of common needs across Member States driven by the identification of areas where EU action can be of greatest value.

[53] https://ec.europa.eu/health/non-communicable-diseases/mental-health/eu-compass-action-mental-health-and-well-being_en#:~:text=The%20EU%2DCompass%20for%20Action,Mental%20Health%20and%20Well%2Dbeing.

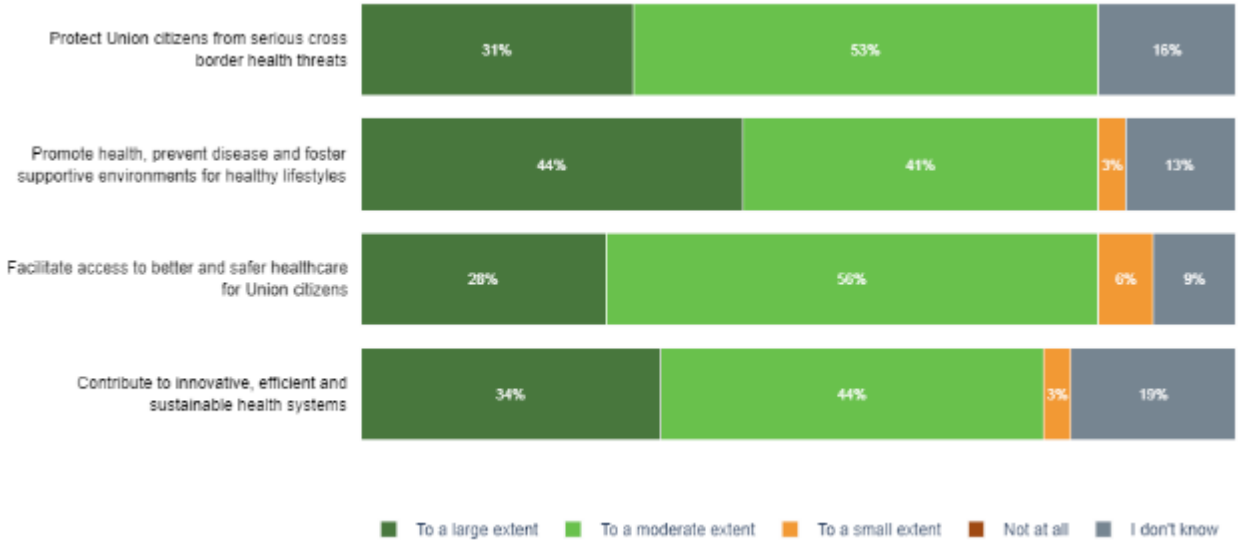
3.1.2. Q2. To what extent were the Programme's thematic priorities sufficiently covered by the funded actions to achieve the Programme's objectives and Commission's wider priorities?

This section assesses the extent to which the Programme's thematic priorities were sufficiently covered by the funded actions to achieve the Programme's objectives and Commission's wider priorities. The assessment draws together the evidence collected through desk research and consultation activities. The study's results demonstrate that there was clear alignment between funded actions and the specific thematic priorities set out by the Programme. Further, the funded actions were aligned with the Commission's wider priorities. The following subsections presents the evidence base/findings that substantiate this assessment.

Alignment between funded actions and thematic priorities (Q2a)

There is clear alignment between funded actions and the specific thematic priorities set out by the Programme. In the targeted stakeholder survey, a large majority of respondents said that the Programme's funded actions were aligned with the Programme's four specific objectives. In particular, 14 respondents (44%) said actions were aligned to a large extent with objective 1.

Figure 8. Targeted stakeholder survey: To what extent were the Programme's funded actions aligned with the Programme's specific objectives? (n=32)



This was further strengthened by results from various interviews with several stakeholders[54], all reporting that, from their perspectives, funded actions have been aligned with the thematic priorities of 3HP. See A5.2 in Annex 5 for more detailed responses from interviewees.

A minority of respondents noted obstacles to full alignment. A national governmental policy maker reported that actions under some objectives of 3HP were implemented or used more than others. For example, actions related to health security (objective 2) were not used often. Two EU-level policy makers reported that the objectives and thematic priorities were very broad and wide-reaching, therefore it was not possible to address them all with the same level of intensity or funding. One reported the Programme tried to achieve the best they could with the available budget.

[54] An academic / research stakeholder, a few governmental policy makers and governmental public health organisations, a stakeholder from an organisation representing patients and services users.

Alignment between funded actions and Commission priorities (Q2b)

The funded actions were also aligned with the Commission's wider priorities. To assess the alignment between 3HP funded actions and the Commission's wider priorities, the study team reviewed publicly available European Commission policy documentation and examined the link between DG SANTE's specific objectives related to the 3HP spending and the Commission's wider priorities over the evaluation period. The review focused on the main strategic documents which provide the overarching framework for EU action in health over the period 2014-2020.[55] These documents together provide a perspective on the alignment between funded actions and wider Commission priorities, as illustrated by the mapping of DG SANTE's specific objectives against relevant Commission priorities over the evaluation period (see A5.2 in Annex 5). This analysis shows that DG SANTE's specific objectives related to 3HP spending contribute to the Commission's wider priorities over the evaluation period.

During the period 2014-2015, DG SANTE's specific objectives were directly aligned with 3HP objectives, and these stem from the general objective of EU health policy to improve the health of EU citizens and reduce health inequalities. DG SANTE's actions in 2014 and 2015, as described in the annual management plans and activity reports for the relevant years, built on the EU Health Strategy objectives complemented by the principles enshrined in the "Investing in Health" approach, and contributed to the objectives of the overall EU growth strategy, the Europe 2020 strategy for smart, sustainable and inclusive growth (A5.2 in Annex 5).

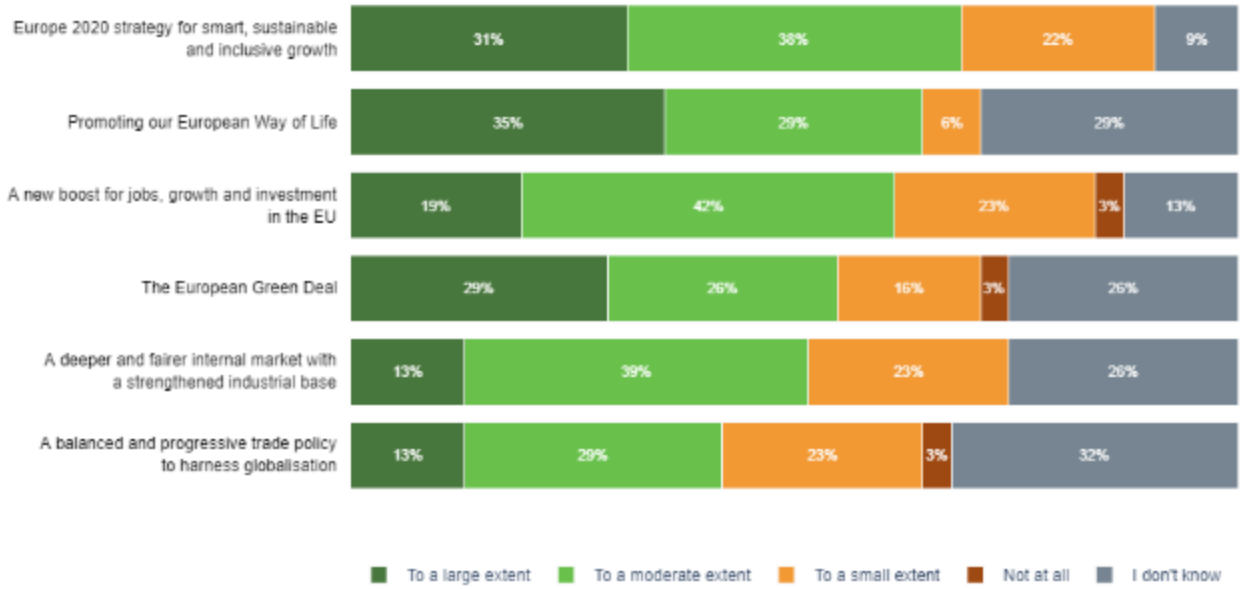
For the period 2016-2020, DG SANTE's annual management plans clearly established a structural link between the Commission's political priorities and DG SANTE action, which was missing in the previous two years. For example, the DG's activities in 2016-2019 contributed to three of the Juncker Commission's ten priorities, and in 2020 to two of the six priorities of the Von der Leyen Commission. A5.2 in Annex 5 illustrates how DG SANTE's specific objectives related to the 3HP spending correspond to the Commission's political priorities in 2016-2019 (Juncker's Commission) and in 2020 (Von der Leyen's Commission).

In 2020 3HP spending was not allocated to any activity under the General objective 1: A European Green Deal. In terms of 3HP funded actions, only one of the six priorities of the Von der Leyen Commission is relevant, that is "Promoting our European Way of Life". However, despite the lack of health-related expenditure linked to the first general objective, the European Green Deal, and in particular the Farm to Fork Strategy contributes to the overall objective of promoting good health in the EU.

This alignment was also confirmed through the consultation activities undertaken in this study. In an interview, a stakeholder from an international public health organisation reported that the 3HP was aligned with the Commission's wider priorities, as during the implementation of 3HP there were other funding mechanisms focusing on migration health in the EU. In the targeted stakeholder survey, a large majority of respondents said that the Programme's thematic priorities were relevant to the Commission's wider priorities over the implementation of the Programme. In particular, more than 30% of respondents said the Programme's thematic priorities were relevant to a large extent to the following two Commission's wider priorities: "Promoting our European Way of Life" and "Europe 2020 strategy for smart, sustainable and inclusive growth". Notably, there were large rates of "I don't know" responses to this item, illustrating how those involved with 3HP may not have been aware of the Commission's wider priorities.

[55] Together for Health: A Strategic Approach for the EU 2008-2013; the Social Investment Package "Investing in Health", Europe 2020: A strategy for smart, sustainable and inclusive growth, and DG SANTE's Strategic Plans 2016-2020 and 2020-2024); and the annual DG SANTE management plans and activity reports (and annexes to the reports) which provide an overview of the DG's main outputs for each year.

Figure 9. Targeted stakeholder survey: To what extent were the thematic priorities relevant to the Commission's wider priorities over the implementation of the Programme? (n=32)



Q2 Conclusions

In conclusion, there was clear alignment between funded actions and the specific thematic priorities set out by the Programme, particularly for objective 1. Importantly, the funded actions were aligned with the Commission's wider priorities, as demonstrated by a detailed mapping of Commission documentation. This was also confirmed by many consulted stakeholders, although note that consulted stakeholders were less knowledgeable about alignment with the Commission's wider priorities, perhaps because stakeholders involved in 3HP may not have had high awareness of the Commission's strategy and priority more widely.

3.1.3. Q3. How relevant is the Programme to EU citizens, and in particular, is the Health Programme close to citizens and responding to their needs?

This section assesses the extent to which the Programme was relevant to EU citizens, and the closeness of the Programme to citizens and their needs. The assessment draws together the evidence collected through consultation activities and social media listening, as well as using the example of the alcohol case study. The study's results demonstrate that actions funded under the Programme are directly relevant/responding to the needs of EU citizens. The following text presents the evidence base/findings that substantiate this assessment.

Relevance of 3HP to citizens' needs (Q3a and Q3b)

The 3HP has largely been relevant to citizens' needs, as assessed through stakeholder consultations. In the targeted stakeholder survey, almost 90% of respondents believed that the Programme's thematic priorities were relevant in light of citizens' perceptions of key health issues in the EU, to at least a moderate extent (28 responses, 87%). Similarly, almost nine in ten respondents believed that the Programme responded to citizens' health needs, to at least a moderate extent (27 responses, 84%). In an interview, a stakeholder from a healthcare professionals' organisation also reported that the 3HP was much more in line with the needs of users, professionals and governments than previous years.

Figure 10. Targeted stakeholder survey: To what extent are the thematic priorities relevant in light of citizens' perceptions of key health issues in the EU? (n=32)

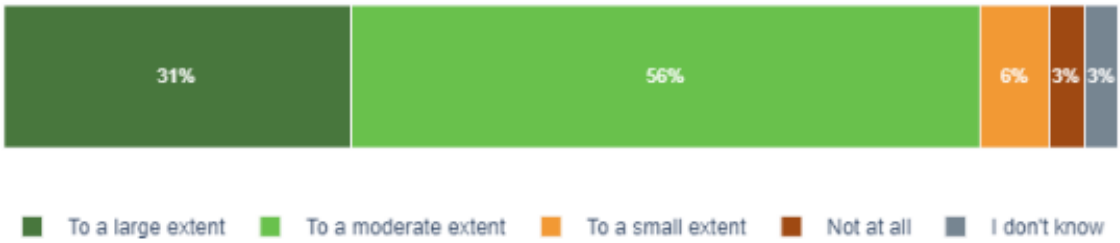


Figure 11. Targeted stakeholder survey: In your opinion, to what extent has the Programme responded to citizens' health needs? (n=32)

However, evidence also uncovered diverging views on the extent to which, at an operational level, the 3HP has responded to citizen's needs.

- A national public authority involved in the Programme implementation underlined that, at the local operational level, the thematic priorities were not relevant per say, due to their broad nature, which was further exasperated due to the mismatch of health priorities between the Programme and the national context, citing that, in their country, critical challenges faced by citizens were seen as a greater problem, such as the waiting list to receive medical services, and that this was not (and could not be) resolved by the Programme thematic priorities. However, this example demonstrates the complex nature of public health and competences- as such a challenge relates to national healthcare systems, which is outside the remit of EU Health Programmes.
- Two EU-level NGOs who benefitted from the Programme noted that the funding opportunities for childhood cancer were valuable but insufficient to address the magnitude of the issues in this disease area. They added that more dedicated and sustainable funding streams are needed to further support the European Reference Network on Paediatric Cancer (ERN PaedCan) and other pre-existing paediatric cancer structures in Europe, as well as to introduce additional initiatives to ease the burden of childhood cancer. These were concrete areas where EU-level action could further increase the relevance of 3HP to citizens' needs; and progress in this area can be seen in the EU4Health Programme with dedicated actions being funded under the Europe's Beating Cancer Action Plan.

In order to further understand citizens' expectations and needs, and build the evidence base for this study, a social media listening was conducted to extract data from Twitter between July 2020 – July 2022 to understand coverage and trends of discussions on the case study topics: alcohol, nutrition, health inequalities, anti-microbial resistance, health technology assessments and vaccinations. Across the topic areas, the alcohol topic made up the majority of tweets (93.5%), and there was a wide variety of discussion around alcohol across the targeted countries, which indicates the topic as an area of high public interest. See A5.3 in Annex 5 for further information about social media trends. The 3HP accordingly responded to this priority area for citizens: outputs from the RAHRA Joint Action implemented in the 2HP were further developed by another funding mechanism during the 3HP, specifically by the DEEP SEAS service contract and thematically by the Presidency Conference on alcohol marketing.

Therefore, through these two actions, we evidenced the efforts of the 3HP to continue exploring and researching on ways to reduce alcohol-related harm in the EU. Overall, case study findings show that the 3HP successfully contributed to a more comprehensive and uniform approach concerning possible pathways to regulate alcohol marketing across the EU as well as addressing the objectives and priorities in the area of alcohol marketing. See Annex 3 for the alcohol case study.

A more detailed discussion of how the objectives and actions of the 3HP remained relevant changes in public/citizens' expectations and behaviours in relation to health and healthcare can be found under Q1.

Q3 Conclusions

Through the targeted stakeholder survey results, it is clear that actions funded under the Programme were directly relevant and responded to the needs of EU citizens, for example exploring and researching on ways to reduce alcohol-related harm in the EU (alcohol was an important topic to citizens). There were a few cases in which actors in certain fields felt the 3HP should have allocated more funding to their areas of interest, however these comments were minimal. A limitation to the analysis under this question was that it was not possible to map social media trends over the period of programme implementation (from 2014 onwards); this would have allowed more detailed mapping of social media trends to actions under the programme.

3.2. Effectiveness

This criterion seeks to assess how effective the 3HP has been at meeting its own objectives in terms of its quantitative and qualitative effects and implementing recommendations from previous evaluations. It specifically assesses the effectiveness of the "exceptional utility" criteria, the extent to which the Programme's actions, outcomes and results have been published and accessible, and if the results are likely to be sustainable.

3.2.1. Q4. What have been the (quantitative and qualitative) effects of the Programme?

This section discusses the extent to which actions implemented under the 3HP contributed to a more comprehensive and uniform approach to health and healthcare in the EU, as well as to improvements in health and healthcare in the EU and at Member State level. It also reflects on the 3HP contribution to the EU's influence on health and healthcare standards, policies and practices at international level. The assessment draws together the evidence collected through desk research, including the in-depth analysis conducted in the case studies on selected policy areas, and from consultation activities.

The study's results demonstrate that the 3HP contributed to a more comprehensive and uniform approach to health issues across the EU, the knowledge produced by the 3HP was used in policy making and the 3HP contributed to improvements in health and healthcare in the EU and at Member State level. Some limitations to the 3HP contribution emerge which are related to the national dimension. Further, the 3HP contributed, to some extent, to the EU's influence on health and healthcare standards, policies and practices at international level. The following subsections present the evidence base that substantiates this assessment.

3HP contribution to a more comprehensive and uniform approach to health and healthcare in the EU (Q4a)

Overall, the 3HP contributed to a more comprehensive and uniform approach to health issues across the EU, especially in some policy areas such as alcohol marketing, health technology assessment and antimicrobial resistance. However, some limitations exist mostly due to national differences in terms of organisation of health systems and national priorities, which cannot be completely addressed by the Programme.

Most targeted stakeholder survey respondents reported that the 3HP contributed at least to a moderate extent to a more comprehensive and uniform approach to addressing health issues across different policy areas (i.e., antimicrobial resistance 63%, health inequalities affecting vulnerable groups 62%, vaccination 61%, health technology assessment 56%, alcohol marketing 54%, childhood obesity 51%). This perception was confirmed by interviewed stakeholders who reported that the 3HP was effective in promoting knowledge exchange or in increasing awareness among national and regional authorities on the need for cooperation in health. Further details are available in A5.4 in Annex 5.

Importantly, the case studies findings show that the 3HP has contributed to a more comprehensive and uniform approach in specific policy areas. This is especially the case for alcohol marketing, health technology assessment and antimicrobial resistance. The 3HP contributed to a more comprehensive and uniform approach concerning possible pathways to regulate alcohol marketing across the EU (see the case study report in Annex 3) as evidenced through the outputs of the Presidency Conference on Cross-border Aspects in Alcohol Policy - Tackling Harmful use of Alcohol in relation to cooperation, information exchange and the importance of updating current legal frameworks on alcohol marketing across Member States. When considering health technology assessment, the outputs of EUnetHTA JA3 (i.e., the network infrastructure, the joint assessments, scientific guidance and tools) the collaborative infrastructure and the produced practical tools and methodologies which increased cooperation and coordination among HTA national agencies, and the use of joint assessments are all elements conducive to a more comprehensive and uniform approach to HTA in the EU

(see the case study report in Annex 3). Conversely, in other areas (e.g., childhood obesity and food reformulation) the 3HP has laid the foundation for more uniform and comprehensive approaches to be adopted in the future (see the case study report in Annex 3).

Moreover, the study found that measures implemented by Member States were aligned with the specific objectives and thematic priorities of the 3HP and national actions reflected approaches developed through 3HP funding. However, some limitations exist mostly due to national differences in terms of organisation of health systems and national priorities.

The desk research conducted under Q1 to understand the needs across the participating countries and compare them with the allocation of 3HP funding across each of the objective areas shows that 3HP funding allocations generally matched the priorities of participating countries. Furthermore, these findings are corroborated by views of stakeholders consulted as part of this study. Further details can be found in A5.4 in Annex 5.

Lastly, documentary evidence showed that the 3HP contributed to an increase in the robustness, timeliness and comparability of health data across EU countries. This was achieved through the establishment of several EU-wide data systems such as:[56]

- establishment of an EU quality register ensuring the safety of medical devices;
- establishment of an Organ Database which facilitated 34.000 transplants in 2017 alone; and
- set-up of an EU-wide tobacco tracking and tracing system to combat illicit tobacco products trafficking.

The 2020 Health Programme Statement[57] noted that 23 Member States were using the above tools and mechanisms to contribute to effective results in their health systems, addressing shortages of resources both human and financial, and facilitating voluntary uptake of innovations in public health intervention and prevention.

• *3HP contribution to improvements in health and healthcare in the EU and at Member State level (Q4b)*

Overall, the knowledge produced by 3HP funded actions was used in policy making and the 3HP contributed to improvements in health and healthcare in the EU and at Member State level. This is particularly the case for Joint Actions; this funding mechanism has been particularly effective in enabling collaboration, fostering coordination efforts amongst Member States, facilitating the sharing of existing good practices and fostering cross-collaboration on different issues. However, some limitations related to the national dimension emerged such as national capacity limiting participation in the 3HP and coordination and engagement between the national and subnational levels.

Most targeted stakeholder survey respondents believed that the 3HP actions led to new knowledge and evidence which were used in the development of policy and decision-making (25 respondents said this was true to at least a moderate extent, 79%). This was also the case for stakeholders participating in this study's interviews and focus groups, who reported that 3HP action in areas such as cancer, AMR, HTA, blood, tissues and cells influenced national strategies and helped create, or strengthen, national legislation (see A5.4 in Annex 5).

Some of the Programme's achievements contributed to improvements in health and healthcare in the EU and at Member State level, in terms of implementation of best practices, coordination of efforts across Member States and changes to policy and practice at EU level.

According to the 2019 and 2020 Health Programme Statements, the 3HP encouraged sharing of best practices. In April 2018 DG SANTE launched the online "Best Practice Portal", a repository of best practices evaluated by the Steering Group on Health Promotion, Disease

[56] European Commission.,(n.d.). Union Action in the field of health (Health Programme 2019).[Pending publication]. [Accessed November 2021]. Found in European Commission (2019) Health Programme Statement.

[57] European Commission.,(n.d.). Union Action in the field of health (Health Programme 2020).[Pending publication]. [Accessed November 2021].

Prevention and Management of Non-Communicable Diseases. The Best Practice Portal helps Member States find (and potentially transfer in their own system) reliable and practical information on implemented best practices in the area of health promotion, disease prevention, and the management of non-communicable diseases. Since June 2018, it counted more than 6 650 visitors from all EU Member States as well as neighbouring countries and 200 types of actions[58] have been certified and published on the portal according to the European Parliament mid-term review.

A European Parliamentary Research Service study (2019)[59] listed 3HP's major achievements as: the State of Health in the EU, including the Health at a Glance publications and the Country Health Profiles; the EU Compass for action on mental health and wellbeing; the European quality assurance scheme for breast cancer services; activities financed by 3HP into prevention of viruses organised through the Health Security Committee; the European Network for Health Technology Assessment; the Joint Action to support the e-health network, and the establishment of European Reference Networks. These projects were seen to promote best practices, improve healthcare procedures, strengthen preparedness nationally and on a pan-European level, standardise cross-border health data, and increase citizens' access to specialised knowledge and care.

Corroborating these findings, different interviewed stakeholders and participants to this study's focus groups confirmed the importance of sharing best practices and the 3HP contribution to this process. However, some challenges were pointed out, including the limited funding dedicated to scaling up best practices, limits in the ability of a particular funding instrument (i.e., project grant) to promote implementation of best practices compared to other instruments and, not least, the low level of engagement of national ministries in the promotion of best practices (see A5.4 in Annex 5).

Furthermore, a successful example of sharing best practices is provided by the CHRODIS+ Joint Action which involved taking good practices from certain countries related to nutrition in schools and implementing them in other countries. Additionally, during CHRODIS+, they had a pilot implementation of an integrated multi-morbidity care model. The ministries of health were impressed with the results, so they decided to multiply this project in other healthcare institutions using funds from the European structural fund.

Moreover, findings from the case study on nutrition demonstrate that the examined 3HP funded actions have contributed to the sharing of best practices in the area of nutrition and childhood obesity. See the box below for further information on the case study on nutrition.

Relevant findings of Case study on Nutrition

The EU has acted through the 3HP to improve nutrition policies and actions at Member State level. Specifically related to the sub-theme of childhood obesity with links to food reformulation, there have been three main actions through the 3HP:

- **Joint Action on Nutrition and Physical Activity (JANPA)**, which aimed to contribute to halting the rise in overweight and obesity in children and adolescents by 2020, in alignment with the goals of the EU Action Plan on Childhood Obesity 2014-2020.
- **Presidency Conferences on Drug Shortages and on Healthy Nutrition for Children**, which aimed to strengthen the understanding that children are the most vulnerable group of consumers, requiring better protection and more active prevention policies.
- **Joint Action on Implementation of Validated Best Practices in Nutrition (Best-ReMaP)**: this action is ongoing and aims to, inter alia, offer an opportunity to monitor the impact of national regulations aimed at decreasing the salt, sugar and fat content of processed food.

The conference seems to have had a surprisingly large impact compared to its cost, and the JANPA joint action has also provided a wealth of tools for policy makers wishing to enact policies to improve the nutrition of EU citizens. The Best-ReMaP joint action is yet to produce many outputs aside from a website.

[58] Lomba, N., 2019. The benefit of EU action in health policy: The record to date, European Parliamentary Research Service.
[59] Lomba, N., 2019. The benefit of EU action in health policy: The record to date, European Parliamentary Research Service.

Through these three actions, best practices have been shared among Member States and key stakeholders, in particular around the themes of nutrition and physical activity, as well as on ways to reduce unhealthy food marketing to children. The identification and exchanging of best practices is conducive to a more comprehensive and uniform approach to tackling childhood obesity in the EU; while it is not yet possible to conclude that such an approach has already been fully achieved, it can be assumed that cooperation and exchange of practices among Member States will likely contribute to achieving it in the long-term. Similarly, it is not possible to assess the contribution of EU action to decreasing childhood overweight and obesity across Europe, given that such a reduction is a longer-term impact whose realisation is dependent on a variety of factors. However, the above funded actions have raised awareness and created useful tools which will reasonably contribute to make progress in this area. It is important to note that in order for the reported results of the funded actions to lead to the desired outcomes in a sustainable way, it will be crucial for the EU and Member States to take up the recommendations and tools produced by these funded actions. If these tools are not used, the impacts of the funded actions will be very limited.

The full case study can be found in Annex 3.

When considering the overall 3HP contributions to improvements across the EU, most targeted stakeholder survey respondents believed that the Programme actions led to general improvements in health and healthcare in the EU and at Member State level (23 respondents said this was true to at least a moderate extent, 73%), in particular in the fields of vaccination, AMR prevention and HTA. On the other hand, childhood obesity and health status and access to care of vulnerable groups were considered areas where the 3HP only contributed to a small extent to improvements. The findings related to childhood obesity are in line with the evidence discussed under Q1 as child and infant health has emerged as a topic which was not adequately addressed under the 3HP. The relatively smaller contribution perceived by stakeholders in the area of health status and access to care of vulnerable groups might be explained by changes which occurred in the European landscape in terms of health needs related to increased migration. As discussed under Q1, despite the Programme overall remained relevant to health needs linked to migration some stakeholders reported that refugee and migrant health was not a topic adequately addressed by the 3HP (see A5.4 in Annex 5 for further details).

When considering the area of vaccination, the findings of the dedicated case study demonstrate that the outputs of the examined 3HP funded actions have contributed to enhancing cooperation and collaboration among actors involved in vaccination and improved knowledge and best practices exchanges. See the box below for further information on the case study on the European response to the challenges related to vaccination.

Relevant findings from the case study on European response to the challenges related to vaccination

The EU has acted through dedicated 3HP funding to address vaccination issues. Especially, five funded actions have showed progress towards responding to vaccination challenges:

- The Joint Action on vaccination (**EU-JAV**) aimed to stimulate long-lasting EU cooperation against vaccine-preventable diseases. It aimed to build concrete tools to strengthen national responses to vaccination challenges in Europe and therefore improve population health.
- The project Innovative Immunisation Hubs (**ImmuHubs**) which aimed to support EU efforts to improve vaccine uptake by strengthening joint efforts with the Coalition for Vaccination and other stakeholders to deliver better vaccine education to health professionals and better information to the public.
- The project Common Approach for REfugees and other migrants' health (**CARE**) aimed to promote and sustain a good health status among migrants and local populations in five Member States experiencing strong migration pressure.
- The project **MIG-HealthCare** aimed to promote effective community-based care models to improve physical and mental health care services, support the inclusion and participation of migrants and refugees in Europe and to reduce health inequalities, including access to vaccination.
- The IOM direct grant for **Re-Health** aimed to support EU Member States in improving healthcare provision for migrants and contribute to the integration of newly arrived migrants and refugees in EU Member State health systems.

Overall, in the context of the examined funded actions a wide range of activities has been conducted engaging with a variety of stakeholders. Those activities have produced a wealth of outputs for the benefit of policy makers, health and social care professionals and other stakeholders, including technical guidance,

monitoring tools, training programmes and awareness raising materials. Those outputs have contributed to enhancing cooperation and collaboration among actors involved in the challenges associated with vaccination and improved knowledge and best practices exchanges. The desired long-term impacts of such outputs and outcomes have been identified as increased vaccination rates and increased access to vaccination across Europe, reduced number of vaccine-preventable diseases and higher awareness of the challenges linked to those. It is not possible to assess the 3HP contribution to achieving those long-term impacts, given that their realisation depends on a variety of factors not necessarily linked to the outcomes of a single action in the field of health policy. However, the outputs and outcomes of the examined 3HP funded actions (e.g., the produced tools, the increased coordination among Member States and cooperation among the different actors involved) have the potential to improve vaccination efforts in Europe by strengthening national immunisation programmes and therefore are likely to contribute to the achievement of the above-mentioned long-term impacts.

The full case study can be found in Annex 3.

Examples of actions which improved health and health care in the EU and at Member State level included:

- The European Reference Networks, which reportedly have improved the visibility of rare diseases and helped patients and doctors.
- Joint Actions[60], which reportedly contributed to more cooperation between Member States, a more effective implementation of the Programme's priorities and a better integration of the Programme at the national level.

When considering Joint Actions more broadly, this funding mechanism has enabled collaboration, fostered coordination efforts amongst Member States, facilitated the sharing of existing good practices and fostered cross-collaboration on different issues, including in the area of AMR.

Relevant findings from Case study on Anti-Microbial Resistance (AMR) Joint Action on AMR – EU-JAMRAI

The 3HP supported Member State collaboration through the Joint Action on Antimicrobial Resistance and Healthcare-Associated Infections (JAMRAI, September 2017-February 2021). The Joint Action was launched with the intention to foster synergies among Member States, propose concrete steps to strengthen the implementation of One Health policies to tackle the rising threat of AMR and reduce Healthcare-Associated Infections (HCAIs). The overarching objective of EU-JAMRAI was to support EU Member States to develop and implement effective one health policies to combat AMR and reduce healthcare-associated infections through the appropriate involvement of each stakeholder group in planned actions.

EU-JAMRAI conducted activities and produced a wealth of outputs benefiting policy makers at national and EU level as well as other stakeholders. Overall, the outputs have contributed to increased cooperation and coordination among Member States, the European Commission and its agencies. Furthermore, the funded action developed concrete recommendations to tackle AMR and HCAIs and enabled the sharing of existing good practices. Lastly, EU-JAMRAI produced sustainable results, especially when considering the support provided to Member States in terms of facilitating exchange and providing recommendations for action against AMR. Moreover EU-JAMRAI identified two main ways to ensure sustainability: ensure direct follow-up and cooperation between Member States and/or continue action at EU level, when and if necessary, using EU funding as an enabling mechanism. It is soon to assess the overall impact of EU-JAMRAI, given the limited time that involved actors have had to take up and apply the Joint Action's main outputs. However, it can be concluded that the outputs produced in the context of this Joint Action and the increased cooperation and coordination it facilitated are concrete achievements contributing to make progress in the fight against AMR.

The full case study can be found in Annex 3.

Furthermore, Joint Actions were noted as being a well-designed mechanism which coexisted with national programmes and national priorities. They were also described as being accessible to Member States in comparison to other funding mechanisms, potentially as all Joint Actions qualified for the 80% grant rate under the exceptional utility criteria. The public-facing HaDEA database on funded actions lists 27 Joint Actions as part of the 3HP (of which 9 are ongoing). Specific information on each of these Joint Actions is provided in Table 48 of Annex 5. France and Italy coordinated 4 Joint Actions each, and a total 14 countries

[60] Consulted stakeholders mentioned iPAAC (Innovative Partnership for Action Against Cancer Joint Action), EU-JAV (European Joint Action on Vaccination), CHRODIS (Joint Action on Chronic Diseases).

coordinated at least 1 Joint Action. Joint Actions under the 3HP received a total European Commission contribution of 93,793,221 EUR (an average of 3,473,823 EUR per Joint Action).

The establishment of 24 European Reference Networks (ERNs) is also considered a flagship achievement of the 3HP. The ERNs demonstrate a high level of coordination, involving healthcare providers across Europe and aim to tackle complex or rare medical diseases or conditions that require highly specialised treatment and a concentration of knowledge and resources (see A5.4 in Annex 5).

The findings above are corroborated by information emerging from this study's interview programme, as most stakeholders overall considered the 3HP effective in contributing to improvements to health and healthcare in the EU and at member States level, including in terms of coordination of efforts across Member States (see A5.4 in Annex 5).

Alongside the successes, some difficulties and limitations were raised. A national policymaker highlighted that in many Member States, responsibility for health systems is not at national level but at regional level; however, coordination and engagement between the national and subnational levels is not always in place. Moreover, many national policymakers highlighted national capacity as a challenge in participation in the 3HP. For instance, one governmental public health organisation reported that as Member States must use some of their own resources to take part in a Joint Action, this can be a burden to taking part and the 3HP would address needs better if it were less onerous to implement. Another stakeholder from governmental public health organisations reported that some countries struggled with implementation and the difference in capacities among countries should be acknowledged structurally. Some barriers to participation have been identified by stakeholders from governmental public health organisations, including the language and heavy bureaucratic procedures, especially in the context of Joint Actions.

- *3HP contribution to EU's influence on health and healthcare standards, policies and practices at international level (Q4c)*

The available evidence suggests that the 3HP contributed to some extent to the EU's influence on health and healthcare standards, policies and practices at international level.

This assessment is based on findings emerging from this study's consultation activities as most surveyed public authorities believed that the 3HP outputs (e.g., establishment of Joint Actions and ERNs, evaluations and studies, establishment of EU-wide data systems) were used at an international level, and that the EU's coordination with international bodies in the field of health had been strengthened in 3HP priority areas. Views expressed in this study's targeted survey were also confirmed by data from this study's interview programme and focus group on Joint Actions, as detailed in A5.4 in Annex 5. Examples of successful actions funded under the 3HP which contributed to EU's influence on health issues at international level include the Orphanet nomenclature of rare diseases.

Q4 Conclusions

In conclusion, the 3HP contributed to a more comprehensive and uniform approach to health issues across the EU, in some policy areas more than in others (i.e., in the areas of AMR and HTA more than in the field of childhood obesity). Furthermore, measures implemented by Member States were aligned with the specific objectives and thematic priorities of the 3HP, as was discussed more extensively under Q1. Consulted stakeholders reported that national actions reflected evidence and evidence-based approaches developed through 3HP funding. Lastly, the 3HP was found to have contributed to an increase in the robustness, timeliness and comparability of health data across EU countries, through the establishment of several EU-wide data systems such as the EU quality register ensuring the safety of medical devices and the organ database.

Moreover, the knowledge produced by the 3HP was used in policy making as it has informed national strategies and initiatives (e.g., in the areas of cancer, AMR, HTA, blood, tissues and

cells). The 3HP has also contributed to improvements in health and healthcare across the EU, in particular in the fields of vaccination, AMR prevention and HTA. However, some limitations to the 3HP contribution to improvements in health across Europe emerge which are related to the national dimension. In particular, some factors limiting the 3HP contribution to health improvements are linked to the national capacity to participate in the 3HP and to coordinate and engage between different governance levels (i.e., national, subnational and local levels). While it is worth acknowledging them in view of finding ways to facilitate participation of countries with less resources, it needs to be noted that those limitations are not directly connected to the 3HP, rather they pertain to the national dimension of participating countries.

In terms of the 3HP's effectiveness at the international level, this study found limited evidence substantiating the assessment of the 3HP contribution to EU's influence on health and healthcare standards, policies and practices at international level. This is, however, partly explained by the geographical scope of the 3HP which is limited to its participating countries. However, the available information stemming from this study's consultation activities shows that the 3HP contributed to some extent to the EU's influence on health and healthcare standards, policies and practices at international level, especially in the field of rare diseases, AMR and vaccination. For example, action under the 3HP has empowered the rare disease community, including experts and patient organisations, in promoting global networks for rare diseases, and the Orphanet nomenclature of rare diseases is now implemented in non-EU countries. Moreover, 3HP action contributed to bringing higher visibility to vaccination at the international level.

3.2.2. Q5. To what extent have the Programme's objectives (general and specific) been met? To what extent can factors influencing the observed achievements be linked to the EU intervention?

This section discusses the extent to which actions implemented under the 3HP contributed to achieving its objectives and presents factors which have hindered it. The assessment draws together the evidence collected through desk research and consultation activities.

The study's results demonstrate that funded actions contributed to achieving the 3HP objectives to a very good extent, in particular objective 1 and objective 4. However, some areas (e.g., health security, socioeconomic determinants of health) were less addressed than others. Factors hindering the full achievement of the 3HP objectives include lack of resources, expertise and data, difficulties engaging with stakeholders, and lack of political will in Member States. While the identified factors are mostly related to the national dimension, thus not directly attributable to the 3HP, there is room for EU action to address them. The following subsections present the evidence base that substantiates this assessment.

Funded actions contribution to achieving 3HP objectives (Q5a)

Overall, funded actions contributed to achieving the 3HP objectives to a very good extent, in particular objective 1 and objective 4. The available data shows that the most effective funded actions were Joint Actions and Projects. However, there are some areas (e.g., health security, socioeconomic determinants of health) which were not effectively addressed and instruments (e.g., Presidency conferences) which were less effective than others.

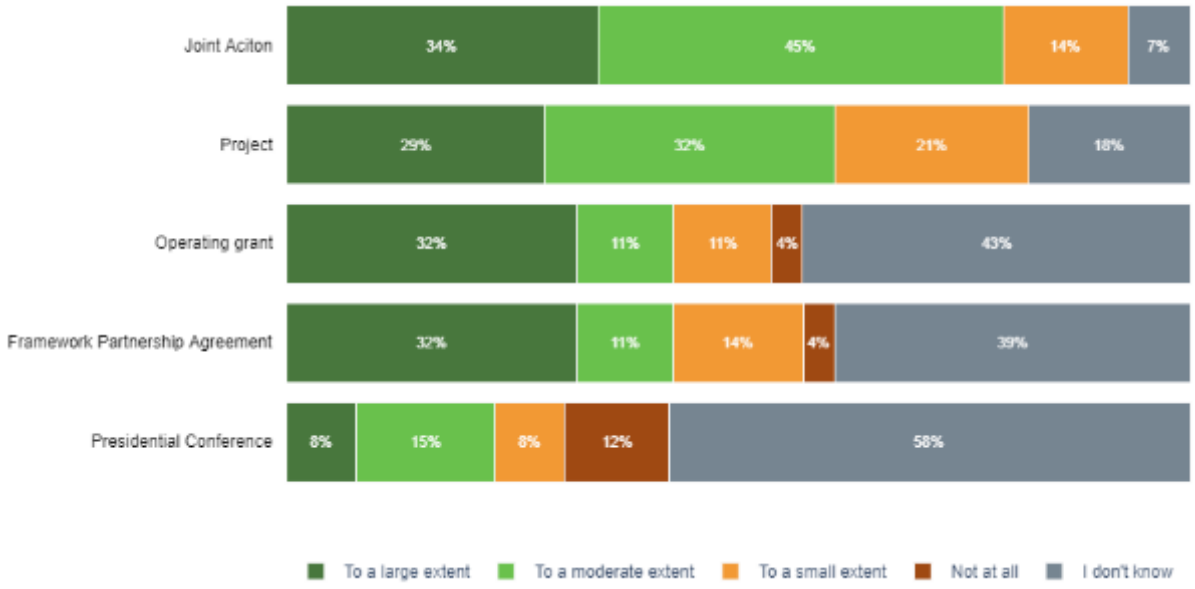
Over the 3HP implementation period, a number of health topics have been considered by the Commission as particularly important and the related funded actions have been singled out as 'highlights of the year' in the annual implementation reports of the Programme. The review of the 3HP implementation reports covering the reference period 2014-2020 shows that the Commission has considered particularly important over the years themes such as chronic diseases, migrant's health, lifestyle risk factors, HTA, rare diseases and vaccination. The great majority of funded actions identified as 'highlights of the year' were Joint Actions, followed by Projects, and to a lower extent Direct Grants to international organisation and service

contracts. A complete overview of the priority themes and related funded actions is presented in A5.5 in Annex 5.

When comparing the above priority themes with the health needs identified under Q1 (see 3.1.1. Q1. To what extent have the Programme's scope, including its objectives and priorities been relevant to health needs across the EU, considering their evolution over the evaluation period?), it emerges that some of the themes that the Commission has identified over the years as the most important ones, were also considered as the most relevant health needs across the EU. This is especially the case for themes under objective 1 (i.e., lifestyle risk factors such as drugs, tobacco and harmful alcohol consumption; and chronic diseases) and objective 4 (i.e., rare diseases). Conversely, other 3HP priority themes identified by the Commission were not recognised as key health needs across the EU. This was observed, in particular, for priority themes under objectives 2 and 3. This can be partly explained by the fact that national strategies in the participating countries very much focused on areas under 3HP objective 4 (Better and safer healthcare) and 3HP objective 1 (Health promotion), as discussed under Q1.

The effectiveness of Joint Actions and Projects, as assessed in the Programme annual implementation reports, is confirmed by this study's targeted survey findings. Targeted survey respondents were asked about which funded actions contributed to achieving the objectives of the Programme. The actions that were most frequently mentioned were: Joint Actions (23 responses, 79%) and Projects (17, 61%). In contrast, Presidency Conferences were less frequently mentioned, with some respondents citing they did not contribute to achieving the objectives of the Programme at all, even if they have a high political visibility.

Figure 12. Targeted stakeholder survey: To what extent have the funded actions you have been involved in contributed to achieving the objectives of the Programme? (n=32)



Most stakeholders interviewed as part of this study confirmed the effectiveness of funded actions in achieving the 3HP objectives. Participants in this study's focus group on project grants provided examples of successful actions such as the European Reference Networks and other consulted stakeholders identified some themes which were effectively addressed, including safety of care, AMR, vaccination, nutrition and alcohol. Further details are provided in A5.5 in Annex 5.

When considering the theme of alcohol, findings from the dedicated case study show that the 3HP has successfully contributed to addressing the objectives and priorities in the area of alcohol marketing, as detailed in the box below.

Relevant findings from the Case study on Alcohol

The EU has acted through the 3HP to address alcohol consumption. Specifically related to the sub-theme of the effectiveness of reducing alcohol related harm and alcohol marketing. This topic is explored through an in-depth examination of Reducing Alcohol Related Harm (RAHRA) joint action under the Second Health Programme (2HP) and its progression into the Third Health Programme (3HP) through the "Conference on Cross-border Aspects in Alcohol Policy- Tackling Harmful use of Alcohol":

- The Joint Action on Reducing Alcohol Related Harm **(RAHRA)**, which aims to support Member States in carrying out work on common priorities in line with the 2006 EU Alcohol Strategy and strengthen Member State capacity to reduce and address alcohol harm. RAHRA contributed to capacity building and strengthen the ability to deliver a survey methodology and monitoring instrument for alcohol related-harm.
- The Presidency Conference named "**Conference on Cross-border Aspects in Alcohol Policy- Tackling Harmful use of Alcohol"**, which aimed to continue the work of RAHRA under the 2HP on alcohol- related harm by focusing on strengthening Member State capacity to implement effective health policy and tackle cross-border issues with an emphasis on cross-border marketing. Furthermore, the objective was to discuss recent developments and envisage the future steps through common efforts to tackle the harmful use of alcohol in the EU. This Presidency Conference increased the understanding of cross-border issues in alcohol related harm across Member States, enabled exchange of information and views on alcohol, and facilitated future cooperation and coordination.

The EU has acted to develop actions that aim to improve alcohol policies across the EU. However, when analysing the type of actions implemented during the 3HP, there was a discontinuity with the work initiated during the 2HP by the RAHRA Joint Action (JA). Even though Member Sates requested to continue with a Joint Action on alcohol consumption during the 3HP, this was not fully achieved using the same funding instrument and to the same degree.

Even though a Joint Action on alcohol consumption was not funded under the 3HP, outputs from the RAHRA Joint Action implemented in the 2HP were further developed by other funding mechanisms, specifically by the DEEP SEAS[61] service contract and by the Presidency Conference on alcohol marketing. Therefore, through these two actions, the study team evidenced the efforts of the 3HP to continue exploring and researching ways to reduce alcohol-related harm in the EU.

Overall, the case study findings show that the 3HP has successfully contributed to a more comprehensive and uniform approach concerning possible pathways to regulate alcohol marketing across the EU as well as addressing the objectives and priorities in the area of alcohol marketing.

The full case study can be found in Annex 3.

While most consulted stakeholders agreed that the funded actions effectively addressed the 3HP specific objectives, some areas emerged as less addressed. Representatives from governmental public health organisations mentioned socio-economic health determinants, health literacy and digital health as areas where more work was needed. An academic institution reported there was strong emphasis on objective 1, but other 3HP objectives needed to be addressed more. A national policy maker highlighted health security as an area which was not addressed effectively while a representative from EU institutions noted a lack of engagement with crisis preparedness. As discussed under Q1, overall, health threats were not a topic which was highly prioritised by participating countries during the 3HP implementation period, and, when considering the programme overall, objective 2 received the lowest amount of funding within the 3HP. However, the comparatively lower amount of 3HP funding dedicated to objective 2 can be explained by the fact that themes related to health security and cross-border health threats were addressed also via other EU-level actions and mechanisms not directly funded in the context of the 3HP (e.g., the 'Early Warning and Response System' (EWRS), the Health Security Committee, the EU Civil Protection Mechanism).

The effectiveness of 3HP funded actions is also reflected in the positive trend of most key performance indicators. Figure 13 shows that trends are positive for most indicators identified in the Annex of the 2020 Health Programme Statement[62] which show progress in a few specific areas. For example, by the end of 2020, 24 out of 30 ERNs had been established in

61 DEEP SEAS., 2014. About DEEP SEAS. Available at: About DEEP SEAS | Deep Seas (deep-seas.eu)

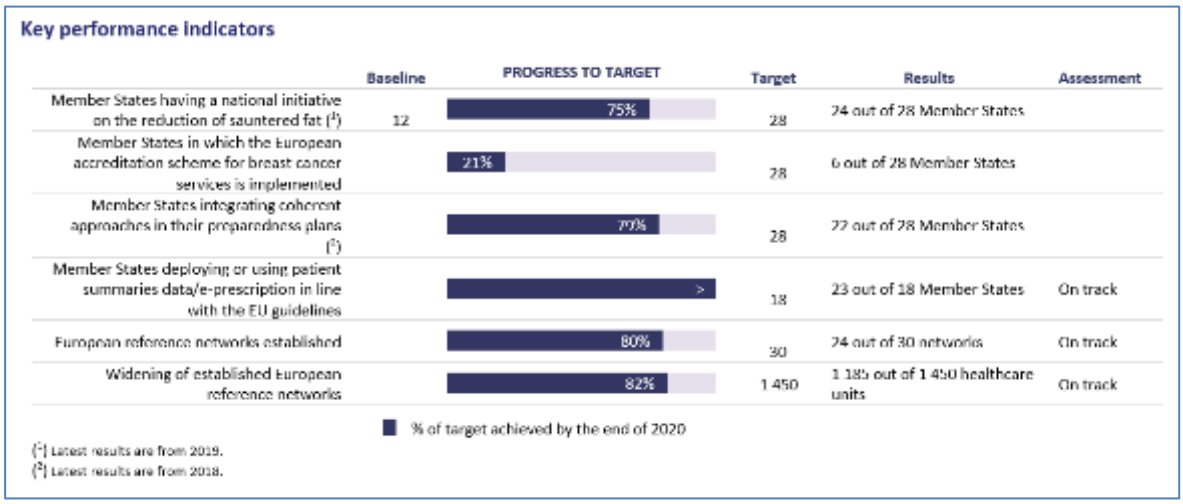
62 European Commission.,(n.d.). Union Action in the field of health (Health Programme 2020).[Pending publication]. [Accessed November 2021].

accordance with Directive 2011/24/EU, showing good progress related to the 3HP specific objective 4 on access to better and safer healthcare for Union citizens. As discussed under Q4, the establishment of the ERNs is considered a flagship achievement of the 3HP and an action which improved health and health care in the EU and at Member State level, since those networks promoted a high level of coordination between healthcare providers across Europe and pooled knowledge and resources to tackle the complex issue of rare diseases.

Furthermore, when considering the indicators relevant to the 3HP specific objective 3 'advice produced and number of Member States using the tools and mechanisms identified in order to contribute to effective results in their health systems', it is worth noting the progress achieved in the area of HTA. Findings from the case study on the EUnetHTA JA3 (Annex 3) show that the production of joint assessments and the number of countries that have used them increased under Joint Action 3 as compared to the previous Joint Action (EUnetHTA Joint Action 2). As discussed under Q4 and further in section 3.4 on EU added value, the outputs of EUnetHTA Joint Action 3 supported Member States informing national strategies and initiatives. Further, HTA is an area of strong EU added value in that it created a collaborative infrastructure for national and local HTA authorities and enabled sustainable cooperation which also reflected in the recently adopted HTA regulation.

When considering other indicators, the 'number of Member States in which the European accreditation scheme for breast cancer services is implemented' saw a decrease. However, this is explained by the fact that in 2019, developers of guidelines and/or national authorities of (only) six Member States have used, implemented or adapted in their national cancer plans the European guidelines, evidence base or methodology developed by the European Commission initiative on breast cancer, coordinated by the Joint Research Centre.

Figure 13. 3HP extract of key performance indicators



- Source: Annex of the 2020 Health Programme Statement[63]

Factors hindering the achievement of the 3HP objectives (Q5b)

Consulted stakeholders identified several factors hindering the achievement of the 3HP objectives, including insufficient resources, expertise and data, difficulties engaging with stakeholders, lack of political will in Member States and difficulties in quantifying/measuring success.

Various stakeholder groups highlighted different types of challenges. National policy makers and representatives from governmental public health organisations reported limitations such as lack of resources, difficulties engaging with stakeholders and insufficient results

[63] European Commission.,(n.d.). Union Action in the field of health (Health Programme 2020).[Pending publication]. [Accessed November 2021].

dissemination and therefore knowledge of instances of successful implementation. A national policy maker also felt that although objectives were met in regard to implementation,

> *'the real impact and sustainability of the actions beyond the duration of the programme fade away' (GP_26).*

A representative from a governmental public health organisation identified the lack of data and knowledge of population health needs as a limiting factor.

> *'If Member States don't have mechanisms already existing which measure needs and adapt European programmes to their national priorities, then there is a problem in the chain of implementation' (GPH_28)*

Other challenges included:

- A stakeholder from an NGO highlighted the need for increased synergies across different EU programmes (beyond the Health Programme), including on themes such as vulnerable and marginalised groups and marginalised groups, drugs, hepatitis, and HIV which are topics that have impacts or are influenced by other policy fields.
- A stakeholder from an organisation representing patients and service providers reported that lack of political will in Member States which prevented participation and therefore impacted populations' ability to benefit from 3HP actions.
- Lastly, representatives from academic institutions pointed out that lack of cultural awareness (especially in the area of migrants' health), differences in countries' engagement, lack of expertise and difficulties in quantifying success, were all factors hindering the achievement of the 3HP objectives.

Q5 Conclusions

In conclusion, funded actions contributed to achieving the 3HP objectives to a very good extent (particularly under objective 1 and objective 4), although there were a few areas which were less funded than others, including health security and socioeconomic determinants of health. The finding above is in line with the conclusions under Q1, as health threats was not an area which was highly prioritised by participating countries (at the start of the Programming period), and when considering the 3HP as a whole, objective 2 received the lowest amount of funding within the 3HP. However, it is important to note that the theme of health threats was addressed by the Commission via other means and mechanisms outside of the 3HP (e.g., EWRS, Health Security Committee, ECDC, EU Civil Protection Mechanism).

That being said, there were some factors which hindered the achievement of the 3HP objectives, and these have been found to limit the 3HP contribution to improvements in health across Europe. These factors were, however, mostly related to limitations at the national and beneficiary level (thus not directly attributable to the 3HP), including: limited resources, capacity, political will and difficulties engaging with stakeholders. Nevertheless, there is room for strengthened and more effective EU action to address those limitations and support Member States. Increased resources at EU level dedicated to health issues (including, but not limited to, the 3HP) would contribute to address the national difficulties in participating in the Health Programme. Further, an even stronger role of the Commission in brokering the existing knowledge and pooling the existing data and resources being generated would contribute to closing the knowledge gaps where needed while also steering national action.

3.2.3. Q6. How effective was the introduction of "exceptional utility" criteria in the Regulation establishing the Programme to incentivize participation of low GNI countries?

This section assesses the extent to which the 'exceptional utility' criteria incentivised participation of low-GNI countries. The assessment draws together the evidence collected through the analysis of trends from the public-facing database and consultation activities. The study's results demonstrate that programme participation by low GDP countries did not

increase over time, and while participation did increase as compared to the 2HP, this was not attributable to the criteria. The following text presents the evidence base/findings that substantiate this assessment.

The exceptional utility criteria

The exceptional utility criteria provided for a higher level of co-funding for actions that include a certain proportion of members from low-GNI countries. The exceptional utility criteria applied to three funding mechanisms: Joint Actions, Project Grants and Operating Grants**.** It allowed for a higher rate of co-funding for all organisations in an action that includes a certain proportion of members, with a certain level of involvement, from low GNI participating countries. These criteria were introduced during 2HP; however, they have evolved over time and were different in 3HP compared to 2HP. The precise parameters differed depending on the funding mechanism in question; see Table 5.

Table 5. Criteria for exceptional utility

Funding mechanism	Criteria for exceptional utility under 3HP (2014 – 2016)
Joint Actions	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.
Projects	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 most demonstrate excellence in furthering public health in Europe and a very high EU added value[64]
Operating grants	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.

Source: Mid-term evaluation[65]

As reported in the mid-term evaluation, a country needed a GNI of less than 90% of the EU average to qualify for the exceptional utility criteria. 16 countries met these requirements (CY, CZ, EE, EL, ES, HR, HU, LT, LV, MT, PL, PT, RO, SI, SK). Non-EU Member States (e.g., Moldova) were not included in these criteria. Importantly, due to the slow change in GNI figures, the list of 16 Member States was the same throughout the whole duration of the programme (2014-2020).

The exceptional utility criteria started from the beginning of the programme in 2014, as it was included of the 3HP adopted in 2014 Regulation (EU) N° 282/2014 Article 7 point 3. The exceptional utility criteria initially only applied to Joint Actions, but it was then extended to

[64] This last part "and a very high EU added value" was removed in the 2016 AWP.
[65] Coffey International Development (2017)

Project Grants and to Operating Grants. When an action was awarded "exceptional utility", all participating organisations could receive the higher rate of funding (of up to 80% compared to the "regular" co-funding rate of 60%) irrespective of the type of mechanism[66]. Another change made between 2HP and 3HP is that there were no longer conditions aiming to "promote the involvement of new actors for health".

The exceptional utility criteria were used relatively often; according to the annual implementation reports, there were between 2-12 funded actions which met these criteria per year. In the targeted stakeholder survey organised as part of this study, respondents often did not know whether their Member State had used this mechanism (see A5.6 in Annex 5), and therefore limited evidence was found to assess this.

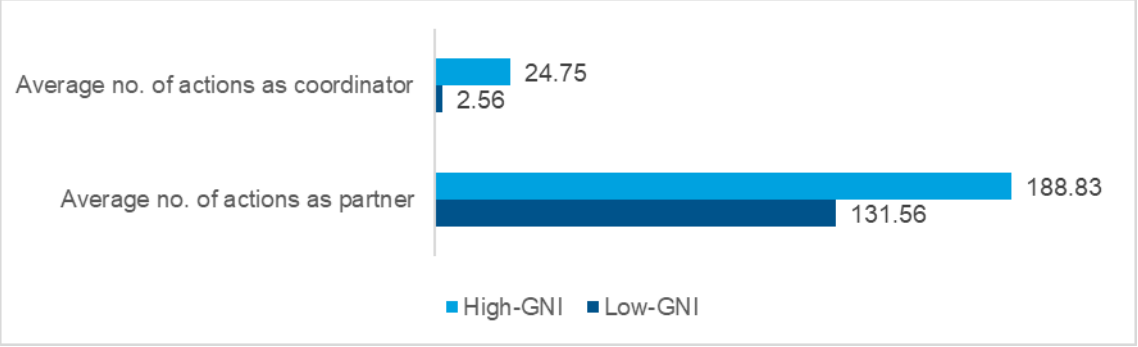
Participation rates of low- and high-GNI[67] countries (Q6a)

Low-GNI countries had a lower overall participation rate in 3HP actions when compared with high-GNI countries.

During interviews undertaken as part of this study, EU-level government policy makers felt that there were more partners participating low-GNI countries due to added benefits from the exceptional utility criteria. Some other stakeholders reflected on benefits of the criteria. Two of the three public authorities who said in the targeted stakeholder survey that their Member State applied for funding using the exceptional utility criterion (in Italy[68] and Poland) added that their country's participation had been incentivized by the criterion to a small extent, and the third one (in Lithuania) said the criterion had incentivised their participation to a moderate extent. In the focus group on Joint Actions, a governmental public health organisation reported that the criteria were sensible and effective for partners who worked heavily on the action. In the same focus group, a stakeholder from a Governmental public health organisation reported that the criteria made it much easier for partners to participate as a 40% contribution is prohibitive to some partners, so the 20% level makes it more accessible. Also in the same focus group, an academic / research organisation stakeholder reported that in two Joint Actions they worked on, they used the exceptional utility criteria so that more budget could go to low GNI countries. Finally, a stakeholder from HaDEA mentioned information sessions run by the Agency as particularly useful for alerting potential beneficiaries to actions.

However, in an interview, one EU-level government policy maker felt unsure as to whether the exceptional utility criterion was enough to attract low GNI countries. Indeed, the public-facing data (Figure 14) indicates that low-GNI countries were less likely on average to participate in funded actions as partners or coordinators than high-GNI countries. See Annex A5.6 in Annex 5 for country-level graphs.

Figure 14. Average number of actions Member States took part in the 3HP



[66] Coffey International Development (2017)

[67] Note in the present section, "low-GNI" and "high-GNI" are used to refer to countries which did and did not meet the exceptional utility criteria, respectively.

[68] Note that Italy is not a low-GNI country as considered by the criteria. Therefore, this public authority may have participated in an action where the lead partner on a funded action fell under the criteria.

Consulted stakeholders shed some light on why low-GNI countries may have been hindered despite the criteria. A governmental public health organisation reported that while the criteria did incentivise low-GNI countries, this may have been because of pressure from other countries:

> *"Participation is a common interest for all countries and high-income countries push low-income countries to participate." (GPH_5)*

A key barrier (to participation by low-GNI countries in the 3HP) was administrative issues and costs. In an interview, an EU-level government policy maker highlighted that it can be difficult for some countries to accept the role of project coordinator, particularly without adequate finances. The three public authorities who said in the targeted stakeholder survey their Member State did not apply for funding using the exceptional utility criterion (in Croatia, Ireland and Sweden) said that a number of factors determined the decision to not apply for funding under the exceptional utility criterion, including: the lack of administrative capacity to manage actions in the Member State, the administrative burden (once project is up and running), and the complexity of application process. Only six academic/research organisations and NGOs (50%) said that the scope of the exceptional utility criterion reduced the differences in costs and benefits between countries. Similarly, more than half of surveyed respondents said they did not know whether simplification measures related to the exceptional utility criteria had, in practice, reduced administrative costs (17 responses, 53%). See A5.6 in Annex 5. Those who did provide an answer tended to say that these measures did not reduce administrative costs, or only to a small extent.

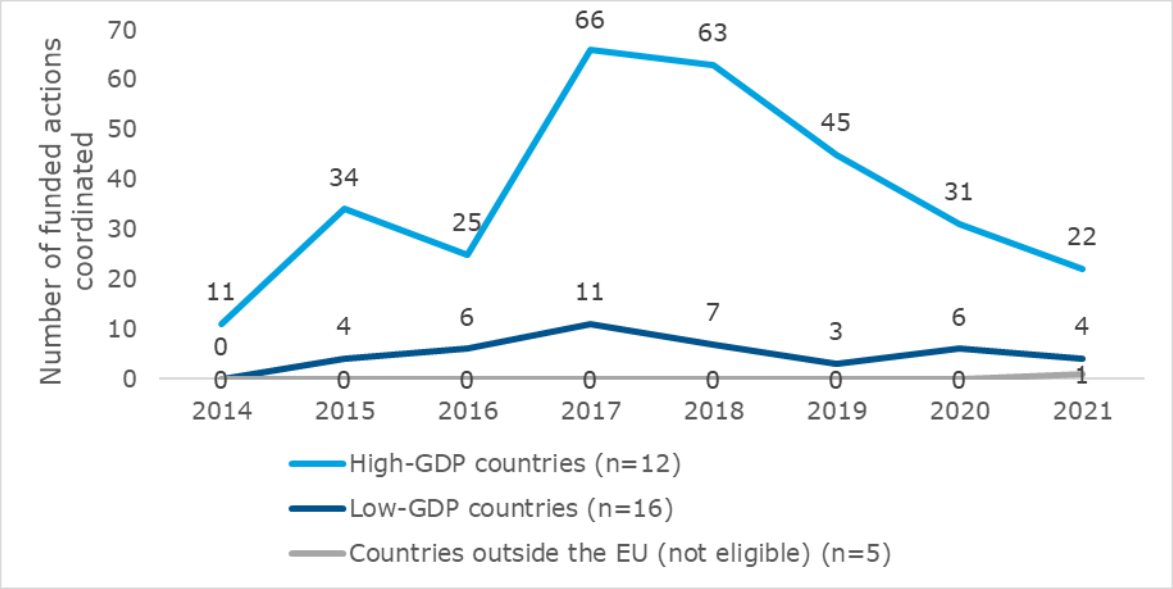
Further, in the focus group on Joint Actions, an academic / research organisation stakeholder reported that the criteria were a good instrument, but it is not always easy to use. Similarly, in the focus group on Project Grants, a stakeholder from an NGO said that applying to the exceptional utility criteria meant additional work as there are two conditions that must be met, one related to partners, and the other related to allocation in the budget.

In order to improve participation of low-GNI countries, an EU-level government policy maker and a governmental public health organisation both suggested that percentages should be changed, for example a raise from 60-80% to 70-90%. A government policy maker from outside the EU also suggested that the criteria needed to be improved and used more effectively.

Participation of low-GNI countries over time (Q6a)

Programme participation by low-GNI countries did not increase over time. Low-GNI countries did not coordinate more than 11 funded actions in one year, and in 2014 did not coordinate any actions at all. In contrast, the high-GNI countries coordinated between 11 and 66 actions per year. Some eligible countries (e.g., Czechia, Latvia, Lithuania and Poland) did not coordinate any funded actions at all.

Figure 15. Number of funded actions coordinated per year



- *Source: Public-facing HaDEA database on funded actions*

The types of funded actions coordinated by low-GNI countries also did not increase over time: none of the low-GNI countries coordinated the 36 operating grants or the 54 framework partnership agreements. However, eligible countries were proportionately more likely to coordinate a Presidency Conference: 4 of 10 conferences were coordinated by eligible countries. These findings are corroborated by an interviewed national policymaker who stated that it was often the case that newer Member States were not that successful in terms of participation in the Programme and specific actions such as tenders and projects. This was due mainly to limited national resources and tendency to prefer national operational programmes as part of European Structural and Investment Funds.

Participation of low-GNI countries since 2HP (Q6a)

Programme participation by low GNI countries has not increased as compared to the 2nd HP, according to data analysis conducted as part of this study.

The scope of the criteria was expanded between 2HP and 3HP. Previously, a country had to have a GDP per capita in the lower quartile of all EU MS, however this was increased to include those with a GNI of less than 90% of the EU average. Therefore, nine additional countries were eligible for the criteria under 3HP but not under 2HP.[69] Therefore, comparing participation across the health programmes can potentially indicate the influence of the criteria on Programme participation.

The "new" nine eligible countries did take part in more 3HP actions as partners than 2HP actions, however this was almost the exact same average increase as for the other low-GNI countries[70], therefore this increased participation is likely not due to the exceptional utility criteria. Further, all low-GNI countries coordinated fewer actions in 3HP compared to 2HP, and this decrease was starker for the "new" low-GNI countries.[71] See A5.6 in Annex 5 for more information. Taken together, low-GNI countries did not experience an exceptional increase in participation in 3HP. Explanatory factors for why this occurred did not emerge from the analysis, however as noted in the mid-term evaluation the conditions and practical details of the criterion may be either poorly understood or not sufficiently attractive.

[69] CY, CZ, EE, ES, EL, MT, PT, SI, SK

[70] The nine "new" low-GNI countries on average took part in 74.00 more actions in 3HP than 2HP, and the "old" low-GNI countries took part in 74.71 more on average. The high-GNI countries on average took part in 84.46 more actions.

[71] The nine "new" low-GNI countries on average coordinated 1.33 fewer actions in 3HP than 2HP, and the "old" low-GNI countries coordinated 0.71 fewer on average. High-GDPGNI counties on average coordinated 2.08 more actions in 3HP than 2HP.

Q6 Conclusions

The exceptional utility criteria intended to facilitate higher participation of low-GNI countries in the Programme, and stakeholders did perceive the criteria as having a positive impact. However, low-GNI countries had a lower overall participation rate in 3HP actions as coordinators and partners when compared with high-GNI countries. Further, programme participation by low-GNI countries did not increase over time, and programme participation by low-GNI countries did not increase as compared to the 2nd HP (in fact, low-GNI countries coordinated fewer actions in 3HP compared to 2HP). The reasons for why the criteria did not facilitate much increased participation are not abundantly clear, however overall administrative issues and costs were identified.

3.2.4. Q7. To what extent are the Programme's actions, outcomes and results published by Commission services, Programme beneficiaries and other stakeholders? To what extent are they made accessible to the international scientific and health community and to the wider public in the EU?

This section discusses the extent to which 3HP results were published, were made available to wider stakeholders and the public, and lastly were used by stakeholders in research or other activities. In particular, the study team examined the HaDEA public-facing database and collected views from stakeholders through this study's consultation activities on publication, dissemination and use of 3HP results.

The study's results demonstrate that 3HP results have, to some extent, been published and publications resulting from the 3HP have been made available to the wider stakeholders and public to a moderate extent. In this regard, it emerges that improvements to the dissemination of results are needed. These could be attained through Commission support to the dissemination of 3HP results by way of organising knowledge transfer activities (e.g., communities of practice, policy dialogues and other events). Lastly, 3HP results have been used by stakeholders; however, this could be further strengthened if limitations to dissemination are addressed.

This assessment draws together the evidence collected through desk research and consultation activities, as presented in the following sub-sections.

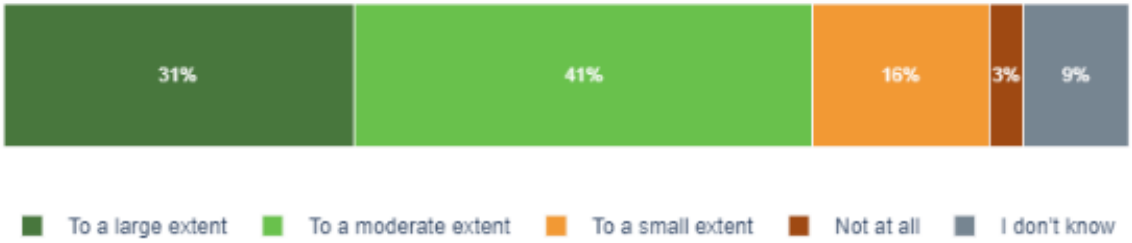
- *Publication of 3HP results and accessibility to the wider scientific and health community and to the public (Q7a and Q7b)*

The available data suggests that 3HP results have, to some extent, been published over the course of the 3HP implementation period by the Commission on the HaDEA dedicated public-facing database. Stakeholders also reported that publications resulting from 3HP actions have been published in scientific journals. Moreover, publications resulting from the 3HP are available to the wider stakeholders and to the general public to a moderate extent. However, the study found that improvements to the dissemination of results are needed.

The analysis of the HaDEA public-facing database identified 4,866 outputs related to 277 of the 339 funded actions under 3HP listed in the database. This corresponds to at least 1 output for 82% of the actions in the database, and an average of 17 outputs per funded action. Outputs were mainly classified as "documents and reports" (4,026 in total) but other types include "websites, patent filing, videos" (383), and "demonstrators, pilots and prototypes" (62). In the HaDEA public-facing database, outputs were classified as "layman", "newsletters" and "others". The most prevalent category was "others", making up 79% of all outputs, compared with only 2% of outputs being "newsletters" (2%) and "layman" (2%). More information can be found in Annex A5.7 in Annex 5.

The publication of 3HP results and outputs on the HaDEA dedicated database was confirmed by interviewed stakeholders and by participants in the focus group on Joint Actions. Moreover, different stakeholders from academic institutions and national policymakers reported that scientific publications linked to 3HP actions were published in scientific journals. When considering the accessibility of 3HP publications to the wider scientific and health community, most targeted stakeholder survey respondents said they had access to publications resulting from the Programme's actions/outcomes/results (23 respondents said this was true to at least a moderate extent, 73%). Among those who said this was not true or only to a small extent, reasons provided included the fact that many deliverables were delayed due to the COVID-19 crisis and uncertainty as to where these publications can be found.

Figure 16. Targeted stakeholder survey: To what extent do you have access to publications resulting from the Programme's actions/outcomes/results? (n=32)



Those findings are partly corroborated by information collected via this study's interview programme and focus groups.

Some stakeholders indicated that dissemination activities were effective in reaching out to the scientific community and the wider public. In particular, satisfaction was expressed by different consultees from academic institutions, EU institutions and governmental public health institutions, with the dissemination of reports and the organisation of events, conferences and information days.

However, several consulted stakeholders reported limitations to access to publications and dissemination activities. Stakeholders from academia, for instance, flagged a lack of contact between researchers and the private sector, the need for better engagement with health services, and a lack of emphasis on dissemination in the context of the funded actions they were involved in. Similar concerns were raised by representatives from governmental public health organisations who reported that dissemination of results was not formally required and that, in the case of Joint Actions, despite a huge volume of activities, specialists and the wider population had not been systematically informed of such results. The findings above point to difficulties in developing and implementing dissemination activities in the context of the funded actions on the part of 3HP beneficiaries, including Member States' competent authorities in the case of Joint Actions. Furthermore, representatives from EU institutions reported that there is no systematic way in place to monitor the extent to which 3HP beneficiaries disseminate findings after a project, therefore it can be difficult to assess how funded actions directly impact citizens.

Additional specific support from the EU-level, using the existing funding programmes (such as the EU4Health - as a successor to the 3HP) which could harmonise and strengthen dissemination of outputs, was suggested during stakeholder consultations. In particular, it was suggested that the European Commission could support the dissemination of projects results, through communities of practices, roundtables, and other tools, as a way to translate the results of the projects into action and bring this evidence into policy making. For instance, the support provided by CHAFEA (now HaDEA) in disseminating and promoting the tool developed under the SCIROCCO funded action was considered a concrete example of actions facilitating dissemination and thus sustainability of 3HP results.

• *Use of 3HP results (Q7c)*

3HP results have been used by stakeholders; however, there is room for improvement if limitations to dissemination are addressed.

- Data and insights that emerged from the consultation activities held as part of this study show that stakeholders have used outputs and results from 3HP activities. An interviewed stakeholder from an organisation representing patients and services users highlighted some results used by stakeholders, including outputs from the European Network for Health Technology Assessment - Joint Action 3 (EUnetHTA JA3)[72] which supported legislation; results of CHRODIS and CHRODIS +[73] which generated screening guidelines.
- Findings from the case study on the EUnetHTA JA3 show that the production and use of pharmaceutical assessments (both joint assessments and collaborative assessments) increased under Joint Action 3 as compared to the previous Joint Action (EUnetHTA Joint Action 2) funded under the 2nd Health Programme. When considering other technologies there has been increased production of joint assessments and collaborative assessments; but a slightly decreased use which can partly be explained by limited national capacity and increased outputs under Joint Action 3, and by the fact that other HTA processes are not fully established in some countries. For both pharmaceuticals and other technologies there is an increased number of countries that have used JA/CA under Joint Action 3 compared to Joint Action 2.[74] Further details on the HTA case study can be found in Annex 3.
- Stakeholders from healthcare professional organisations and national policy makers mentioned other EU funded actions that produced results used by stakeholders, including the RARHA Joint Action[75] and the Oramma project.[76] A representative from an international organisation reported that products such as the OECD 'Health at a Glance' publication, chronic disease reports and reports on pharmaceuticals all had very good response from policy makers in countries and at the EU level.

Moreover, 3HP results have been reported as being impactful for different actors in different ways. A representative from a governmental public health organisation reported that dissemination of results has raised awareness among patients and healthcare providers in the field of digital health, tackling scepticism and helping realise a European digital health space. A stakeholder from a healthcare service provider reported that the scientific publications resulting from actions helped prove to ministries of health that interventions were effective. Similarly, a representative from a healthcare professional association felt that communication measures allowed them to create an impact at user level at the local and regional level.

Only a few stakeholders who participated in this study's interview programme were uncertain as to whether tools produced, including in the context of Joint Actions, were used, in particular a stakeholder from an organisation representing patients and services users and a representative from an academic institution.

• *Q7 Conclusions*

In conclusion, 3HP results have, to varying extents, been published by the Commission services and by other stakeholders in scientific journals. Furthermore, publications resulting

[72] EUnetHTA Joint Action 3 aimed to define and implement a sustainable model for the scientific and technical cooperation on Health Technology Assessment (HTA) in Europe.

[73] The Joint Action addressing chronic diseases and promoting healthy ageing across the life cycle (CHRODIS) and the Joint Action and the Joint Action CHRODIS-PLUS: Implementing good practices for chronic diseases aimed to promote and facilitate the exchange and transfer of good practices across Europe, addressing chronic conditions, with a specific focus on health promotion and prevention of chronic conditions, multi-morbidity and diabetes.

[74] EUnetHTA Work Package 7, Deliverable 7.2 – Final report. Available at: https://www.eunethta.eu/wp-content/uploads/2020/07/Final-Deliverable-7.2-report-after-consultation_FINAL.pdf?x69613

[75] The Joint Action on Reducing Alcohol Related Harm [RARHA] aimed to support Member States to cooperate towards uptake, exchange and development of common approaches relating to the underpinning priorities of the EU alcohol strategy.

[76] The ORAMMA project aimed to promote safe pregnancy and childbirth through efficient provision of, access to, and use of quality skilled care for all migrant and refugee women and their infants.

from the 3HP are available to the wider stakeholders and to the general public to a moderate extent. It emerges that 3HP beneficiaries, in particular Member States competent authorities involved in Joint Actions, faced difficulties in publishing and disseminating the results of funded actions. In fact, the findings emerging from the consultation activities point to the need to improve dissemination of 3HP results. However, while the Commission could provide support to the dissemination of 3HP results by way of organising knowledge transfer activities (e.g., communities of practice, policy dialogues and other events), the observed limitations to the dissemination of 3HP results cannot be considered a shortcoming of the Programme itself, rather a responsibility of Programme beneficiaries, in particular Member States competent authorities involved in funded actions (i.e., Joint Actions).

Lastly, 3HP results have also been used by stakeholders in various ways, for example for sharing insights, knowledge and findings on pertinent topics, in particular in the contexts of Joint Actions (such as EUnetHTAs, CHRODIS and CHRODIS+, and the RARHA Joint Action). Despite those successes and considering the limitations to dissemination discussed above, it can be concluded that there is room for improvement in the use of 3HP results if those limitations are addressed.

3.2.5. Q8. To what extent have the recommendations from previous evaluations been implemented?

This section discusses the extent to which the recommendations from the 3HP mid-term evaluation have been implemented.

The study's results demonstrate that some of the recommendations (i.e., maintaining a focus on thematic areas of strong EU added value, and strengthening and building links between the 3HP and wider Commission & EU policy agenda to maximise impact) have been sufficiently addressed, while others (e.g., spelling out how action targeting health promotion & health systems should generate EU added value, and investing in the resources necessary to improve systems for monitoring programme implementation) have not yet been fully taken onboard. This assessment draws together the evidence collected through desk research and consultation activities, as presented in the following sub-sections.

Implementation of previous recommendations (Q8a to Q8j)

DG SANTE and CHAFEA (now HaDEA) have taken steps to address the 10 recommendations included in the 3HP mid-term evaluation.

Table 6 presents an overview of the findings emerging from the analysed evidence as to the extent to which recommendations have been successfully implemented over the remainder of the 3HP, and since its mid-term evaluation. The complete analysis and related findings are included in A5.8 in Annex 5.

Table 6. Implementation of recommendations included in the 3HP mid-term evaluation

Recommendations	Extent to which recommendation have been implemented	Supporting evidence
Recommendation 1: Maintaining a focus on thematic areas of strong EU added value (Q8a)	DG SANTE **sufficiently** prioritised and acted upon areas of greatest added value to the EU	Desk research (EQ18) Targeted Survey Targeted interviews Focus group

Recommendations	Extent to which recommendation have been implemented	Supporting evidence
Recommendation 2: Strengthening and building links between the 3HP and wider Commission & EU policy agenda to maximise impact (Q8b)	DG SANTE **sufficiently** strengthened and built links between the Programme and wider Commission & EU policy agenda to maximise impact	Desk research (EQ2) Targeted Survey
Spelling out how action targeting health promotion & health systems should generate EU added value (Q8c)	The limited data available shows that consulted stakeholders believe that DG SANTE **did not sufficiently** spell out how action targeting health promotion and health systems should generate EU added value.	Targeted interviews
Recommendation 4: Refining 3HP thematic priorities and streamlining them in EU4Health to focus spending on areas with the greatest potential impact (Q8d)	DG SANTE has refined the 3HP thematic priorities and streamlined them in EU4Health only **to a moderate extent.** This is partly due to the collaborative nature of designing the EU4Health programme which comprises different actors. In addition, following the COVID-19 pandemic, EU action through EU4Health has been significantly redesigned and restructured, ultimately breaking the continuity with the 3HP. Therefore, it is difficult to assess the uptake of this recommendation.	Desk research Targeted interviews
Recommendation 5: Refining the EU-added value criteria and fully integrating these into the application process (Q8e)	While the EU added value criteria were improved compared to 2HP, most stakeholders did not know whether those criteria improved the application process and the extent to which they were used by DG SANTE & Chafea in a more integrated way in the application process	Desk research Targeted Survey Targeted interviews
Recommendation 6: Integrating multi-annual planning with existing programme processes (Q8f)	DG SANTE integrated multi-annual planning within existing programme processes **to a good extent; however, some limitations exist**	Desk research Targeted Survey Targeted interviews
Recommendation 7: Developing a broader strategy to increase participation from poorer MS & underrepresented organisations (Q8g)	DG SANTE & Chafea (now HaDEA) developed a broader strategy to increase participation from lower-income MS & underrepresented organisations (distinct from the exceptional utility criterion). Nonetheless, low-GNI countries participation in the 3HP has not increased as compared to the 2HP, which is reasonably due to conditions pertaining the national dimension.	Desk research (EQ6) Targeted Survey Targeted interviews
Recommendation 8: Investing in the resources necessary to improve systems for monitoring programme implementation (Q8h)	It is unclear whether the appropriate resources have been invested to monitor the Programme's implementation. Furthermore, most consulted stakeholders across all groups (both in the interview programme and the focus groups) raised concerns about the effectiveness of the systems for monitoring the programme implementation	Desk research Targeted interviews

Recommendations	Extent to which recommendation have been implemented	Supporting evidence
Recommendation 9: Implementing and using programmatic and action specific monitoring indicators (Q8i)	The limited data available shows that consulted stakeholders expressed satisfaction with key performance indicators developed by Chafea (now HaDEA) and outcome indicators developed in the context of individual funded actions	Targeted interviews
Recommendation 10: Improving dissemination of action results (Q8j)	DG SANTE and Chafea have adopted and implemented a dissemination strategy which overall improved dissemination results. . However, limitations at the stakeholders' level exist in terms of engaging with the dissemination activities.	Desk research Targeted interviews

Q8 Conclusions

In conclusion, some of the recommendations stemming from the 3HP mid-term evaluation have been addressed successfully. These include maintaining a focus on thematic areas of strong EU added value, strengthening and building links between the 3HP and wider Commission & EU policy agenda to maximise impact, developing a broader strategy to increase participation from poorer MS & underrepresented organisations and improving dissemination of action results. Conversely, some recommendations were not sufficiently taken up, including spelling out how actions targeting health promotion and health systems should generate EU added value and investing in the resources necessary to improve systems for monitoring Programme implementation. The latter recommendations, alongside with those which were only partially met, should be followed upon in the context of the new EU4Health Programme (and beyond). Similarly, despite progress achieved in terms of dissemination of results and participation of low-GNI countries, there are still limitations which affect full uptake; however, these are not fully attributable to the 3HP and are in the large part issues stemming from national competences and operational/dissemination limitations at the national and regional levels.

3.2.6. Q9. How are the results and effects of the Programme likely to last at the end of its implementation if funding ceases to exist (self-sustainability)?

This section assesses the extent to which the Programme results and its effects were sustainable. The assessment draws together the evidence collected through consultation activities and examination of case study topics. The study's results demonstrate that Programme results and effects were, overall, sustainable, although there were a few explicit barriers to sustainability. This assessment draws together the evidence collected through desk research and consultation activities, as presented below.

When considering the assessment below, it is important to note that the need for sustainability of a funded action depends on the type of mechanism used and the explicit need for the funded action: for example, in the focus group on procurement contracts, a stakeholder from the European Commission reported that sustainability element is not considered in the same way during Procurement actions as it is in Grants. A procurement is instigated to fulfil a specific need in a specific point in time to feed in a policy-making or legislative process. Once this is delivered, the only issue surrounding sustainability is the usability of the results. However, for Grants, sustainability must be considered more strongly and explicitly, due to the nature of such actions and the way that networks and NCAs collaborate and build relationships.

Sustainability of the 3HP actions (Q9a)

Actions assessed in-depth through the case study analysis demonstrated good examples of sustainability. This was particularly true for funded actions which were aligned to explicit health needs and were known as policy areas where strong EU-added value was present.

- For example, 25% of targeted stakeholder survey respondents reported that Programme results and effects were very sustainable following HTAs (See A5.7 in Annex 5) The work developed under EUnetHTA strengthened the collaboration of national HTA agencies, promoting coordination and increasing production of HTA joint work. The activities of EUnetHTA laid a strong foundation for sustainable cooperation, and this has been reflected in the permanent framework for joint work established by the HTA Regulation.[77] The Regulation replaces the current system based on the voluntary network of national authorities and the project-based cooperation (Joint Actions EUnetHTA) with a permanent framework for joint work. See Annex 3 for more detailed information on this case study.
- Another area where funded actions within the 3HP were deemed sustainable related to AMR (13% of targeted stakeholder survey respondents found actions under AMR very sustainable), and in particular the Joint Action on AMR (EU-JAMRAI). WP4 of EU-JAMRAI focused entirely on the sustainability of the Joint Action after its completion, with a sustainability strategy developed to consolidate and further develop EU-JAMRAI results. Many EU-JAMRAI activities targeted Member State authorities, beyond just dissemination efforts. Additionally, the network created through the different activities has served as a basis to build a network of supervisory bodies in human health. Next steps for this network of supervisory bodies will be discussed in the AMR One Health Network and further taken up. As above, see A5.9 in Annex 5 for more detailed information.
- Further, the ERNs established through the 3HP had sustainable impacts: one of the tools the Commission developed for the ERNs was the Clinical Patient Management System (CPMS), which allowed for cross-border virtual consultations. Another tool was the registry for 5 ERNs which collected data at EU level for patients with rare diseases; these registries will be interoperable.[78] Specifically, the ERN PaedCan (a Framework Partnership Agreement) set the basis for the further development of this important model to address healthcare delivery for paediatric cancers as a collection of rare diseases.[79]
- Finally, the SCIROCCO[80] funded action has created sustainable outputs, as the tool is used in 35 countries by hundreds of thousands of users, and the users have reportedly found it very useful. CHAFEA (now HaDEA) was reportedly helpful in disseminating the evidence and promoting the tool. However, there are now questions about where to store the tool following the conclusion of 3HP.[81]

More broadly, some consulted stakeholders felt the effects of the 3HP were sustainable. In the targeted stakeholder survey, six respondents (19%) thought that the results of the Programme were very sustainable. Similarly, some interviewees and focus group participants felt the actions they were involved in were sustainable and mentioned other specific topics or Joint Actions which were seen as having particularly high sustainability; see A5.7 in Annex 5.

This study found that there were common elements and aspects of the 3HP itself which helped ensure projects would be sustainable following their conclusion, and overall, there was an increase in focus and planning around sustainability from both Member States and the Commission involved in the 3HP. For example, according to the case study analysis, and

[77] Judit Erdös et al. (2019), "European Collaboration in Health Technology Assessment (HTA): goals, methods and outcomes with specific focus on medical devices", Wien Med Wochenschr.
[78] Academic and research organisation, in the focus group on project grants.
[79] Targeted survey respondents.
[80] SCIROCCO – Scaling Integrated Care in Context. The SCIROCCO project validated and tested a self-assessment tool to identify the maturity of the health and social care systems for the adoption and scaling up of integrated care solutions.
[81] Government policy maker, in the focus group on project grants.

further corroborated by a governmental public health organisation during interviews, introducing an obligatory Work Package (WP) focusing just on the sustainability of the funded action, was a key success factor of the Joint Action on AMR (EU-JAMRAI). Stakeholders from an international organisation felt that when funds were more structured- by way of clarity on objectives and anticipated outputs, outcomes and clear reporting mechanisms, the sustainability of a funded action was almost by default more assured. Further, a stakeholder from DG SANTE highlighted that implementation of good practices are a positive way of ensuring sustainability as it helps ensure key stakeholders take up practices which have been determined to be the strongest. Related to good practices, in the focus group on Joint Actions, an academic/research organisation stakeholder discussed how the transfer of good practices to other regions needs to be further supported by practical implementation guidelines which, in turn, would support knowledge transfer from experts (supporting the good practice) to beneficiaries (implementing the good practice). An academic / research stakeholder reported that academic publications which follow a funded action do provide some sustainability.

Another key element in ensuring sustainability were the relationships and connections built through a funded action. An interviewed academic/research stakeholder stated that stakeholders were effectively engaged and had ownership and built networks which will last beyond the duration of the 3HP, which is crucial for sustainability. In the focus group on Joint Actions, an academic/research organisation stakeholder reported that a defining factor in sustainability was having a partner who "*has expertise in terms of sustainability strategies and defining actions to have sustainable results*". Similarly, in the same focus group a governmental public health organisation reported that results rely on the extent to which a broader network across Europe has been created:

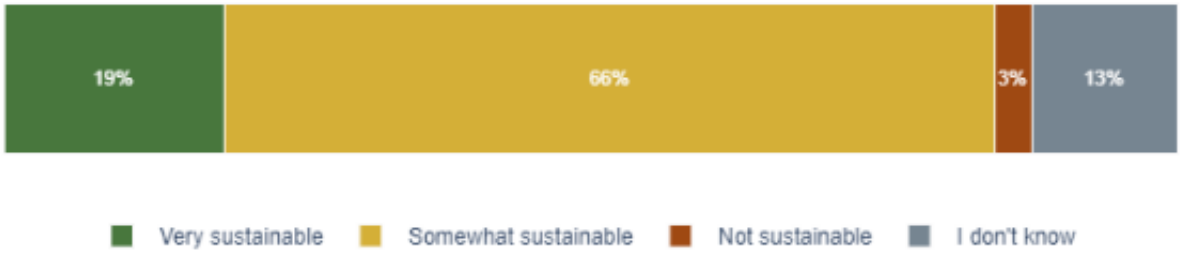
"We coordinated the JA within an area of expertise we already have ourselves, so what we took away from the JA was getting to know more partners across Europe and tools and what was developed were used in other works. Applying for new EU projects, we reach out to old partners, but we now know more NGOs, and are continuing to work with them."

The relationships, connections, and cooperation fostered through the 3HP represent a key element of the Programme's added value beyond the concrete action deliverables. See Section 3.4 for more information about added value.

Challenges to sustainability (Q9a)

In contrast to elements assessed as contributing positively to the sustainability of 3HP actions, most targeted stakeholder survey respondents felt that the results of the 3HP were somewhat sustainable (21 responses, 66%).

Figure 17. Targeted stakeholder survey: How sustainable do you think the results of the Programme (and its funded actions) are? (n=32)



A challenge impeding full and successful sustainability related to the integration of funded actions' results into policy making. Indeed, some stakeholders in interviews and focus groups noted that results from the Programme were not always integrated into policy, which was seen as a lost opportunity. For example, an interviewed stakeholder from a Healthcare Professionals' Association working on a Joint Action of rare cancers was concerned about the sustainability of the JA and the ERN PaedCan, as the recommendations needed to be followed up with implementation in order to make a difference.

Another challenge to sustainability found through stakeholder consultations was related to the design of the Programme, with actions not lending themselves to increasing sustainability- either due to the limited time duration of funded actions, or a slight mismatch between the results of the funded actions and the ability to implement them directly at local level. In the targeted stakeholder survey organised as part of this study, an EU public authority involved in the Programme design explained that results were mostly too limited in scale and or ambition to be sustainable. Furthermore, in the focus group on Project Grants, an NGO stakeholder highlighted that the short duration of funded actions has a negative impact on the sustainability of Project Grants in particular. In the same focus group, a government public health organisation mentioned that their project (SH-CAPAC)[82] was undertaken in response to the 2015 refugee crisis, but only lasted one year, which in this case was barely enough to establish a network of stakeholders to implement fully its objectives.

Stakeholders also discussed barriers faced related to specific funded actions; see A5.9 in Annex 5.

Some stakeholders provided recommendations for how to make the 3HP or similar programmes more sustainable, including creating an EU-level repository of outputs and outcomes of the funded actions, and more opportunities or funding for continuing existing projects to develop or be disseminated across more Member States. Moreover, as discussed under Q10, a few stakeholders reported some discrepancies in impacts foreseen and achieved due to insufficient funding and lack of follow-up work after a funded action ended. The findings emerging from the consultation activities point to the opportunity of continued efforts to fund critical actions which have proved successful under the 3HP and displayed a strong EU added value component. Against this background, efforts could be made to incentivise funding to continue and strengthen such critical actions, including by creating synergies between the health programme and other EU financial instruments addressing health issues. Section 4.6 of this report presents the study team's recommendations based on overall analysis.

External determinants of sustainability (Q9a)

The sustainability of 3HP actions depended on some external factors: mainly action taken by the participating countries, as the participating countries are able to take on board results and learning. In some cases, participating countries facilitated sustainability. An EU-level government policy maker felt that the 3HP allowed Member States to see whether actions are suitable and if they are, they can apply for other funding, and indeed an interviewed academic/research stakeholder stated that many projects received more funding to continue beyond the 3HP. In the focus group on Joint Actions, an academic/research organisation stakeholder highlighted policy dialogues as a useful approach to make actions more sustainable, commenting on good buy-in from policymakers in Member States. As a specific example of Member States creating sustainability, an EU-level government policy maker mentioned that Member States drafted and introduced their national cancer strategies following 3HP.

Another important external factor which made the effects of the 3HP more sustainable was found to be the link with EU legislation being adopted in that particular policy area. Findings from the case study on HTA show that the EUnetHTA Joint Action 3 funded under the 3HP created a collaborative infrastructure for national and local HTA authorities and enabled sustainable cooperation which reflected in the recently adopted HTA regulation. Additional information on the EUnetHTA Joint Action 3 can be found in Annex 3. In the focus group on Joint Actions, a governmental public health organisation further discussed the links to EU directives:

[82] The funded project SH-CAPAC, "Supporting health coordination, assessments, planning, access to health care and capacity building in Member States under particular migratory pressure", aimed to build and strengthen capacities among relevant stakeholders in the 19 target Member States covered by the project to adequately address health related challenges due to migratory pressure.

"sustainability depends on if a [Joint Action] works on implementing and supporting the implementation of an EU directive, which the different Member States are interested in. That would make it more sustainable. Other thematic areas depend on the support of the Member State. There's a big difference if you are aligned with an EU directive that's going to be implemented or not"

However, there were also some challenges to sustainability which were external to the 3HP itself and related to issues with sustained funding over time and political will, notably:

- Permanence of EU budget and funding: A stakeholder from DG SANTE highlighted difficulties in achieving sustainability due to there being no permanent funding in the EU budget. This stakeholder reported they have tried to tackle this by institutionalising processes (for example surveillance for communicable diseases was replaced by establishing the European Centre for Disease Prevention and Control) and encouraging Member States to take over financing of important initiatives.
- Limitations to Member States' ability to take over the funding of completed projects: an EU-level governmental public health organisation reported that the funding for eHaction[83] was the last for supporting the policy and in the future will have to be financed by Member States which may threaten sustainability. Additionally, as presented under Q5, national policy makers and representatives from governmental public health organisations identified the lack of resources as a factor limiting the longer-term impact of the 3HP and the sustainability of its results.
- Barriers related to political will or interest to continue with specific activities at the national level. Different consulted stakeholders, comprising governmental public health authorities and healthcare professional organisations, reported factors such as limited national engagement with the 3HP and lack of interest of competent national authorities in using 3HP results or implementing recommendations stemming from 3HP actions. For instance, a coordinator from the EU (JAV)[84] who participated in this study's focus group on Joint Actions raised concerns around Member States who are not willing to follow recommendations from the JA. While not being attributable to the 3HP, consulted stakeholders felt that such factors were barriers to the sustainability of the 3HP results and its ability to produce long-term impacts.

Q9 Conclusions

In conclusion, the results of the 3HP were found to be sustainable overall, and examples of areas with high sustainability included HTAs, the Joint Action on AMR and the ERNs. Sustainability was aided by some elements of the Programme, such as the addition of an obligatory work package on sustainability in the Joint Action on AMR (EU-JAMRAI), as well as through strong connections built between key stakeholders at the co-design stage of actions and throughout their implementation period. However, challenges to sustainability were also identified, for examples as results were not always integrated into policy. Finally, the sustainability of 3HP funded actions was dependent on external factors (mainly the decisions taken by the participating countries), and while these factors sometimes aided sustainability, they also presented challenges (e.g., a lack of political will in participating countries).

As noted in the introduction to this question, not all mechanisms and actions had the same need for sustainability, for example a procurement is instigated to fulfil a specific need in a specific point in time to feed in a policy-making or legislative process, whereas the nature of grants necessitated more explicit consideration of sustainability.

[83] The Joint Action eHAction supported the eHealth Network, which aimed to set targets for exploring eHealth to facilitate the management of chronic diseases and multi-morbidity, by increasing sustainability and efficiency of health systems, and by facilitating personalized care and empowering the citizen.

[84] The European Joint Action on Vaccination (EU-JAV) aimed to build concrete tools to improve vaccination coverage in EU and therefore improve population health.

3.3. Efficiency

This criterion seeks to assess the efficiency and cost-effectiveness of the 3HP, compared to the benefits of the Programme. It seeks to specifically examine how factors linked to the Programme influence the efficiency with which achievements were attained, the efficiency of distribution of Programme credits among the four thematic priorities, the impact of the simplification measures, and the efficiency of monitoring processes and reporting systems.

3.3.1. Q10. To what extent has the Programme been cost effective?

This section assesses the cost-effectiveness of the Programme in terms of deviation from planned resource budgets and the extent to which the impacts achieved through 3HP funded actions have matched the impacts foreseen. The qualitative assessment is based on evidence collected through desk research and consultation activities.

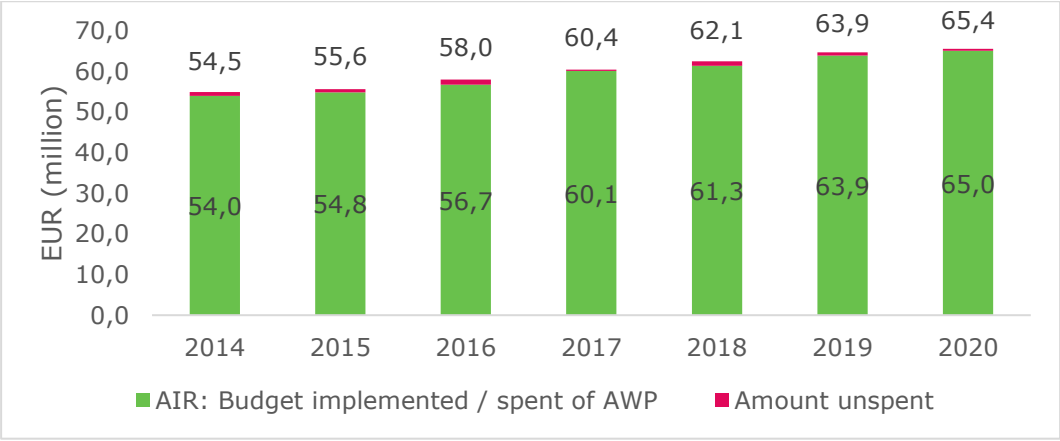
Overall, the Programme has been found to be cost-effective, with little deviation from planned resource allocations and expected results achieved with resources allocated. The following subsections present the evidence base that substantiates this assessment.

Deviation from planned resource budgets (Q10a)

Overall, the Programme actions have not deviated greatly from their planned resource allocations; this was substantiated by an assessment undertaken of the costs and spending incurred as part of the 3HP and planned versus actual implementation of the budgets. Main reasons for deviation in spending when it has occurred have been 1) lack of suitable applications for project grants in 2017 leading to redistribution of funding to other funding mechanisms, and 2) reallocation of funding following changes in the health landscape due to major events such as the migrant crisis or COVID-19. These factors are discussed in more detail in the paragraphs below.

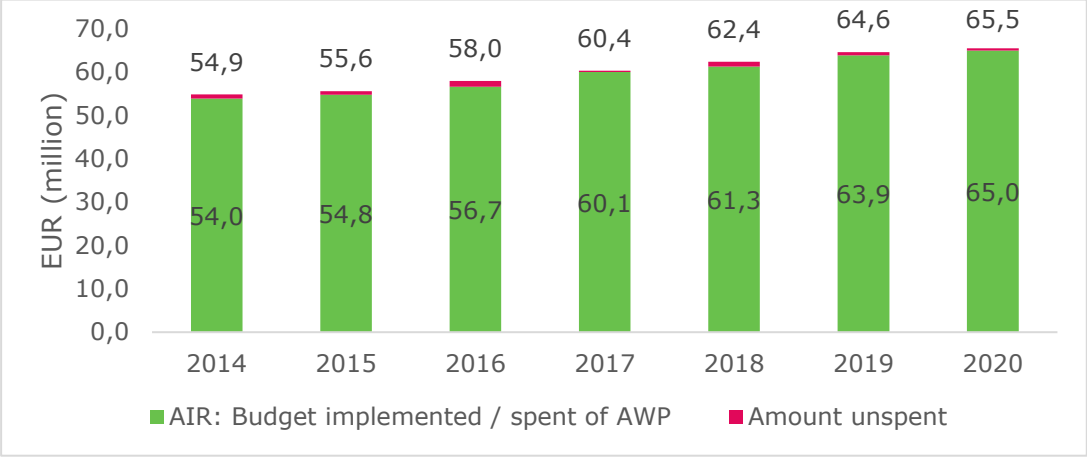
Figure 18 illustrates the planned and actual budget spent for the 3HP per year. There has been a gradual increase in the overall budget each year, with an increase of around EUR 11 M between 2014 and 2020.

Figure 18. Planned (AWP: Overall budgetary envelope / total available budget) and actual budget spent by year



Source: ICF analysis of AWPs and AIRs. The number above the bar signifies the Overall budgetary envelope / total available budget from the AWP.

Figure 19. Planned (AIR: Total available budget) and actual budget spent by year



Source: ICF analysis of AWPs and AIRs. The number above the bar signifies the Total available budget from the AIRs.

A detailed comparison of planned to actual spend by funding mechanism and year is presented in Annex 5.

A reason for spending deviation was funding reallocation when no suitable proposals for project grants were put forward in 2017. The 2017 AIR staff working document stated that in this year, 11 proposals in total were submitted to calls for proposals. Ten proposals were evaluated and 1 was rejected. Detailed information about the other nine proposals was not provided, however the AIR did state that no single proposal reached the threshold values. Therefore, no projects were funded in 2017 and the budget was re-allocated to other financial mechanisms. Further information about this re-allocation is not provided in the AIR staff working document, however examination of the spend on other mechanisms shows that more money was spent on the following categories of action than was originally planned in 2017: operating grants for NGOs, joint actions, conference grants to the Member States holding the EU Presidency, procurement (service contracts), prizes and horizontal actions.

Further, variations in funding were sometimes due to changes in the health landscape, and a direct result of the 3HP adapting to changing needs identified. For example, in 2015 the AWP was amended to add actions in response to the migration crisis in the summer of 2015: four projects on migrants' and refugees' health and one direct grant to the International Office of Migration (IOM) (EUR 1 000 000).[85] DG SANTE's 2020 Annual Activity Report[86] showed that in 2020 actions under the 3HP were reoriented to the largest extent possible towards tackling the COVID-19 pandemic without having to terminate ongoing activities.

Figure 20 details differences between actual and planned spending per year per funding mechanism (Project grants, operating grants, Joint Actions, and procurement).[87]

[85] European Commission., 2018. Report from the Commission to the European Parliament and the Council: Implementation of the Third Programme of the Union's action in the field of health in 2015. Available from: https://ec.europa.eu/health/sites/default/files/funding/docs/implementation2015_en.pdf [Accessed November 2021].

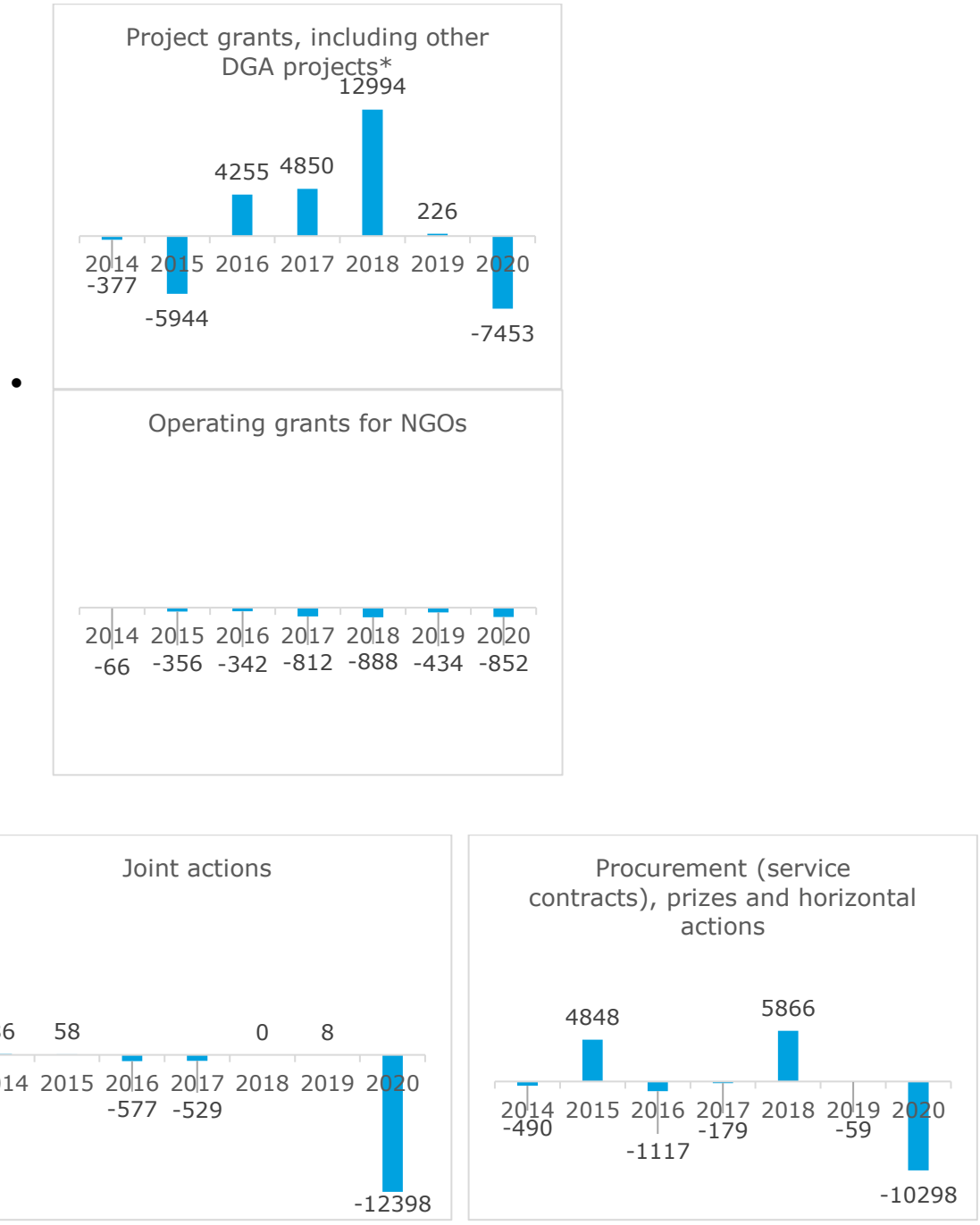
[86] European Commission., 2021. Annual Activity Report 2020: DG Health and Food Safety (SANTE). Available from: https://ec.europa.eu/info/system/files/annual-activity-report-2020-health-and-food-safety_en_0.pdf [Accessed November 2021]

[87] Values calculated as follows:

$$Difference\ value = planned\ spend\ on\ a\ project\ type\ (from\ AWP) - actual\ spend\ on\ a\ project\ type\ (from\ AIR)$$

A positive value indicates that the 3HP spent **less money than planned** in an area, and a negative value indicates the programme went **over its budget** in that area. Information for all funding mechanisms can be found in Annexe 5.

Figure 20. Difference between actual and planned spend per year per funding mechanism (thousand EUR)



Source: ICF calculations based on AWPs and AIRs per year

Conference grants for the EU presidency was the funding mechanism with the least variation between planned and actual spend (less than EUR 170 000 of variation each year), and most years this category underspent its budget. Operating grants for NGOs and Joint Actions were also relatively close to their budgets, with less than EUR 1 M of variation most years. However, there was an anomaly in 2020 whereby there was no planned spending on Joint Actions in the 2020 AWP, therefore the spending of roughly EUR 12 million was “over budget”. Direct grants for international organisations were often over budget by over EUR 1 M, however project grants, other actions, and actions implemented through grant procedures via a cross sub-delegation to Eurostat were nearly always under budget. Finally, procurement (service contracts), prizes and horizontal actions was a category with considerable variation, ranging from around EUR 10 000 000 over budget in 2020 to EUR 5 866 000 under budget in 2018. It

was not clear from the Programme documentation why this was the case, however some consulted stakeholders reported deviation from planned resource budgets due to personnel costs, partners leaving the funded action, the COVID-19 pandemic, a lack of Member State capacity, or changing priorities over the course of the action.

Impacts foreseen and achieved within the budget and opportunity costs (Q10b)

Overall, the Programme has achieved the foreseen impacts related to its objectives in a cost-effective manner. The Programme was relatively cost-effective and produced high quality (and quantity) of outputs and work achieved within the provided budget. On the one hand, the findings presented under Q4 and Q5 point to the effectiveness of the 3HP in achieving its objectives, and on the other hand consultees' perceptions on the 3HP cost-effectiveness overall confirm that results and expected impacts were achieved within the allocated budget. It is worth noting that a few limitations were identified in terms of limited funding and lack of follow-up work after a funded action ended; however, those limitations do not invalidate the positive impacts of the work achieved with the resources allocated.

As discussed under Q4 and Q5 on the effectiveness of the Programme, 3HP funded actions contributed to achieving the 3HP objectives to a very good extent, supporting a more comprehensive and uniform approach to health issues across the EU and contributing to improvements in health across the EU, in particular in the fields of vaccination, AMR prevention and HTA. Examples of produced outputs and related outcomes are detailed in the case studies conducted as part of this study (see Annex 3).

The flexibility of the management of the budget and the adaptability of the 3HP to changing circumstances was an important success factor in achieving those impacts in a cost-effective manner. Overall, due to the high number of partners involved in some actions and the duration of projects, changes to budgets were foreseen and not cause for concern. Several consulted stakeholders (particularly those involved in Project Grants and Joint Actions) expressed satisfaction with the fact that the budget could be changed without having to request an amendment from the Agency; budgets were permitted to be transferred between allowed institutions at a certain percentage because of COVID-19. Funding could be transferred across different cost categories and partners, which was useful to many stakeholders with the uncertainty catalysed by the pandemic. Another factor identified by a few stakeholders which increased cost efficiency was organisations' internal measures to ensure it. Conversely, a few stakeholders reported some discrepancies in impacts foreseen and achieved due to insufficient funding and lack of follow-up work after a funded action ended. These findings complement what was discussed under Q9 regarding ways to ensure the sustainability of funded actions. In this regard, efforts could be made to incentivise funding to continue and strengthen critical and successful actions, including by supporting synergies between the 3HP (and future health programmes) and other EU financial instruments addressing health issues. Further details on the consultees' perceptions on the cost-effectiveness of the 3HP and the extent to which it the foreseen impacts were achieved can be found in Annex 5.6.

Q10 Conclusions

In conclusion, the Programme was seen as cost-effective considering changes in the health landscape over its implementation period, and the size and scope of funded actions undertaken., The assessment on the efficiency of the 3HP is primarily based on findings emerging from this study's consultation activities and evidence gathered to address other evaluation criteria.

Data assessed in this study shows that there was not significant deviation from planned resource budgets, and stakeholders consulted confirmed this, highlighting the positive impacts of work achieved with the resources allocated, even in cases where funding was not deemed to be wholly sufficient. Flexibility of funding allocation was particularly efficient and underlines a strong success factor of the Programme as a whole.

3.3.2. Q11. To what extent are the costs associated with the Programme proportionate to the benefits it has generated? What factors are influencing any particular discrepancies? How do these factors link to the Programme?

This section discusses the extent to which the 3HP costs are proportional to the expected results, as well as factors influencing the 3HP results and the discrepancies between the 3HP costs and expected results, and whether these factors can be attributed to the 3HP.

Although management and operational costs were generally deemed reasonable, costs related to the administration, preparation, coordination, and personnel were seen to cause discrepancies in cost and benefits, especially for countries with lower GDP and smaller organisations involved in funded actions.

Due to a lack of documentary evidence, this assessment is qualitative in nature since it is solely based on the evidence collected through this study's consultation activities, as presented in the following sub-sections. The evidence emerging from the consultation activities was triangulated and synthesised to avoid the inclusion of unsubstantiated opinions and anecdotal evidence.

Costs in relation to expected results within the Programme (Q11a)

Specific 3HP funded actions were found to entail costs which were proportional to the benefits. This is especially the case for funded actions which have been particularly effective and produced sustainable results such as the ERNs. Further, some costs associated with the 3HP were reasonable and kept to a minimum necessary to achieve expected results. This is particular the case for management costs for funding and 3HP operational costs. Conversely, other costs were deemed to be too high, such as administrative costs for applicants and CHAFEA and monitoring and reporting costs for Member States and the Commission.

Consulted stakeholders identified specific actions having costs which were proportional to benefits. These include the SCIROCCO Exchange Project which developed a self-assessment tool for integrated care with a limited budget, which is now used by regional and national healthcare authorities in the EU and beyond.[88] Another stakeholder from a research/academic organisation highlighted that the benefits of the ERNs were high compared to related costs. As discussed under Q4 on the 3HP effectiveness and Q9 on the sustainability of 3HP results, the ERNs were a flagship achievement of the 3HP, being among the most effective actions with sustainable impacts. In fact, one of the tools the Commission developed for the ERNs was the Clinical Patient Management System (CPMS), which allowed for cross-border virtual consultations. Another tool was the registry for 5 ERNs which collected data at EU level for patients with rare diseases; these registries will be interoperable.[89] Moreover, one stakeholder mentioned that positive impacts of the Programme were difficult to quantify due to the value of networking (see Annex 5.7).

Most respondents to this study's targeted survey found that management costs for funding (10 out of 20, 50%) and 3HP operational costs (design and implementation) (8 out of 10, 40%) were deemed to be the most reasonable, at least to a moderate extent). However, a large proportion of respondents said other types of costs were either not reasonable or only to a small extent: administrative costs for applicants and CHAFEA (now HaDEA) (8 out 20, 40%), and monitoring and reporting costs for Member States and the Commission (5 out of 20, 25%). This view was also shared by interviewed stakeholders and respondents to this study's OPC. In particular, interviewed stakeholders felt that administrative costs, though improved and simplified over the 3HP implementation period, were still high. Some stakeholders reported

[88] This was mentioned by a government official/policymaker in the Project Grants focus group.
[89] Academic and research organisation, in the focus group on project grants.

that the level of detail required for monitoring and reporting was still *'heavy'* and at times *'bureaucratic'.* Answers to this OPC study were consistent with other consultation activities; costs that were deemed the most reasonable were programme operational costs (design and implementation) whilst least reasonable were administrative costs for applicants (see A5.11 in Annex 5 for further details on responses to this study's targeted survey and OPC).

Factors influencing 3HP results and discrepancies between the 3HP costs and expected results (Q11b and Q11c)

Factors influencing discrepancies between 3HP funded action costs and expected results were mostly related to: 1) additional costs linked to the preparation and coordination of the action and unforeseen delivery costs; 2) limitations related to the co-funding requirements and limited financial and human resources for the 3HP. When they occurred, those factors produced disparities between Programme costs and expected results. However, a number of factors, both internal and external to the 3HP, have been identified which have positively influenced the expected results, including the collaboration between Member States and the development of guidance to assist funding applicants. The evidence substantiating this assessment is based on this study's consultation activities.

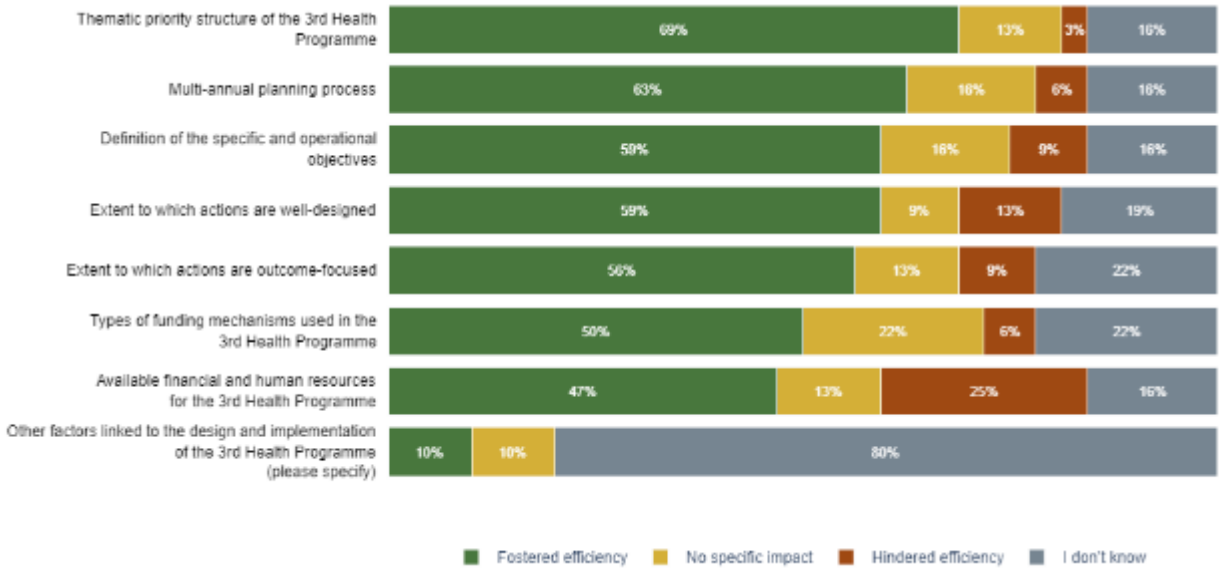
Stakeholders consulted as part of this study's consultation activities highlighted additional costs related to the preparation, coordination, administration and programme delivery as an important factor influencing disparities between Programme funded actions costs and the expected results. 17 out of 32 targeted survey respondents (54%) reported that those additional costs impacted Programme results at least to a moderate extent. Similarly, interviewed stakeholders and participants in this study's focus groups reported similar additional costs in the preparatory stages or during the implementation of a funded action which were not covered by 3HP funding (see A5.11 in Annex 5).

Moreover, limitations linked to the co-funding requirements and limited financial and human resources were identified as a factor producing disparities between costs and results.

Interviewed stakeholders reported that co-funding requirements were too high, thus impacting organisations and Member States with less access to financial and human resources. This view was shared by different stakeholders, including representatives from NGOs, international organisations, academic organisations, governmental public health organisations and government and policy makers (see A5.11 in Annex 5).

A quarter of respondents to this study's targeted survey highlighted that the limited availability of financial and human resources for the Programme hindered the efficiency with which achievements were attained (8 out of 32, 25%). This was a much larger proportion than any other factor (see Figure 21). This issue was particularly felt by stakeholders from low GDP countries who were not able to attend meetings and contribute to actions in the same way as countries with higher GDP (see Q14 for more information on this point).

Figure 21. Targeted stakeholder survey: In your view, how have the following factors influenced the efficiency with which achievements were attained? (n=32)



Conversely, a number of factors, both internal and external to the 3HP, were identified which have positively influenced the 3HP expected results. According to targeted survey respondents, factors linked directly to the Programme which positively influenced the 3HP results were the collaboration between Member States and the development of a guidance to assist funding applicants (22 out of 32 responses each, 69%), followed by facilitation and coordination of the 3HP by DG SANTE/CHAFEA (20 out of 32, 63%). Most interviewed stakeholders concurred that Member State collaboration was essential to the achievement of results, for instance by creating new networks of experts which outlasted Joint Actions.

There were also some factors outside of the scope of the Programme which were identified by this study's targeted survey respondents as that positively influencing the Programme's results: science and technological progress in the area of health and healthcare (25 out of 32, 79%), followed by solutions developed at national level, or by private or non-for-profit actors (19 out of 32, 60%) and changes in citizens' opinions or perspectives on health systems (13 out of 32, 41%).

A more detailed analysis of costs and benefits related to administration, monitoring, and reporting can be found in the sections below (Q15, 16, and 17).

Q11 Conclusions

In some cases, the efficiency of the Programme was not as strong as it could have been due to elements of the Programme's design. Whilst operational and management costs were reasonable, administrative costs were sometimes disproportionately heavy, increasing workload of those involved in actions and potentially putting countries with low GDP or smaller organisations off becoming involved, or being involved in future work. High co-funding requirements in some instances led to discrepancies in costs and benefits felt by some stakeholders; those without resources at their disposal were less able to feel the benefits of collaboration with other Member States within the 3HP. A limitation of this assessment is the lack of desk research to substantiate stakeholders' claims, particularly in relation to reports of inadequate funding.

3.3.3. Q12. To what extent do factors linked to the Programme influence the efficiency with which the observed achievements were attained? What other factors influence the costs and benefits?

This section assesses the extent to which factors linked to the Programme (e.g., number of priorities, available financial and human resources, various financial mechanisms, established procedures, intended results, political focus) influenced the efficiency with which achievements were attained, and other factors influencing costs and benefits. The assessment is based on desk research and consultations with stakeholders. Findings indicate that the design and implementation of the 3HP – particularly in regard to funding mechanisms – had a clear impact on the efficiency with which achievements were attained. Other factors impacting efficiency of achievements included the number of partners involved in actions, timing of projects and funding, and sustainability measures. These findings are substantiated by evidence in the subsequent sub-sections below.

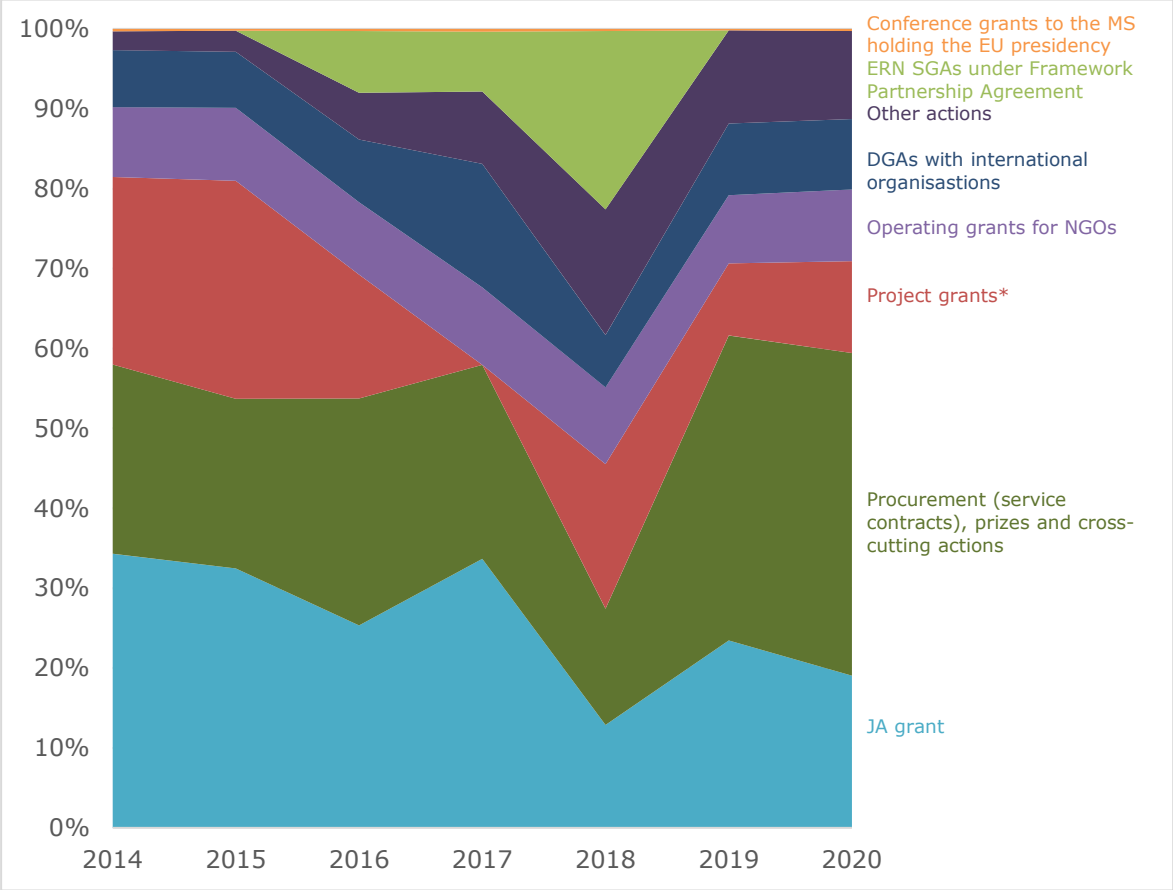
Factors relating to the implementation of the Programme (Q12a)

The allocation of funding by mechanism impacted the efficiency of the programme.

As noted in the mid-term evaluation, the varied 3HP funding mechanisms have strengths and weaknesses, and entail different administrative burdens and costs. Funding was seen by stakeholders as a main factor in the efficiency with which results were attained: this study's targeted survey respondents saw type of funding mechanism (16 out of 32 respondents, 50%) and available financial and human resources (15 out of 32 respondents, 47%) as factors fostering efficiency with which results were attained.

Figure 22 illustrates the allocation of funding per year per mechanism according to Annual Implementation Reports.

Figure 22. Funding allocation by funding mechanism



- *Source: Annual Implementation Reports. *In 2018 and 2019 project grants include other DGA projects*

In total, the most funding went to Procurement (service contracts), prizes and cross-cutting actions (28%), followed by Joint Actions (26%), and project grants (15%). The remaining categories received the following percentages of funding: 9% to operating grants for NGOs; 9% to DGAs with international organisations; 9% to 'other actions'; and 5% to ERN SGAs under Framework Partnership Agreement; and finally, conference grants to MS holding the EU presidency: <1%.

The split of funding across funding mechanism did change over time: funding was more evenly divided in the earlier years but diverged over time. In 2018 there was a large increase in the proportion of funding used on ERN SGAs under framework partnership agreements (from 7% in 2017 to 22% in 2018), and in 2019 there was a large increase in the percentage of funding used on the category "procurement (service contracts), prizes and cross-cutting actions" (from 15% in 2018 to 38% in 2019).

In sticking with trends from the 2HP and mid-point of 3HP, there was a decrease in spending allocated to projects overall and in 2017 there was no funding used on Project Grants (this is discussed in more detail under Q10). Similarly, while joint actions increased in the first half of 3HP, spending decreased in the second half. As discussed under Q5, Joint Actions and Projects were the most effective funded actions, so the relatively low amounts of funding for Joint Actions and Projects may have been detrimental.

In addition to the split of funding by mechanism, design features of the Programme also impacted its efficiency. 60% of targeted survey respondents reported that well-designed actions fostered efficiency of achievements attained. However, there were some design features of actions which limited efficiency. The study identified a few factors which limited to some extent the efficiency of funded actions. Those factors revolve around stakeholders'

engagement and the sustainability of funded actions. In particular, it emerged that on the one hand a high number of actors involved in a funded action resulted in coordination difficulties, thus impacting efficiency. This was especially the case with Joint Actions involving a large number of partners, as reported by a few consulted government officials. On the other hand, some consulted stakeholders (i.e., patients' and services users' organisations) raised concerns about the under-representation of certain groups in specific funded actions (i.e., Joint Actions). Those findings, while seeming to contradict one other, point to the need to find an appropriate balance of stakeholders' participation to the funded actions, which was not fully achieved on some occasions. Lastly, the limited sustainability also represented a factor impacting the efficiency of a funded action. For example, several stakeholders from governmental public health organisations identified a lack of accountability mechanisms for Member States after an action officially ended. However, as discussed under Q9, many limitations to sustainability fell under participating countries' competences and therefore were not the fault of the 3HP.

Factors external to the implementation of the Programme (Q12b)

There were also some factors which were external to the 3HP which impacted the efficiency with which results were achieved:

- The internal rules of organisations and agencies participating in the Programme at times reduced the efficiency of actions. A stakeholder from a governmental public health organisation reported that within their agency, a decision had been made - when participating in 3HP financial mechanisms - to 'put the Joint Action as close as possible to the regular organisation'. Since this decision was made, funds have been utilised more efficiently, adding value to the department. However, in another example internal rules were seen as a hindrance: a stakeholder from the focus group on Joint Actions (GAPP) reported that her organisation's internal rules on managing a budget was a barrier to efficient use of funding. Organisations are nominated by the Ministry of Health, but they cannot spend funding to hire staff and they must verify that the amount received is spent within the financial year otherwise it goes to state budget. If the project lasts for 36 months, and payments are received at month 1 and month 18, the timeframe may overlap with financial years. However, the 3HP could not have impacted such internal factors, and possible flexibility at the national level would have helped in this instance.
- As discussed further below under Q14, available financial and human resources was identified as a defining factor in efficiency of achievements.
- One stakeholder belonging to the government official/policy-makers group highlighted that one participating country had a lack of knowledge on their population's health data, which meant that Joint Actions were not tailored to national context. Stakeholders across other groups also emphasised the need for implementation to be more country-specific.

Q12 Conclusions

In conclusion, the design and implementation of the 3HP is closely linked with efficiency with which achievements are attained. Whilst allocation of the 3HP budget to different funding mechanisms was largely efficient, the split between funding mechanisms changed over time to provide less funding to the most effective implements (Joint Actions and projects). Further, there were some design features of actions which limited efficiency, including a large number of partners in actions, the design and set-up phase of actions, and limitations to an action's sustainability (see Q9).

3.3.4. Q13. To what extent was the distribution of Programme credits among the four thematic priorities efficient?

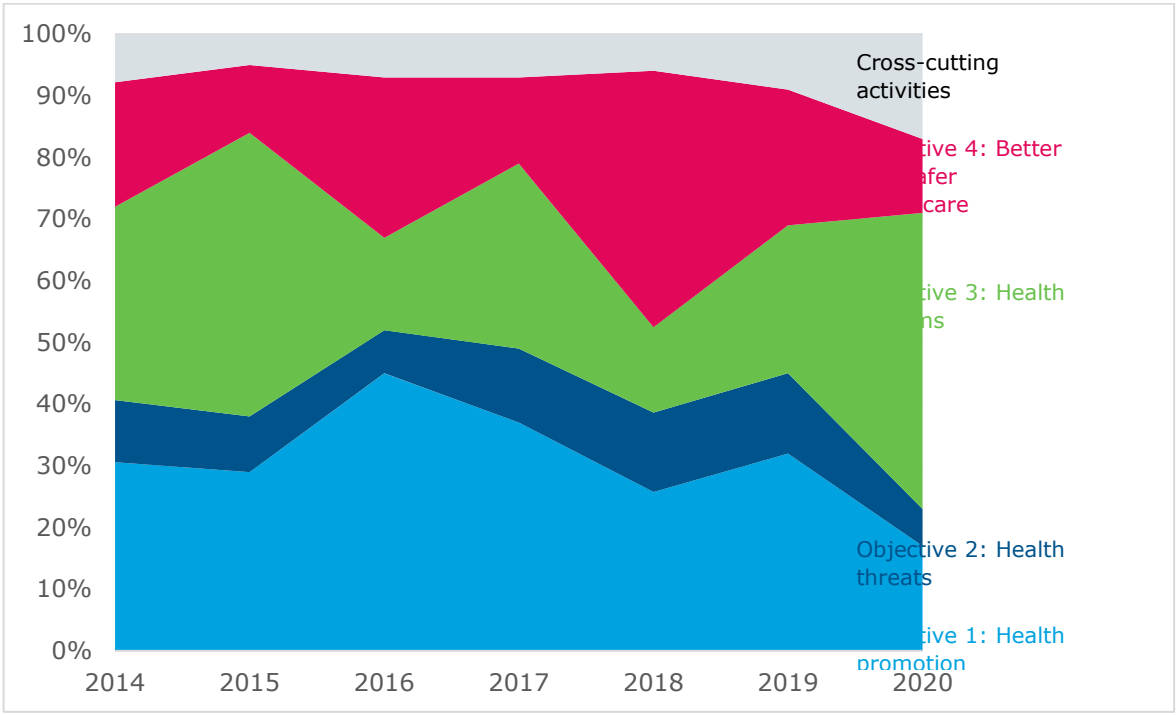
This section assesses the extent to which the distribution of Programme credits among the four specific objectives was efficient, including whether objectives allocated credits were

aligned with EU health priorities and whether funding allocation was considered critical to achieve expected results. The assessment draws on desk research and stakeholder consultations. The findings indicate that although allocation of funding to credits was not even, it was efficient, as it aligned with participating countries' priorities (see Q1) and with EU set objectives. Funding was crucial for achieving results and identifying priorities which may not have had funding without the 3HP. This finding is substantiated with evidence in the following sub-sections.

Allocation of funding between objective areas (Q13a)

The four specific objectives were allocated funding in line with EU health priorities. Figure 23 illustrates how funding was allocated per year of the programme by overall priority area (Table 32 of A5.13 in Annex 5 gives a breakdown of the thematic priorities which were planned to be addressed by actions in each year of the Programme).

Figure 23. Allocation of funding by objective area and year



- *Source: Annual Implementation Reports*

As discussed under Q1, the 3HP provided funding in a way which met the key health needs in the EU over the time of programme implementation. For example, health promotion (objective 1) was highly prioritised by participating countries and accordingly received a large amount of funding. This was confirmed in the consultation activities: a majority of stakeholders consulted in interviews and focus groups felt that there was an efficient distribution of Programme credits among the four thematic priorities and several stakeholders mentioned priorities being in line more widely with EU objectives.

For example, those who had received Operating Grants largely agreed that they were in line with 3HP objectives, and stakeholders in the Procurement Contracts focus group also felt that the funding was aligned with EU set objectives. On the contrary, a few stakeholders felt that distribution of credits among the four thematic priorities was slightly inefficient. One stakeholder from a government public health organisation wished that the programme had some leeway to act on unanticipated priorities through contingency funding, and a stakeholder in the government officials/policymakers group felt that not all priorities were addressed with the same rigour due to the broadness of the Programme's scope.

Importance of funding allocation to achieving expected results (Q13b)

Most stakeholders consulted considered funding allocation to be critical to achieve expected results. 69% of targeted survey respondents felt that the thematic priority structure of the Programme fostered efficiency. Stakeholders from the Operating Grants focus group also felt that funding allowed them to plan and deliver on projects with (financial) security. Several stakeholders in the government official/policy-makers group highlighted that work in rare diseases and cooperation across Member States in Joint Actions would not have been possible without the Programme. Those in governmental public health organisations also emphasised how invaluable funding was to achieving results: one stakeholder reported that funds would not have been directed to the identified priorities without the Third Health Programme, and another stakeholder from the same group highlighted that funding was critical for enabling low GDP countries to achieve results with other Member States. A stakeholder from a healthcare professionals' association also highlighted how external stakeholders would not have been engaged in innovations in healthcare systems in the same way without 3HP funding.

Q13 Conclusions

In conclusion, the distribution of Programme credits among the four specific objectives was efficient in that it addressed the key health needs identified during the implementation period, with funding allocation deemed critical to achieve expected results. In fact, as found during desk research and discussed under Q1, the 3HP provided funding in a way which met the key health needs in the EU over the time of the Programme implementation. Moreover, as presented more broadly under Q4 and Q5, the allocated funding was effective (to a very good extent) in achieving the expected results. The criticality of funding to achieving expected results was also substantiated by stakeholders' views.

3.3.5. Q14. If there are significant differences in costs (or benefits) between participating countries, what is causing them? How do these differences link to the Programme?

This section assesses whether there were any significant differences in costs or benefits between participating countries, the causes of this, and whether differences link to the 3HP. The assessment draws together the evidence collected through consultation activities and desk research.

Overall, there were significant differences in costs, and benefits, felt between participating countries. Countries with low GDP were less able to participate in the 3HP and received less funding. Although capacity issues of countries are not directly linked to the Programme, capacity differences should be considered more in Programme funding requirements. Evidence to substantiate this can be found in the sub-sections below.

Differences in costs and benefits occurring between participating countries (Q14a)

The desk research undertaken as part of this study indicates that the distribution of funding and actions has not been evenly spread across participating countries. The analysis of the HaDEA public-facing database on funded actions found that across the 3HP, there were 25 coordinating countries. The Netherlands coordinated the largest number of funded actions (65), followed by Belgium (55)[90] and France (45). Funded actions coordinated by these three countries represented 49% of all funded actions under the 3HP. Overall, countries in Western Europe were much more likely to coordinate a funded action than countries in Northern or

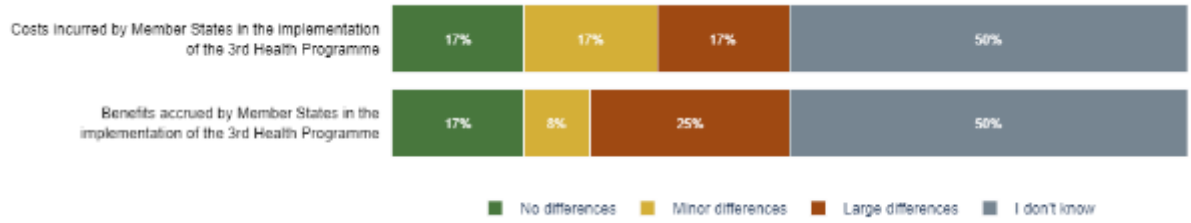
[90] 28 of the organisations marked as coordinated by Belgium are pan-European organisations headquartered in Belgium

Eastern Europe. Table 48 of Annex 5 shows the number of funded actions coordinated by each of the 25 countries.

Of the 25 coordinating countries which received EC contributions, France (32,720,931 EUR), the Netherlands (32,441,746 EUR) and Belgium (31,331,572 EUR)[91] received the highest amount. The contributions those countries received accounted for 43% of the total amount disbursed. Croatia (13,687 EUR), Slovakia (41,780 EUR), Bulgaria (61,439 EUR) and Romania (66,000 EUR) received the lowest amounts of funding. Table 49 of Annex 5 shows EC contributions by country and the average contribution per funded action.

These disparities in EC funding and in number of actions coordinated led to some differences in costs and benefits between participating countries according to targeted survey respondents and consulted stakeholders. In the targeted stakeholder survey, some academic/research organisations and NGOs reported there were differences in costs and benefits between countries involved in the Programme (although it is to be noted that many respondents did not know about this topic; see Figure 24).

Figure 24. Targeted stakeholder survey: Have there been any differences between participating countries in the following…? (n=12, only academic/research organisations or NGOs)



The factors which impacted these differences are discussed in the section below.

Factors resulting in differences observed and linkage to the Programme (Q14b and Q14c)

A number of factors were identified which cause differences in costs and benefits for the 3HP participating countries. Those include cost differences between countries and cross-country differences in term of financial resources, organisational capacity to deliver funded actions and administrative burden of applying for and receiving 3HP funding.

Some stakeholders identified cost differences and related cross-country differences in terms of resources as a factor resulting inf differences in costs and benefits. While being an external factor to the 3HP and related to the beneficiary level, this factor is intertwined with the co-funding requirement of the 3HP and the exceptional utility criteria.

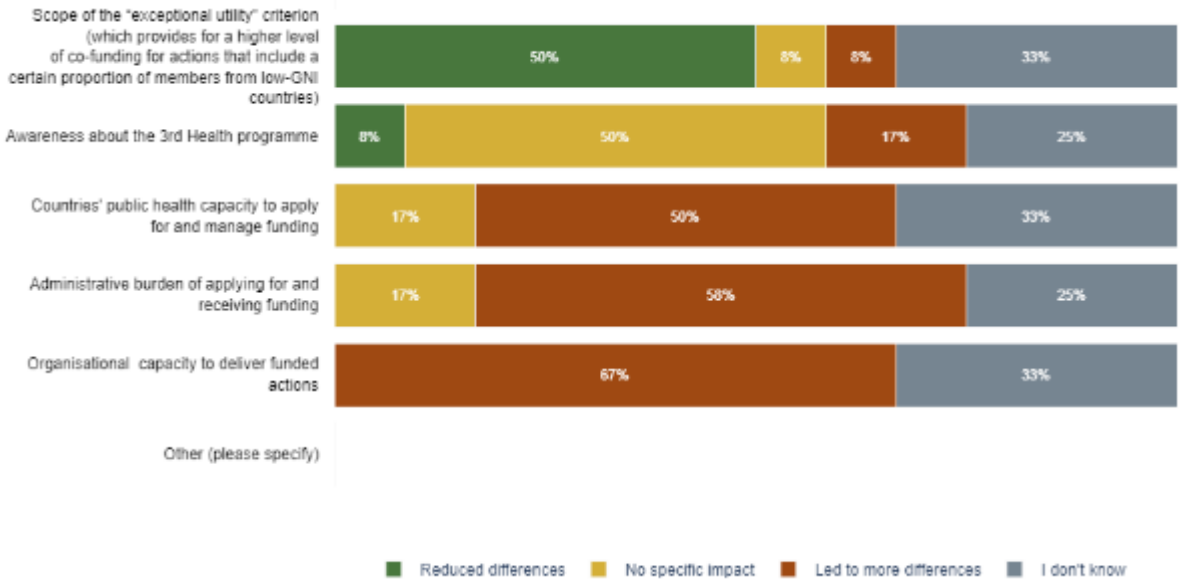
Some respondents believed that cost differences between countries were caused by differing staff expenses, which impacted achievable goals and work performance. This issue was also raised by a stakeholder who had worked on the GAPP Joint Action, who reported that varied rates of personnel costs between countries was a barrier to equal distribution of costs (and benefits). Similarly, a stakeholder from a governmental public health organisation felt that the divergence in daily payment amounts from participating countries in Joint Actions should be reconsidered. This study's targeted survey respondents also reported that tasks and the level of involvement of Member States in projects/actions dictated to what degree countries benefitted from the Programme, and relatedly the exceptional utility criteria were perceived by half of respondents as a factor which reduced differences in costs and benefits. This was echoed by stakeholders in the Joint Actions focus group, who believed the 20% co-funding enabled participation from low GNI countries. Although stakeholders felt exceptional utility criteria did increase participation of low GDP countries, many felt that there was still an

[91] 28 of the 55 organisations marked as coordinated by Belgium are EU organisations

overrepresentation of Western European countries involved in actions due to lower capacity/resources of lower GDP countries and due to 3HP co-funding requirements being too high for such countries. A stakeholder from a governmental public health organisation highlighted that countries with low GDP struggled to see the same benefits of Joint Actions due to not having the resources and capacity to participate. Finally, in the Joint Actions focus group, a stakeholder highlighted how the criteria is not always easy to use, and the impact COVID-19 had on capacity/resources of countries the criteria targets. The analysis conducted under Q6 indeed found that on the whole, the criteria did not adequately increase the participation of low-GNI countries.

Other factors affecting differences were identified in the targeted survey as: organisational capacity to deliver funded actions (8, 67%), administrative burden of applying for and receiving funding (7, 58%), and countries' public health capacity to apply for and manage funding (6, 50%). See Figure 25.

Figure 25. Targeted stakeholder survey: In your view, how have the following factors impacted the differences in costs and benefits between countries? (n=12, only academic/research organisations or NGOs)



Finally, a few stakeholders perceived a limited engagement and consultation with national stakeholders in setting the 3HP priorities as impacting differences in costs and benefits between participating countries.

Q14 Conclusions

- In conclusion, there were significant differences in costs and benefits between participating countries, as countries with lower GDP were less able to participate in the Programme (especially in coordinating roles) and Western European countries lead the most actions and received the most funding for actions. Accordingly, countries with less capacity and funding consequently did not feel the same benefits as other countries. Although the exceptional utility criteria increased participation of low GDP countries, differences in capacity still prevented these countries' fuller participation and they thus required further support from the 3HP.

3.3.6. Q15. To which extent did the simplification measures contribute to the efficiency of the Programme? Was there further scope for simplification to make the Programme implementation more efficient?

This section assesses the extent to which simplification measures contributed to the efficiency of the Programme, and whether there was further scope for simplification to make the 3HP more efficient. The assessment draws together the evidence collected through desk research and consultation activities.

Simplification measures did improve efficiency of the Programme, however, there was further scope for simplification. In the sub-sections below, these findings are substantiated by evidence.

Extent to which simplification measures reduced administrative costs for applicants and Chafea (Q15a)

As identified in the 3HP mid-term evaluation, a wide range of systems and processes were simplified and digitised to streamline the administration of the 3HP. These are presented in the paragraphs below.

The most commonly identified systems and processes were the following:

- Application and grant management procedures were simplified and digitised
- Procedures for awarding joint actions and grants were simplified
- The rules of the Programme changed to make them less complex, i.e., through the harmonisation of co-financing rates to 60% (or up to 80% in cases of exceptional utility)
- Operating grants were allowed to be funded through framework contracts (which run for up to three years)
- In a call for proposals in 2016[92], it was highlighted that ERN grants had been made longer-term (5 years) to 'establish a partnership procedure for important actors at EU level; offer a clearer financial perspective for ERNs; and provide more stability and efficiency gains for all involved'. The procedure for this was the signing of an FPA and insurance of annual co-funding through an SGA. It was acknowledged that two proposals were a heavier administrative burden on applicants, but it was expected that the process would simplify awarding of ERNs in the future.
- A negotiation process was introduced for joint actions
- There have been simplifications to requirements for amendment procedures, most importantly the ability for beneficiaries to transfer resources between different cost categories without the need for an amendment
- Electronic tools were introduced for the submission of proposals, management of grants and e-reporting and monitoring. In 2015, electronic monitoring and reporting were introduced to save time; beneficiaries and CHAFEA became paperless.[93]
- All electronic tools were centralised on the Participant Portal
- There have been some simplification measures which relate specifically to the exceptional utility criteria
- Conditions have been simplified and made less restrictive, especially for joint actions where there were previously five criteria and now there are just two. The original criteria which needed to be fulfilled included the proportion of funding which needed to be allocated to staff.

[92] Third EU Health Programme (2014-2020) Mono-Beneficiary European Reference Networks' Grants (ERN Grants) (HP-ERN-2016) Framework Partnership Agreements (FPA) Guide for Applicants

[93] European Commission. (2018). REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL: Implementation of the third Programme of the Union's action in the field of health in 2015. Available from: https://ec.europa.eu/health/sites/default/files/funding/docs/implementation2015_en.pdf

- Conditions aiming to "promote the involvement of new actors for health" no longer needed to be satisfied
- There was no longer an explicit upper limit on the proportion of funded projects which can be awarded exceptional utility, whereas under the second half of the 2HP the conditions stipulated that: "No more than 10% of funded projects should receive EU co-funding of over 60%".
- The threshold of funding awarded to low GNI countries for Projects and Joint Actions has risen to 30% (compared to 25% for the lowest quartile under the 2HP).

Efforts were made to improve the efficiency of the 3HP through simplifying and streamlining existing Programme procedures. In 2015, the EU was impacted by a large increase in refugees entering Europe. In response, CHAFEA (now HaDEA) quickly launched related direct grants and call for proposals for projects and was able to sign the selected grant agreements within less than 3 months of the 2015 AWP amendment. According to the 2015 Annual Implementation Report[94], this was helped by simplified administrative procedures introduced in 2014 as well as the participant portal for online submissions and the online evaluation and electronic signature of grant agreements. Also in 2015, electronic monitoring and reporting were introduced to save time; beneficiaries and CHAFEA (now HaDEA) became paperless.[95]

Given that ERNs were a focus of 3HP action in 2016, HaDEA used all simplification tools at its disposal to streamline the EU financial contribution to the ERNs. Awarding FPAs and subsequent specific grants reportedly made implementation and reporting easier and provided the ERNs with a stable operating framework.[96] ERNs were a strong example of EU added value of the 3HP as well as of its effectiveness, as discussed in Q4 and Q18.

Some stakeholders consulted as part of this study felt that these simplification measures reduced administrative costs and improved efficiency of the Programme. One stakeholder from a healthcare service provider saw *'constant improvement in the administration'* over the course of the 3HP. A stakeholder from research/academic organisation believed that simplification measures reduced paperwork and improved operationally running the Joint Action he was involved in. Stakeholders in the focus group on project grants also generally agreed that simplification measures helped to reduce cost, and they found the application process smooth, praising in particular the funding portal which produced manuals and useful links. Participants in the focus group on operating grants concurred, stating that simplification measures had reduced administrative costs for applicants to a moderate extent. A government official/policy mentioned that the Public Procurement Management helped to *'automatise the process'* and reduced operators' administrative burden.

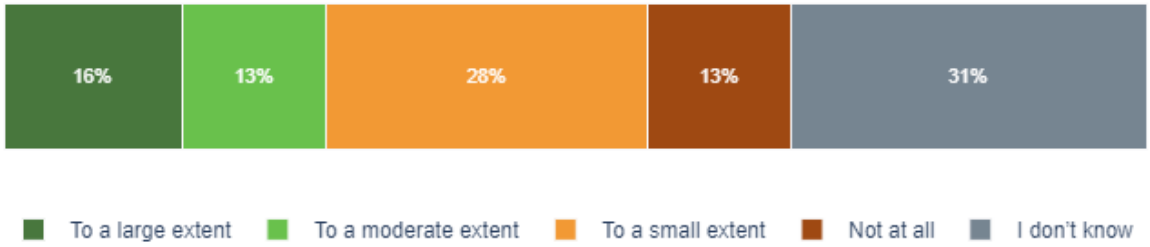
31% of respondents in this study's targeted survey, however, did not know whether the simplification measures contributed to the efficiency of the Programme, and those who did answer were divided (see Figure 26). Ways in which simplification measures were deemed to be efficient were in the introduction of electronic tools for the submission of proposals, management of grants and e-reporting and monitoring (subject to the system functioning efficiently), the introduction of a negotiation process for Joint Actions, and the ability for beneficiaries to transfer resources between different cost categories without the need for an amendment.

[94] European Commission., 2018. COMMISSION STAFF WORKING DOCUMENT Accompanying the document: Report from the Commission to the European Parliament and the Council Implementation of the third Programme of Community action in the field of health in 2015. Available from: https://ec.europa.eu/health/sites/default/files/funding/docs/com2018_818_en.pdf [Accessed November 2021].

[95] European Commission., 2018. Commission Staff Working Document Accompanying the document: Report from the Commission to the European Parliament and the Council Implementation of the third Programme of Community action in the field of health in 2015. Available from: https://ec.europa.eu/health/sites/default/files/funding/docs/com2018_818_en.pdf [Accessed November 2021].

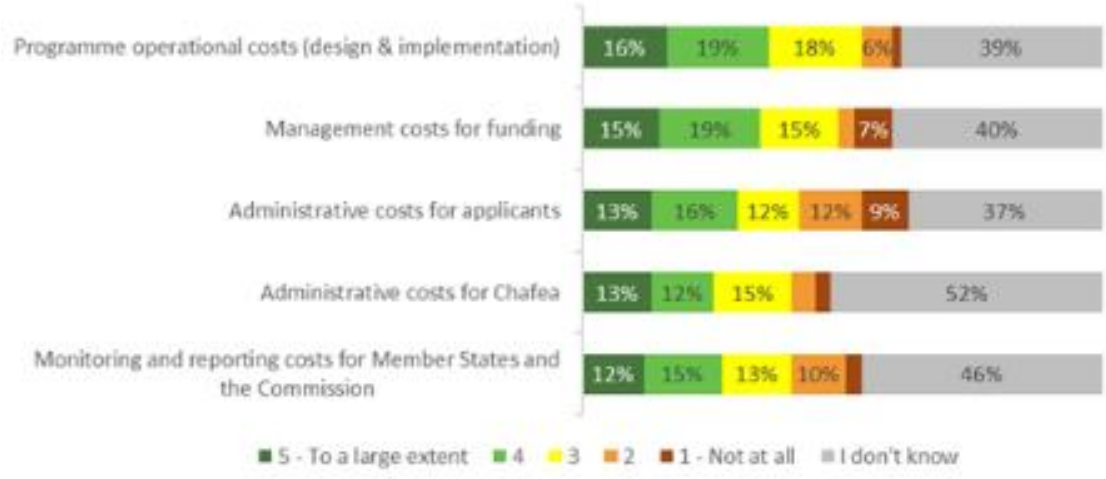
[96] European Commission., 2019. Report from the Commission to the European Parliament and the Council: Implementation of the third Programme of Union action in the field of health in 2016. Available from: https://ec.europa.eu/health/sites/default/files/funding/docs/implementation2016_en.pdf [Accessed November 2021].

Figure 26. Targeted stakeholder survey: To what extent did the simplification measures reduce administrative costs for applicants and Chafea? (n=32)



However, some stakeholders still felt administrative costs were unreasonable, in spite of the implementation of simplification measures. In the OPC, administrative costs for applicants were deemed the least reasonable cost associated with the 3HP (6 respondents said they were not at all reasonable, 9%); see Figure 27.

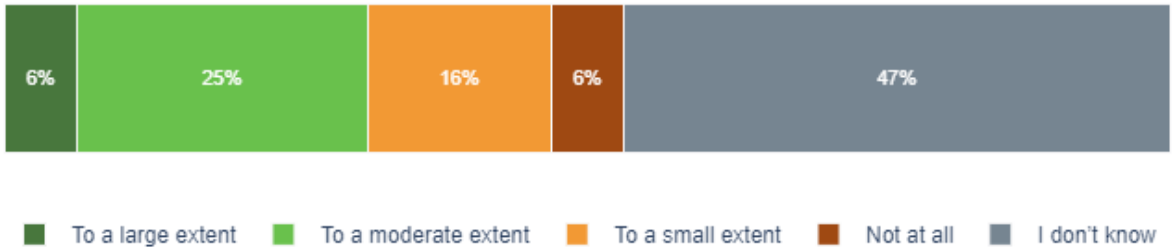
Figure 27. OPC: To what extent do you believe costs associated with the 3rd Health Programme are reasonable and kept to the minimum necessary in order to achieve the expected results? (n=67)



Scope to further reduce costs (Q15b)

Almost half of the respondents in the targeted survey did not know if there was further scope to reduce costs. Those who felt it was possible suggested further simplifying and rationalising (e.g., by using unit costs or lump sums[97]), improving the reporting system, or simplifying specific information requested in the application form (budget breakdown).

Figure 28. Targeted stakeholder survey: To what extent is there scope to further reduce costs? (n=32)



[97] Such mechanisms have now been included in the context of EU4Health.

Some stakeholders consulted still felt that simplification measures had not reduced administrative burden and suggested further improvements to further reduce costs (see Annex 5.9). Most proposed changes amongst consulted stakeholders were to do with application processes. One government/policy maker stated that more flexibility was still needed in Project Grant funding for Joint Actions. The stakeholder worked on a Joint Action on vaccination where the Ministry of Health were nominated as the competent authority to work with a university, but they were not able to justify the affiliated entity aspect of the university. Another stakeholder from a healthcare professionals' association felt that applications for ERNs should not be on an annual basis to reduce administrative burden. Another stakeholder felt that increased awareness of simplification processes would increase efficiency (see Annex 5.9).

Q15 Conclusions

As identified in the mid-term evaluation, a wide range of systems and processes were simplified and digitised to streamline the administration of the 3HP. On the whole, these measures (particularly the digitalisation of the process/online platforms) did increase efficiency of the Programme and alleviate some administrative burden on applicants. However, there was some scope to simplify processes, especially in relation to applications for funding. A limitation of this assessment is that many stakeholders in the targeted survey and OPC did not have much knowledge on simplification measures and scope to reduce burden.

3.3.7. Q16. To what extent were the monitoring processes and resources (at the Commission and MS level) cost-effective? How the role and benefits of the monitoring systems [i.e., to plan and promote the results of the Programme and encourage stakeholders (internal and external) to make use of them] are assessed, against the costs of these monitoring systems (also considering any administrative burden involved)?

This section assesses the extent to which monitoring processes and resources were cost-effective and the role and benefits of the monitoring systems against their costs.

Overall, monitoring processes were cost-effective to some extent, but resources could be deployed more efficiently to simplify processes and to centralise information for applicants. Due to a lack of documentary evidence, this assessment is qualitative in nature since it is solely based on the evidence collected through this study's consultation activities, as presented in the following sub-sections. The evidence emerging from the consultation activities was triangulated and synthesised to avoid the inclusion of unsubstantiated opinions and anecdotal evidence.

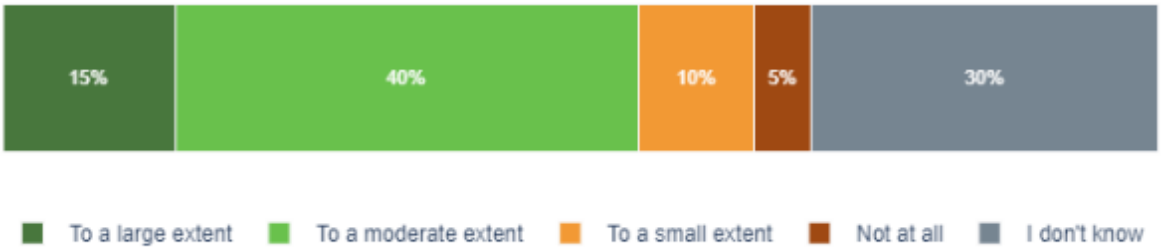
Efficiency of monitoring processes in management of supported actions and proportionality of monitoring costs to expected results (Q16a and Q16b)

Monitoring processes were found to be fairly efficient and reasonable and key factors enabling their efficiency were the relevance and clarity of indicators. Although they were improved throughout the 3HP implementation period, mainly through the digitalisation of the process, further simplification could be achieved, and improvements could be made to increase efficiency of monitoring processes, for example by further centralising information.

Most targeted survey respondents who were involved in the management and administration of a 3HP action said that the monitoring costs were reasonable and kept to the minimum necessary in order to achieve the expected results, at least to a moderate extent (11 out of 20,

55%). Only two respondents (15%) said they were not at all reasonable, or only to a small extent. See Figure 29.

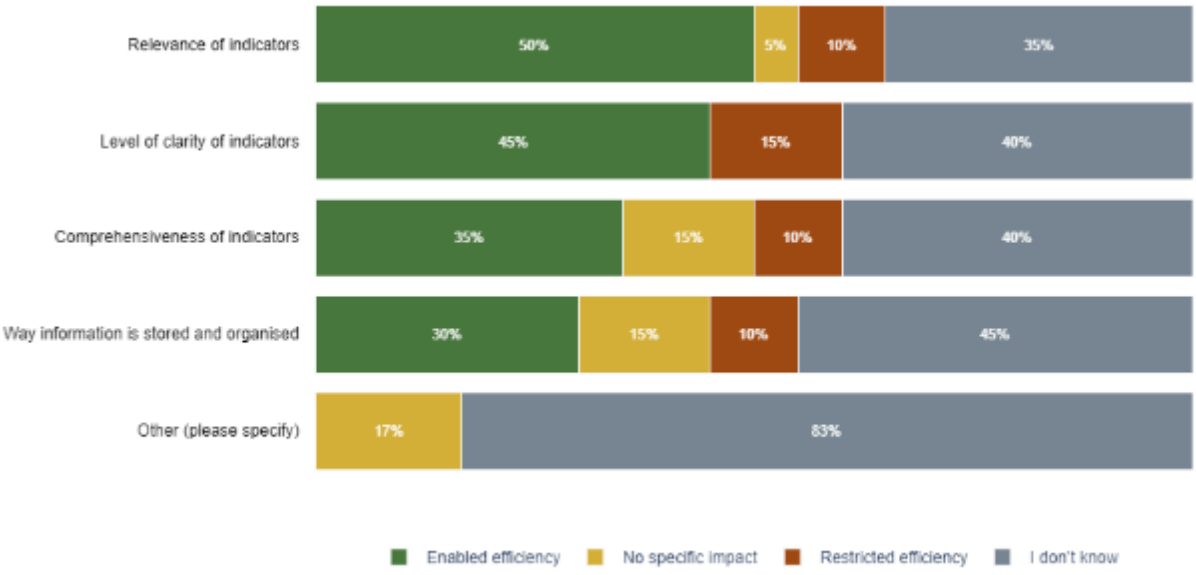
Figure 29. Targeted stakeholder survey: To what extent do you consider the monitoring costs are reasonable and kept to the minimum necessary in order to achieve the expected results? (n=20, only those involved in the management and administration of an action from the Programme (e.g. filled in an application form))



Respondents to the OPC had little knowledge of the cost-effectiveness of the monitoring systems within the 3HP (46% did not know, 31 out of 67 respondents). The rest of the respondents were fairly evenly spread between stating monitoring costs were reasonable to a small/moderate/large extent, with only 2 respondents (3%) saying costs were not reasonable at all.

According to this study's targeted survey respondents, the key factors enabling efficiency were the relevance of indicators (10 out of 20, 50%) and the level of clarity of the indicators (9 out of 20, 45%). Other factors are shown in Figure 30 below.

Figure 30. Targeted stakeholder survey: In your view, how have the following factors influenced the efficiency of the monitoring processes? (n=20, only those involved in the management and administration of an action from the Programme (e.g. filled in an application form)



Furthermore, consulted stakeholders who believed the monitoring processes enabled efficient management of actions highlighted the positive impacts of the digitalisation of the process. For example, a stakeholder from an academic/research organisation who had worked on an ERN noticed that digitalisation of monitoring reduced the burden of collecting 18 different indicators for 24 ERNs in different healthcare settings. Moreover, a stakeholder from an international organisation believed that the monitoring (and reporting) process helped them plan the work effectively, understand expectations, and improved the quality of delivery.

Interviews with stakeholders revealed that whilst some stakeholders noticed improvements in the monitoring process, many still felt it could be further simplified (particularly stakeholders from healthcare professionals' associations and NGOs). These stakeholders mentioned the process being *'heavy'* (NGO) and too detailed (government policy maker), especially for smaller organisations and experts brought in who were unfamiliar with processes (for more information, see Annex 5.16).

Further centralisation of information in regard to the monitoring process was a key theme arising from consultations with stakeholders. A few stakeholders in the focus group on project grants mentioned that the 3HP could do more to disseminate information about different types of funding available, providing guidance on how to make use of synergies from other programmes, funding mechanisms, and frameworks. Participants suggested that a platform for facilitation and coordination of projects was needed and argued that it would be useful to be informed by the Commission of a duplication of projects to establish joint efforts with the other projects. Stakeholders felt that this would prevent inefficient use of resources. An interviewed government and policy maker felt there should be a European mechanism to disseminate all implemented actions. Increased dissemination of project information was seen to make the 3HP more efficient as a whole. Additionally, a stakeholder from a research/academic organisation suggested communication with project officers would be better facilitated through a set platform (as opposed to email) to '*increase accountability on all sides'.*

Some stakeholders suggested different, more efficient methods for monitoring the 3HP. Several government and policy makers in the focus group on procurement mechanisms highlighted the difficulty of measuring/monitoring impact of funding as there is no specific framework for measuring results of activities and therefore quantifying progress is challenging. Another participant in the focus group suggested that operational units should put emphasis on what is the best that can be achieved with the available budget at the beginning as a better way of monitoring. One government and policy maker reported that there is a need for a dedicated data collection system to perform monitoring activities per objective and per priorities, as there is currently a missing link between individual projects and specific objectives and thematic priorities. An academic / research stakeholder reported that there should have been an overall objective which was quantifiable and measurable (e.g., improvement in healthy life expectancy – quantifiable health goals and measurable indicators). The stakeholder urged that there should be quantifiable health goals at the EU level.

Q16 Conclusions

In conclusion, although monitoring processes were improved throughout the Programme (mainly through digitalisation of the process) to increase efficiency, there is scope for further improvement. Cost-effectiveness of actions could have been improved if there were a more centralised information system dedicated to disseminating information about different funding to ensure synergies across projects, to better disseminate implemented actions, to coordinate projects, and to allow communication with project officers. Furthermore, there is still need for more measurable monitoring indicators. These conclusions are based on stakeholders' views and knowledge, which in some cases were limited.

3.3.8. Q17. What are the benefits of the reporting systems against their costs and how could they be effectively implemented?

This section assesses the benefits resulting from the reporting systems against their costs and how they could be more effectively implemented.

The main benefit of the reporting system was the improved access to information through digitalisation; however, costs of reporting were not wholly reasonable due to administrative burden. Reporting systems could be simplified to be more efficient, and more guidance could be given to stakeholders on expectations around reporting on actions.

Due to a lack of documentary evidence, this assessment is qualitative in nature as it is solely based on the evidence collected through this study's consultation activities, as presented in the following sub-sections. The evidence emerging from the consultation activities was triangulated and synthesised to avoid the inclusion of unsubstantiated opinions and anecdotal evidence.

Benefits resulting from the reporting system (Q17a)

A number of benefits have resulted from the reporting system, including allowing the tracking of actions progress against their original plan, and increasing visibility of the 3HP and its actions. Factors which made the reporting system more efficient included the Compass and SYGMA reporting systems, which enabled beneficiaries to report back to the Commission with less administrative burden and to track projects from start to end.

Respondents to this study's targeted survey who were involved in the management and administration of actions reported benefits of the electronic reporting system, including allowing the tracking of actions progress against their original plan (11 out of 20, 55%), increasing visibility of the Programme and its actions (6 out of 20, 30%) and allowing Programme participants to manage actions' budgets effectively (5 out 20, 25%).

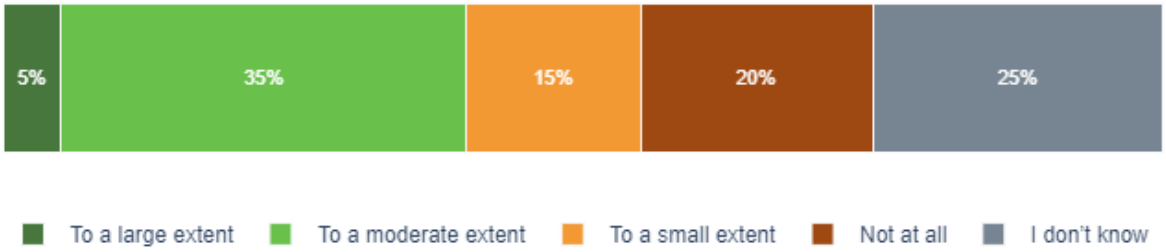
Other benefits identified by interviewed stakeholders were: the portal, which made reporting more efficient (according to a government and policy maker); the Compass and SYGMA reporting systems, which enabled beneficiaries to report back to the Commission with less administrative burden and to track projects from start to end (according to a government and policy maker); and the role of Framework Partnership Agreements and Specific Grant Agreements in reducing administrative burden for applicants and the European Commission in terms of regular applications, payments, and reporting (according to a government/policy maker).

Costs of the reporting system and improvements (Q17b and Q17c)

The costs of the reporting were not wholly reasonable, mostly due to the administrative burden they entailed.

Eight targeted survey respondents out of 20 (40%) said that the costs of the reporting system were reasonable and kept to the minimum necessary to achieve expected results, at least to a moderate extent. However, seven others (35%) said they were not at all reasonable, or only to a small extent. In the OPC, 46% of respondents did not know if reporting costs for Member States and the Commission were reasonable.

Figure 31. Targeted stakeholder survey: To what extent do you believe the costs of the reporting system are reasonable and kept to the minimum necessary, in order to achieve the expected results? (n=20, only those involved in the management and administration of an action from the Programme (e.g. filled in an application form))



Stakeholders consulted as part of this study were mixed on whether the costs associated with the reporting were proportionate in relation to the benefits. An interviewed stakeholder from an international organisation praised the Commission 4-step reporting cycle. Conversely, a

stakeholder from a governmental public health organisation stated that better guidance was needed about expectations, otherwise costs outweighed benefits.

Targeted survey respondents provided some suggestions on ways in which the reporting system could be more effectively implemented. The most frequent answer was 'simplifying the reporting procedure (reducing administrative burden, time and efforts required) (13 out of 20 respondents, 65%).

Finally, in line with this study's targeted survey findings, a few stakeholders consulted in focus groups and interviews expressed that reporting systems could be more effectively implemented in the 3HP. Suggested improvements were related to reducing administrative burden on applicants. For example, stakeholders participating in the focus group on project grants highlighted the need to reduce the level of detail required for financial reports, and two interviewed stakeholders from NGOs and organisations representing patients and services users groups mentioned the administrative burden of submitting operating grant reports specifically. For smaller organisations without technical capacity and knowledge, the administration involved in operating grant reports was off-putting according to a stakeholder from organisations representing patients and services users. The interviewed stakeholder from an NGO also felt that submitting a few smaller operating grant reports throughout the year as opposed to one big report annually may be more efficient, while an interviewed government and policy maker stakeholder stated that the main reporting cost was related to human resources (i.e., the officers' time); this stakeholder asked for funding allocations specifically for performance and monitoring in the EU4Health. The above suggestions would need to be carefully evaluated to make sure that they do not bring additional administrative burden while trying to actually reduce it.

Q17 Conclusions

In conclusion, although there were benefits to the electronic reporting system, administrative burden associated with reporting was still high. The reporting process could be further simplified, and the administrative burden associated to it further reduced. Suggestions to improve the efficiency of the reporting systems include the reduction of details required for reports and frequency of reporting as a way of reducing the administrative burden on applicants. It is important to note that this assessment was based only on stakeholders' views and knowledge.

3.4. EU-Added Value

This criterion seeks to assess the value of the 3HP over and above what could have been achieved in its absence. It also specifically examines if or how the EU added value criteria led to the development of proposals that better addressed these aspects.

3.4.1. Q18. What is the additional value resulting from the Programme, compared to what could reasonably have been expected from Member States acting at national and/or regional levels, and compared to what the EU would have achieved without the Programme?

The EU has no direct or shared competences in the area of health, as the main responsibility to organise, manage and deliver health services and medical care lies with the Member States. However, the importance of EU action in the field of health is acknowledged in the Treaty on the Functioning of the European Union (e.g., art. 6 and 168 TFEU) which stipulates that the Union plays a role in supporting, coordinating and supplementing national actions. Within the remit of its competences, EU action in the field of health can add value to national efforts and support Member States in achieving common objectives and tackling common challenges such

as tackling cross-border health threats, preventing and managing non-communicable diseases, promoting good health, improve access to care and supporting health systems.

Against this background, this criterion assesses the extent to which the 3HP has produced added value and its results have gone beyond what Member States would have achieved acting a national and regional level. It also discusses the extent to which the 3HP results has led to results that go beyond what the EU would have achieved in its absence. The assessment draws together the evidence collected through desk research, the assessment of other evaluation questions as part of this study and consultation activities.

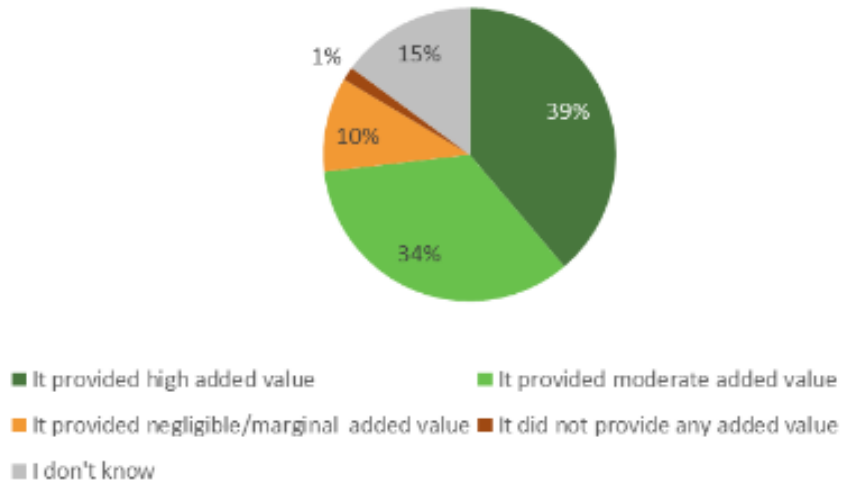
The results of this study demonstrate that the 3HP achieved more than what Member States could have attained acting alone and led to results which could have not been accomplished in its absence. 3HP funded actions brought EU added value by enabling the exchange of best practices and encouraging cooperation and coordination amongst Member States, while also enabling mutual learning and the development of new knowledge in health policy areas. EU action through the 3HP had no detrimental impact on existing Member State actions in respect of health and healthcare, as it did not disrupt or slow national actions, rather it enabled coordination and cooperation across the EU. Consequently, the areas of EU action are deemed appropriate in view of EU and national competences. The following subsections present the evidence that substantiates this assessment.

- *The added value of the 3HP (Q18a and Q18b)*

The 3HP achieved more than what Member States could have attained acting alone and led to results which could have not been accomplished in its absence. Moreover, they brought EU added value by enabling the exchange of best practices and encouraging cooperation and coordination amongst Member States, while also enabling mutual learning and the development of new knowledge in health policy areas.

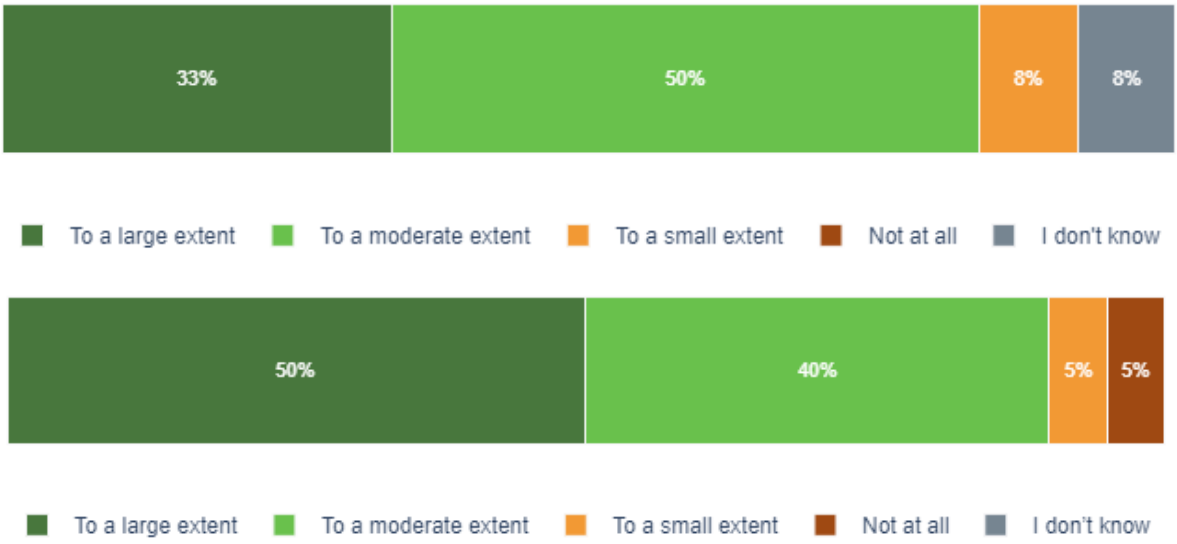
Most stakeholders consulted as part of this study reported that the 3HP has provided added value. Figure 32 shows that most respondents to the OPC considered that the 3HP provided added value, at least to a moderate extent, and achieved more than what Member States could have achieved acting separately (49 out of 67, 73%).

Figure 32. OPC: What has been the Programme's contribution, beyond what Member States could have achieved acting alone? (n=67)



This was supported by this study's targeted survey respondents who, as shown in Figure 33, also agreed that the 3HP provided added value beyond what could have been achieved by Member States acting alone.

Figure 33. Targeted stakeholder survey: To what extent do you believe the Programme provided added value, beyond what Member States could have achieved acting alone? (first graph: n=12, all but public authorities; second graph: n=20, only public authorities)



When considering specific thematic areas, the 3HP mid-term evaluation identified the added value of 3HP actions in areas such as capacity building against health threats, pooling expertise and resources across the EU to reduce health inequalities, collaboration in the field of health technology assessment (HTA) and eHealth, exchange and implementation of best practice for promoting health and preventing diseases. This was also confirmed by stakeholders consulted as part of this study's consultation activities, demonstrating a consistent approach to providing added value throughout the full implementation period of the 3HP. For instance, interviewed government and policy makers, and governmental public health organisations mentioned that 3HP thematic priorities were successfully addressed during its implementation, mostly by bringing EU added value in the areas of health promotion, health technology assessment, rare diseases, health determinants and associated risk factors.

When looking at reported EU added value across the 3HP funding mechanisms, stakeholders reported that procurement contracts led to the production of EU-wide studies that provided valuable information on the public health situation and issues across EU. This was perceived to go beyond the capacity of single Member States. Additionally, the additional value of having an EU-level health programme was also validated by stakeholders who attended the focus group on Joint Actions. For instance, stakeholders representing governmental public health organisations mentioned that the 3HP enabled partners to have contact with other EU organisations and to use that support to have a greater impact at national level.

More broadly, and considering all the funding mechanisms, the 3HP funded actions provided EU added value by enabling the exchange of best practices and encouraging cooperation and coordination amongst Member States, while also enabling mutual learning and the development of new knowledge in health policy areas.

When considering the 3HP contribution in terms of best practices, as discussed under Q4, and according to the 2019 and 2020 Health Programme Statements[98], the 3HP strongly supported the sharing of best practices. This can be seen through DG SANTE's online "best practice portal" that was launched in 2018 where several Member States visited the platform and many actions were published on the portal.[99] Moreover, the European Parliamentary Research

[98] European Commission.,(n.d.). Union Action in the field of health (Health Programme 2019).[Pending publication]. [Accessed November 2021].; European Commission.,(n.d.). Union Action in the field of health (Health Programme 2020).[Pending publication]. [Accessed November 2021].

[99] LOMBA, N., 2019. The benefit of EU action in health policy: The record to date.

Service study (2019)[100] listed the sharing of best practices and networking across Member States as an example of EU added value of the Programme.[101] For example, the EU Compass for action on mental health and wellbeing, which is a web platform that collects and shares best practices and monitors policies at national and regional level relating to mental health, was discussed as a positive development which was above what Member States could have achieved alone. The 3HP added value through exchange of best practices was reaffirmed by respondents to this study's OPC who considered that "exchanging good practices between Member States" was the most important EU added value criteria of the programme (23 out of 67, 34%).

However, the sharing of best practices was not uniformly achieved across all funding mechanisms. In this study's focus group on project grants, stakeholders reported that project grants enabled innovative and collaborative actions, but that this funding mechanism did not sufficiently promote the implementation of best practices among Member States, in comparison with Joint Actions.

The 3HP also brought EU added value by encouraging cooperation and coordination on specific policy issues among Member States. This is especially the case in areas such as rare diseases, HTA and alcohol consumption. As discussed under Q4 on the 3HP contribution to improvements in health across Europe, the establishment of 24 European Reference Networks is considered a flagship achievement of the 3HP. The ERNs demonstrate a high level of coordination, involving healthcare providers across Europe, and are an example of how EU measures add value to Member States' action by coordinating efforts and pooling resources and expertise across Europe. Furthermore, as presented under Q9, numerous stakeholders mentioned that the Commission developed several tools that prolonged sustainability within ERNs. These tools also brought EU added value given their ability to promote cooperation and coordination among Member States, even beyond the lifetime of the funding Programme. For instance, Clinical Patient Management Systems (CPMS) tools allowed cross border consultations, while a registry for 5 ERNs was a tool developed to collect data at EU level for patients with rare diseases. This was confirmed by participants from the project grants focus group who also considered that ERNs had a strong EU added value.

Moreover, another achievement which brought EU added value in terms of coordination and cooperation amongst Member States (as discussed under Q4) was the establishment of several EU-wide data systems including: an EU quality register to ensure the safety of medical devices; an organ database to facilitate transplants; and an EU-wide tobacco tracking and tracing system to combat the trafficking of illicit tobacco products.

Further examples of how the 3HP brought added value in terms of increased cooperation and coordination can been seen in the case study findings (see Annex 3). For instance, in the alcohol case study, the "Conference on Cross-border Aspects in Alcohol Policy-Tackling Harmful use of Alcohol" brought stakeholders from different sectors, facilitating future cooperation and coordination in the alcohol field. The case study on HTA also demonstrates that this is another area of strong EU added value. Findings from the case study show that the EUnetHTA Joint Action 3 funded under the 3HP created a collaborative infrastructure for national and local HTA authorities and enabled sustainable cooperation which reflected in the recently adopted HTA regulation. Additional information on the EUnetHTA Joint Action 3 can be found in the box below. The ability to coordinate efforts across the EU was also validated by several stakeholders[102] who agreed that the 3HP brought EU added value by enabling coordination and cooperation among Member States (see A5.18 in Annex 5 for further details).

Relevant findings from Case study on Health Technology Assessment

[100] LOMBA, N., 2019. The benefit of EU action in health policy: The record to date.
[101] LOMBA, N., 2019. The benefit of EU action in health policy: The record to date.
[102] Stakeholders representing academic and research organisations, government and policy makers, governmental public health organisations, and non-governmental organisations (NGO's).

The EU has acted in the area of health technology assessment for many years to address the challenges that prevent Member States, economic operators, patients and healthcare professionals from realising the benefits of HTA. Specifically, the 3HP has financed the European Network for Health Technology Assessment - Joint Action 3 (EUnetHTA JA3) which builds on the lessons of earlier EUnetHTA Joint Actions funded under previous health programmes. The overall objective of EUnetHTA Joint Action 3 was to define and validate the model for joint work on HTA to be continued after the completion of the Joint Action. Building on this general objective, the Joint Action set to increase production of high quality HTA joint work, promote the uptake and implementation of joint HTA work at the national, regional and local level, and support evidence-based, sustainable and equitable choices in healthcare and health technologies.

EUnetHTA JA3 has produced a wealth of outputs which are different in nature, ranging from the network infrastructure, the joint assessments, scientific guidance and tools.

The EUnetHTA JA3 outputs have contributed to increased cooperation and coordination among HTA national agencies and have facilitated a more efficient production and (to a more limited extent) use of HTA in countries across Europe. Despite the progress achieved so far, shortcomings and challenges are still present which prevent a fully comprehensive and uniform approach to HTA at present. Those shortcomings can be attributed to still existing practical barriers and differences in national processes and methodologies.

However, the EUnetHTA JA3 has created a collaborative infrastructure used by national and local HTA authorities. In fact, it has achieved its overarching objective, by laying a strong foundation for sustainable cooperation which is reflected in the permanent framework for joint work established by the recently adopted HTA Regulation. The adoption of the HTA Regulation aims to tackle the still existing shortcomings in HTA collaboration across the EU and it has largely benefited from the work done in the context of the different HTA Joint Actions, funded under the 3HP and previous programmes. It is important to note that, given the recent adoption of the HTA Regulation, it is not possible at this stage to fully assess the contribution of the Joint Action (and of the 3HP) to the creation of a well-functioning HTA system.

While it is acknowledged that the realisation of the desired longer-term impacts (i.e., the sustainability of health systems, a more efficient allocation of resources in healthcare, greater innovation and transparency, and a higher level of human health protection) is dependent on a variety of factors that go beyond the contribution of EU action on HTA, it can be reasonably assumed that the outcomes achieved under the 3HP on HTA are conducive to achieving those impacts.

The full case study can be found in Annex 3.

Lastly, the 3HP brought EU added value by enabling mutual learning and the development of new knowledge. This study's OPC showed that many respondents considered that one of the most important EU added value criteria of the 3HP was "supporting networks for knowledge sharing or mutual learning" (14 out of 67, 21%). This was also the case for stakeholders from healthcare service providers and organisations representing them, and government policy makers who attended this study's focus group on project grants. They highlighted that the 3HP enabled mutual learning and synergies between different stakeholder and Member States. Stakeholders from government public health organisations and NGOs also considered that the EU added value of the 3HP relied on its ability to create new knowledge. They mentioned that research, scientific knowledge, and innovation was generated in the different thematic areas of the 3HP. In the same vein, an interviewed government public health stakeholder noted that the 3HP was a bridge to enable science, research and policies to impact Member States daily activities in the field of health. However, other interviewed stakeholders were more sceptical of how useful and practical new knowledge generated through the 3HP would be in impacting citizens' health.

- *Q18 Conclusions*

In conclusion, the 3HP provided added value compared to what could have been achieved by the EU in absence of the Programme and by Member States acting alone. In particular, the 3HP funded multiple actions which demonstrated strong EU added value by encouraging Member States to exchange best practices, cooperate and coordinate with each other on pertinent policy issues. In this regard, EU action through the 3HP had no detrimental impact on existing Member State actions in respect of health and healthcare, as it did not disrupt or slow national actions, rather it enabled coordination and cooperation across Europe. As a consequence, the focus areas of EU action supported through the 3HP are deemed appropriate in view of the distribution of competences between the EU and national levels. Furthermore, the 3HP enabled mutual learning, knowledge exchanges and provided EU added

value in different areas, especially in areas such as health promotion, health technology assessment, rare diseases and alcohol policy. It was, however, not possible to assess to what extent 3HP funded actions were implemented at Member State level, potentially further substantiating EU added value overall.

3.4.2. Q19. How far have the EU added value criteria led to the development of proposals that better addressed these aspects? Are all of these criteria still relevant? Which criteria have been most/least addressed?

A set of seven criteria was built into the 3HP Regulation which identified areas where 3HP funded actions should provide added value:[103]

- Exchange good practices between Member States;
- Support networks for knowledge sharing or mutual learning;
- Address cross-border threats to reduce their risks and mitigate their consequences;
- Address certain issues relating to the internal market where the Union has substantial legitimacy to ensure high-quality solutions across Member States;
- Unlock the potential of innovation in health;
- Actions that could lead to a system for benchmarking to allow informed decision-making at Union level; and
- Improve efficiency by avoiding a waste of resources due to duplication and optimising the use of financial resources.[104]

This section assesses the extent to which the EU added value criteria listed above led to the development of proposals that better address these criteria. The assessment draws together the evidence collected through desk research, the assessment of other evaluation questions as part of this study and the consultation activities.

Study results demonstrate that the EU added-value criteria were well-defined and used in funding proposals to some extent. Some of the criteria which were considered the most important included sharing of best practices and supporting networks for mutual learning, which are notably amongst the areas which brought strong added value as discussed under Q18. Further, the EU added value criteria remained relevant throughout the 3HP implementation period and are considered useful in the context of future health programmes. The following subsections presents the evidence base/findings that substantiate this assessment.

EU added value criteria in funding proposals (Q19a and Q19c)

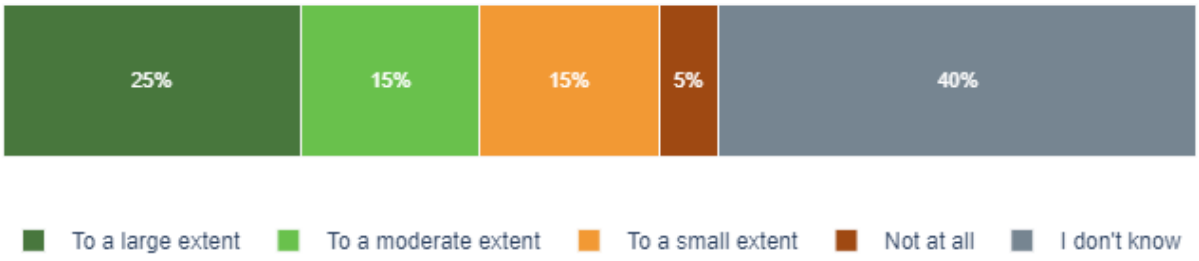
Evidence from this study's consultation activities shows that the seven added value criteria were well-defined and used in funding proposals to some extent. The criteria which were considered the most important comprised sharing of best practices, supporting networks for mutual learning and avoiding inefficient duplication of work.

As seen in Figure 34, 8 out of 20 (40%) this study's targeted survey respondents who were involved in the management and administration of a 3HP action said the criteria were well-defined to at least a moderate extent. However, it is worth noting that a large proportion of respondents said they did not know.

[103] European Union., 2014. Regulation (EU) No 282/2014 of the European Parliament and the Council 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/EC. Available from:https://eurlex.europa.eu/legalcontent/EN/TXT/PDF/?uri=CELEX:32014R0282&from=EN [Accessed November 2021]

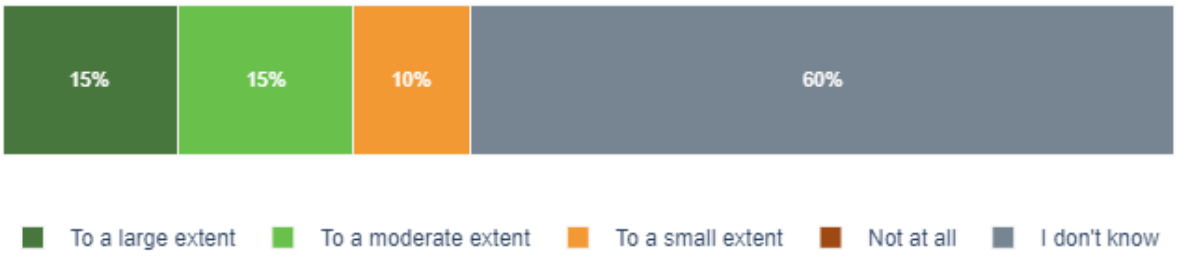
[104] European Commission. n.d. Funding under the 3rd Health Programme 2014-2020: The European Added Value. Available from: https://ec.europa.eu/chafea/health/programme/documents/factsheets-hp-av_en.pdf [Accessed July 2022].

Figure 34. Targeted stakeholder survey: To what extent have the seven added value criteria been well-defined in funding proposals? (n=20, only those involved in the management and administration of an action from the Programme (e.g. filled in an application form))



As regards the extent to which the seven added value criteria were used, Figure 35 shows that a majority of this study's survey respondents who were involved in the management and administration of a 3HP action said they did not know (12 out of 20 respondents, 60%). Among those who did provide an answer, six out of 20 (30%) said the criteria were used to at least a moderate extent.

Figure 35. Targeted stakeholder survey: To what extent were the seven added value criteria used in funding decisions? (n=20, only those involved in the management and administration of an action from the Programme (e.g. filled in an application form))



As discussed under Q18, 3HP funded actions provided EU added value by enabling the exchange of best practices and encouraging cooperation and coordination amongst Member States, while also enabling mutual learning and the development of new knowledge in health policy areas. This is corroborated by evidence emerging from this study's OPC as "exchanging good practices between Member States", "supporting networks for knowledge sharing or mutual learning" and "improving efficiency by avoiding waste of resources due to duplication and optimising use of financial resources" were considered the most important EU added value criteria by OPC respondents (see Figure 36). Relating to improving efficiency, stakeholders in several focus groups held as part of this study also noted that funding was on some occasions issued to actions with similar aims or targeting the same population group.

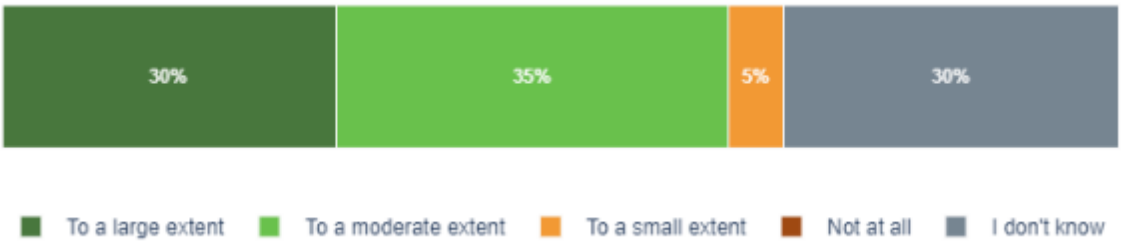
Figure 36. Which of the 7 EU value added criteria, listed below do you consider the most important? Please select up to three criteria (n=67)

Continued relevance of EU added value criteria (Q19b)

The EU added value criteria remained relevant throughout the 3HP implementation period and are considered useful in the context of future health programmes.

Findings from this study's targeted survey show that a large proportion of respondents who were involved in the management and administration of a 3HP action (13 out of 20, 65%) said that the criteria remained relevant to at least a moderate extent (see Figure 37).

Figure 37. Targeted stakeholder survey: To what extent have the added value criteria remained relevant to what you see as key health needs and priorities during 2014-2020? (n=20, only those involved in the management and administration of an action from the Programme (e.g., filled in an application form))



Moreover, the important developments and revisions initiated by CHAFEA (now HaDEA) helped increase the relevance of these criteria during the 3HP implementation period and improve overall EU- added value. In fact, the CHAFEA's (now HaDEA) guide for applicants for Project Grants released in 2018[105], expanded on the EU added value criteria, with areas to achieve EU added value in this new guide listed as:

- Impact on target groups
- Long-term effect and potential multiplier effect such as replicable, transferable, and sustainable activities;
- Contribution to complementarity, synergy, and compatibility with relevant EU and EU Member States policies and programmes including compatibility with the European Platform on RD registration and the EC European Reference Networks' Platform.

Further, the guide listed ways to achieve added value as:

- Implementing EU legislation;
- Promoting best practice;
- Benchmarking for decision-making;
- Reducing cross-border threats; strengthening free movement of persons;
- Strengthening networking activities.

[105] 3rd Health Programme (2014-2020) Project Grants (HP-PJ) Guide for Applicants, European Commission

When considering the future relevance of the EU added value criteria, most respondents to this study's targeted survey indicated that the seven added value criteria should be retained in future health programmes. As seen in Figure 38, more than half of the respondents (18 out of 32, 56%) said they should be retained as they are, a few said that they should be modified somewhat (6 out of 32, 19%), and only one (1 out of 32, 3%) said they should be significantly modified. Suggestions for improving these criteria included:

- Ensuring the involvement of civil society actors (NGOs) throughout the programme
- Putting a stronger focus on health equity, health promotion and education
- Including evidence-based work (activities, policies)
- Allocating funding to areas of unmet needs where EU action has particular added value, such as rare diseases including childhood cancers.

Figure 38. Targeted stakeholder survey: To what extent should the added value criteria be retained in future health programmes? (n=32)

Further improvements to help strengthen the EU added value of EU action in health, as assessed through triangulation of consultation activities- including numerous interviews with diverse stakeholder groups-, centred around strengthening cooperation across the wider European Institutions, notably across Directorate-Generals of the European Commission (DGs), and that involvement of technical institutions and agencies would be beneficial in addition to DGs.

Q19 Conclusions

In conclusion, the seven added value criteria were well-defined and used in funding proposals to some extent. A significant proportion of stakeholders were not aware of the extent to which the criteria were well-defined or used, suggesting that there is scope to making the process of integrating the EU added value criteria in proposals clearer and more systematic. The criteria which were considered the most important comprised sharing of best practices and supporting networks for mutual learning, which corresponds to some of the areas where the 3HP funded actions provided stronger EU added value. Finally, the EU added value criteria remained relevant throughout the 3HP implementation period and are considered useful in the context of developing future health programmes and defining priorities most suited (and needed) in health policy at the EU-level.

3.5. Coherence

This criterion seeks to assess the internal coherence of the 3HP (how its actions were coherent with its objectives), as well as how the 3HP has been coherent with wider EU funding and priorities.

3.5.1. Q20. Are the actions implemented under the 3HP coherent with its objectives? How has the coherence of the Programme influenced its effectiveness?

This section discusses the extent to which actions implemented under the 3HP were coherent with its objectives and how the coherence of the 3HP influenced its effectiveness. The assessment draws together the evidence collected through desk research and consultation

activities. In particular, the study team reviewed DG-SANTE's annual activity reports over the period 2014 – 2020 and mapped the activities to the specific objectives and thematic priorities of the 3HP by year to assess the alignment of actions taken as part of the 3HP with its objectives and, when possible, with each other. This documentary evidence was further complemented with evidence from this study's consultation activities.

The study's results demonstrate that 3HP funded actions were coherent with each other and aligned with the Programme's objectives. Further, barriers to effectiveness of the 3HP discussed under EQ5 (e.g., lack of resources, expertise and data, lack of political will in Member States) are not related to the internal or external coherence of the 3HP. The following subsections present the evidence base that substantiates this assessment.

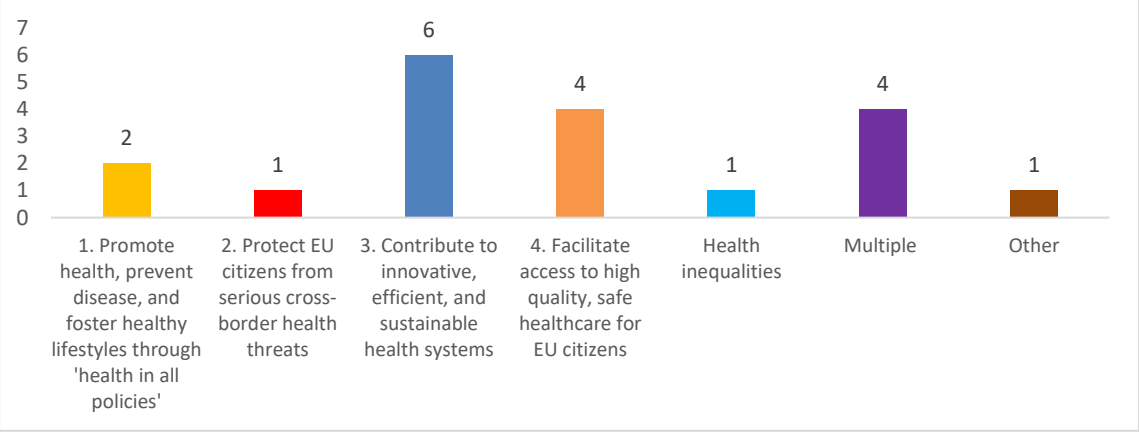
Alignment of funded actions with each other and with the 3HP objectives (Q20a and Q20b)

DG SANTE's activities related to the 3HP are aligned with the thematic priorities and specific objectives of the Programme and 3HP funded actions were coherent with each other and with the Programme's objectives. The study's findings presented below substantiate this assessment.

This study assessed the level of alignment between actions implemented under the 3HP and the Programme's objectives up until 2020. DG-SANTE's annual activity reports were reviewed, and activities were mapped to the specific objectives and thematic priorities of the 3HP by year. The link between DG-SANTE's fields of activity and the 3HP's specific objectives were therefore identified. The analysis conducted shows that almost all of DG-SANTE's fields of activity are aligned with the thematic priorities of the Programme and therefore the Programme's objectives, with very few exceptions mostly related to the cross-cutting area of health inequalities. Furthermore, some of DG-SANTE's fields of activity are linked to more than one Programme objective.

Figure 39 and Figure 40 below illustrate DG SANTE's fields of activity related to 3HP spending mapped by the four priority areas and the cross-cutting area of health inequalities, in a selected year (2018) and over time up to 2020.[106]

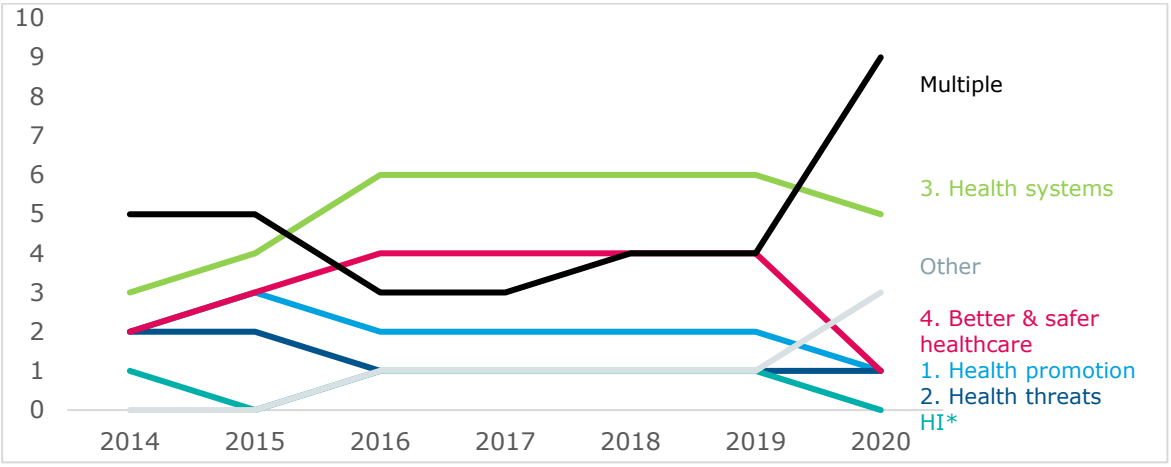
Figure 39. Fields of activity captured per 3HP objective area (2018)



Source: ICF analysis of DG SANTE's annual activity reports. The vertical axis illustrates how many DG SANTE fields of activities relate to 3HP objectives.

[106] The fields of activity which present a link to more than one general objective/thematic priority are listed under "Multiple". This is the case for activities in the field of medicinal products which are relevant to thematic priority 3.6 implementation of Union legislation in the field of medical devices, medicinal products and cross-border healthcare and to thematic priority 4.3 patient safety and quality of healthcare. The item "Multiple" mostly represent activities under objectives 3 and 4 for the period 2014-2019. In 2020, also reflecting the increased focus on combating the spread of the COVID-19 pandemic, the item "Multiple" also represents activities under objective 2 protect EU citizens from serious cross-border health threats.

Figure 40. Fields of activity captured per 3HP objective area over the period 2014 – 2020



*Source: ICF analysis of DG SANTE's annual activity reports. *Health inequalities / determinants of health. The vertical axis illustrates how many DG SANTE's fields of activity relate to 3HP objectives.*

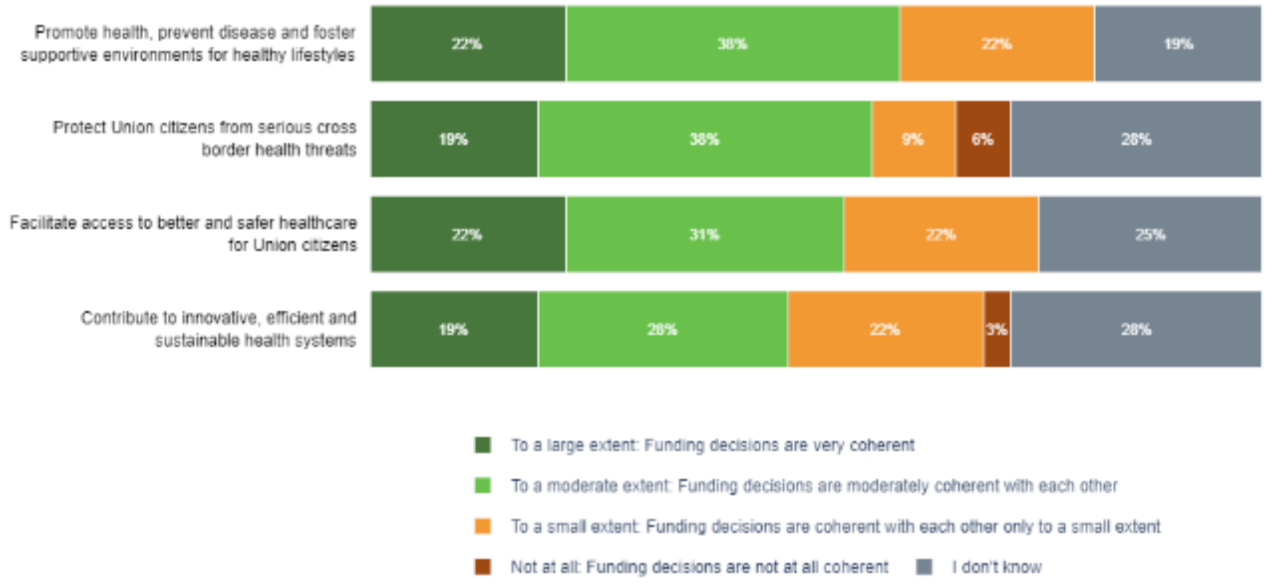
A focus on health promotion, health systems and access to safe healthcare remained relatively stable over the implementation period. Among the three objectives, objective 3 focusing on health systems received greater attention over the period under examination. The focus on health threats (objective 2) generally remained low throughout the 3HP implementation[107], however it increased between 2019 and 2020, likely due to the COVID-19 pandemic. This growth is reflected by the 2020 peak of the item "Multiple" which gathers fields of activity presenting a link to more than one general objective, including objective 2 protect EU citizens from serious cross-border health threats (see Figure 40).

This was complemented by targeted survey respondents who were asked to what extent the Programme's specific objectives enabled consistent and coherent decisions across the Programme period. As shown in Figure 41, the majority of respondents mentioned that all four of the Programme's specific objectives enabled consistent and coherent funding decisions across actions during the Programme period. Few respondents (7 out of 32, 22%) said that there were synergies which improved overall performance between actions and the following two specific objectives: "Objective 1: Promote health, prevent disease and foster supportive environments for healthy lifestyles" and "Objective 4: Facilitate access to better and safer healthcare for Union citizens".

Very few respondents said that funding decisions were not at all coherent with the specific objectives "Objective 2: Protect Union citizens from serious cross border health threats" (2 out of 32, 6%) and "Objective 3: Contribute to innovative, efficient and sustainable health systems" (i.e., that there were inconsistencies between actions, gaps, duplications or contradictions, which lead to inefficiencies) (2 out of 32, 3%). This was mainly due to issues linked with relationships between different actors/beneficiaries, programme management and communication with core stakeholders, and the lack of national political uptake or capitalisation of findings arising from the Programme's funded actions.

[107] DG SANTE's annual activity reports for the period 2016 to 2019 list one main field of activity that relates to 3HP objective 2, "Tackling and improving the preparedness for serious cross-border health threats". The analysis is based on DG SANTE main fields of activity (as identified in the activity reports) captured per 3HP objective area and does not reflect individual actions/projects undertaken under the Programme.

Figure 41. To what extent did the Programme's specific objectives enable consistent and coherent funding decisions across actions during the Programme period? (n=32)



Furthermore, four stakeholders representing healthcare service providers, government and policy makers, and academic organisations who attended the focus group on Project Grants believed the actions had been coherent with the objectives of the Programme. In particular, stakeholders highlighted that:

- The ERNs project was fully aligned with objective 4, thematic priority on ERNs.
- The SCIROCCO project was in line with objective 3; the participant representing this project also highlighted the coherence with national and local level needs.
- The YOUNG50 #Stay Healthy – Cardiovascular Risk Prevention project was in line with objectives 1, 3 and 4.

When considering interlinkages between effectiveness and coherence of the 3HP, it emerges that barriers to effectiveness of the 3HP do not appear to relate to the internal or external coherence of the Programme. As presented under EQ5, overall, funded actions contributed to achieving the 3HP objectives to a very good extent, in particular objective 1 and objective 4. However, some consulted stakeholders identified factors hindering the achievement of the 3HP objectives, including lack of resources, expertise and data, difficulties engaging with stakeholders, lack of political will in Member States and difficulties in quantifying/measuring success. Among the factors hindering the effectiveness of the 3HP, none were found to be related to its internal or external coherence.

Q20 Conclusions

In conclusion, 3HP funded actions were aligned with the Programme's objectives and coherent with each other, as demonstrated by a detailed mapping of Commission documentation and substantiated by many consulted stakeholders. Further, the barriers to the effectiveness of the 3HP identified under Q5 (e.g., lack of resources, expertise and data, lack of political will in Member States) do not relate to the internal and external coherence of the 3HP. Only very few consulted stakeholders objected to the coherence of funded actions with objectives 2 and 3; while this has been taken into account in the analysis, it does not undermine the above conclusion.

3.5.2. Q21. To what extent have the priorities of the Programme led to more synergy, focus and coherence between the EU-funded actions in delivering on similar objectives? Did the Programme encourage cooperation with the European Structural and Investment Funds and other EU financial instruments? To which extent is the Programme coherent with wider EU policy and with international obligations?

This section discusses the extent to which the priorities of the 3HP have led to more coherence between the EU-funded actions. It also explores whether the 3HP encouraged cooperation with other EU financial instruments, including the European Structural and Investment Funds and whether it was coherent with wider EU policy and with international obligations. The assessment draws together the evidence collected through desk research and consultation activities.

The study's results demonstrate that 3HP funded actions were aligned with 3HP objectives and thematic priorities, and some of DG SANTE's activities related to 3HP spending are linked to more than one of the 3HP objectives; therefore, 3HP funded actions are focused in relation to thematic priorities while also exhibiting synergies with one another. Further, the 3HP has overall encouraged cooperation and was aligned with other EU financial instruments directing funding to health-related activities (i.e., European Structural and Investment Funds and Horizon 2020), despite some limitations were uncovered. Lastly, 3HP funded actions contributed to EU wider policies and wider international obligations. The following subsections present the evidence base that substantiates this assessment.

Internal coherence of the 3HP (Q21a)

Overall, funded actions are mostly aligned with 3HP objectives and some of DG SANTE's activities related to 3HP spending are linked to more than one of the 3HP objectives.

When considering the internal coherence of the Programme, the analysis under Q20 shows that actions implemented within the Programme are mostly aligned to its objectives over the implementation period. Furthermore, when mapping DG SANTE's main fields of activity related to 3HP spending to Programme objectives and thematic priorities, some fields of activity are linked to more than one Programme objective. This is the case, for example, for DG-SANTE's fields of activity related to pharmaceuticals and medical devices (period 2014-2019) which are relevant to the health systems objective (thematic priority 3.6 *Implementation of Union legislation in the field of medical devices, medicinal products and cross-border healthcare*) and to the access to care objective (thematic priority 4.3 *Patient safety and quality of healthcare*). In 2020, among the fields of activity identified in DG SANTE's activity report, there are several that are related to more than one Programme's objectives as well. As an example, activities in the field of medicinal products and the regulatory framework can be linked to objectives 3 and 4 (Health systems and Access to care), while are also given a specific focus on combating the spread of COVID-19, thus contributing to objective 2 (Cross-border health threats).

- #### *Coherence of the 3HP with other EU financial instruments (Q21b)*

The 3HP encouraged cooperation with other EU Programmes in the field of health to some extent and was aligned with other EU financial instruments directing funding to health-related activities (i.e., European Structural and Investment Funds and Horizon 2020). Provisions for cooperation between the 3HP and other EU financial instruments were established in the 3HP Regulation. Some limitations to the coherence of the 3HP with other financial instruments, however, were uncovered through desk research and further identified by consulted stakeholders.

Links with other EU financial instruments were built into the design of the 3HP. Regulation 282/2014 establishes that the Programme should promote synergies with other EU programmes funding actions in the field of health, such as the Framework Programme for Research and Innovation 2014-2020 (Horizon 2020), and the European Structural and Investment Funds (ESI Funds). Direct links between the Programme and Horizon 2020 are established for specific thematic priorities. This is the case for action in the field of health technology assessment under objective 3 (Contribute to innovative, efficient and sustainable health systems): the Programme aimed to facilitate the uptake of the results stemming from research projects supported under Horizon 2020. Similarly, the Programme aimed to facilitate the uptake of Horizon 2020 projects' results in the area of effective and efficient investment and innovation in public health and health systems (Objective 3 – Thematic Priority 3.4 Setting up a mechanism for pooling expertise at Union level).[108]

Moreover, Horizon 2020 and the ESI funds directed funding to health-related activities over the 3HP implementation period (2014-2020).

When considering EU action in the field of research and innovation, the Regulation establishing Horizon 2020 included health, demographic change and well-being as a specific objective under the priority 'Societal challenges'.[109] Research priorities included topics such as personalised medicine, health promotion and disease prevention, innovative health and care systems, infectious diseases, global health and the digital transformation in health and care. Examples of health-related projects financed under Horizon 2020 can be found in Annex A5.21 in Annex 5.

The ESI Funds aimed to provide support to deliver the Europe 2020 strategy to creating more and better jobs and a socially inclusive society.[110] Among other policy priorities, this support was also directed towards health-related issues. In particular, the Regulation establishing the European Regional Development Fund (ERDF)[111] identifies health as a focus for investment, especially in terms of strengthening ICT applications for e-health; investing in health and social infrastructure which contributes to national, regional and local development; reducing inequalities in terms of health status. Within the context of the ESI funds, also the European Social Fund (ESF) included a focus on health-related issues. The Regulation establishing the ESF identifies as investment priorities active and healthy ageing as well as enhancing access to affordable, sustainable, and high-quality health care services.[112] Interlinkages and synergies between the 3HP and the ESI Funds were sought and created during the 3HP implementation period as results stemming from 3HP funded actions served as a basis for actions financed through the ESI Funds. Examples of health-related actions financed in the context of the ESI funds include the promotion of digital public services through the deployment of e-health solutions and the provision of accessible medical services to vulnerable groups.[113] More details can be found in A5.21 in Annex 5.

108 European Union., 2014. Regulation (EU) No 282/2014 of the European Parliament and the Council 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/EC. Available from: https://eurlex.europa.eu/legalcontent/EN/TXT/PDF/?uri=CELEX:32014R0282&from=EN. [Accessed July 2022]

109 European Union., 2013. Regulation (EU) No 1291/2013 of the European Parliament and of the Council establishing Horizon 2020 - the Framework Programme for Research and Innovation (2014-2020) and repealing Decision No 1982/2006/EC. Available from: https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32013R1291&qid=1581593105949&from=EN#:~:text=Horizon%202020%20is%20hereby%20established,2014%20to%2031%20December%202020.&text=Horizon%202020%20shall%20maximise%20Union,by%20Member%20States%20acting%20alone. [Accessed July 2022]

110 European Commission, Directorate-General for Regional and Urban Policy (2015), European Structural and Investment Funds 2014-2020: Official texts and commentaries.

111 European Union., 2013. Regulation (EU) No 1301/2013 of the European Parliament and of the Council on the European Regional Development Fund and on specific provisions concerning the Investment for growth and jobs goal and repealing Regulation (EC) No 1080/2006. Available from: https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32013R1301&from=EN. [Accessed July 2022]

112 European Union., 2013. Regulation (EU) No 1304/2013 of the European Parliament and of the Council on the European Social Fund and repealing Council Regulation (EC) No 1081/2006. Available from: https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32013R1304&from=EN [Accessed July 2022]

113 European Commission, European Structural and Investment Funds 2014-2020. 2020 Summary report of the programme annual implementation reports covering implementation in 2014-2019.

The ability of the 3HP to complement and create synergies with other EU Programmes, in particular ESI funds and the Horizon 2020 Programme, was agreed upon by respondents to this study's consultation activities. Stakeholders consulted explained that the 3HP was coherent with contributions of the ESI funds and the Horizon 2020 and added that complementarities between the 3HP and these other EU instruments made it possible to investigate every aspect of several topics (e.g., chronic diseases, non-communicable diseases, rare diseases) in-depth. While the majority of this study's consultees agreed that the 3HP was coherent with other EU financial instruments, some consulted stakeholders disagreed and identified a few limitations linked to the nature of the financial instruments. For instance, synergies between Joint Actions funded under the 3HP and Horizon 2020 projects were difficult to unlock because the latter programme was more research oriented. Further details on evidence emerging from this study's consultation activities related to the 3HP coherence with other EU financial instruments can be found in A5.21 in Annex 5.

- *Coherence of the 3HP with EU wider policies and wider international obligations (Q21c)*

3HP funded actions contributed to EU wider policies and wider international obligations. When looking at the external coherence of the Programme with wider EU policies, the findings discussed under Q2 show that funded actions within the 3HP contributed to wider EU policies over the evaluation period. In particular, DG SANTE's specific objectives related to the 3HP spending were consistently aligned to and built on the EU wider policy priorities: the Europe 2020 strategy for smart, sustainable and inclusive growth in 2014-2015; the Juncker Commission's priorities in 2016-2019; and the Von der Leyen Commission' priorities in 2020. For example, as illustrated in Table 24 and Table 25 of A5.2 in Annex 5, during the period 2016-2019 DG SANTE's specific objectives 1.3 Cost-effective health promotion and disease prevention and 1.4 Effective, accessible and resilient healthcare systems in the EU contributed to the Commission priority *A new boost for jobs, growth and investment in the EU*, and in 2020 DG SANTE's specific objective 2.2 Patients' access to safe, innovative and affordable medicines and medical devices contributed to the Commission priority *Promoting our European Way of Life.*

This was confirmed by some stakeholders representing NGO's, international organisations and organisations representing patients and service users that reported that the 3HP was aligned with EU wider policies. For example, one stakeholder representing an NGO highlighted the alignment in relation to migrants' health as there were other EU funding mechanisms besides the 3HP addressing this topic. Furthermore, a national policy maker that attended the focus group on Procurement Contracts mentioned that the work of the 3HP during the migration crisis was linked to the EU wider policy tackling this challenge, as it was not only addressing a specific objective of the programme but a wider EU priority.

When considering the alignment of the Programme with wider international obligations that share common objectives with the Programme, information reviewed shows that the Programme was well-aligned with the WHO common policy framework Health 2020[114] and the European Action Plan for Strengthening Public Health Capacities and Services.[115] In particular, the four priority areas suggested by the Health 2020 framework[116] and the avenues for action

[114] World Health Organisation (2013), "Health 2020. A European policy framework and strategy for the 21st century", Denmark. Available from https://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf

[115] World Health Organisation (2012), European Action Plan for Strengthening Public Health Capacities and Services, Denmark. Available from: https://www.euro.who.int/__data/assets/pdf_file/0005/171770/RC62wd12rev1-Eng.pdf

[116] The Health 2020 framework four priority areas are: 1. Investing in health through a life-course approach and empowering people; 2. Tackling the Region's major health challenges of noncommunicable and communicable diseases; 3. Strengthening people-centred health systems, public health capacity and emergency preparedness, surveillance and response; 4. Creating resilient communities and supportive environments. World Health Organization.,2013. Health 2020: A European policy framework and strategy for the 21st century. Available from: https://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf.

identified in the European Action Plan[117] are broad topics which can be related to multiple 3HP specific objectives and, within each objective, to different thematic priorities. Further details on the Health 2020 policy framework and its alignment with the 3HP are included in A5.21 in Annex 5.

- *Q21 Conclusions*

In conclusion, 3HP funded actions were found to be focused in relation to addressing thematic priorities while also exhibiting synergies with one another. As presented under Q20, a detailed mapping of Commission documentation, substantiated by many consulted stakeholders, demonstrates the internal coherence of the 3HP. When considering the external coherence of the 3HP with other EU financial instruments, it emerges that the 3HP overall encouraged cooperation and was aligned with other instruments financing health-related activities, in particular the European Structural and Investment Funds and Horizon 2020. Such alignment and cooperation cannot be considered as fully achieved as some limitations were identified in terms of interlinkages between financial instruments, however it is worth noting that synergies and interlinkages were sought with other financial instruments.

Lastly, 3HP funded actions systematically contributed to EU wider policies and priorities (i.e., the Europe 2020 strategy for smart, sustainable and inclusive growth in 2014-2015; the Juncker Commission's priorities in 2016-2019; and the Von der Leyen Commission' priorities in 2020), as discussed under EQ2, and were aligned with wider international obligations, in particular the WHO common policy framework Health 2020 and the European Action Plan for Strengthening Public Health Capacities and Services.

3.5.3. Q22. To what extent has the Programme proved complementary to other EU or Member States targets, interventions and initiatives in the field of health?

This section discusses the extent to which the 3HP has been coordinated and complementary with other EU-level policies in the field of health over time and up until 2020. In particular, the study team has identified a selection of EU health-related initiatives adopted over time and mapped them against the 3HP objectives. Documentation was also reviewed to assess the policy coordination between different Commission services and between different EU policies and mechanisms involving health. Furthermore, this section discusses the coherence of the 3HP with Member State initiatives in the field of health drawing from findings under Q1 on the alignment between national strategies and the allocation of 3HP funding across its four objectives.

The study's results demonstrate that the 3HP has been coherent with other EU policies in the field of health over time and up until 2020 and that there is an alignment between the different European Commission services and different EU policies in the field of health. Furthermore, the 3HP was coherent with Member States' strategies and initiatives in the field of health.

This assessment draws together the evidence collected through desk research and consultation activities, as presented in the following sub-sections.

- *Coherence of the 3HP with other EU-level policies in the field of health (Q22a)*

The 3HP has been coherent with other EU policies and related activities in the field of health over time and up to 2020. Both before the entry into force of the Regulation establishing the 3HP and during the implementation of the Programme, the EU adopted legislation and multiannual action plans which are in line with the objectives of the 3HP. This demonstrates

[117] Avenues for action include, among others, health promotion, diseases prevention, and response to health hazards and emergencies. World Health Organization., 2012. European Action Plan for Strengthening Public Health Capacities and Services. Available from: https://www.euro.who.int/__data/assets/pdf_file/0005/171770/RC62wd12rev1-Eng.pdf.

the continued effort to ensure coherence and complementarity among different EU policies and activities in the field of health. This was confirmed by several stakeholders representing government and policy makers, academic and research organisations and governmental public health organisations, who agreed that the 3HP had been aligned and coherent with other EU policies in the field of health.

To support the above, a selection of EU health-related initiatives adopted over time and up to 2020 has been mapped against the 3HP objectives (including the EU legal frameworks for medicinal products for human use and for medical devices, and activities in the field of tobacco control) finding that those initiatives are aligned with 3HP objectives. In particular, initiatives such as the eHealth Action Plan 2012-2020 and the Action Plan for the EU Health Workforce[118], the EU Action Plan on Childhood Obesity 2014-2020 and the European One Health Action Plan against Antimicrobial Resistance, were aligned 3HP objectives. The detailed mapping is presented in A5.22 in Annex 5.

Furthermore, the documentation reviewed as part of the desk research also indicates that there is alignment between different Commission services in terms of policy direction in the field of health. The analysis described under EQ21 points to the external coherence of the 3HP with other EU financial instruments such as the ESI Funds and Horizon 2020. This coherence is also reflected in the policy coordination between different Commission services and between different EU policies and mechanisms involving health. This is particularly the case for the European Semester that identified different health-related priorities which present a strong level of coherence with the specific objectives of the 3HP. Similarly, the activity of DG REFORM through the Structural Reform Support Programme and of DG REGIO and DG RTD have been found to be overall aligned with the 3HP objectives. The evidence substantiating this assessment can be found in A5.22 in Annex 5.

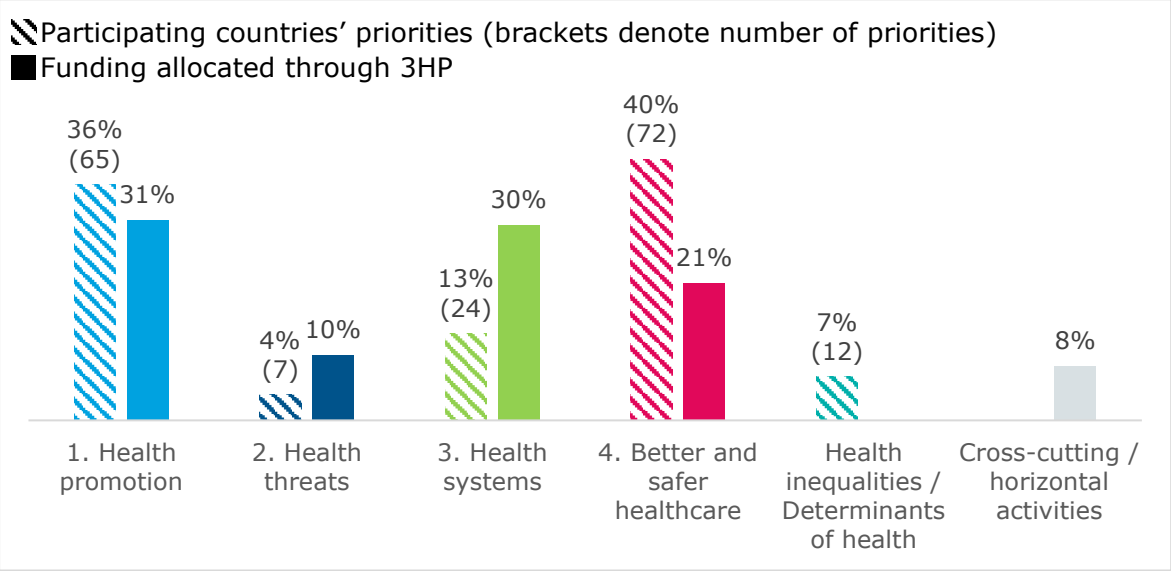
- *Coherence of the 3HP with Member State interventions/initiatives in the field of health (Q22b)*

Overall, the 3HP was coherent with Member States' strategies and initiatives in the field of health. As part of the desk research, national level strategies were mapped and analysed to understand the needs across the participating countries and were compared with the allocation of 3HP funding across each of the objective areas (see Q1).

Findings presented in Figure 42 indicate that 3HP funding allocations generally matched the priorities of participating countries. Countries have prioritised health promotion (3HP objective 1) and better and safer healthcare (3HP objective 4), and this has been reflected in the larger amounts of funding provided to these areas.

[118] The eHealth Action Plan 2012-2020 and the Action Plan for the EU Health Workforce were both adopted before the entry into force of the 3HP and covered the 3HP implementation period.

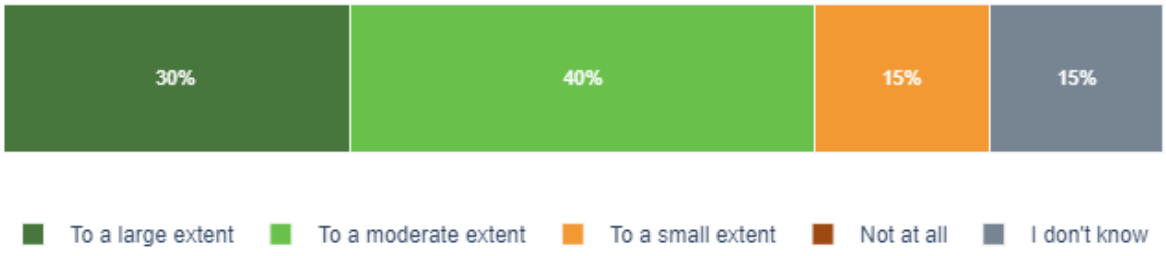
Figure 42. Percentage of participating countries' priorities in an objective area compared to funding allocated by the 3HP to that objective area



- *Source: Annual Implementation Reports; ICF analysis of participating countries' health strategies. Note that in Annual Implementation Reports, funded actions and funding are separated by priority areas, while funded actions relating to health inequalities / determinants of health are not identified in this way. There were 138 participating countries' priorities which did not map to the objective areas; these were not included in this graph.*

The alignment between the 3HP and Member State initiatives on health was confirmed by targeted survey respondents from public health authorities when asked to what extent had the Programme been aligned with and addressed national health priorities during the Programme period (Figure 43, a majority of public authorities said that the Programme was aligned with and addressed national health priorities during the Programme period to at least a moderate extent (14 out of 20 responses, 70%)). Among the three respondents (3 out of 20, 15%) who said this was true only to a small extent, one cited the structure of the Programme (e.g., definition of the scope and of the priorities), and another explained this was due to the changing needs and priorities in health during the 3HP implementation period which made it difficult to ensure full alignment.

Figure 43. Targeted stakeholder survey: To what extent has the Programme been aligned with and addressed national health priorities during the Programme period? (n=20, public authorities only)



Additionally, half of respondents to the OPC believed that the Programme complemented and/or created synergies with national initiatives and/or programmes, to at least a moderate extent (33 out of 67 responses, 49%). When probed, respondents added that:

- National initiatives were often stimulated by the opportunities launched in the framework of the Programme and aligned to its priorities.
- One Joint Action developed a toolset to assist European countries implement the Orphanet nomenclature of rare diseases (ORPHA codes, standardised coding system).

- Another Joint Action transferred and implemented good practice examples from national initiatives on physical activity in primary schools (Active Schools Flag) to other Member States.
- The iPAAC (Innovative Partnership for Action Against Cancer) Joint Action was very effective in terms of providing ready-made solutions that could be implemented in the Polish National Oncology Strategy.

Furthermore, several interviewed stakeholders representing government policy makers, governmental public health organisations, NGOs, academic and research organisations and organisations representing patients and service users agreed that the 3HP priorities and objectives were aligned with Member states initiatives in the field of health. Among the national initiatives that were aligned with the 3HP, stakeholders mentioned:

- Actions on tobacco use and alcohol abuse in young people
- Obesity
- Prevention of frailty

On the contrary, evidence collected from the OPC also pointed at limited coherence between the 3HP and national level initiatives. A few respondents (13 responses, 19%) said the 3HP was not coherent with national initiatives and/or programmes. For instance, a public authority explained that the VISTART Joint Action activities on "Strengthening the Member States' capacity of monitoring and control in the field of blood transfusion and tissue and cell transplantation" under the 3HP have not been directly translated into national programmes, as the process of amending the Directives in this area has not yet been completed and therefore, for example, it is not possible to carry out inspections in the area of substances of human origin of one country in another country.

• *Q22 Conclusions*

In conclusion, the study found that the 3HP was coherent with other health-related EU policies and it has been aligned with Member States' strategies and initiatives in the field of health. Other health-related EU policies covering the 3HP implementation period (2014-2020) have been found to align with 3HP specific objectives. Examples of EU policies in the field of health which were mapped against the 3HP objectives include activities in the field of serious cross-border health threats, including the establishment of the Early Warning & Response System, the Action Plans on Childhood Obesity (2014-2020), on HIV/AIDS in the EU and neighbouring countries (2014-2016), and the One Health Action Plan against Antimicrobial Resistance (2017), and the EU legal frameworks for medical products and medical devices. During the 3HP implementation period, the Commission has also adopted different policy initiatives which were aligned with the 3HP objectives, including the Communication on effective, accessible and resilient health systems, and the Communication on enabling the digital transformation of health and care in the Digital Single Market. The adoption of those actions demonstrates the continued efforts to ensure coherence and complementarity among different EU policies and activities in the field of health.

The study also found that the 3HP was largely aligned with Member States' priorities and strategies in the field of health. It emerged that 3HP funding allocations generally matched the priorities of participating countries and the 3HP was found to enable complementarity and synergies with national initiatives. A few differing stakeholders' views emerged, mentioning that the structure of the 3HP (e.g., definition of the scope and of the priorities), and the changing needs and priorities in health during the 3HP implementation period did not allow for a full alignment between the 3HP and participating countries priorities. However, these views reflected a minority of all stakeholders consulted and could not be fully substantiated by other components of this study.

4. Conclusions and recommendations

This section presents the overall study conclusions by evaluation criterion, and then offers several wider recommendations to consider in future EU health work.

4.1. Relevance

During the implementation of the Third Health Programme (3HP), the main health needs identified across the EU related to health promotion and better and safer healthcare, although some health needs did change over time due to anticipated, and unexpected, developments. The 3HP was largely relevant in that it addressed these health needs, for example health promotion (objective 1) was highly prioritised by participating countries and accordingly received a large amount of funding. Health threats (objective 2) was not an area which was highly prioritised by participating countries (at the start of the Programming period), and when considering the 3HP as a whole, objective 2 received the lowest amount of funding within the 3HP. Under objective 4, rare diseases were identified as a specific key health need in the EU which was addressed appropriately by actions within the 3HP. The Programme was also relevant in that there was clear alignment between funded actions and the specific thematic priorities set out by the Programme, particularly for objective 1. Importantly, the funded actions were aligned with the Commission's wider priorities, which meant that actions funded under the Programme were directly relevant and responded to the needs of EU citizens, in particular in topic areas such as alcohol and rare diseases.

Factors which facilitated the relevance of the Programme include the active and inclusive participation of 3HP participating countries in the design of the Programme, and that by design the Programme was adaptable and flexible to ongoing developments and changes in health or policy areas influencing health. Accordingly, the 3HP for the most part remained relevant to changes in health needs over time, such as increased (and sudden) migration and pandemics (notably COVID-19), and it was flexible enough to respond to the emerging health needs in these areas.

4.2. Effectiveness

Funded actions contributed to achieving the 3HP objectives to a very good extent (particularly under objective 1 and objective 4), although there were a few areas which were less addressed than others, including health security and socioeconomic determinants of health. Wider strengths of the 3HP which contributed to its overall effectiveness were that it contributed to a more comprehensive and uniform approach to health issues across the EU through funded actions (and their results) but also more horizontally by fostering cooperation and dialogue. For example, the 3HP increased the robustness, timeliness and comparability of health data across EU countries through the establishment of several EU-wide data systems such as the organ database, the EU quality register ensuring the safety of medical devices and the EU-wide tobacco tracking and tracing system to combat illicit tobacco products trafficking.

3HP results have, to varying extents, been published by the Commission services and by other stakeholders in scientific journals. 3HP results have also been used by stakeholders in various ways, for example for sharing insights, knowledge and findings on pertinent topics, in particular in the contexts of Joint Actions (such as EUnetHTA, CHRODIS and CHRODIS+, and the RARHA Joint Action). Such knowledge produced by the 3HP was used in policy making as it has informed national strategies and initiatives, and it contributed to improvements in health and healthcare across the EU, in particular in the field of HTAs.

In terms of the 3HP's effectiveness at the international level, this study found limited evidence substantiating the assessment of the 3HP contribution to EU's influence on health and healthcare standards, policies and practices at international level. This is, however, partly explained by the geographical scope of the 3HP which is limited to its participating countries.

More broadly, the results of the 3HP were found to be sustainable overall, and examples of areas with high sustainability included HTAs, the Joint Action on AMR and the ERNs.

Sustainability was aided by some elements of the Programme, such as the addition of an obligatory work package on sustainability in the Joint Action on AMR (EU-JAMRAI), as well as through strong connections built between key stakeholders at the co-design stage of actions and throughout their implementation period.

That being said, there were some factors which hindered the achievement of the 3HP objectives (including the longer-term sustainability of results), and these have been found to limit the 3HP contribution to improvements in health across Europe. These factors were, however, mostly related to limitations at the national and beneficiary level (thus not directly attributable to the 3HP), including: limited resources, capacity, political will, and difficulties publishing and disseminating the results of funded actions on the part of 3HP beneficiaries. Nevertheless, there is room for strengthened and more effective EU action to address those limitations and support Member States. Increased resources at EU level dedicated to health issues (including, but not limited to, the 3HP) would contribute to address the national difficulties in participating in the Health Programme. Further, an even stronger role of the Commission in brokering the existing knowledge and pooling the existing data and resources being generated would contribute to closing the knowledge gaps where needed while also steering national action. Examples include the Commission providing stronger support to the dissemination of 3HP results by way of organising knowledge transfer activities (e.g., communities of practice, policy dialogues and other events).

The exceptional utility criteria intended to facilitate higher participation of low-GNI countries in the Programme, and stakeholders did perceive the criteria as having a positive impact. However, low-GNI countries had a lower overall participation rate in 3HP actions as coordinators and partners when compared with high-GNI countries. Further, programme participation by low-GNI countries did not increase over time, and programme participation by low-GNI countries did not increase as compared to the 2nd HP (in fact, low-GNI countries coordinated fewer actions in 3HP compared to 2HP). The reasons for why the criteria did not facilitate much increased participation are not abundantly clear, however overall administrative issues and costs were identified.

Finally, and influencing an increased effectiveness of the 3HP, some of the recommendations stemming from the 3HP mid-term evaluation have been addressed successfully. These include maintaining a focus on thematic areas of strong EU added value, strengthening and building links between the 3HP and wider Commission & EU policy agenda to maximise impact, developing a broader strategy to increase participation from poorer MS & underrepresented organisations and improving dissemination of action results. Conversely, some recommendations were not sufficiently taken up, including spelling out how actions targeting health promotion and health systems should generate EU added value and investing in the resources necessary to improve systems for monitoring Programme implementation. The latter recommendations, alongside with those which were only partially met, should be followed upon in the context of the new EU4Health Programme (and beyond).

4.3. Efficiency

The Programme was relatively cost-effective considering changes in the health landscape over its implementation period, and the size and scope of funded actions undertaken. The assessment on the efficiency of the 3HP is primarily based on findings emerging from this study's consultation activities and evidence gathered to address other evaluation criteria. Data assessed in this study shows that there was not significant deviation from planned resource budgets, and stakeholders consulted confirmed this, highlighting the positive impacts of work achieved with the resources allocated, even in cases where funding was not deemed to be wholly sufficient. Flexibility of funding allocation was particularly efficient and underlines a strong success factor of the Programme as a whole. The distribution of Programme credits among the four thematic priorities was efficient in that it addressed the key health needs identified during the implementation period., with funding allocation deemed critical to achieve expected results. A particular strength of the Programme was the flexibility of funding

allocation, which for example allowed the Programme to respond to key health threats which emerged.

As identified in the mid-term evaluation, a wide range of systems and processes were simplified and digitised to streamline the administration of the 3HP. On the whole, these measures (particularly the digitalisation of the process/online platforms) did increase efficiency of the Programme and alleviate some administrative burden on applicants. However, there was some scope to simplify processes, especially in relation to applications for funding.

In some cases, the efficiency of the Programme was not as strong as it could have been due to elements of the Programme's design. Whilst operational and management costs were reasonable, administrative costs were sometimes disproportionately heavy, increasing workload of those involved in actions and potentially putting countries with low GDP or smaller organisations off becoming involved, or being involved in future work. Further, there were some design features of actions which limited efficiency, including a large number of partners in actions, the design and set-up phase of actions, and limitations to actions sustainability.

There was also some room for further improvement related to monitoring processes. Cost-effectiveness of actions could have been improved if there were a more centralised information system dedicated to disseminating information about different funding to ensure synergies across projects, to better disseminate implemented actions, to coordinate projects, and to allow communication with project officers. Similarly, although there were benefits to the electronic reporting system, administrative burden associated with reporting was still high. The reporting process could be further simplified, and the administrative burden associated to it further reduced. These conclusions are based on stakeholders' views and knowledge, which in some cases were limited.

- There were significant differences in costs and benefits between participating countries, as countries with lower GDP were less able to participate in the Programme (especially in coordinating roles) and Western European countries lead the most actions and received the most funding for actions. Accordingly, countries with less capacity and funding consequently did not feel the same benefits as other countries. Although the exceptional utility criteria increased participation of low GDP countries, differences in capacity still prevented these countries' fuller participation and they thus required further support from the 3HP.

4.4. EU added value

The 3HP provided added value compared to what could have been achieved by the EU in the absence of the Programme and by Member States acting alone. In particular, the 3HP funded multiple actions which demonstrated strong EU added value by encouraging Member States to exchange best practices, cooperate and coordinate with each other on pertinent policy issues. In this regard, EU action through the 3HP enabled coordination and cooperation across Europe on important themes and sub-themes in public health, and importantly, had no detrimental impact on existing Member State actions in the area of public health. As a consequence, the focus areas of EU action supported through the 3HP are deemed appropriate in view of the distribution of competences between the EU and national levels. Furthermore, the 3HP enabled mutual learning, knowledge exchanges and provided EU added value in different areas, especially in areas such as health promotion, health technology assessment, rare diseases and alcohol policy. It was, however, not possible to assess to what extent 3HP funded actions were implemented at Member State level, potentially further substantiating EU added value overall.

Lastly, the seven added value criteria were well-defined and used in funding proposals to some extent. A significant proportion of stakeholders were not aware of the extent to which the criteria were well-defined or used, suggesting that there is scope to making the process of integrating the EU added value criteria in proposals clearer and more systematic. The criteria which were considered the most important comprised sharing of best practices and supporting networks for mutual learning, which corresponds to some of the areas where the 3HP funded actions provided stronger EU added value. Finally, the EU added value criteria remained

relevant throughout the 3HP implementation period and are considered useful in the context of developing future health programmes and defining priorities most suited (and needed) in health policy at the EU-level.

4.5. Coherence

3HP funded actions were aligned with the Programme's objectives and coherent with each other. Funded actions were found to be focused in relation to thematic priorities, while also exhibiting useful synergies with one another, demonstrating high internal coherence.

In relation with other EU financial instruments, the 3HP overall encouraged cooperation and was aligned with other instruments financing health-related activities, in particular the European Structural and Investment Funds and Horizon 2020. However, such alignment and cooperation cannot be considered as fully achieved as some limitations were identified in terms of interlinkages between financial instruments.

3HP funded actions have systematically contributed to wider EU policies and priorities (i.e., the Europe 2020 Strategy for smart, sustainable and inclusive growth in 2014-2015; the Juncker Commission's priorities in 2016-2019; and the Von der Leyen Commission' priorities in 2020), and were aligned with wider international obligations, in particular the WHO common policy framework Health 2020 and the European Action Plan for Strengthening Public Health Capacities and Services.

4.6. Recommendations

As the successor to the Third Health Programme - the EU4Health - has already begun and is in its intermediate stages, this section focuses on recommendations for future EU work or action on health more broadly but can also be considered in the next annual planning for the EU4Health.

The mid-term evaluation made a series of recommendations, and some of these were addressed successfully as discussed above. However, some recommendations were not sufficiently taken up and therefore future EU action on health should take these into account and consider their relevance in the next planning. Reflections stemming from the mid-term recommendations are described below, followed by recommendations which emerged from the present analysis.

4.6.1. Reflections on mid-term recommendations

Building on the mid-term recommendations, there should be a continued focus on areas of EU added value as they clearly emerged from the present analysis.

- Future EU action in the field of health should continue encouraging cooperation and coordination amongst Member States in areas such as rare diseases, HTA and eHealth, while also fostering exchange and implementation of best practices in the field of health promotion and disease prevention, in particular sub-themes which have emerged in importance. Likewise, it should be clearly spelled out how actions in those specific fields should generate EU added value.
- Investments should be made to improve systems for monitoring the implementation of actions.
- Synergies between EU health action and wider Commission priorities and EU policies should be maintained and further strengthened. Clear links between EU action in the area of health (i.e., EU4Health) and other EU financial instruments would support those synergies.

4.6.2. Design of Programme and funding frameworks

Improving the outcomes and impacts of funding actions begin at design stage. A number of important findings across the main evaluation criteria pointed towards the design of funding structures and suggestions for improvement.

- Re-thinking of how cross-cutting policy issues can be integrated within the priority areas of the Programme. If there are key topics which represent important health needs, these should be given explicit attention and funding, rather than being included as a "cross-cutting issue". For example, in the 3HP, there were actions funded under the topics of mental health and health inequalities, however stakeholders did not always perceive these to be adequately addressed, likely because they were not named as specific thematic priorities- even if at certain moments during the Programme's implementation, funding and emphasis was provided.
- The flexibility and adaptability of the 3HP was one of its key strengths, and this should continue, which would pave the way for more flexibility in cases of sudden onset emergencies or changes in health needs. The Commission could consider some sort of formalised mechanism to protect such flexibility and ensure its sustainability in future Programmes.
- The Commission should continue to simplify processes within the Programme to reduce burden on applicants and participants, particularly in regard to the level of detail required in applications. In cases where simplification measures are implemented, these should be promoted to raise awareness. In 3HP, it would have been useful to further simplify monitoring by reducing details required and having a dedicated platform which centralises/disseminates information on funding, facilitation/coordination of projects, and communication channels with Project Officers in one place.
- Similarly, the Commission should further reduce administrative processes through reducing level of detail required and frequency of reporting. Smaller organisations particularly may be provided with further support for reporting. A consideration may also be useful in relation to updating monitoring indicators so that actions are more quantifiable (e.g., having indicators per objectives or an overall measurable objective). In addition, a better alignment between the objectives of an action or a single task and the related budget allocated could be sought to reduce burden on participants and clarify expectations.

4.6.3. Facilitating and strengthening participation of all countries

The participation of all EU countries in the Programme can only strengthen the outputs, outcomes and impacts. Full participation also has an impact on the added value of funded actions and should remain an important factor for improvement.

- Structures should be put in place to remove barriers for countries with less resources. For example, increased resources at EU level dedicated to health issues would contribute to address the national difficulties in participating in the 3HP. Further, an even stronger role of the Commission in brokering the existing knowledge and pooling the existing data would contribute to closing the knowledge gaps where needed while also steering national action. For example, the Commission could provide support to the dissemination of 3HP results by way of organising knowledge transfer activities (e.g., communities of practice, policy dialogues and other events).
- Active participation of participating countries in the design of certain funded actions, notably Joint Actions, is seen as an important success. This could be further built upon and strengthened, which would also help tailor EU-level action to national contexts in an efficient manner.
- Administrative costs for applicants and participants with lower capacity could be reduced through decreasing details required from them. Co-funding requirements could be lowered to ensure broader participation, and lower GDP countries' resources might be further considered regarding funding allocation.

4.6.4. Ensuring sustainability

The sustainability of funded actions can have a profoundly positive effect on EU and national health policies and systems. Guiding and actively supporting beneficiaries in conceptualising and implementing actions to foster sustainability is a key element of consideration for future planning.

- Mechanisms and support should be provided to ensure sustainability measures are planned or negotiated at the start of funded actions, so that the full responsibility of sustainability measures does not fall to Member States. Joint Actions have been particularly successful in this, due to certain focus and obligations on the sustainability aspects of the work and could be considered as good practice.
- An EU-level repository of outputs and outcomes of funded actions, saved in an accessible and coherent way, would further strengthen sustainability (and provide further EU added value). This would make the connection between past and future actions easier and increase knowledge of what has been done in the past to inform future actions.
- Finally, the Commission should continue to fund critical actions whose thematic areas incorporate a strong EU added value component, which will strengthen sustainability of those (and other related) actions and provide the most added-value and foster continued collaboration at the EU level.

Annexes

Annex 1 References

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Annex 2 Analytical framework

Analytical framework

Table 7. Revised Evaluation Matrix

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
	Relevance				•
1	• To what extent have the Programme's scope, including its objectives and priorities been relevant to health needs across the EU, considering their evolution over the evaluation period?				
1a	*To what extent did the objectives and priorities of the Programme, its actions and other activities, address health and healthcare needs and problems at EU-level over the evaluation period?*	• *Problems, needs and their drivers identified as part of the Programme were correctly defined.* • *No relevant problems or needs were left out of the Programme at the time.* • *The implementation mode of the Programme was relevant given needs and context at the time.*	• *[Quantitative] A majority of stakeholders agree that problems/needs/drivers were correctly defined* • *[Qualitative] Expert **stakeholders'** recollection of problems at the time* • *[Qualitative] Available literature from 2014-2020 reflects the problems/needs/drivers of the Programme*	• ***Document review** looking at sources from 2014-2020 that address problems, needs and drivers related to health and healthcare* • ***OPC*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Social media analysis*** • ***Focus groups***	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP
1b	*To what extent have each of the objectives and priorities remained relevant to health and healthcare needs and problems at EU-level over time and up until 2020?*	• *The problems and drivers that led to the choice of the Programme's objectives are still relevant.* • *Each of the objectives and actions have remained relevant considering changes in:* • *science and technological progress in the area of health and healthcare* • *solutions developed at national level, by public, private and not-for-profit actors* • *changes in prevalence & severity of NCDs & CDs*	• *[Quantitative] A majority of stakeholders agree that problems/needs/drivers remain relevant defined* • *[Qualitative] Expert views on extent to which there is still a need to focus on each of the Programme's priority areas* • *[Qualitative] Extent to which Member States still require support in the areas identified by the Programme* • *[Qualitative] Extent to which:* • *EU knowledge needs to be improved and in which domains* • *health officials and healthcare providers use*	• ***Document review**, particularly:* • *review of data on prevalence and severity of NCDs & CDs* • *literature reviews on the state of play in health & healthcare research & innovation* • ***Mapping of project database*** • ***OPC*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews**,* • ***Social media analysis*** • ***Focus groups***	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP • EU-level collected data on health indicators to help understand the relevance of the 3HP

	Evaluation questions	Judgment criteria	Quantitative and qualitative indicators	Research methods	Sources for document review
		• *The implementation mode of the Programme remains relevant given evolving needs and context.*	*new knowledge developed through the Programme* • *[Qualitative] Overview and assessment of health and healthcare solutions (technologies, therapies, products) developed between 2014-2020* • *[Quantitative & qualitative] Changes in prevalence, incidence and severity of NCDs and CDs*		
2	• To what extent were the Programme's thematic priorities sufficiently covered by the funded actions to achieve the Programme's objectives and Commission's wider priorities?				
2a	*To what extent were the Programme's funded actions aligned with the thematic priorities of the Programme?*	• *There is a clear alignment between funded actions and the specific thematic priorities set out by the Programme.*	• *[Qualitative] Available information from the Programme period reflects alignment between funded actions and Programme priorities* • *[Quantitative] A majority of stakeholders agree that funded actions align with thematic priorities* • *[Quantitative] % of total number of funded actions that align with specific Programme themes*	• ***Document review*** • ***Mapping of project database*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Focus groups***	• 3HP Implementation documentation •
2b	*To what extent were the funded actions aligned with the Commission's wider priorities?*	• *There is a clear alignment between funded actions and wider Commission priorities.*	• *[Qualitative] Available information from the Programme period reflects alignment between funded actions and wider Commission priorities* • *[Quantitative] A majority of stakeholders agree that funded actions align with wider Commission priorities*	• ***Document review*** • ***Mapping of project database*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews**, particularly with SANTE & Chafea and NFPs & PCs* • ***Focus groups***	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP
3	• How relevant is the Programme to EU citizens, and in particular, is the Health Programme close to citizens and responding to their needs?				
3a	*How relevant is the Programme to EU citizens?*	• *Each of the objectives and actions have remained relevant considering changes in public/citizens' expectations and behaviours in relation to health and healthcare*	• *[Quantitative] A majority of stakeholders agree that funded actions are relevant to public/EU citizens' expectations and behaviours in relation to health and healthcare* • *[Qualitative] Available information from the*	• ***Document review**, particularly: review of existing data on public/citizens' expectations & behaviours* • ***OPC*** • ***Social media analysis***	• Strategic Documents (policies/reports) to understand relevance of the 3HP • EU-level collected data on health indicators to help

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
			Programme period demonstrates that funded actions are relevant to public/citizens' expectations and behaviours in relation to health and healthcare	• ***Stakeholder interviews***	understand the relevance of the 3HP
3b	*Is the Programme close to citizens and responding to their needs?*	• *Actions funded under the Programme are directly relevant/responding to the needs of EU citizens*	• *[Quantitative and Qualitative] Survey data & other research on public/citizens' expectations & behaviours in relation to health & healthcare* • *[Qualitative] Available information on the extent to which funded actions directly address the needs of citizens*	• ***Document review**, particularly: review of existing data on public/citizens' expectations & behaviours* • ***Targeted stakeholder survey*** • ***Social media analysis***	• Strategic Documents (policies/reports) to understand relevance of the 3HP • EU-level collected data on health indicators to help understand the relevance of the 3HP
	Effectiveness				•
4	• What have been the (quantitative and qualitative) effects of the Programme?				
4a	*To what extent has the Programme contributed to a more comprehensive and uniform approach to health and healthcare in the EU?*	• *Measures implemented by Member States are aligned with the Programme* • *National programmes and actions reflect evidence and evidence-based approaches developed through Programme funding* • *Health data is more robust, timely and comparable across EU countries*	• *[Qualitative] Level of alignment or divergence between national level actions in relation to Programme priorities and actions* • *[Qualitative] Level or degree of MS use of evidence and evidence-based approaches developed under the Programme* • *[Qualitative] Extent to which health data is more robust, timely and comparable across EU countries*	• ***Document review*** • ***Mapping of project database*** • ***OPC*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Focus groups*** • ***Case studies***	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP • EU-level collected data on health indicators to help understand the relevance of the 3HP
4b	• *To what extent has the Programme contributed to improvements in health and healthcare in the EU and at Member State level?*	• *Programme actions that have led to new knowledge and evidence have been used in the development of policy and decision-making* • *Programme actions have led to improvements in health and healthcare in the EU and at MS level in terms of:* • *Implementation of best practices by MS*	• *[Quantitative & Qualitative] Number and content of scientific studies and best practice, guidance, etc. developed as part of the Programme* • *[Qualitative] Extent of implementation of best practices by EU MS* • *[Qualitative] Coordination efforts by EU MS* • *[Qualitative] Changes in EU policy and practice* • *[Qualitative] Stakeholder views on how studies,*	• ***Document review*** • ***Mapping of project database*** • ***OPC*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Focus groups*** • ***Case studies***	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP • EU-level collected data on health indicators to help understand the relevance of the 3HP

	Evaluation questions	Judgment criteria	Quantitative and qualitative indicators	Research methods	Sources for document review
		• *Coordination of efforts across MS* • *Changes in policy and practice at EU level*	*reports and evidence produced through the Programme contributed to decision making at EU or national level* • *[Qualitative] Extent to which stakeholders attribute improvements to the Programme* • *[Qualitative] Extent to which documentation corroborates stakeholder views on relationship between new knowledge and policy-making or decision-making* • *[Qualitative] Extent to which factors other than the Programme can explain any improvements*		
4c	• *To what extent has the Programme contributed to the EU's influence on health and healthcare standards, policies and practices at international level?*	• *Programme outputs have been used at an international level* • *The EU's coordination with international bodies in the field of health has been strengthened in Programme priority areas*	• *[Qualitative] Expert views on how the Programme contributed to the EU's influence on standards, policies and practices at global level (WHO, SDGs)* • *[Quantitative &Qualitative] extent to which documentation and other stakeholder interviews confirm expert views*	• ***Document review*** • ***Mapping of project database*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Focus groups*** • ***Case studies***	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP •
5	• To what extent have the Programme's objectives (general and specific) been met? To what extent can factors influencing the observed achievements be linked to the EU intervention?				
5a	*To what extent have the funded actions contributed to achieving the objectives of the 3HP?*	• *There is a clear indication that funded actions meet the Programme's objectives* • *The actions funded by the Programme have led to high-quality, publicised and influential outputs that support Programme objectives*	*For a subset of the actions:* • *[Qualitative] Available information from the Programme period demonstrates that funded actions meet the Programme's objectives* • *[Qualitative] Quality of outputs from funded actions* • *[Quantitative] A majority of stakeholders agree that funded actions meet the Programme's objectives* • *[Quantitative &Qualitative] Information on publication & dissémination efforts* • *[Qualitative] Influence of actions on decision-making*	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Mapping of project database*** • ***Focus groups*** • *Results of analysis under EQ4 on Programme effects*	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
			• *[Qualitative] Impact on achieving strategy objectives*		
5b	*Regarding the objectives partially met or unmet, which factors hindered the achievement of the objectives?* •	• *The cause and effect chain for achieving the objectives was effective* • *The explanatory factors that hinder and enable achieving Programme objectives can be identified*	• *[Qualitative] For question 5a, where objectives have not been met, assessment of what has contributed to objectives not being met*	• *Review of evidence gathered in support of question 5a* • ***Focus groups***	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP
6	• How effective was the introduction of "exceptional utility" criteria in the Regulation establishing the Programme in order to incentivize the participation of low GDP countries?				
6a	*To what extent did the 'exceptional utility' criterion incentivize participation of low GDP countries?* •	• *Programme participation by low GDP countries has increased:* • *over time* • *as compared to participation in the 2nd HP* • *As compared to participation during the first half of the Programme period (i.e. since the mid-term evaluation)*	• *[Quantitative] Trends in participation of low GDP countries over the Programme period and compared to 2HP* • *[Quantitative] Success rates of applicants seeking to benefit from the criterion, and as compared to success rates for regular funding* • *[Quantitative & Qualitative] Number of low GDP countries participating, levels of funding provided* • *[Qualitative] Stakeholder views on extent to which low GDP country participation was incentivized by the criterion* • *[Qualitative] Stakeholder views on any changes or improvements made since the mid-term evaluation that improved or might have led to improved participation (even if this is not directly reflected in the quantitative results)* • *[Qualitative] Stakeholder views on any factors leading to lower participation by low GDP countries that is specific to the criterion and Programme in general (e.g. awareness / understanding of the criterion)*	• ***Document review*** • ***Mapping of programme data****, particularly:* • *Participation by low GDP countries/ organisations (number & geographic distribution)* • *Projects (number and types) funded under the criterion in comparison to regular funding* • *Funding allocations (proportions and amounts) to low GDP countries/ organisations overall and under the criterion* • ***Targeted stakeholder surveys*** • ***Stakeholder interviews***	• 3HP Implementation documentation • •

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
			• *[Qualitative] Stakeholder views on wider factors that may influence participation external to the criterion (e.g. securing co-financing, administrative capacity to manage actions in the MS)*		
7	• To what extent are the Programme's actions/outcomes/results published by Commission services, by Programme beneficiaries and other stakeholders? To what extent are they made accessible to the international scientific and health community and to the wider public in the EU?				
7a	*To what extent are Programme results published?* •	• *Programme results have been published by:* • *Commission services* • *Programme beneficiaries* • *Other stakeholders*	• *[Quantitative & Qualitative] Number, type and source of publications*	• ***Document review,*** *including programme monitoring & reporting data* • ***Mapping of project database-*** *focus on outputs and outcomes*	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP
7b	*To what extent are publications made accessible to the wider scientific and health community and to the public?*	• *Publications are available to wider stakeholders and the public*	• *[Quantitative & Qualitative] Number & type of publications available Open Access (green & gold)*	• ***Document review,*** *including programme monitoring & reporting data* • ***Mapping of project database***	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP
7c	*To what extent are the results used by stakeholders?*	• *Publications have been used by other stakeholders in research or other activities*	• *[Qualitative] Stakeholder views on quality of deliverables and dissemination efforts*	• ***Document review*** • ***Mapping of project database*** • ***Social media analysis***	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP •
8	• To what extent have the recommendations from previous evaluations been implemented?				
8a	*To what extent has SANTE maintained a focus on thematic areas of strong EU added value*	• *SANTE has undertaken activities that focus on areas identified as having the most EU added value since the mid-term evaluation* • *SANTE has identified MS needs where the Programme can provide added value and acted on these*	• *[Qualitative] Documented priorities and actions reflect a focus on areas of greatest added-value* • *[Qualitative] Stakeholder views on extent to which areas of greatest added value have been prioritised and acted upon*	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews***, • *Results of analysis under EQ18 on EU added value of the Programme*	• Document review supporting EQ18 • Strategic Documents (policies/reports) to understand relevance of the 3HP •

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
8b	*To what extent has SANTE strengthened and built links between the HP and wider Commission & EU policy agenda to maximise impact?*	• *SANTE has learned from experiences of successful coordination and extended these efforts where they have worked and/or undertaken new such efforts*	• *[Qualitative] Programme actions indicate an effort to coordinate with wider Commission & EU policy agenda* • *[Qualitative] Stakeholder views on extent to which coordination has occurred*	• ***Document review*** • ***Targeted stakeholder surveys*** • ***OPC*** • ***Stakeholder interviews***, • *Results of analysis under coherence EQs*	• Document review supporting EQ21 • 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP
8c	*To what extent has SANTE spelt out how action targeting health promotion & health systems should generate EU added value?*	• *SANTE has defined in detail the mechanisms by which best practices should be taken up in practical terms and timescales for doing so since the mid-term evaluation* • *This information has been shared with key stakeholders* • *Operational objectives for the next Programme have been revised to detail how the Programme should generate added value*	• *[Qualitative] Guidance has been created which details how actions generate added value* • *[Qualitative] Operational objectives for the next Programme have been clearly revised to take this into account* • *[Qualitative] Stakeholder views on extent to which this information has been shared with stakeholders and reflected in the next Programme's objectives*	• ***Document review*** • ***Stakeholder interviews***, • *Results of analysis under EQ18 on EU added value of the Programme*	• Document review supporting EQ18 • 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP
8d	*To what extent has SANTE refined 3HP thematic priorities and streamlined them in EU4Health to focus spending on areas with the greatest potential impact?*	• *Thematic priorities have been refined since the mid-term evaluation to reflect more concretely their anticipated results* • *Thematic priorities have been streamlined for the next Programme to avoid overlap or ambiguity as well as any redundancies*	• *[Qualitative] Documented refinements to existing priorities to reflect anticipated results* • *[Qualitative] Documented efforts to streamline priorities in the EU4Health programme* • *[Qualitative] Stakeholder views on extent to which existing priorities have been refined and streamlined for the future*	• ***Document review*** • ***Stakeholder interviews***	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP
8e	*To what extent have SANTE & Chafea refined the EU-added value criteria and fully integrated these into the application process?*	• *The EU-added value criteria have been refined & their use integrated more fully into the application process*	• *[Qualitative] Stakeholder views on the extent to which the EU added value criteria have improved & been used in a more integrated way in the application process* • *[Qualitative] Stakeholder views on the extent to which applicants & assessment panellists understand the EU added*	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews***, • ***Mapping of project database*** • *Results of analysis under EQ19 on the EU added value criteria*	• Document review supporting EQ19 • 3HP Implementation documentation

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
			value criteria & how to apply them • *[Qualitative] Review of Programme documents demonstrate these changes, including development of 'how to guides' or other guidance*		
8f	*To what extent has SANTE integrated multi-annual planning with existing programme processes?*	• *Multi-annual planning has been integrated with the formal priority setting process since the mid-term evaluation*	• *[Qualitative] Stakeholder views on the extent to which multi-annual planning has become more formally incorporated into priority setting* • *[Qualitative] Stakeholder views on the extent to which they feel more connected to the multi-annual planning processes* •	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews***,	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP
8g	*To what extent have SANTE & Chafea developed a broader strategy to increase participation from poorer MS & underrepresented organisations?*	• *A broader strategy to increase participation from poorer MS & underrepresented organisations has been developed since the mid-term evaluation* • *Low-GDP MS are participating in the Programme at higher rates or granted greater proportions of funding since the mid-term evaluation* • *The exceptional utility criterion is being used more since the mid-term evaluation*	• *[Qualitative] A strategy from increasing participation has been developed and/or implemented* • *[Quantitative] Resources allocated/dedicated to increasing participation from low GDP MS over the Programme period & compared with mid-term evaluation*	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • *Results of analysis under EQ6 on exceptional utility criterion*	• Document review supporting EQ6 • 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP •
8h	*To what extent have SANTE & Chafea invested in the resources necessary to improve systems for monitoring programme implementation?*	• *Additional resources have been allocated to monitoring systems since the mid-term evaluation* • *Real-time, accurate information about HP implementation is available to programme managers*	• *[Quantitative] Resources allocated/dedicated to Programme monitoring & trends in resource levels so allocated over the Programme period* • *[Qualitative] An electronic monitoring system has been developed and/or implemented* • *[Qualitative] Stakeholder views on the extent to which additional resources have been focused on monitoring*	• ***Document review*** • ***Stakeholder interviews*** • *Results of analysis under EQ16 on monitoring processes & resources*	• Document review supporting EQ16 • 3HP Implementation documentation

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
			• *[Qualitative] Stakeholder views on the extent to which monitoring data has become more accurate / easier to access / less fragmented*		
8i	*To what extent have SANTE & Chafea implemented and used programmatic and action specific monitoring indicators?*	• *Programmatic and action specific monitoring indicators have been introduced and used since the mid-term evaluation* • *Existing programme monitoring indicators have become more comprehensive since the mid-term evaluation* • *A system for reporting on, collecting and presenting data on action specific indicators has been put in place*	• *[Qualitative] Programme documents demonstrate implementation of more specific monitoring indicators* • *[Qualitative] Programme documents demonstrate that a system for monitoring action specific indicators has been put in place* • *[Qualitative] Stakeholder views on the extent to which programme & action specific monitoring indicators have been implemented & used, as well as a system for monitoring action indicators has been put in place*	• ***Document review*** • ***Stakeholder interviews*** • *Results of analysis under EQ16 on monitoring processes & resources*	• Document review supporting EQ16 • 3HP Implementation documentation
8j	*To what extent has dissemination of action results been improved?*	• *Dissemination of action results has clearly increased and the quality of dissemination efforts has improved since the mid-term evaluation*	• *[Quantitative & Qualitative] Trends in number, type and source of publications since the mid-term evaluation and comparison with mid-term results* • *[Qualitative] Stakeholder views on quality of dissemination efforts since the mid-term evaluation and comparison with mid-term results*	• ***Document review*** • ***Mapping of project database*** • ***Stakeholder interviews*** • *Results of analysis under EQ7*	• Document review supporting EQ7 • 3HP Implementation documentation
9	• How are the results and effects of the Programme likely to last at the end of its implementation if funding ceases to exist (self-sustainability)?				
9a	*To what extent are the Programme results and effects likely to be sustainable?* •	• *Programme results and effects demonstrate evidence of being continued regardless of Programme funding (utilising sustainability plans where they have been requested in projects)* •	• *[Qualitative] Stakeholder views on the sustainability of Programme results* • *[Qualitative] Reviewing specific levers and barriers to sustainability of how the work funded by 3HP has been sustained.*	• ***Document review*** • ***Mapping of project database*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Case studies*** • *Results of analysis under effectiveness EQ4*	• Document review supporting EQ4 • Project documentation in database • Strategic Documents (policies/reports) to understand relevance of the 3HP • EU-level collected data on health indicators to help

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
					understand the relevance of the 3HP
	Efficiency				•
10	• To what extent has the Programme been cost effective?				
10a	*To what extent could the same results have been achieved with fewer resources?*	• *Programme actions have deviated from their planned resource budgets* • *Presence of Programme actions which had high costs but low impacts*	• *[Quantitative] Comparison of planned vs actual implementation budgets* • *[Qualitative] Expert opinion on planned and actual budgets and factors influencing deviations (including reasons)* • *[Quantitative / Qualitative] Action and causal chain effectiveness* • *[Quantitative] Actual implementation budgets* • *[Qualitative] Assessment of effectiveness of the Programme*	• ***Document review*** • ***Mapping of project database*** • ***Stakeholder interviews*** • *Responses to effectiveness questions*	• 3HP Implementation documentation • •
10b	*Regarding Programme objectives partially met or unmet, what have been the opportunity costs?*	• *The degree to which the impacts foreseen for the Programme have matched the impacts achieved, and where there are discrepancies, an assessment of the opportunity costs of these*	• *[Quantitative & Qualitative] Degree of objective achievement (e.g. assessment of Programme effectiveness)* • *[Quantitative & Qualitative] Typology of benefits anticipated for each of the objectives* • *[Qualitative] Assessment of any discrepancies between the expected and achieved impacts*	• ***Document review****, namely considering:* • *Response to effectiveness question EQ5* • *Impacts anticipated for 3HP* • ***Stakeholder interviews*** • ***Cost-effectiveness analysis***	• 3HP Implementation documentation •
11	• To what extent are the costs associated with the Programme proportionate to the benefits it has generated? What factors are influencing any particular discrepancies? How do these factors link to the Programme?				

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
11a	*To what extent are the Programme costs proportional to the expected results?*	• *Costs associated with the Programme are reasonable and kept to the minimum necessary in order to achieve the expected results, including:* • *Programme operational costs (design & implementation)* • *Management costs for funding* • *Administrative costs for applicants & Chafea* • *Monitoring & reporting costs for MS and the Commission*	• *[Quantitative & Qualitative] Typology and accounting of costs associated with the implementation of the Programme* • *[Quantitative & Qualitative] Typology and (where possible) accounting of benefits associated with the implementation of the Programme* • *[Qualitative] Stakeholder views on the extent to which costs are reasonable given the objectives and expected results*	• ***Document review*** • ***Mapping of project database*** • ***OPC*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Cost-effectiveness analysis*** • *Analysis of efficiency EQs, especially 14-17*	• 3HP Implementation documentation •
11b	*What factors influence any disparities between Programme costs and expected results?*	• *Identification of factors, both internal and external to the Programme related to any disproportionate costs found*	• *[Qualitative] Stakeholder views on factors that disproportionately affect costs relative to expected benefits*	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Cost-effectiveness analysis*** • *Analysis of efficiency EQ12*	• 3HP Implementation documentation •
11c	*To what extent are these factors linked to the Programme?*	• *The degree to which factors identified as creating disproportionate costs can be directly linked to the Programme*	• *[Qualitative] Stakeholder views on the extent to which identified factors are directly linked to the Programme*	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Cost-effectiveness analysis*** • *Analysis of efficiency EQ 12*	• 3HP Implementation documentation •
12	• To what extent do factors linked to the Programme (e.g. the number of priorities, available financial and human resources, various financial mechanisms, established procedures, intended results, political focus) influence the efficiency with which the observed achievements were attained? What other factors influence the costs and benefits?				
12a	*How does the design and implementation of the Programme influence the*	• *Identification of factors relating to the implementation of the Programme*	• *[Quantitative & Qualitative] Typology and accounting of costs associated with the*	• ***Document review*** • ***Mapping of project database***	• 3HP Implementation documentation

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
	efficiency with which achievements were attained?	*resulting in discrepancies in the efficiency of achieving its objectives* • *Identification of the magnitude to which factors related to the implementation of the Programme influence the efficiency of achieving its objectives*	*implementation of the Programme* • *[Quantitative & Qualitative] Typology and (where possible) accounting of benefits associated with the implementation of the Programme* • *[Quantitative / Qualitative] Action and causal chain effectiveness* • *[Quantitative] Actual implementation budgets* • *[Qualitative] Stakeholder assessment of factors influencing the effectiveness of the Programme*	• ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Cost-effectiveness analysis***	•
12b	*What other factors influence the costs and benefits of the Programme?*	• *Identification of factors external to the implementation of the Programme resulting in discrepancies in the efficiency of achieving its objectives* • *Identification of the magnitude to which factors external to the implementation of the Programme influence the efficiency of achieving its objectives*	• *[Quantitative & Qualitative] Typology and accounting of costs associated with the implementation of the Programme* • *[Quantitative & Qualitative] Typology and (where possible) accounting of benefits associated with the implementation of the Programme* • *[Quantitative / Qualitative] Action and causal chain effectiveness* • *[Quantitative] Actual implementation budgets* • *[Qualitative] Stakeholder assessment of factors influencing the effectiveness of the Programme*	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Cost-effectiveness analysis***	• 3HP Implementation documentation •
13	• To what extent was the distribution of Programme credits among the four thematic priorities efficient?				
13a	*To what extent were the four thematic priorities allocated Programme credits in line with EU health priorities?*	• *Identification of the degree to which Programme funding was distributed across the four thematic priorities* • *Identification of EU health priorities*	• *[Quantitative] Actual implementation budgets* • *[Qualitative] Mapping of EU health priorities onto the Programme's four thematic priorities* • *[Qualitative] Stakeholder assessment of the alignment of the four thematic priorities and EU health priorities*	• ***Document review*** • *Mapping of project database* • ***Stakeholder interviews*** • ***Cost-effectiveness analysis***	• Strategic Documents (policies/reports) to understand relevance of the 3HP • 3HP Implementation documentation •

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
13b	*To what extent was the funding allocation considered to be critical to achieve the expected results?*	• *Assessment of whether the allocation of resources under the four thematic priorities is proportional to the expected results* •	• *[Quantitative] Actual implementation budgets* • *[Quantitative & Qualitative] Typology and accounting of costs associated with the implementation of the Programme* • *[Quantitative & Qualitative] Typology and (where possible) accounting of benefits associated with the implementation of the Programme* • *[Qualitative] Stakeholder assessment of the role of the distribution of funding allocation in the achievement of Programme objectives* • *[Quantitative] Analysis of MS/EU level health trends and wider macroeconomic indicators*	• ***Document review*** • ***Stakeholder interviews*** • ***Cost-effectiveness analysis*** • ***Secondary data analysis of relevant health indicators*** *(i.e. Eurostat, Eurobarometer, OECD, WHO)*	• 3HP Implementation documentation •
14	• If there are significant differences in costs (or benefits) between participating countries, what is causing them? How do these differences link to the Programme?				
14a	*What if any differences in costs (or benefits) occurred between participating countries?*	• *Assessment of the distribution of Programme funding across Member States* • *Identification of the costs incurred by Member States in the implementation of the programme* • *Identification of the benefits accrued by Member States in the implementation of the programme* •	• *[Quantitative] Actual implementation budgets* • *[Quantitative & Qualitative] Typology and accounting of costs associated with the implementation of the Programme* • *[Quantitative & Qualitative] Typology and (where possible) accounting of benefits associated with the implementation of the Programme* • *[Qualitative] Stakeholder assessment of the role of the distribution of funding allocation, type of funding mechanism, thematic priorities, and thematic objectives in the achievement of Programme objectives* • *[Quantitative] Analysis of MS/EU level health trends and wider macroeconomic indicators*	• ***Document review*** • ***Mapping of project database*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Cost-effectiveness analysis*** • ***Secondary data analysis of relevant health indicators*** *(i.e. Eurostat, Eurobarometer, OECD, WHO)*	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP • EU-level collected data on health indicators to help understand the relevance of the 3HP •

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
14b	*What factors resulted in any differences observed (where significant)?*	• *Assessment of the significance of factors relating to programme design and implementation (i.e. funding mechanism, thematic objective, thematic priority, funding levels) in creating differences in the costs and benefits experienced by Member States* • *Assessment of the significance of factors external to the programme (i.e. wider health trends, country-level factors) in creating differences in the costs and benefits experienced by Member States* •	• *[Quantitative] Actual implementation budgets* • *[Quantitative & Qualitative] Typology and accounting of costs associated with the implementation of the Programme* • *[Quantitative & Qualitative] Typology and (where possible) accounting of benefits associated with the implementation of the Programme* • *[Qualitative] Stakeholder assessment of the role of the distribution of funding allocation, type of funding mechanism, thematic priorities, and thematic objectives in the achievement of Programme objectives* • *[Quantitative] Analysis of MS/EU level health trends and wider macroeconomic indicators*	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Cost-effectiveness analysis*** • ***Secondary data analysis of relevant health indicators*** *(i.e. Eurostat, Eurobarometer, OECD, WHO)*	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP • EU-level collected data on health indicators to help understand the relevance of the 3HP • •
14c	*To what extent can the differences be linked to the Programme itself?*	• *Assessment of the significance of factors relating to the programme in determining differences in the cost and benefits observed in Member States, relative to factors external to the programme*	• *[Quantitative] Actual implementation budgets* • *[Quantitative & Qualitative] Typology and accounting of costs associated with the implementation of the Programme* • *[Quantitative & Qualitative] Typology and (where possible) accounting of benefits associated with the implementation of the Programme* • *[Qualitative] Stakeholder assessment of the role of the distribution of funding allocation, type of funding mechanism, thematic priorities, and thematic objectives in the achievement of Programme objectives* • *[Qualitative] Stakeholder assessment of the role of external factors in the achievement of Programme objectives*	• ***Document review*** • ***Stakeholder interviews*** • ***Cost-effectiveness analysis*** • ***Secondary data analysis of relevant health indicators*** *(i.e. Eurostat, Eurobarometer, OECD, WHO)*	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP • EU-level collected data on health indicators to help understand the relevance of the 3HP

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
			• *[Quantitative] Analysis of MS/EU level health trends and wider macroeconomic indicators*		
15	• To which extent did the simplification measures contribute to the efficiency of the Programme? Was there further scope for simplification to make the Programme implementation more efficient?				
15a	*To what extent did the simplification measures reduce administrative costs for applicants and Chafea?*	• *The simplification measures led to a reduction in the administrative costs for applicants and Chafea*	• *[Qualitative] Programme information indicating the extent to which simplification measures reduce administrative costs* • *[Qualitative] Stakeholder assessment of the extent to which simplification measures reduce administrative costs*	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews***	• 3HP Implementation documentation
15b	*To what extent is there scope to further reduce costs?*	• *Assessment of potential improvements to the simplification measures to further reduce costs*	• *[Qualitative] Programme information indicating the extent to which simplification measures can be improved to further reduce administrative costs* • *[Qualitative] Stakeholder assessment of the extent to which simplification measures can be improved to further reduce administrative costs*	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews***	• 3HP Implementation documentation
16	• To what extent were the monitoring processes and resources (at the Commission and MS level) cost-effective? How the role and benefits of the monitoring systems [i.e. to plan and promote the results of the Health Programme and finally to incite stakeholders (internal and external) to make use of them] are assessed, against the costs of these monitoring systems (also considering any administrative burden involved)?				
16a	*To what extent do the monitoring processes enable efficient management of supported actions?*	• *Monitoring resources are adequate to support the established processes* • *The monitoring framework includes indicators, targets, and objectives that enable effective measurement of results* • *Monitoring processes are effective across all MS* • *Monitoring processes enable*	• *[Qualitative] Programme information indicating the effectiveness of monitoring processes* • *[Qualitative] Stakeholder assessment of the effectiveness of monitoring processes in the management of supported actions and the dissemination and promotion of results* •	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Cost effectiveness analysis***	• 3HP Implementation documentation

	Evaluation questions	Judgment criteria	Quantitative and qualitative indicators	Research methods	Sources for document review
		effective dissemination and promotion of Programme results			
16b	*To what extent are the monitoring costs proportional to the expected results?*	• *Monitoring does not entail resources beyond the minimum necessary to achieve the expected results*	• *[Quantitative] Data on monitoring costs across the implementation period at Commission and (if available) Member State level* • *[Qualitative] Stakeholder assessment of the proportionality of monitoring costs relative to the effectiveness of the monitoring processes* •	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Cost effectiveness analysis***	• 3HP Implementation documentation
17	• What are the benefits of the reporting systems against their costs and how could they be effectively implemented?				
17a	*What benefits have resulted from the reporting system?*	• *Identification of benefits to stakeholders resulting from the reporting system*	• *[Qualitative] Programme information identifying benefits of the reporting system* • *[Qualitative] Stakeholder assessment of the benefits resulting from the implementation of the reporting system*	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews***	• 3HP Implementation documentation
17b	*What are the costs of the reporting system and are these proportionate in relation to the benefits?*	• *Identification of costs to stakeholders resulting from the reporting system*	• *[Qualitative] Programme information indicating the costs resulting from the reporting system* • *[Qualitative] Stakeholder assessment of the costs resulting from the implementation of the reporting system*	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews***	• 3HP Implementation documentation •
17c	*Are there any ways in which the reporting systems could be more effectively implemented?*	• *Assessment of improvements in the implementation of the reporting system*	• *[Qualitative] Programme information indicating ways the reporting systems could be effectively implemented* • *[Qualitative] Stakeholder assessment of the scope for potential improvements to be made to the reporting system*	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews***	• 3HP Implementation documentation •
	EU-added value				•
18	• What is the additional value resulting from the Programme, compared to what could reasonably have been expected from Member States acting at national and/or regional levels, and compared to what the EU would have achieved without the Programme?				

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
18a	*Why has action at EU-level been the most appropriate? To what extent have the results produced under the Programme gone beyond what Member States would have achieved in its absence (considering public and private initiatives at international, national and local levels)?*	• *Improvements cannot be viewed as a result of Member States efforts and initiative alone, i.e. Member States took actions as a result of the Programme that would otherwise not have taken place, or would have occurred more slowly or to a lesser extent* • *There is a clear link between the characteristics of health and healthcare challenges and the need for action at EU-level* • *There was no detrimental impact on existing Member State actions in respect of health and healthcare (i.e. the EU Strategy did not disrupt or slow existing activity or activity that was already planned)* • *Areas for EU action are appropriate in view of EU and national competencies*	• *[Qualitative] Stakeholder views on the extent to which EU level action (i.e. the Programme) provided added-value* • *[Qualitative] EU dimension vs national dimension of the problems the Programme has aimed to resolve* • *[Qualitative] Evidence that MS actions have been helped/incentivized (and not harmed) by the Programme*	• ***OPC*** • ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • ***Focus groups*** • *Synthesis of evidence collected through other EQs*	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP • EU-level collected data on health indicators to help understand the relevance of the 3HP
18b	*To what extent have the results produced under the Programme gone beyond what the EU would have achieved in its absence?*	• *The Programme has led to results that go beyond what the EU would have achieved in its absence*	• *[Qualitative] Stakeholder views on the potential impact of discontinuing the Programme* • *[Qualitative] Expert views on what if scenarios involving the discontinuation of the Programme*	• ***Document review*** • ***Stakeholder interviews*** • ***Social media analysis*** • ***Focus groups*** • *Synthesis of evidence collected through other EQs*	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP • EU-level collected data on health indicators to help understand the relevance of the 3HP
19	• How far have the EU added value criteria led to the development of proposals that better addressed these aspects? Are all of these criteria still relevant? Which criteria have been most/least addressed?				
19a	*To what extent have the EU added value criteria led to proposals that better address the need for added value?*	• *The eight added-value criteria are well-defined and evidenced in funding proposals*	• *[Qualitative] Extent to which each of the criteria are assessed to be well-defined*	• ***Document review*** • ***Mapping of project database***	• 3HP Implementation documentation

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
		• *The cause-effect chain can be established between the added value criteria as applied in proposals and the extent to which the Programme has produced results with added value*	• *[Qualitative] Extent to which each of the criteria have been evidenced in funding proposals* • *[Qualitative] Evidence of linkages between added value as applied in proposals and Programme results* • *[Qualitative] Stakeholder views on the added value criteria, including their definition, and the relationship between their use in proposals and Programme results*	• ***Targeted stakeholder surveys*** • ***Stakeholder interviews***	
19b	*To what extent are the added value criteria still relevant?*	• *The added value criteria are relevant in light of current added-value needs & priorities*	• *[Qualitative] Extent to which each of the criteria are assessed to be aligned with added value needs & priorities for health* • *[Qualitative] Stakeholder views on the relevance of added value criteria in relation to current needs & priorities*	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews***	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP
19c	*To what extent have the added value criteria been addressed in funding proposals?*	• *The added-value criteria have all been addressed in funding proposals, and in proportion to their relative importance*	• *[Qualitative & Quantitative] Measurement of the extent to which each of the criteria have been applied in funding proposals* • *[Qualitative] Stakeholder views on the relevance of added value criteria in relation to current needs & priorities*	• ***Document review*** • ***Targeted stakeholder surveys*** • ***Stakeholder interviews*** • *Analysis of added value EQ19a*	• 3HP Implementation documentation
	Coherence	•	•	•	•
20	• Are the actions implemented under the 3rd Health Programme coherent with its objectives? How has the coherence of the Programme influenced its effectiveness?				
20a	*How well have the actions implemented under the Programme aligned with its objectives, over time and up until 2020? Conversely, are there any gaps, areas of tension or inconsistencies? Where there have been inconsistencies or gaps, what has caused these? What have been the impacts?*	• *The actions undertaken as part of the Programme have appropriately addressed its objectives* • *The actions undertaken have been aligned with each other where possible* • *There have been no tensions between the actions undertaken as*	• *[Qualitative] Extent to which each of the actions have supported the objectives of the Programme* • *[Qualitative] Extent to which actions have been aligned with one another where relevant* • *[Qualitative] Evidence of tensions between different objectives or actions*	• ***Document review****, including outputs and deliverables associated with actions undertaken* • ***Mapping of programme database*** • ***Stakeholder interviews*** • ***Focus groups***	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP •

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
		part of the Programme and no gaps in terms of actions taken in relation to Programme objectives	*undertaken as part of the Programme* • *[Qualitative] Evidence of sufficient uptake of opportunities so that objectives are well-covered in relation to actions* • *[Qualitative] Stakeholder insights on factors leading to inconsistencies and gaps* • *[Qualitative] Stakeholder insights on impacts of inconsistencies and gaps*	• *Intervention logic mapping to identify potential synergies, complementarities or tensions*	
20b	*How has the coherence of the Programme influenced its effectiveness?*	• *Programme effectiveness (as assessed in effectiveness EQs) was influenced by Programme coherence (as assessed in other coherence EQs)*	• *[Qualitative] Evidence of Programme coherence influencing effectiveness* • *[Qualitative] Stakeholder insights on factors leading to coherence influencing effectiveness (or a lack thereof)* • *[Qualitative] Stakeholder insights on impacts of coherence (or lack thereof) on Programme effectiveness*	• ***Document review*** • ***Stakeholder interviews*** • *Analysis of effectiveness EQs* • *Analysis of other coherence EQs*	• 3HP Implementation documentation
21	• To which extent have the priorities of the Programme led to more synergy, focus and coherence between the EU-funded actions in delivering on similar objectives? Did the health Programme encourage cooperation with the European Structural and Investment Funds and other EU financial instruments? To which extent is the Programme coherent with wider EU policy and with international obligations?				
21a	*To what extent have the Programme priorities led to more synergy, focus and coherence between the funded actions over time and up until 2020?* *Where there have been inconsistencies or a lack of focus and coherence, what has caused this? What have been the impacts?*	• *Programme priorities are reflected in the coherence of funded actions (and with reference to the assessment of coherence in EQ20).* • *Programme actions are clearly focused in relation to the priority areas.* • *Programme actions clearly exhibit synergies with one another and in relation to priority areas.*	• *[Qualitative] Evidence of the alignment of priorities with funded actions* • *[Qualitative] Evidence of focus and synergies between priorities and funded actions* • *[Quantitative] Analysis of planned and realised funding for actions in relation to Programme priorities* • *[Qualitative] Expert stakeholders agree that that coherence, focus and synergies exist between funded actions and priorities* • *[Qualitative] Insights from stakeholders on factors leading to any lack of*	• ***Document review*** • ***Targeted stakeholder surveys**, particularly with NCAs* • ***Stakeholder interviews*** • ***Focus groups***	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
			coherence, focus and/or synergy.		
21b	*Did the health Programme encourage cooperation with the European Structural and Investment Funds and other EU financial instruments?*	• *Provisions for cooperation were established within the Programme* • *Cooperation activities were undertaken with the European Structural and Investment Funds and other EU financial instruments*	• *[Qualitative] Evidence of provisions being made in Programme documentation to cooperate with other EU financial instruments* • *[Qualitative] Evidence of cooperation activities being undertaken with other EU financial instruments* • *[Quantitative] Analysis of planned and realised funding for actions where cooperation was undertaken* • *[Qualitative] Insights from stakeholders on factors leading to cooperation and/or any areas where there was a lack of cooperation and reasons for this.*	• ***Document review*** • ***Stakeholder interviews*** • ***Focus groups***	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP
21c	*To what extent has the Programme been aligned with wider EU policy and international obligations with common objectives? Where there have been inconsistencies or gaps, what has caused these? What have been the impacts?*	• *Wider EU policies incorporate, are aligned with, and/or do not contradict the Programme, in particular:* • *Research & Innovation framework programmes* • *EU Cohesion Policy* • *Food and food safety* • *International obligations with common objectives are aligned with and/or do not contradict the Programme, in particular:* • *WHO European Action Plan (EAP-PHS)* • *Sustainable development goals*	• *[Qualitative] Comparison of wider EU policies between 2014-2020 against Programme objectives* • *[Qualitative] Comparison of international obligations with common objectives between 2014-2020* • *[Qualitative] Expert assessment of how EU Programme objectives are reflected in wider EU policies and vice versa* • *[Qualitative] Expert assessment of how EU Programme objectives are reflected in meeting international obligations with common objectives* •	• ***Document review,*** *including mapping of wider EU policies and international obligations related to health and healthcare, to be compiled based on:* • *Expert/DG SANTE recommendations* • *NCA survey* • *Complementary document review* • ***Stakeholder interviews***	• 3HP Implementation documentation • Strategic Documents (policies/reports) to understand relevance of the 3HP • EU-level collected data on health indicators to help understand the relevance of the 3HP
22	• To which extent has the Programme proved complementary to other EU or Member States targets/interventions/initiatives in the field of health?				
22a	*To what extent has the Programme been coordinated and complementary with* ***other EU-level policies in the field of health*** *over time and up until 2020?*	• *Other EU policies and related activities in the field of health incorporate and/or do not contradict the*	• *[Qualitative] Comparison of other relevant EU-level policies and interventions from 2014-2020 against Programme objectives*	• ***Document review,*** *including mapping of EU interventions related to health to be compiled based on:*	• Strategic Documents (policies/reports) to understand relevance of the 3HP

	Evaluation questions	***Judgment criteria***	***Quantitative and qualitative indicators***	***Research methods***	Sources for document review
	Where there have been inconsistencies or gaps, what has caused these? What have been the impacts?	*Programme, in particular:* • *EU Framework on mental health & well-being* • *Directive 2011/21/EU on patients' rights to cross-border healthcare* • *Decision 1082/2013/EU on serious cross-border health threats* • *ECDC Early Warning & Response System* • *EU legal frameworks for medical products & medical devices* • *Tobacco legislation*	• *[Qualitative] Expert assessment of how Programme objectives are reflected in other relevant EU-level health policies* • *[Qualitative] Insights from DG SANTE, other DGs and EU Agencies, as well as other stakeholders on factors leading to inconsistencies and gaps* • *[Qualitative] Insights from stakeholders on impacts of inconsistencies and gaps*	• *Expert/DG SANTE recommendations* • *Survey of NCAs* • *Complementary document review* • ***Stakeholder interviews*** • ***Focus groups***	
22b	*To what extent has the Programme been coordinated and complementary* ***with Member State interventions/initiatives in the field of health*** *over time and up to 2020?* *What have been the drivers for this?* *Where there have been inconsistencies or gaps, what has caused these? What have been the impacts?*	• *Member State interventions/initiatives developed between 2014-2020 in the field of health incorporate and/or do not contradict the Programme*	• *[Qualitative] Comparison of relevant Member State policies and interventions from 2014-2020 in relation to Programme objectives* • *[Qualitative] Expert assessment of how Programme objectives are reflected in Member State health policies and interventions* • *[Qualitative] Insights from Member State representatives and other stakeholders on factors leading to inconsistencies and gaps* • *[Qualitative] Insights from stakeholders on impacts of inconsistencies and gaps*	• ***Document review,*** *including mapping of EU interventions related to health to be compiled based on:* • *Expert/DG SANTE recommendations* • *Survey of NCAs* • *Complementary document review* • ***Stakeholder interviews*** • ***Focus groups***	• Documents on MS-level policies in the field of health and related analysis and commentaries, e.g. MS health strategies • Strategic Documents (policies/reports) to understand relevance of the 3HP

Annex 3 Case studies

Case study report: Study supporting the final Evaluation of the 3rd Health Programme 2014-2020

Table of Contents

1. Methodological approach

- This section summarises the case study methodological approach which was followed in order to produce six case studies on thematic focus areas which benefited from funding under the 3rd Health Programme 2014-2020.

1.1. Introduction

The case study component contributed to the overarching study evaluating the 3rd Health Programme (3HP) by providing a deep dive on a specific theme (and sub-theme within that theme) to give greater insight into the specific objectives against outcomes and impacts.

To achieve this, the study team used contribution analysis to enable the identification of concrete links between thematic objectives and their specific outcomes and impacts. Contribution analysis involved unpacking the intervention logic for specific activities of the 3HP, isolating the hypothesis (or hypotheses) underpinning the various steps involved – e.g., from outputs to outcomes, or from outcomes to impacts – and exploring to which extent the evidence available supported the hypothesis.

The contribution of the funded actions was analysed along each step of the pathway for impact and in the outcomes section we made a judgment of how each step contributed to the expected outcome. The case studies were used to answer the following evaluation questions related to the effectiveness of 3HP, and contribute to the analysis within these areas in the main body of the study report:

- EQ4a: To what extent has the Programme contributed to a more comprehensive and coordinated approach to health and healthcare in the EU?
- EQ4b: To what extent has the Programme contributed to more equitable improvements in health and healthcare in the EU and at Member State level?
- EQ4c: To what extent has the Programme contributed to the EU's influence on health policies and practices at an international level?
- EQ5: To what extent have the Programme's objectives (general and specific) been met?
- EQ9a: To what extent are the Programme results and effects likely to be sustainable? What drivers and barriers exist in relation to sustainability?

Further details on the judgement criteria, quantitative and qualitative indicators, research methods and sources that were used to answer each evaluation question can be found in the evaluation matrix of this study (annexed to the main body of the study report).

The case studies focused on six themes, as outlined below.

- Alcohol
- Nutrition
- Health Technology Assessment (HTA)
- Anti-Microbial Resistance
- Health inequalities
- Vaccinations

The relevant sub-themes are outlined in Table 8.

Table 8. Case studies themes and sub-themes

Case study theme	Case study sub-theme

Alcohol	Alcohol marketing & RAHRA joint action
Nutrition	Childhood obesity with links to food reformulation
Anti-microbial Resistance	Joint Action on AMR (EU-JAMRAI)
Health inequalities	Vulnerable groups including migrants, ethnic minorities including Roma
Health Technology Assessment	Evolution of the EUnetHTA Joint Actions
Vaccinations	European response to the challenges related to vaccination

1.2. Step-by-step approach to carrying out the case studies

This section outlines the process used for carrying out the case studies.

1.2.1. Refining case study approach

The scope and focus of the case studies was refined during the inception phase of the study. This involved preliminary desk research and consulting with DG SANTE and HaDEA staff. The aspects that were refined were:

- Identifying a single sub-theme for each case study
- Elaborating the specific evaluation questions to be answered for each case study
- Developing propositions to be tested for each case study.

1.2.2. Selecting case studies

The case study themes were identified by DG SANTE. The six case studies were selected to maximise the strength of the evidence drawn from them, based on the contribution of activities under each theme to achieving 3HP objectives.

Following an initial meeting with DG SANTE, the study team set out the rationale for selection of case studies, identified how the theme related to 3HP objectives and relevant activities undertaken under 3HP in that area and then identified a specific sub-theme for each theme. This was confirmed in the revised inception report.

1.2.3. Drafting the intervention logic and establishing causal pathways per case study

Intervention logics, specific to each case study, were developed and identified one line of enquiry to follow. The line of enquiry (or pathway for impact linked to the intervention logic) was underlined by a set of assumptions. The pathway for impact was outlined in the description of the intervention logic. When relevant, assumptions were included in the body of the text - for example, one assumption for most case studies was that the desired long-term impacts were also influenced by external factors. This did not allow to casually link outputs/outcomes to the desired impacts. The case studies used the findings from the data collection activities undertaken in this evaluation study (desk research, open public consultation, targeted stakeholder surveys, stakeholder interviews, focus groups and social media analysis) to test these assumptions and ascertain the level of contribution of the 3HP to the specific impact desired and other contributing factors.

1.2.3.1. Constructing a draft intervention logic based on preliminary findings of the desk review

The study team first created a draft intervention logic based on preliminary findings of the desk review phase of the study, using the template shown in Table 9., which is included in the interim report. This was complemented by the refined evaluation matrix that indicated the expected information sources for the case studies.

During the preliminary review, challenges were encountered in obtaining important pieces of information for the case studies, namely accessing the final reports and other relevant reporting documentation for some of the actions in the case studies. Therefore, after identifying this data gap, DG SANTE and HaDEA provided outstanding information to map available qualitative and quantitative evidence against the intervention logic

Once the desk review and consultation activities were concluded and data was analysed, the study team mapped the available qualitative and quantitative evidence against the draft intervention logic per case study theme. All gaps in data were communicated to DG SANTE and some targeted searches were carried out to address those gaps.

1.2.3.2. Refine intervention logic and identifying causal pathways

Based on feedback from DG SANTE and the mapping carried out in the previous step, the study team further refined the intervention logic for each case study. The relevant pathways between the inputs and impacts for each case study were then identified.

1.2.4. Assessing contribution of the 3HP to causal pathways

1.2.4.1. Utilise available qualitative and quantitative evidence to test the intervention logic

The study team utilised the findings from the consultation activities and the desk review and assessed whether the selected 3HP activities led to the intended outcomes and impacts.

This was done by identifying data to evidence whether each section of the pathway occurred as intended (i.e. whether inputs and activities led to outputs, outputs to outcomes, outcomes to impacts). Where there was evidence that a section of the pathway had been 'broken' (i.e. the input did not lead to the intended output and so on), this meant that any changes relating to the thematic areas of the 3HP during the implementation period could not be attributed to the 3HP itself.

Where sections of the pathways between inputs and outcomes were intact, these were used to describe the impact of the 3HP (see section on assembling the contribution story).

1.2.4.2. Assess strength of the evidence

The strength of the evidence assessment prioritised documentation on the projects (interim, final reports), as closest to the project and most likely to provide data on elements of the intervention logic, and systematically reviewed consultation data gathered as part of the main study. The following aspects were taken into consideration when considering other sources:

- What is the quality of the evidence? Does the evidence come from verifiable sources? Is the evidence based on peer-reviewed literature compared to grey literature or opinion pieces?
- What evidence exists on the assumptions and risks behind the links between each section of the intervention logic?

- Which links are strong (good evidence available, strong logic, or wide acceptance) and which are weak (little evidence available, weak logic, or little agreement among stakeholders)?
- What evidence exists about the identified other influencing factors and the contribution they have made?

For each case study, the body of evidence was deemed satisfactory and has supported the main findings in each of the case studies, included below.

1.2.4.3. Test assumptions

The study team tested the identified assumptions through an internal review process, as well as a series of cross-analysis meetings, to provide feedback and challenge to the contributions proposed. Where relevant, data collected as part of the main study evaluating the 3HP was reviewed, and if supporting assumptions and findings, was cross-checked and included.

Table 9. Template to map available data and construct intervention logic per case study

	Drivers / problems ***Why did the action / activity come about?***	**Proposed solution** ***How was it decided that the action/activity was the best approach / solution?***	**Objectives of the action / activity**	**Inputs / activities** ***How was the action/activity prepared/delivered? By whom?***	**Outputs** ***What did the action/activity produce?***	**Impacts / potential impacts** ***What happened after the action/activity finished? What changed?***
Overview						
Key dates						
Programme factors						
External factors influencing this sub-theme						
Stakeholders engaged at each step						
Documents used						
Gaps in information						
Sources to plug gaps where possible						

1.2.5. Synthesising findings and writing up case studies

1.2.5.1. Assembling the contribution story

With the information gathered in the preceding steps, the study team assembled a contribution story that expressed why it was reasonable to assume that the actions of the programme had contributed to the observed outcomes and impacts.

Utilising contribution analysis, a reasonable causal claim was made when:

- The key assumptions behind why the intervention were expected to work was plausible, supported by evidence, and agreed upon by at least some of the key stakeholders.
- The activities of the intervention were implemented as set out in the intervention logic.
- The intervention logic, or key aspects of this, were supported and confirmed by evidence on observed results and underlying assumptions i.e. the chain of expected outcomes occurred.
- Other influencing factors were assessed and either shown not to have made a significant contribution or their relative role in contributing to the desired result has been recognised.

The study team assessed the main weaknesses of the contribution story for each case study and used available data to strengthen this where possible.

1.2.5.2. Writing up the case study

Despite the initial plan for case studies to be approximately 5 pages long, length was extended to approximately 15 pages due to large amounts of data collected from desk research and consultation activities.

The structure followed for each case study is as follows:

- 1. Introduction
  a) Background information on the case study
  b) Rationale for selection and case study focus (sub-theme and specific 3HP activities assessed)
- 2. Intervention logic for case study
  a) Description of the intervention logic and the pathway
  b) Description of the indicators to support the pathway
  c) Findings: pathway for impact
- 3. Conclusion

1.2.5.3. Intervention logic per case study

An intervention logic was developed to illustrate the proposed interventions of the actions and their intended effects addressed in each case study. The study team initially proposed to develop the case studies using the logical sequence presented in figure 44. However, after analysing the subthemes and actions developed in each case study, the study team modified the intervention logic, which is presented in figure 45, and focused on presenting the problems, objectives, inputs, activities, outputs, intermediate impacts, and impacts.

Figure 44. Intervention logic outline

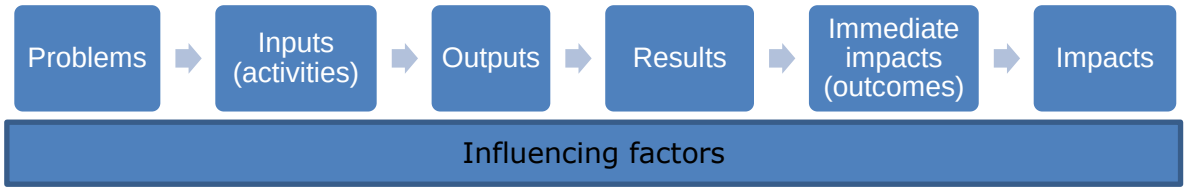
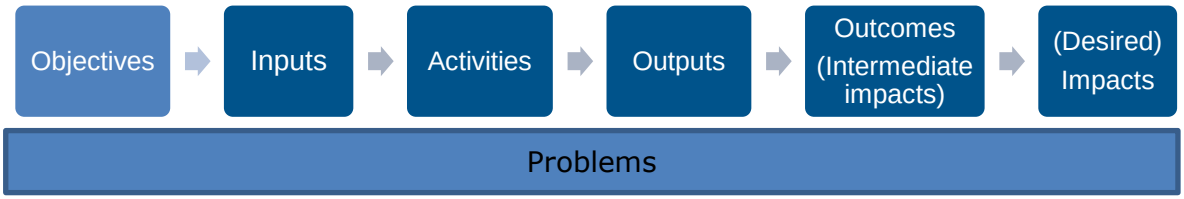


Figure 45. Updated Intervention logic outline



1.2.5.4. Indicators to support the links in pathways from activities to outcomes per case study

Documentation and consultation activities did not allow the study team to develop reliable quantitative indicators through, for example, a cost-effective analysis. As a result, the body of qualitative evidence was expanded and used to support findings presented in each case study.

1.2.6. Using the case studies in the final report

Within the final report, the case studies were summarised in boxes under 'effectiveness' to illustrate how specific 3HP actions contributed to advancing EU objectives under the specific thematic areas. Each box included the following aspects:

- **Theory of change** – what changes the 3HP aspired to bring about within each theme, and how the actions funded under 3HP intended to support this change
- **Contribution story** – what were the observed results during the programme period, and what contributed to these results
- **Learning** – what we learnt about how actions funded under 3HP in each case study area have contributed to relevant outcomes, and how can these contributions be continued in future

2. Case study: Alcohol consumption

This case study focuses on selected work undertaken by the European Commission to address alcohol consumption in the EU, through an assessment of the effectiveness of the Third Health Programme (3HP) actions. This topic is explored through an in-depth examination of Reducing Alcohol Related Harm (RAHRA) joint action under the Second Health Programme (2HP) and its progression into the Third Health Programme (3HP) through the "Conference on Cross-border Aspects in Alcohol Policy- Tackling Harmful use of Alcohol".

2.1. Introduction

2.1.1. Background

Europe has "one of the highest levels of alcohol-related deaths in the world".[119] Alcohol use is the third most common risk factor for disease and death in the EU, behind tobacco consumption and high blood pressure[120]. Alcohol consumption in adolescence is very common across Europe, with the risk of early exposure translating into problematic alcohol use and dependence in adulthood. It is responsible for about 1 in 4 deaths for 20–24-year-olds[121].

The social and economic costs of alcohol-related harm in the EU are significant. They include costs related to healthcare, crime, policing, accidents and productivity losses. These costs were estimated at €155 billion in 2010[122].

In 2006, the European Commission adopted an EU Strategy to support Member States in reducing alcohol-related harm[123]. The Strategy focused on five priority themes: protecting children and young people; reducing injuries and deaths from alcohol-related road accidents; preventing harm among adults and reducing negative economic impacts; awareness-raising on the health impacts of harmful alcohol consumption; and gathering reliable statistics. The Strategy also identified areas where EU action could help combat the harmful effects of alcohol use in the EU while complementing national policies. These included tackling cross-border issues, facilitating information exchange and identifying and disseminating best practices through the establishment of a European Alcohol and Health Forum (EAHF) and Committee on National Alcohol Policy and Action (CNAPA).

2.1.2. Rationale for selection and case study focus

The subtheme of this case study is the effectiveness of reducing alcohol related harm and alcohol marketing. The EU strategy to support Member States in reducing alcohol related harm[124] highlights the need for preventive measures that address under-age drinking, heavy drinking patterns and alcohol related consequences such as road accidents.

119 WHO (2019) New WHO factsheet reveals Europe struggles to implement policies to reduce alcohol consumption [online]. Available from: http://www.euro.who.int/en/health-topics/noncommunicable-diseases/pages/who-european-office-for-the-prevention-and-control-of-noncommunicable-diseases-ncd-office/news/news/2019/01/new-who-factsheets-reveal-europe-struggles-to-implement-policies-to-reduceth April 2019

120 European Commission., 2009. Alcohol factsheet. Available at: FactsheetAlcohol (europa.eu)

121 WHO Europe, Accessed 05.02.2022. Available at: https://www.euro.who.int/en/health-topics/disease-prevention/alcohol-use/alcohol-use

122 RAHRA., 2015. RAHRA Final Conference Happened on 13/14 October in Liston. Available at: RARHA

123 European Commission., 2006. Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions and the Committee of the Regions. An EU strategy to support Member States in reducing alcohol related harm. Available at: EU Strategy to reduce alcohol related harm

124 European Commission., 2006. Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions and the Committee of the Regions. An EU strategy to support Member States in reducing alcohol related harm. Available at: EU Strategy to reduce alcohol related harm

Alcohol marketing impacts on early alcohol consumption and patterns of drinking in young people[125]. A 2001 Council Recommendation[126] urged the development of policies to enforce marketing restrictions that would likely influence young people. Additionally, the EU Alcohol & Health Forum Science Group reported in 2009 that alcohol marketing has an impact on early alcohol consumption and patterns of drinking in young people.

This case study focuses on two funded actions that are most relevant to this sub-theme: the **RAHRA Joint Action**[127] (funded under the 2nd Health Programme) and **the Conference on Cross-border Aspects in Alcohol Policy- Tackling Harmful use of Alcohol**[128] (funded under 3HP).

These two actions were developed under different health programmes, however, thematically, RAHRA's outcomes were expanded into several actions under the 3HP such as DEEP SEAS project [129] and the **Conference on Cross-border Aspects in Alcohol Policy- Tackling Harmful use of Alcohol**. Thus, RAHRA's Joint Action became a significant action for the European Commission as it initiated the work on alcohol consumption (as part of the 2HP) and further developed it into new actions falling under the 3HP.

Given the relation between RAHRA and the 3HP actions, together with the relevance of the topic addressed by RAHRA for the subtheme of this case study, we analysed the work of this action under the 2HP. Hence, as the subtheme of this case study relates to the effectiveness of reducing alcohol related harm and alcohol marketing, the two actions analysed by the study team are the work developed by **RAHRA** and the **Presidency Conference** under the 3rd Health Programme.

Furthermore, as shown in Table 10, the 3HP has also funded many other actions which relate to the broader theme of alcohol, illustrating the commitment of the EU and the 3HP to reducing alcohol-related harm.

Table 10. Other actions taken within the alcohol theme under the 3HP

Action	Timescale	EC Contribution (EUR)
Operating grants		
Cancer Leagues Collaborating in Cancer Prevention and Control at the National and European Level[130]. The European Cancer Leagues (ECL) focuses on cancer control actions across the EU. Through this initiative they aim to deliver strategic added value by exchanging good practices, inform EU policy development, strengthen the cooperation between cancer societies	01/01/2017 - 31/12/2017 (12 months; finalised)	32 3015

125 European Commission., (n.d). Does marketing communication impact on the volume and patterns f consumption of alcoholic beverages, especially by young people? A revie of longitudinal studies. Scientific Opinion of the Science Group of the European Alcohol and Health Forum. Available at: https://ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/docs/science_o01_en.pdf

126 European Council.,2001. Council recommendation of 5 June 2001 on drinking of alcohol by youth people, in particular children and adolescents (2001/458/EC.) Available at : EUR-Lex - 32001H0458 - EN - EUR-Lex (europa.eu)

127 European Commission., (n,d). CHAFEA Health Programme Database. Joint Action on reducing alcohol related-harm (RAHRA) [20132202]. Available at: Health Programme DataBase - European Commission (europa.eu)

128 European Commission., (n,d). CHAFEA Health Programme Database. The Presidency conferences to be financed under the work programme 2017 and organised under the Estonian Presidency: (1) a conference on Cross-Border Aspects in Alcohol Policy - Tackling Harmful Use [EE-PCY] [785803]. Available at: Health Programme DataBase - European Commission (europa.eu)

129 DEEP SEAS, 2014. About DEEP SEAS. Available at: https://www.deep-seas.eu/about-deep-seas/

130 European Commission., (n,d). CHAFEA Health Programme Database. The Presidency conferences to be financed under the work programme 2017 and organised under the Estonian Presidency: (1) a conference on Cross-Border Aspects in Alcohol Policy - Tackling Harmful Use [EE-PCY] [785803]. Available at: Health Programme DataBase - European Commission (europa.eu)

Action	Timescale	EC Contribution (EUR)
and stakeholders to tackle the increasing chronic disease burden.		
Joint Actions		
The Joint Action on Chronic Disease (CHRODIS PLUS)[131] worked to help reduce the burden of preventable diseases by promoting the implementation of policies and practices that have been proven to work across the EU.	01/01/2014-01/04/2017 (39 months; finalised)	4 606 576
Projects		
Focus on Youth, Football & Alcohol[132], a joint initiative with the objective to reduce underage drinking and heavy episodic drinking among young people, as both strongly affect the health and welfare of Europe's population.	01/09/2017 - 31/08/2020 (24 months; finalised)	552 168.45
Local Strategies to Reduce Underage and Heavy Episodic Drinking[133]*:* To support municipalities in developing and implementing tailored local alcohol strategies to reduce underage and heavy episodic drinking. Seven different settings for alcohol prevention were addressed including parental work, schools, children in families with alcohol problems, alcohol in public space, party scenes, festivals, gastronomy and retail, refugees and traffic safety. The strategies were developed, implemented and evaluated for two municipalities each in 11 Member States, representing the different EU regions.	01/04/2017 - 30/09/2019 (30 months; finalised)	745 979
Raising awareness and action-research on heavy episodic drinking (HED) among low-income youth and young adults in Southern Europe (ALLCOOL)[134]*.* This project aimed to tackle the growing trend of HED in South European countries by analysing the relationship between HED and lower socio-economic youth and young adults (15-30 years old) in these regions.	01/05/2016 - 31/07/2018 (24 months; finalised)	236 843.8
The STAD in Europe (SiE) project[135] aims to tackle heavy episodic drinking by restricting the availability of	01/06/2016 - 31/05/2019	698 416.59

131 CHRODIS., 2014. CHRODIS. Available at: CHRODIS - Joint Action on Chronic Diseases

132 Focus on Youth Football & Alcohol.,2022. Home. Available at: https://www.fyfaproject.eu/index.php

133 EURONET.,2022. Reducing underage & heavy drinking in local communities. Available at: https://www.euronetprev.org/projects/localize-it/

134 European Commission., (n,d). CHAFEA Health Programme Database. Raising awareness and action-research on Heavy Episodic Drinking among low income youth and young adults in Southern Europe [ALLCOOL] [710063] – Project. Available at: Health Programme DataBase - European Commission (europa.eu)

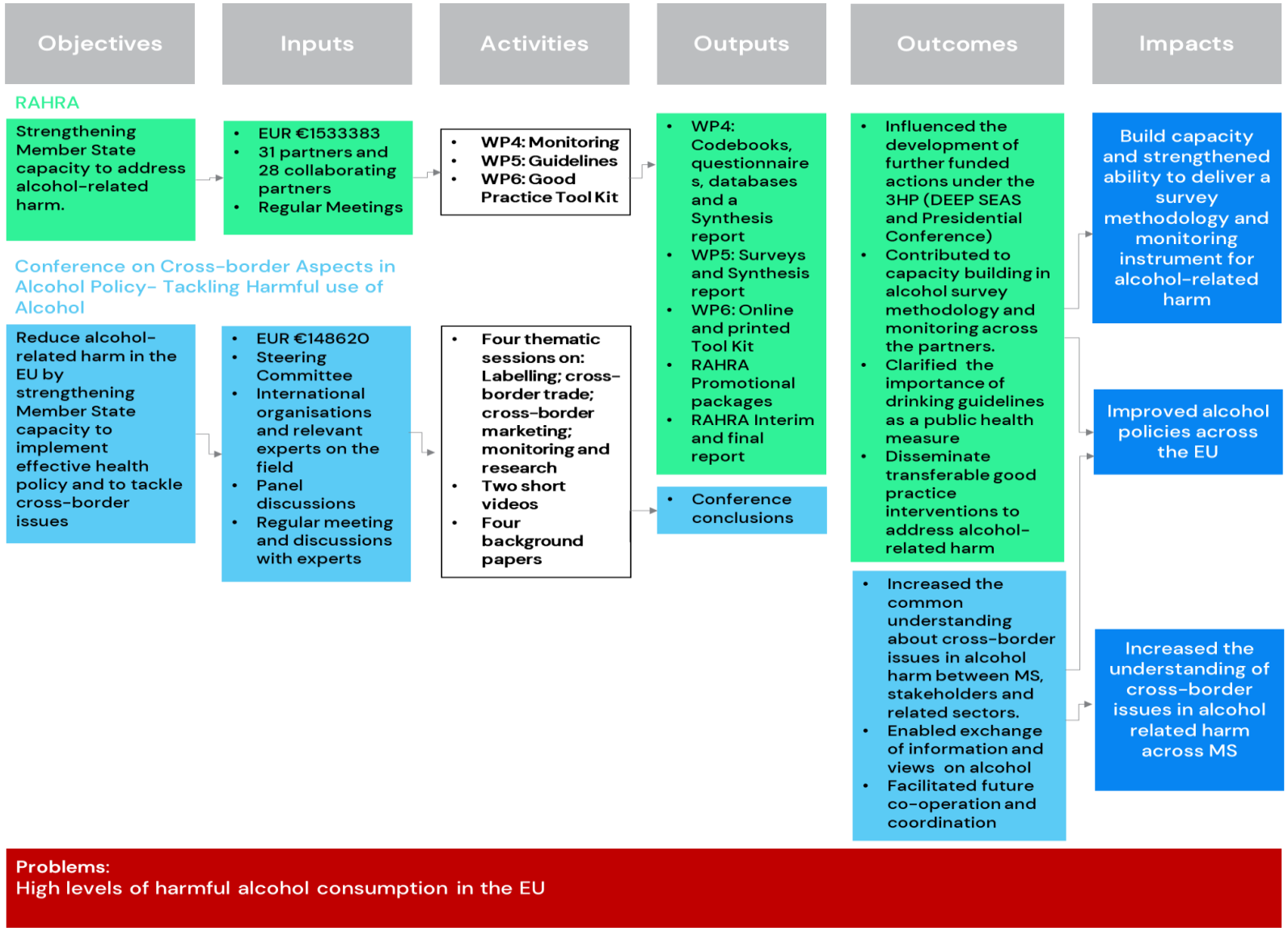
135 European Commission., (n,d). CHAFEA Health Programme Database. STAD in Europe [SIE] [709661] – Project. Available at: Health Programme DataBase - European Commission (europa.eu)

Action	Timescale	EC Contribution (EUR)
alcohol in four drinking environments: licensed premises in nightlife settings; festivals; public environments, such as streets, parks and beaches; and, private environments, such as the home.	(36 months; finalised)	

2.2. Intervention logic underpinning the case study

The intervention logic developed for this case study illustrates the proposed interventions of the two selected actions addressing the effectiveness of reducing alcohol related harm and alcohol marketing, and their intended effects to understand the underlying problem of high levels of harmful alcohol consumption in the EU. It presents the problems, objectives, inputs, activities, outputs, outcomes and impacts of the RAHRA Joint Action and the Conference on Cross-border Aspects in Alcohol Policy-Tackling Harmful use of Alcohol.

Figure 46. Intervention logic



2.3. Findings: pathway for impact

This section presents the findings of each step of the pathway for impact of EU action in the field of alcohol consumption. It illustrates the problems that EU action seeks to address, and the objectives of the funded actions examined in this case study. It then presents the inputs used to conduct the actions, the activities undertaken, and the outputs produced as part of those actions. Lastly, this section discusses the observed outcomes, drawing from evidence collected from targeted desk research undertaken for this case study, coupled with evidence stemming from the consultation activities held as part of this study, and provides an assessment on the contribution that the funded actions and their outputs had on expected outcomes and impacts in this area.

2.3.1. Drivers/ problems

Alcohol-related harm has become a significant issue across the EU. Evidence suggests that addressing alcohol marketing could reduce the impact of alcohol-related harm, particularly on young people and those with a history of alcohol dependence.[136] The two actions examined sought to reduce alcohol-related harm in young people and adults.

2.3.2. Objectives of the funded actions

The 2nd Health Programme sought to tackle alcohol-related harm in the EU through **RAHRA**, a 3-year Joint Action that took place from 2014-2017 to support Member States in carrying out work on common priorities in line with the 2006 EU Alcohol Strategy and strengthen Member State capacity to reduce and address alcohol harm. This **Joint Action**[137] developed a baseline assessment and suggestions for comparative monitoring of alcohol epidemiology across the EU, together with good practice principles for the use of drinking guidelines to address low and high-risk alcohol consumption in public health, and a toolkit on good practices for alcohol information approaches to reduce alcohol related harm in Member States. Furthermore, **RAHRA** targeted health professionals in primary health care, EU policy makers, and governmental and non-governmental public health professionals and researchers.

Prior to the implementation of the 3HP, several meetings of the Health Programme Committee took place (March 2015[138], December 2016[139], December 2017[140], and March 2019[141]). In these meetings, Member States requested that DG SANTE implement another Joint Action on alcohol in the next Health Programme. Some Member States described motivations for such a Joint Action, including excellent results of RARHA, that Joint Actions are developed by Member States, and there were already several Joint Actions carried out on the same theme. However, DG SANTE ultimately declined to initiate another Joint Action and announced that a substantial investment was being made in the alcohol field through a series of procurement activities contained under the 2019 work programme.[142]

136 Babor, T.F., Robaina, K., Noel, J.K. and Ritson, E.B., 2017. Vulnerability to alcohol‐related problems: a policy brief with implications for the regulation of alcohol marketing. Addiction, 112, pp.94-101.

137 European Commission., (n,d). CHAFEA Health Programme Database. Joint Action on reducing alcohol related-harm (RAHRA) [20132202]. Available at: Health Programme DataBase - European Commission (europa.eu)

138 European Commission. (2015). Health Programme Committee: Draft minutes of the Committee meeting of 06 March 2015 [CORRIGENDUM]

139 European Commission. (2017). Health Programme Committee: Draft minutes of the Committee meeting of 7 December 2016.

140 European Commission. (2018). Health Programme Committee: Draft minutes of the Committee meeting of 1 December 2017.

141 European Commission. (2019). Health Programme Committee: Draft minutes of the Committee meeting of 14 March 2019

142 European Commission. (2019). Health Programme Committee: Draft minutes of the Committee meeting of 14 March 2019; European Commission. (2017). Health Programme Committee: Draft minutes of the Committee meeting of 7 December 2016.

Even though no Joint Actions on alcohol were implemented during 3HP, building on the outcomes of RARHA under the 2HP, alcohol marketing was addressed through a conference on the **"Cross-border Aspects in Alcohol Policy-Tackling Harmful use of Alcohol"[143]**. This presidency conference aimed to continue the work of RAHRA on alcohol- related harm by focusing on strengthening Member State capacity to implement effective health policy and tackle cross-border issues with an emphasis on cross-border marketing. Furthermore, the objective was to discuss recent developments and envisage the future steps through common efforts to tackle the harmful use of alcohol in the EU. This conference targeted representatives from ministries and relevant agencies, NGOs, research institutions, the private sector, WHO and the European Commission.

2.3.3. Inputs

RAHRA was a Joint Action coordinated by the Ministry of Health in Portugal (General Directorate for Intervention on Addictive Behaviours and Dependencies – SICAD). It involved the collaborative work of 31 Associate Partners and 28 Collaborating Partners who had regular meeting to address the different topics of RAHRA. This Joint Action ran from 2014 to 2017. The total budget of the Joint Action was €1.533.383.

The **Presidency Conference on Cross-border Aspects in Alcohol Policy-Tackling Harmful use of Alcohol**[144] was led by the Estonian Presidency. The Conference conclusions were compiled on the basis of regular meetings and discussions with experts, as well as presentations and discussions at the conference[145].This conference didn't involve many partners, however, several experts and organisations related to the field were invited to contribute. This conference took place between May 2017 and April 2018, receiving a total of €148.620 of funding from the European Commission.

2.3.4. Activities

The two funded actions conducted a wide range of activities which took different approaches to address the sub-theme.

In **RAHRA**, work was divided in three main core working packages (WP) which focussed on contributing to a better understanding of European and national realities through the harmonization of concepts and data collection, while facilitating the monitoring of alcohol consumption[146,147] .The core WPs were:

- Monitoring (WP4): aimed to generate more comparable data across EU MS on consumption patterns and alcohol related harm;
- Guidelines (WP5): concerned understanding the scientific basis for different guidelines for low risk drinking across Europe, to provide guidance to policy makers.

143 European Commission., (n,d). CHAFEA Health Programme Database. The Presidency conferences to be financed under the work programme 2017 and organised under the Estonian Presidency: (1) a conference on Cross-Border Aspects in Alcohol Policy - Tackling Harmful Use [EE-PCY] [785803]. Available at: Health Programme DataBase - European Commission (europa.eu)

144European Commission., 2017. Conference summary and conclusions. Cross=Border Aspects in Alcohol Policy-Tackling Harmful Use of Alcohol. Available at: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwigh6qzjYT3AhXolmoFHRVDARQQFnoECAcQAQ&url=https%3A%2F%2Fec.europa.eu%2Fresearch%2Fparticipants%2Fdocuments%2FdownloadPublic%3FdocumentIds%3D080166e5b8ee0917%26appId%3DPPGMS&usg=AOvVaw1fr3Hb7kyP1T3qDVet_0cV ; Health Programme DataBase - European Commission (europa.eu)

145 Health Programme DataBase - European Commission (europa.eu)

146 European Commission., (n,d). CHAFEA Health Programme Database. The Presidency conferences to be financed under the work programme 2017 and organised under the Estonian Presidency: (1) a conference on Cross-Border Aspects in Alcohol Policy - Tackling Harmful Use [EE-PCY] [785803]. Available at: Health Programme DataBase - European Commission (europa.eu)

147 Joint Action RARHA 3-year Deliverables (Power Point Presentation). Available form: Apresentação do PowerPoint (europa.eu).[Accessed 11 April].

- Good Practice Tool Kit (WP6): aimed to develop a tool kit to disseminate good practices on early intervention, public awareness campaigns and school-based programmes.

The discussion of the **Presidency Conference on Cross-border Aspects in Alcohol Policy- Tackling Harmful use of Alcohol** focused on identifying the main cross-border challenges of Member States when trying to implement their national alcohol policies and protecting people's rights to make conscious choices and protect their health.[148] Four thematic sessions addressed these challenges, focusing on labelling, cross-border trade, cross-border marketing, and monitoring and research.

Furthermore, the preparations of the Presidency Conference included a short video on cross-border aspects of alcohol policy and, together with WHO and the National Institute for Health Development, a 5-minute video on the nutritional content of alcoholic beverages was created. Additionally, four background papers were prepared to support conference discussions.[149]

2.3.5. Outputs

The **Joint Action** produced several outputs across the three main work packages.

- WP4 produced a synthesis report. This main output was also complemented by the creation of codebooks, questionnaires and databases for monitoring progress in reducing alcohol related harm across Member States.[150,151]
- WP5 produced synthesis guideline reports for lower-risk alcohol consumption to help reduce hazardous and harmful drinking and alcohol related harm[152].
- WP6 produced an online and printed version of a Tool Kit which included low-risk drinking guidelines and self-management tools for public health policy planners. The tool kit was launched during the conference.[153]

The Joint Action also produced promotional packages (visual images, brochure, and pocket folder), an official Joint Action website, bi-annual electronic newsletters, and the interim report and final report[154], all of which were used to promote and disseminate results.

The main output of the **Presidency Conference** was the conference conclusions[155], which summarized the main topics discussed during the conference. These conclusions highlighted the need for more cooperation between the different sectors (health, agriculture, culture, tax and customs) to tackle harmful use of alcohol. Economic operators were also acknowledged as having a significant role in tackling harmful use of alcohol by introducing voluntary measures complementing the legal requirements such as in the field of advertising. Furthermore, the conference concluded that alcohol labelling should be improved to include information about the content, nutritional value and possible risks related to alcohol consumption. Finally, the negative influence of cross-border trade of alcohol beverages across national, regional and EU level, together with the importance of updating current legal frameworks on alcohol marketing were also conclude after the Presidency Conference.

148Conference Summary and Conclusions "Cross-Border Aspects in Alcohol Policy – Tackling Harmful Use of Alcohol". Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5b8ee0917&appId=PPGMS . [Accessed 8 April]

149 Conference Summary and Conclusions "Cross-Border Aspects in Alcohol Policy – Tackling Harmful Use of Alcohol". Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5b8ee0917&appId=PPGMS . [Accessed 8 April]

150 Joint Action RARHA 3-year Deliverables (Power Point Presentation). Available form: Apresentação do PowerPoint (europa.eu).[Accessed 11 April].

151 Health Programme DataBase - European Commission (europa.eu)

152 Joint Action RARHA 3-year Deliverables (Power Point Presentation). Available form: Apresentação do PowerPoint (europa.eu).[Accessed 11 April].

153 Joint Action RARHA 3-year Deliverables (Power Point Presentation). Available form: Apresentação do PowerPoint (europa.eu).[Accessed 11 April].

154 Joint Action RARHA 3-year Deliverables (Power Point Presentation). Available form: Apresentação do PowerPoint (europa.eu).[Accessed 11 April].

155 European Commission., 2017.Conference Summary and Conclusions "Cross-Border Aspects in Alcohol Policy – Tackling Harmful Use of Alcohol". Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5b8ee0917&appId=PPGMS . [Accessed 8 April]

2.3.6. Outcomes

RAHRA published a final evaluation report in 2017[156] presenting the overall results of the Joint Action. The report showed that RAHRA successfully contributed to capacity building among the partners. This was demonstrated through the work of 30 European countries that developed tools to improve alcohol policies, such as the RAHRA SEAS alcohol survey and the RAHRA-HARMES harmonized data base.

Capacity building among partners was confirmed by a numerous stakeholders representing government and policy makers during interviews for the 3HP study[157]. They highlighted that RAHRA gave countries the possibility to engage with a network of partners across the EU and that Member State authorities and stakeholders worked together to produce the results of the Joint Action.

In relation to Specific Objective 1 of WP4 that aimed to "*provide a baseline for comparative assessment and monitoring of alcohol epidemiology, including drinking levels and patterns, and alcohol related harms across the EU",*[158] findings presented in this report show it was successfully achieved. Eleven Members States mentioned in the report are planning to use the RAHRA common methodology to develop alcohol surveys.

In terms of building capacity among the wider public health community, the final internal and external evaluation report[159] of the Joint Action indicated that external experts valued that RAHRA was able to reinforce the capacity in comparative alcohol survey methodology and promote the need for using a common methodology in the future.

In relation to the specific outcomes of RAHRA, findings from the two-wave RAHRA evaluation survey[160] showed that according to the associated partners of RAHRA the development of drinking guidelines, mainly RAHRA's low-risk drinking guidelines, contributed to increasing the awareness of using drinking guidelines as a public health measure.

Furthermore, this Joint Action enabled the dissemination of transferable good practice interventions that Members States could use to address alcohol-related harm. A few stakeholders consulted for this study[161] noted that this Joint Action was able to provide material and recommendations for countries working to address alcohol consumption issues, which strengthened capacity building and collaboration amongst Member States.

Several national level reports in relation to alcohol policy were developed, building on the collaboration fostered though **RAHRA's** conclusions:

- Nasjonal alkoholstrategi (20212025). En helsefremmende og solidarisk alkoholpolitikk. (National Alcohol Strategy (2021–2025). A health-promoting and solidary alcohol policy) [162].

156 RAHRA.,2017. Final Internal and External Evaluation Report: WP3 Deliverable 6. Document provided by DG SANTE

157 Study being conducted by ICF named "Study supporting the final Evaluation of the 3rd Health Programme 2014-2020"

158 RAHRA.,2017. Final Internal and External Evaluation Report: WP3 Deliverable 6. Document provided by DG SANTE

159 RAHRA.,2017. Final Internal and External Evaluation Report: WP3 Deliverable 6. Document provided by DG SANTE

160 Survey directed to the associated partners of the RAHRA Joint Action to gather information on the progress of RAHRA. RAHRA.,2017. Final Internal and External Evaluation Report: WP3 Deliverable 6. Document provided by DG SANTE

161 Stakeholders representing Government public health organisations and Government and policy makers

162 Ministry of Health and Care Services of Norway.,2021. National Alcohol Strategy (2021–2025). A health-promoting and solidarity alcohol policy. Available at: National Alcohol Strategy (2021–2025). A health-promoting and solidarity alcohol policy. - regjeringen.no

- Rapport d'activité 2017 du ministère de la Santé 2017 Activity Report of the Ministry of Health [163]
- Rapport d'activité 2016 du ministère de la Santé 2016 Activity Report of the Ministry of Health [164]
- Study on Council Directive 92/83/EEC on the structures of excise duty on alcohol and alcoholic beverages
- Rehm J et al. (2015) Lifetime-risk of alcohol-attributable mortality based on different levels of alcohol consumption in seven European countries. Implications for low-risk drinking guidelines. Toronto, On, Canada: Centre for Addiction and Mental Health[165].

In relation to the **Presidency Conference**, this action enabled the exchange of information and views on alcohol-related harm and ways to implement effectives alcohol policies and tackle cross-border issues. Also, the conference brought together stakeholders from different sectors, facilitating future cooperation and coordination in the alcohol field.

RAHRA's outcomes in relation to the development of alcohol surveys was able to effectively transition into the work of the 3HP by influencing the development of further actions on alcohol-related harm. This is evidenced by the creation of the DEEP SEAS project whose aim was to *"continue and extend the work undertaken by RAHRA"*[166] together with the Member States that participated in RAHRA[167]. This action was mainly implemented to continue the analysis of the Standard European Alcohol Survey (SEAS), carried out by RAHRA. Furthermore, the Presidency Conference was also thematically influenced by the work of RAHRA on alcohol- related harm by focusing on alcohol marketing.

2.3.7. Impacts / potential impacts

This section discusses the impacts or potential impacts of the two funded actions by incorporating findings from consultation activities and looking at each relevant evaluation question.

Regarding the impacts of **RAHRA** on the actions implemented under the 3HP, findings show that in a meeting of the Health Programme Committee in December 2017[168], DG SANTE reported that the Commission was in the process of implementing calls for tender on alcohol related harm. The aim was to implement the ideas and outputs which were conceptualised and further elaborated within the Joint Action on alcohol related harm; therefore, it seems the outputs of the RAHRA influenced anticipated funded actions within 3HP.

This was confirmed by a stakeholder representing government and policy makers who mentioned that DEEP SEAS contract[169] was implemented during the 3HP to continue and extent the work developed during RAHRA. Specifically, this project expanded on the European Alcohol Survey elaborated by RAHRA. The stakeholder also mentioned that some topics on alcohol consumption that were not addressed in RAHRA were

163 Ministry of Health of Luxembourg., 2018. 2017 Activity Report of the Ministry of Health. Available at: Rapport d'activité 2017 du ministère de la Santé - gouvernement.lu // Le gouvernement luxembourgeois

164 Ministry of Health of Luxembourg., 2016. 2016 Activity Report of the Ministry of Health. Available at Rapport d'activité 2016 du ministère de la Santé - gouvernement.lu // Le gouvernement luxembourgeois

165 Rehm, J., Gmel, G., Probst, C., & Shield, K.D., 2015. Lifetime-risk of alcohol-attributable mortality based on different levels of alcohol consumption in seven European countries. Implications for low-risk drinking guidelines. Available at: lifetime-risk-of-alcohol-attributable-mortality-pdf.pdf (camh.ca)

166 DEEP SEAS., 2014. About DEEP SEAS. Available at: About DEEP SEAS | Deep Seas (deep-seas.eu)

167 DEEP SEAS., 2014. About DEEP SEAS. Available at: About DEEP SEAS | Deep Seas (deep-seas.eu)

168 European Commission. (2018). Health Programme Committee: Draft minutes of the Committee meeting of 1 December 2017.

169 DEEP SEAS contract (Developing and Extending Evidence and Practice from the Standard European Alcohol Survey) funded by the 3rd Health Programme. Retrieved from: About DEEP SEAS | Deep Seas (deep-seas.eu)

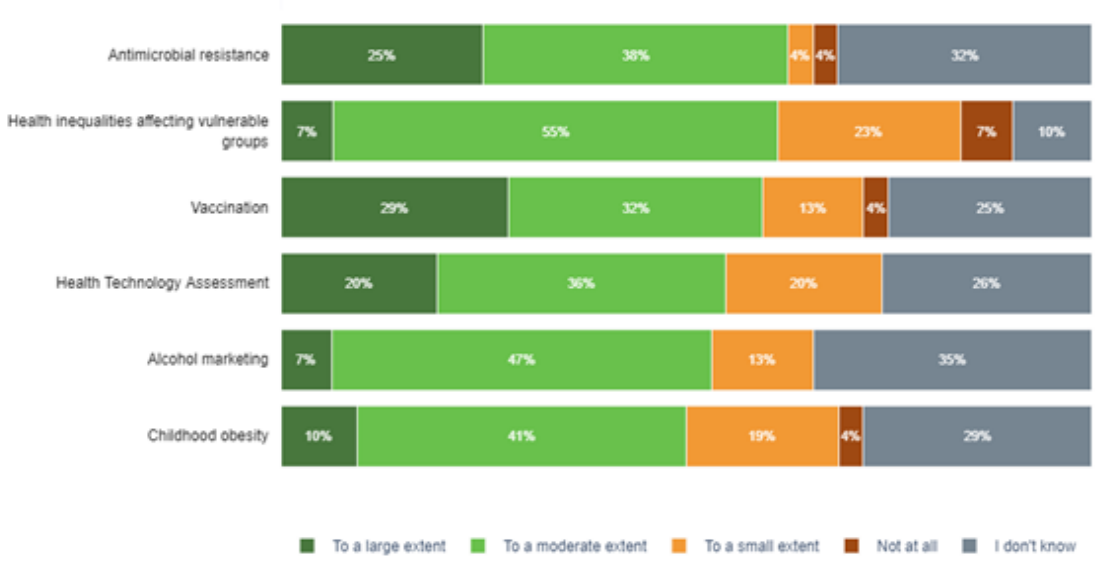
funded under 3HP. For example, "alcohol in the workplace" was part of work package 6 (WP6) of the DEEP SEAS contract.

EQ4a: To what extent has the third health programme contributed to a comprehensive and uniform approach concerning possible pathways to regulate alcohol marketing across the EU?

Information on the **Presidency Conference** in the CHAFEA database[170] stated that the Steering Committee concluded that the initial goal of the conference was achieved, and the discussions and conference conclusions supported the discussions of the Council Conclusions on Cross-border Aspects of Alcohol Policy – Tackling Harmful Use of Alcohol. The involvement of other sectors was highlighted as an important step on a new path, stressing the need to carry on with further similar activities. The conference conclusions were linked to an increased understanding of cross-border issues in alcohol related harm across EU Member States.

This was complemented by most survey respondents (held as part of targeted consultations with various stakeholder groups) from the 3HP study[171] who considered that the Third Health Programme contributed to addressing alcohol marketing to a moderate extent.

Figure 47. To what extent has the Programme contributed to a more comprehensive and uniform approach to addressing health issues across the following policy areas? (n=32)



Findings of this case study confirm the Third Health Programme contributed to a more comprehensive and uniform approach concerning possible pathways to regulate alcohol marketing across the EU. This was evidenced through the outputs of the **Presidency Conference** in relation to cooperation, information exchange and the importance of updating current legal frameworks on alcohol marketing across Member States. Furthermore, this was accompanied by findings from the consultation activities who acknowledge the work of the European Commission on alcohol marketing.

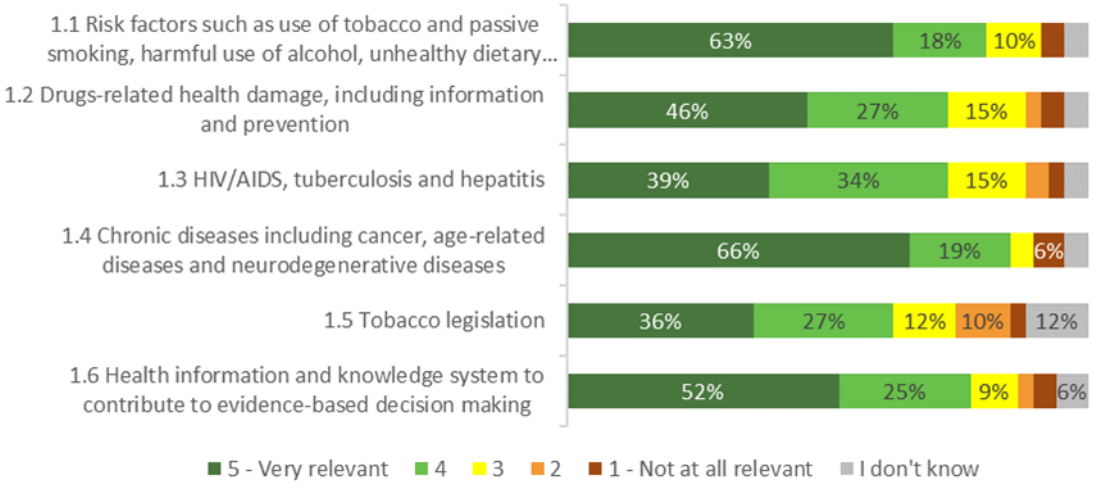
170 European Commission., (n,d). CHAFEA Health Programme Database. The Presidency conferences to be financed under the work programme 2017 and organised under the Estonian Presidency: (1) a conference on Cross-Border Aspects in Alcohol Policy - Tackling Harmful Use [EE-PCY] [785803]. Available at: Health Programme DataBase - European Commission (europa.eu)

171 Study being conducted by ICF named "Study supporting the final Evaluation of the 3rd Health Programme 2014-2020"

EQ5: To what extent have the third health programme's objectives and priorities in the area of alcohol marketing been met?

Respondents form the Open Public Consultation (OPC) were asked to rate the relevance of 3HP priorities in terms of promoting health, preventing disease, and fostering supportive environments for healthy lifestyles. The second most relevant priority identified was "Risk factors such as use of tobacco and passive smoking, harmful use of alcohol, unhealthy dietary habits and physical inactivity" (42 out of 67 respondents said '5 – very relevant', 63%).

Figure 48. Please rate the relevance of each of the 3rd Health Programme priorities on a scale of 1 to 5 (1 is not at all relevant and 5 is very relevant) (n=67)



Furthermore, a large proportion of OPC respondents said that some relevant problems or needs were not identified by the Programme at the time of its development (30 out of 67 responses, 45%). Among those needs, they mentioned that the Health Programme could have focused more on addressing issues related to unhealthy lifestyles. Furthermore, respondents highlighted that the 3HP lacked the ability to recognise addiction as a health problem. Respondents also argued that insufficient resources were invested to address alcohol consumption comprehensively and holistically.

Based on the findings from the consultation activities and outputs of the **Presidency Conference**, the study team found that the Third Health Programme was able to achieve its objectives and priorities in alcohol marketing. Specifically in relation to the relevance of addressing harmful use of alcohol across the EU and the importance of acknowledging the negative impact that cross-border trade of alcohol beverages can have on citizens at national and EU level.

2.4. Conclusion

Overall, the EU has acted to develop actions that aim to improve alcohol policies across the EU. However, when analysing the type of actions implemented during the 3HP, there was a discontinuity with the work initiated during the 2HP by the RAHRA Joint Action (JA). Even though Member Sates requested to continue with a JA on alcohol consumption during the 3HP this was not fully achieved using the same funding instrument and to the same degree.

Minutes form the Health Programme Committee show that in several conversations, Member States requested to incorporate a Joint Action on alcohol consumption into

the 3HP.[172] [173] [174] [175] Even though this was not achieved, outputs from the RAHRA Joint Action implemented in the 2HP were further developed by another funding mechanism during the 3HP, specifically by the DEEP SEAS[176] service contract and thematically by the Presidency Conference on alcohol marketing. Therefore, through these two actions, we evidenced the efforts of the 3HP to continue exploring and researching on ways to reduce alcohol-related harm in the EU.

Overall, case study findings show that the 3HP successfully contributed to a more comprehensive and uniform approach concerning possible pathways to regulate alcohol marketing across the EU as well as addressing the objectives and priorities in the area of alcohol marketing.

172 European Commission. (2015). Health Programme Committee: Draft minutes of the Committee meeting of 06 March 2015 [CORRIGENDUM]

173 European Commission. (2017). Health Programme Committee: Draft minutes of the Committee meeting of 7 December 2016.

174 European Commission. (2018). Health Programme Committee: Draft minutes of the Committee meeting of 1 December 2017.

175 European Commission. (2019). Health Programme Committee: Draft minutes of the Committee meeting of 14 March 2019

176 DEEP SEAS., 2014. About DEEP SEAS. Available at: About DEEP SEAS | Deep Seas (deep-seas.eu)

3. Case study: childhood obesity and food reformulation

This case study presents work done under the 3rd Health Programme (3HP) related to nutrition, focusing specifically on childhood obesity with links to food reformulation and assess the effectiveness of 3HP actions in this area. This topic is explored through an in-depth examination of three actions of the 3HP: Joint Action on Nutrition and Physical Activity (JANPA); Presidency Conferences on Drug Shortages and on Healthy Nutrition for Children; and Joint Action on Implementation of Validated Best Practices in Nutrition (Best-ReMaP).

3.1. Introduction

3.1.1. Background

Overweight and obesity are widespread in most EU countries and represent a major public health issue. In 2016, many countries reached levels of overweight and obesity in excess of 30% and 10% of the population, respectively.[177] Data from 2019[178] indicate that an estimated 52.7% of the adult population in the EU is overweight. Nearly one in five adolescents is either overweight or obese on average across EU countries (2018 data), with an increasing trend as compared to 2010.[179] Obesity and overweight significantly increase the risk of chronic disease, such as cardiovascular diseases, coronary heart diseases, type 2 diabetes and certain cancers. Low consumption of fibre and excess intakes of salt, sugar, trans fats and saturated fats contribute to death and disability caused by chronic diseases.

Promoting healthy nutrition habits and food consumption is key to tackling the rise of obesity and overweight problems. The EU has demonstrated its commitment to improving nutrition through establishing a comprehensive Strategy for Europe on Nutrition, Overweight and Obesity;[180] including nutrition in the Farm to Fork strategy; and targeting overweight and obesity in children through the EU Action Plan on Childhood Obesity (2014-2020).

3.1.2. Rationale for selection and case study focus

The subtheme of this case study is **Childhood obesity with links to food reformulation.** As stated in EU Council and Commission Communications[181], children are considered to be a vulnerable group of consumers and the foods they consume are designed to fulfil their nutritional requirements (e.g., foods intended for infants, baby foods, processed cereal-based foods).

Physical inactivity and poor diet from birth (and even in utero) are important determinants of adiposity[182] leading to overweight and obesity. These factors are independently associated with non-communicable disease risk factors. During the early stages of life, food preferences can directly affect eating behaviour, impacting on children's overall health and increasing the risk of obesity. Once childhood obesity is

[177] Nittari, G., Scuri, S., Petrelli, F., Pirillo, I., di Luca, N. M., & Grappasonni, I. (2019). Fighting obesity in children from European World Health Organization member states. Epidemiological data, medical-social aspects, and prevention programs. La Clinica terapeutica, 170(3), e223–e230. https://doi.org/10.7417/CT.2019.2137
[178] Eurostat, Overweight and obesity - BMI statistics
[179] OECD/European Union (2020), "Health at a Glance: Europe 2020: State of Health in the EU Cycle", OECD Publishing, Paris
[180] European Commission (2007), A Strategy for Europe on Nutrition, Overweight and Obesity related health issues
[181] European Commission. (2021). COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE COUNCIL, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS: EU strategy on the rights of the child. Available from: https://ec.europa.eu/info/sites/default/files/1_en_act_part1_v7_0.pdf [Accessed on: 9 September 2022].
[182] Adiposity refers to the amount of fatty tissue in the body.

established, it is difficult to reverse and often continues into adulthood,[183][184] so it is important to act early. The Cochrane collaboration found that interventions that include diet combined with physical activity interventions can reduce the risk of obesity in young children aged 0 to 5 years.[185]

Food reformulation may offer an avenue through which to improve children's dietary habits. Within the Farm to Fork strategy, initiatives have been launched to stimulate reformulation of processed foods including setting maximum levels for certain nutrients, and nutrient profiles to restrict promotion of foods high in salt, sugars, and/or fat.

This case study focuses on three actions of the 3HP to examine the effects of the Programme on this issue: **Joint Action on Nutrition and Physical Activity (JANPA)**[186]; **Presidency Conferences on Drug Shortages and on Healthy Nutrition for Children**; and **Joint Action on Implementation of Validated Best Practices in Nutrition (Best-ReMaP).**[187] The 3HP also funded many other actions which relate to the broader theme of nutrition, illustrating the commitment of the EU and 3HP in particular to the aim of improving nutrition: see Table 11 below.

Table 11. 3HP Actions related to childhood obesity and food reformulation

Action	Timescale	EC Contribution (EUR)
Framework Partnership Agreements		
European Heart Network - fighting heart disease and stroke[188]*.* This action aimed to prevent avoidable cardiovascular diseases (CVD); strengthen the support for people with CVD; and reinforce cardiovascular research. The proposal's intervention logic was to target policy makers, especially at EU level, to effect changes in policies to achieve small reductions in risk factors across EU's population and thus reduce the overall number of people at risk of cardiovascular diseases (CVD). Activities to underpin the intervention logic included a) effective dissemination to EU policy makers of evidence for action (advocacy); b) training and exchange meetings for member organisations (capacity-building and knowledge-sharing); and c) strategic interaction with stakeholders (cooperation/engagement with alliances).	27/02/2018 - 26/02/2022 (48 months; ongoing)	0
Operating grants		

[183] Al-Khudairy, L., Loveman, E., Colquitt, J.L., Mead, E., Johnson, R.E., Fraser, H., Olajide, J., Murphy, M., Velho, R.M., O'Malley, C. and Azevedo, L.B., 2017. Diet, physical activity and behavioural interventions for the treatment of overweight or obese adolescents aged 12 to 17 years. Cochrane database of systematic reviews, (6).
[184] Singh, A.S., Mulder, C., Twisk, J.W., Van Mechelen, W. and Chinapaw, M.J., 2008. Tracking of childhood overweight into adulthood: a systematic review of the literature. Obesity reviews, 9(5), pp.474-488.
[185] Brown T, Moore THM, Hooper L, et al. (2019). Interventions for preventing obesity in children. Cochrane Database of Systematic Reviews, Issue 7. Art. No.: CD001871. DOI: 10.1002/14651858.CD001871.pub4.
[186] CHAFEA. (n.d.). Joint Action on Nutrition and Physical Activity [JANPA] [677063] - Joint Actions. Available from: https://webgate.ec.europa.eu/chafea_pdb/health/projects/677063/summary [Accessed on: 05 April 2022].
[187] Best-ReMaP. (n.d.). Best-ReMaP. Available from: https://bestremap.eu/ [Accessed on: 05 April 2022].
[188] EHN2017 -Partnership agreement (Health Programme DataBase - European Commission (europa.eu))

Action	Timescale	EC Contribution (EUR)
European Heart Network (EHN) - Cardiovascular Health at the Heart of EU Policies.[189] This aimed to prevent and reduce cardiovascular disease in each of its actions. A major focus of EHN in 2018 was the implementation of its policy recommendations contained in its paper "Transforming European food and drink policies for cardiovascular health". In 2019 they focused on policy areas that included agriculture, trade, food information (front-of-pack labelling) and composition (trans fatty acids), and marketing of HFSS food to children.	01/01/2018 - 31/12/2018 (12 months; Finalised)	370 861
Specific Grant Agreements to EPHA. Through these EPHA implemented work programmes on prevention of chronic, non-communicable diseases (including food).	Granted annually from 2015-2021	2015: 487 440.6 2016: 661 956 2017: 662 661 2018: 584 206.4 2019: 554 996 2020: 585 800 2021: 661 524
Presidency Conferences		
People's food - people's health: Towards healthy and sustainable European food systems[190]. This conference was organised under the 2018 work programme of the Austrian Council Presidency. The conference focused on presenting multi-sectorial best practices in the food system and facilitating a dialogue between all relevant stakeholders in the food sector.	15/02/2018 - 14/03/2019 (13 months; Finalised)	100 000
Projects		
WholEUGrain – A European Action on Whole Grain Partnerships.[191] The objectives of the project were to promote good health through healthy diets, disease prevention, reducing inequalities and establishing supportive environments for healthy lifestyles by developing country-based whole grain public/private partnerships. The project aimed to facilitate the	01/11/2019 - 31/10/2022 (36 months; Ongoing)	855 410.43

[189] Health Programme DataBase - European Commission (europa.eu)
[190] https://europa.eu/newsroom/events/people%E2%80%99s-food-people%E2%80%99s-health-towards-healthy-and-sustainable-european-food-systems_en
[191] WholEUGrain (gzs.si)

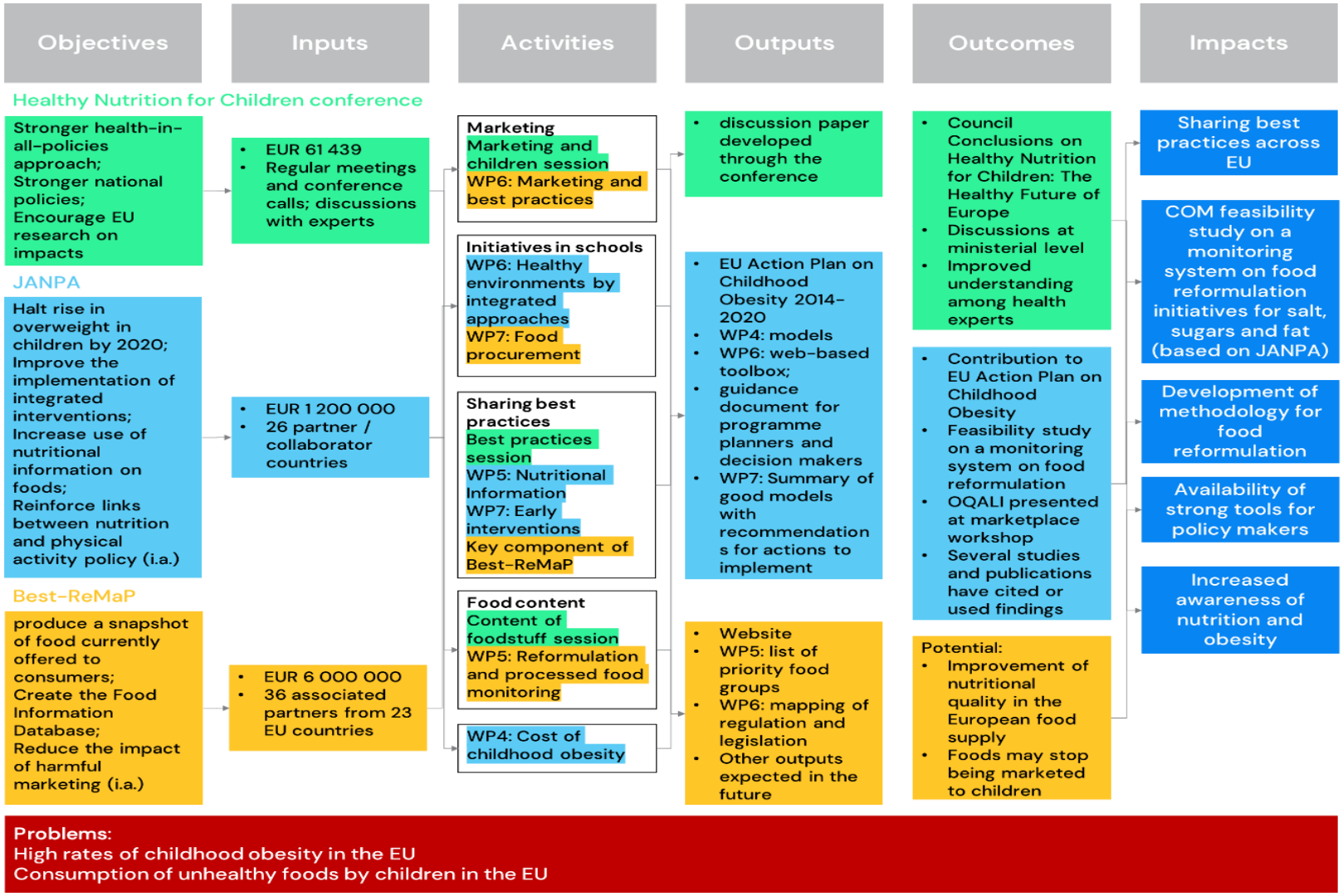
Action	Timescale	EC Contribution (EUR)
transfer of the Danish best practices model for a Whole Grain Partnership[192].		
Innovative Prevention Strategies for type 2 Diabetes in South Asians living in Europe (InPreSD-SA)[193]. Half of the 5 million individuals of South Asian origin in Europe are likely to develop Type 2 Diabetes. The project aimed to build on the findings of recent trials about preventing T2D in this population in order to accelerate knowledge production and the process of implementation of research findings by bringing together European experts in this field. The project focused on dietary behaviour. The project sought to specify how to support South Asian people in the uptake and maintenance of a healthy diet and what to focus on.	01/09/2015 - 31/08/2018 (36 months; Finalised)	636 500
Joint Actions		
CHRODIS-PLUS: Implementing good practices for chronic diseases[194]. This three-year Joint Action worked to help reduce the burden of preventable diseases by promoting the implementation of policies and practices that have been proven to work across the EU.	01/09/2017 - 30/11/2020 (36 months; Finalised)	4 999 999.56

3.2. Intervention logic

The intervention logic developed for this case study illustrates the proposed interventions of the actions and their intended effects to address the underlying problem of poor nutrition and childhood obesity in the EU. Hence, this intervention logic presents the problems, inputs, activities, outcomes and impacts of JANPA, the Presidency Conference on Healthy Nutrition for Children; and Best-ReMaP. The intervention logic for the case study is illustrated in Figure 49. These elements are discussed in more detail in the following sections.

[192] Fuldkornspartnerskabet. (n.d.). The Danish Whole Grain Partnership. Available from: https://fuldkorn.dk/english/ [Accessed on: 07 April 2022].
[193] Health Programme DataBase - European Commission (europa.eu)
[194] CHRODIS - Joint Action on Chronic Diseases

Figure 49. Intervention logic



3.3. Findings: pathway for impact

This section presents the findings of each step of the pathway for impact of EU action in the field of childhood obesity and food reformulation. It illustrates the problems that EU action seeks to address, and the objectives of the funded actions examined in this case study. It then presents the inputs used to conduct the actions, the activities undertaken, and the outputs produced as part of those actions. Lastly, this section discusses the observed outcomes, drawing from evidence collected from targeted desk research undertaken for this case study, coupled with evidence stemming from the consultation activities held as part of this study, and provides an assessment on the contribution that the funded actions and their outputs had on expected outcomes and impacts in this area.

3.3.1. Drivers / problems

There is evidence to suggest that childhood obesity remains a major public health problem in the WHO European Region[195]. Nutritional problems and physical inactivity are seen to be interconnected,[196] which requires that they are addressed in an integrated way. Doing so is expected to promote healthier food environments, make healthy options easier to access, and inform and empower families. The three actions examined here sought to address this.

3.3.2. Proposed solution

The EU has taken several actions on the topic of nutrition and childhood obesity, for example through the High Level Group on Nutrition and Physical Activity (which has ended; this was confirmed in 2021[197]) was seen by an interviewed Governmental Public Health Organisation stakeholder as a key body; the 2008 framework for reformulation was cited amongst its accomplishments. According to the same stakeholder, the EU Action Plan on Childhood Obesity was implemented under Greece's presidency in 2014. **Best-ReMaP** and **JANPA** were both embedded as tools to implement the action plan.

In 2014, the High-Level Group on Nutrition and Physical Activity proposed the implementation of a European Joint Action on Nutrition and Physical Activity.[198] **JANPA** was initiated as a measure contributing to the implementation of this action plan.[199] JANPA aimed to halt the rise of overweight and obesity in children and adolescents by 2020, in alignment with the goals of the EU Action Plan on Childhood Obesity 2014-2020. The mid-term evaluation of the 3HP[200] stated that JANPA was a clear priority area in the 2014 Annual Work Programme, which states the need for an action that facilitates the sharing of good practices between EU Member States on

[195] World Health Organisation. (2021). WHO European Childhood Obesity Surveillance Initiative (COSI) Report on the fourth round of data collection, 2015–2017. Available from: https://www.euro.who.int/en/health-topics/noncommunicable-diseases/obesity/publications/2021/who-european-childhood-obesity-surveillance-initiative-cosi-report-on-the-fourth-round-of-data-collection,-20152017-2021 [Accessed on: 29 April 2022].
[196] CHAFEA. (n.d.). Joint Action on Nutrition and Physical Activity [JANPA] [677063] - Joint Actions. Available from: https://webgate.ec.europa.eu/chafea_pdb/health/projects/677063/summary [Accessed on: 05 April 2022].
[197] Ryan, J.F. (2021). Closure of the EU Platform for Action on Diet, Physical Activity and Health. European Commission Directorate-General for Health and Food Safety. Available from: http://www.babymilkaction.org/wp-content/uploads/2021/08/Closure-of-the-EU-Platform-for-Action-on-Diet_signed.pdf
[198] République française, Anses (n.d.). European Joint Action on Nutrition and Physical Activity JANPA. Available from: https://www.anses.fr/en/content/european-joint-action-nutrition-and-physical-activity-janpa [Accessed on: 06 April 2022].
[199] French Agency for Food, Environmental and Occupational Health & Safety (ANSES) (2017). TACKLING CHILDHOOD OVERWEIGHT AND OBESITY IN EUROPE: Lessons learnt and recommendations from the Joint Action on Nutrition and Physical Activity JANPA. Available from: https://www.anses.fr/fr/system/files/03ENG-LAYMAN-14nov2017_Print_Final.pdf [Accessed on: 06 April 2022].
[200] Coffey International Development, SQW, and Economisti Associati. (2017). Mid-term Evaluation of the Third Health Programme (2014 – 2020): Final report Annex B. Available from: https://ec.europa.eu/health/system/files/2017-10/2014-2020_evaluation_studyannexb_en_0.pdf [Accessed on: 29 April 2022].

national policies related to unbalanced dietary habits and physical inactivity. **JANPA** contributed to this effort by testing a methodology to collect nutritional information, providing a way to compare the content of salt, sugar and fat easily and regularly in food sold in EU supermarkets.

In 2017, a conference "**The Healthy Future of Europe: Healthy Nutrition for Children**" took place under the 2017 work programme through the Bulgarian Council Presidency. The conference aimed to strengthen the understanding that children are the most vulnerable group of consumers. The event ensured continuity of the efforts of previous Presidencies of the Council[201] by focusing on one of the major causes of chronic diseases: the unhealthy diet. Another driver for the conference was the rapid evolution in technologies for food manufacturing and the less rapid development of technologies for assessment of their safety. The event was timed to follow JANPA, as JANPA was finalised in autumn 2017, so this allowed for "a timely demonstration of the value added to national policies by the Public Health Program".[202]

Finally, based on the work of JANPA and an ongoing study on EU Reformulation Monitoring[203], the **Best-ReMaP** Joint Action was initiated in 2020 to adapt, replicate, and implement effective health interventions, based on proven practices in the areas of food reformulation, framing food marketing and public procurement of healthy food in public settings. Best-ReMaP is considered to be an extension of JANPA[204,205], and the proposal for Best-ReMaP stated they would build on JANPA's previous efforts.[206] The Joint Action seeks to contribute to an improved quality of food supplied to citizens of Europe by facilitating the exchange and testing of good practices[207] in several areas.

3.3.3. Objectives of the funded actions

JANPA aimed to contribute to halting the rise in overweight and obesity in children and adolescents by 2020, in alignment with the goals of the EU Action Plan on Childhood Obesity 2014-2020.[208] Through the identification, selection and sharing of data and best practices within the 25 countries involved, the Joint Action sought to advocate based on an estimation and forecast of economic cost of overweight and obesity. It also sought to improve the implementation of integrated interventions to promote nutrition and physical activity for pregnant women and families with young children; improve actions within school settings; and increase the use of nutritional information on foods by public health authorities, stakeholders and families for nutrition policy purposes.[209] The Joint Action also sought to reinforce the links between

[201] An interviewed Governmental Public Health Organisation stakeholder reported that during Germany's presidency it was decided that the countries holding the presidency would "pass the baton" from country to country to highlight nutrition, and there have only been a few country presidencies which have not done so.
[202] Republic of Bulgaria: Ministry of Health. (2018). Final Technical Report: CHAFEA Operating Grant Nr: 807392; Acronym: DSHNCH CONFERENCES; Title: 'Presidency Conferences on Drug Shortages and on Healthy Nutrition for Children — DSHNCH CONFERENCES'.
[203] Study title: "EU wide implementation of the reformulation monitoring (EUREMO)"
[204] OQALI. (n.d.). Best-ReMaP. Available from: https://www.oqali.fr/en/best-remap/ [Accessed on: 29 April 2022].
[205] European Commission. (2020). Proposal: Joint Action on implementation of validated best practices on nutrition (JA Best–ReMaP).
[206] European Commission. (2020). Proposal: Joint Action on implementation of validated best practices on nutrition (JA Best–ReMaP).
[207] Best-ReMaP. (n.d.). About Us. Available from: https://bestremap.eu/aboutus/ [Accessed on: 29 April 2022].
[208] CHAFEA. (n.d.). Joint Action on Nutrition and Physical Activity [JANPA] [677063] - Joint Actions. Available from: https://webgate.ec.europa.eu/chafea_pdb/health/projects/677063/summary [Accessed on: 05 April 2022].
[209] CHAFEA. (n.d.). Joint Action on Nutrition and Physical Activity [JANPA] [677063] - Joint Actions. Available from: https://webgate.ec.europa.eu/chafea_pdb/health/projects/677063/summary [Accessed on: 05 April 2022].

national nutrition, and physical activity policies initiated by the EU Strategy on nutrition, overweight and obesity-related health issues.[210]

The **Healthy Nutrition for Children conference** aimed to strengthen the understanding that children are the most vulnerable group of consumers, requiring better protection and more active prevention policies. The conference had three planned objectives:[211]

- A stronger health-in-all-policies approach and awareness of the importance of nutrition policies oriented towards children, as part of prevention policies;
- Support towards stronger national policies; and
- The need to encourage EU research on the impact of foodstuffs and food ingredients on children's development and chronic diseases.

The Conference also provided the necessary input for the preparation of Council Conclusions on Healthy Nutrition for Children: The Healthy Future of Europe.

Best-ReMaP aims to:[212]

- provide Member States assistance to produce a snapshot of food currently offered to consumers in national markets and with this food snapshot methodology offer an opportunity to monitor the impact of national regulations aimed at decreasing the salt, sugar and fat content of processed food;
- create the Food Information Database to ensure the sustainability of data collection on food reformulation (i.e. changing and regulating the food composition that can be offered on the market) at EU and national levels and of monitoring trends in food reformulation;
- reduce the impact of harmful marketing of food to children in the EU by considering options to extend an existing Scandinavian regulation model across the EU Member States; and
- improve the quality of menus in the kitchens of public institutions by ensuring a more professional and principled procurement procedure.

3.3.4. Inputs

The inputs to the selected actions are provided in Table 12 below.

Table 12. 3HP Actions related to childhood obesity and food reformulation

Action	Coordinator / Coordinator country	Partners	Timescale	EC Contribution (EUR)
Presidency Conferences on Drug Shortages and on Healthy Nutrition for Children	Ministerstvo Na Zdraveopazvenet o (Bulgaria)	N/A	04/11/2017 - 03/08/2018 (9 months; Finalised)	61 439

[210] CHAFEA. (n.d.). Joint Action on Nutrition and Physical Activity [JANPA] [677063] - Joint Actions. Available from: https://webgate.ec.europa.eu/chafea_pdb/health/projects/677063/summary [Accessed on: 05 April 2022].
[211] eu2018bg.bg (2018). FINAL REPORT: Conference "The Healthy Future of Europe: Healthy Nutrition for Children", Sofia, 6 February 2018, National palace of Culture. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5bc1c2b01&appId=PPGMS [Accessed on: 05 April 2022].
[212] Best-ReMaP. (n.d.). About Us. Available from: https://bestremap.eu/aboutus/ [Accessed on: 29 April 2022].

Joint Action on Nutrition and Physical Activity (JANPA)	Agence Nationale de Sécurité Sanitaire de l'Alimentation, de l'Environnement et du Travail (France)	26 European countries (either as partners or collaborating stakeholders) as well as the World Health Organization's Regional Office for Europe and the JRC-EU[213].	01/09/2015 - 30/11/2017 (27 months; Finalised)	1 200 000
Best-ReMaP, 2020-2024	Nacionalni inštitut za javno zdravje (Slovenia)	36 associated partners from 23 EU countries	01/10/2020 - 30/09/2023 (36 months; Ongoing)	6 000 000

The selection of topics for the **Healthy Nutrition for Children conference** was done within **regular meetings and conference calls** with the steering committee[214,215], relevant experts[216], and a broad range of stakeholders.

3.3.5. Activities

The three funded actions conducted or are in the process of undertaking a wide range of activities to address the sub-theme. The main activities are discussed below.

Research has shown that acute exposure to food advertising may increase food intake in children.[217] Therefore, **marketing** was an appropriate focus for several 3HP activities. One of four sessions at the **Healthy Nutrition for Children conference** was titled "Marketing and children". WP6 of **Best-ReMaP** (Marketing and best practices)[218] also seeks to reduce the marketing of unhealthy foods to children by addressing the food nutrition information. The members of Best-ReMaP aim to develop a harmonised EU nutrient profile model, develop guidance on codes of practice, develop a harmonised EU monitoring protocol, and propose an EU framework for action.

Two of the funded actions focused on **initiatives in schools**. **JANPA** WP6 (Healthy environments by integrated approaches) provided guidance on policy options and initiatives at different levels for facilitating more effective actions in kindergartens and schools through collecting and analysing good practices and policy capacity for prevention. Similarly, WP7 of **Best-ReMaP** (Food procurement)[219] seeks to address

[213] French Agency for Food, Environmental and Occupational Health & Safety (ANSES) (2017). TACKLING CHILDHOOD OVERWEIGHT AND OBESITY IN EUROPE: Lessons learnt and recommendations from the Joint Action on Nutrition and Physical Activity JANPA. Available from: https://www.anses.fr/fr/system/files/03ENG-LAYMAN-14nov2017_Print_Final.pdf [Accessed on: 06 April 2022].
[214] Including DG SANTE, WHO, the UNICEF, the BEUC, the Bulgarian Academy of Science and scientists
[215] eu2018bg.bg (2018). FINAL REPORT: Conference "The Healthy Future of Europe: Healthy Nutrition for Children", Sofia, 6 February 2018, National palace of Culture. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5bc1c2b01&appId=PPGMS [Accessed on: 05 April 2022].
[216] e.g. expert of Molecular Genetics at the Bulgarian Academy of Sciences; associated professor in Medical University – Sofia; representative from the Bulgarian Association for the Study of Obesity; Early Childhood Development Officer at UNICEF, Ministry of Health
[217] Boyland, E.J., Nolan, S., Kelly, B., Tudur-Smith, C., Jones, A., Halford, J.C. and Robinson, E., 2016. Advertising as a cue to consume: a systematic review and meta-analysis of the effects of acute exposure to unhealthy food and nonalcoholic beverage advertising on intake in children and adults, 2. The American journal of clinical nutrition, 103(2), pp.519-533.
[218] Best-ReMaP. (n.d.). Reducing the marketing of unhealthy foods to children: Work Package 6. Available from: https://bestremap.eu/marketing/ [Accessed on: 29 April 2022].
[219] Best-ReMaP. (n.d.). Procurement of nutritious food in public institutions: Work Package 7. Available from: https://bestremap.eu/procurement/ [Accessed on: 29 April 2022].

the importance of providing high-quality food in public institutions such as schools and hospitals.

Some activities also focused on **sharing best practices** among Member States and key stakeholders. Through WP5 (Nutritional Information),[220] **JANPA** tested the Oqali monitoring tool[221] to describe the nutritional composition of foods in two pilot countries, and determined that this tool is useful and easily transposable. **JANPA** WP7 (Early interventions) examined and mapped initiatives from a number of Member States related to programmes for overweight and obesity prevention in the early stages of life, and thus targeted families during pregnancy, lactation and early childhood. One of the four sessions of the **Healthy Nutrition for Children conference** focused on success stories and examples of best practices from Member States and Commission initiatives. The conference was attended by health and agriculture experts from the EU Member States, DG SANTE, the World Health Organization, UNICEF, the European Consumer Organization, academics and non-governmental organizations.

The identification of best practices is also a key component of **Best-ReMaP** (this was confirmed through an interview with a Governmental Public Health Organisation stakeholder). This Joint Action had a strong emphasis on selecting best practices based on evidence-based and consultative process which underpinned its activities: best practices for Best-ReMaP were selected at a novel "Marketplace workshop on nutrition and physical activities best practices"[222] organised by the JRC. This marketplace produced a list of three best practices through a highly transparent and broad process, and the governance structure was reportedly very useful in this process. The three best practices are included in Best-ReMaP:[223]

(1) Establishing standardised reformulation and processed food monitoring system based on the successful French/Joint Action on Nutrition and Physical Activity model (supporting the EU Framework for national reformulation initiatives);

(2) Framing of marketing aimed at children of foods and beverages high in fats, sugars or salt; and

(3) Public procurements of food for health in public institutions (primarily kindergartens and schools).

Best-ReMaP held a conference in November 2021 which sought to support the translation of research knowledge to support policy decision-making and leverage the project's innovative and complementary approaches to curb the rise in child and adolescent obesity.[224]

[220] JANPA. (2017). D5.2 Pilot study and identification of participants in a monitoring network. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5b5256720&appId=PPGMS

[221] The pilot studies were implemented following the methodology developed in the Oqali tool (https://www.oqali.fr/en/home/). Since 2008 this tool has allowed monitoring changes in the processed foods supply available on the French market by measuring nutritional quality evolution over time (nutritional composition and labelling information).

[222] European Commission. (2018). Marketplace workshop on nutrition and physical activities best practices. Available from: https://ec.europa.eu/health/other-pages/basic-page/marketplace-workshop-nutrition-and-physical-activities-best-practices_en#a [Accessed on: 29 April 2022]

[223] European Commission. (2020). Proposal: Joint Action on implementation of validated best practices on nutrition (JA Best–ReMaP).

[224] Best-ReMaP. (n.d.). Conference on Policy Solutions for Childhood Obesity: From science to policy implementation. Available from: https://bestremap.eu/conference-on-policy-solutions-for-childhood-obesity/

In terms of **food content and reformulation**, one of the **conference** sessions[225] was titled "'Safe' is not sufficient: how do contents of foodstuff impact health". Similarly, **Best-ReMaP** WP5 (Reformulation and processed food monitoring)[226] aims to increase the offer of healthier processed food across the EU. This work in Best-ReMaP is based on JANPA WP5 results, but also on the EUREMO (EU wide implementation of the reformulation monitoring) snapshot in 16 EU Member States, the majority of which are participating in Best-ReMaP.[227]

JANPA WP4 (**Cost of childhood obesity**) summarised the evidence on childhood obesity and developed JANPA costing models to estimate the lifetime costs attributable to childhood obesity/overweight in participating countries, and the effects of reductions in mean childhood BMI. Through this WP, the Joint Action conducted four reviews of the international literature, collated data in the participating countries, and developed a "scientifically acceptable" costing model.

3.3.6. Outputs

Some of the main outputs created by **JANPA** included papers on the models used in WP4 in Ireland[228],[229] and the pilot study for WP5.[230] The Joint Action also produced a web-based toolbox created through WP6 for program planners and decision makers[231,232] and a related guidance document for programme planners and decision makers about key lessons, main facilitators and barriers for the successful implementation of policy measures and national initiatives in kindergartens and schools[233]. Outputs related to WP7 included a Descriptive working paper defining good models for multi-component interventions[234] and a summary of good models with recommendations for actions to implement[235]. A final evaluation report was published

[225] eu2018bg.bg (2018). Conference report: Conference "The Healthy Future of Europe: Healthy Nutrition for Children", Sofia, 6 February 2018, National palace of Culture. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5bbf54cb6&appId=PPGMS [Accessed on: 05 April 2022].
[226] Best-ReMaP. (n.d.). Processed Food Monitoring and Reformulation: Work Package 5. Available from: https://bestremap.eu/monitoring/ [Accessed on: 29 April 2022].
[227] European Commission. (2020). Proposal: Joint Action on implementation of validated best practices on nutrition (JA Best–ReMaP).
[228] JANPA. (2018). THE LIFETIME IMPACTS AND COSTS OF CHILDHOOD OBESITY/OVERWEIGHT IN EUROPE. PART 1. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5b9c86441&appId=PPGMS
[229] JANPA. (2018). THE LIFETIME IMPACTS AND COSTS OF CHILDHOOD OBESITY OVERWEIGHT IN EUROPE PART 2. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5b9c87990&appId=PPGMS [Accessed on: 06 April 2022].
[230] JANPA. (2017). D5.2 Pilot study and identification of participants in a monitoring network. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5b5256720&appId=PPGMS
[231] JANPA. (2017). D6.4. Web-based toolbox for program planners and decision makers. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5b580c653&appId=PPGMS
[232] JANPA. (n.d.). JANPA Toolbox. Available from: http://janpa-toolbox.eu/#:~:text=JANPA%20is%20a%20joint%20action,design%20and%20implement%20effective%20interventions [Accessed on: 06 April 2022].
[233] JANPA. (2017). A GUIDE FOR PROGRAMME PLANNERS AND DECISION MAKERS ON CREATING HEALTHIER ENVIRONMENTS IN KINDERGARTENS AND SCHOOLS. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5b636d54d&appId=PPGMS
[234] JANPA. (2016). D7.1 Defining good models for multicomponent interventions: Step 1 : Definition and criteria of good practice for early interventions designed to prevent childhood overweight and obesity. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5a721be8a&appId=PPGMS [Accessed on: 06 April 2022].
[235] JANPA. (2017). D7.4 Summary of good models with recommendations for actions to be implemented. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5b641751a&appId=PPGMS

in 2018,[236] and the conclusions and recommendations of the action are also set out in the JANPA position paper.[237] A final brochure[238] provides a detailed description of **JANPA** and the main results obtained.

The **Healthy Nutrition for Children conference** report[239] concluded that key messages from the conference focused on the relationship between food and chronic diseases, the need to ensure a proper environment, including in terms of increased availability of healthy options, the importance of traditional diets and products, as well as the need to limit the exposure of children to marketing. The Presidency developed a discussion paper, and Council Conclusions were published on Healthy Nutrition for Children: The Healthy Future of Europe in the Official Journal of the EU[240].

The first output of **Best-ReMaP** was the creation of the **website,**[241,242] which was made public on 20 December 2020. The website provides project and WP level information on all project activities and features a dedicated page for events and newsletters. Some reports have also been published on the website, including a list of priority food groups under WP5[243] and a mapping of regulation and legislation on marketing best practices under WP6.[244]

Interestingly, Governmental Public Health Organisation stakeholders involved in **Best-ReMaP** indicated in an interview that within the joint action, they are going to run an additional survey / conduct additional research to provide data to the OECD so they can economically evaluate the best practices identified. This was not originally agreed in the proposal but was made possible because they had more funding than anticipated left over due to Covid-19. This flexibility will lead to improved EU-added value of the project.

3.3.7. Outcomes and impacts / potential impacts

This section discusses the outcomes of the funded actions by relevant evaluation question. As **Best-ReMaP** is ongoing, there are not as many outputs and impacts to discuss. Therefore, this section mainly discusses potential impacts for this funded action.

[236] JANPA. D3.7 Publishable final evaluation report. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5bab00045&appId=PPGMS

[237] JANPA. (2017). Janpa position paper. Available from: https://www.anses.fr/fr/system/files/04ENG-POSITION_PAPER-14nov2017_Print_final.pdf [Accessed on: 06 April 2022].

[238] French Agency for Food, Environmental and Occupational Health & Safety (ANSES) (2017). TACKLING CHILDHOOD OVERWEIGHT AND OBESITY IN EUROPE: Lessons learnt and recommendations from the Joint Action on Nutrition and Physical Activity JANPA. Available from: https://www.anses.fr/fr/system/files/03ENG-LAYMAN-14nov2017_Print_Final.pdf [Accessed on: 06 April 2022].

[239] eu2018bg.bg (2018). Conference report: Conference "The Healthy Future of Europe: Healthy Nutrition for Children", Sofia, 6 February 2018, National palace of Culture. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5bbf54cb6&appId=PPGMS [Accessed on: 05 April 2022].

[240] European Union. (2018). NOTICES FROM EUROPEAN UNION INSTITUTIONS, BODIES, OFFICES AND AGENCIES: Council conclusions Healthy Nutrition for Children: The Healthy Future of Europe (2018/C 232/01). Official Journal of the European Union. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5bbeb1aea&appId=PPGMS [Accessed on 05 April 2022].

[241] Best-ReMaP. (n.d.). Best-ReMaP. Available from: https://bestremap.eu/ [Accessed on: 05 April 2022].

[242] Best-ReMaP. (2020). WP2 Report: Mandatory Deliverable 2.2. Website. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5d79464c0&appId=PPGMS [Accessed on: 29 April 2022].

[243] Best-ReMaP. (2020). M5.2 List of the priority food groups. Available from: https://bestremap.eu/wp-content/uploads/2022/08/M5.2-List-of-the-prioritiy-food-groups.pdf [Accessed on: 08 August 2022].

[244] Best-ReMaP. (2021). M6.3 Regulation and legislation mapping report. Available from: https://bestremap.eu/wp-content/uploads/2022/08/M6.3-Regulation-and-legislation-mapping-report.pdf [Accessed on: 08 August 2022].

Some interviewed stakeholders mentioned that the 3HP overall has effectively addressed the topic of nutrition. One stakeholder from a Healthcare service provider /organisation representing them who worked on projects related to chronic diseases mentioned that nutrition was also linked with the topic and was successfully addressed in the 3HP.

EQ4a: To what extent has the programme contributed to a more comprehensive and uniform approach to tackling childhood obesity in the EU?

Overall, around half of respondents to this study's survey (held as part of targeted consultations with various stakeholder groups) felt the 3HP has contributed to a more comprehensive and uniform approach to addressing health issues related to childhood obesity to a large or moderate extent (51%).

Figure 50. To what extent has the Programme contributed to a more comprehensive and uniform approach to addressing health issues across the following policy areas? (n=32)

The intermediate impacts of the funded actions relate primarily to **sharing best practices**, which could lead to a more comprehensive and uniform approach to tackling childhood obesity. For example, **JANPA** represented a direct contribution to the EU Action Plan on Childhood Obesity 2014-2020 and enabled the data and best practices available in the 26 countries involved (25 EU Member States and Norway) to be identified, selected and shared.[245] According to a European Commission report,[246] the work on best practices conducted as part of JANPA is particularly important because the European Commission directly supports EU countries (via the Steering Group on Prevention and Promotion) in a three-step approach: asking EU countries about their priorities for reducing non-communicable diseases; collecting validated best practices in those areas, and making support available for countries to roll out those practices. Further, the page about the **Healthy Nutrition for Children conference** in the CHAFEA database[247] stated that expert discussions at the conference provided improved understanding among health experts on the possibility to introduce national measures based on the protection of public health. Intense discussions among Member State experts reportedly[248] provided insight into each other's perspective, which contributed to the identification of topics suitable for political and expert level discussions. By identifying best practices, actions and initiatives at national, EU and international level the experts were able to liaise on topics where it is difficult to achieve political unanimity in the Council (such as

[245] République française, Anses (n.d.). European Joint Action on Nutrition and Physical Activity JANPA. Available from: https://www.anses.fr/en/content/european-joint-action-nutrition-and-physical-activity-janpa [Accessed on: 06 April 2022].
[246] European Commission., 2019. Health for the EU: A selection of actions funded under the Third EU Health Programme. Special edition for the EU Health Programme Conference 30 September 2019. Luxembourg: European Union. Available from: http://jaotc.eu/wp-content/uploads/2019/10/Health-for-the-EU_30.9.2019.pdf . [Accessed November 2021].
[247] CHAFEA. (n.d.). Presidency Conferences on Drug Shortages and on Healthy Nutrition for Children [DSHNCH CONFERENCES] [807392] - Presidential Conference. Available from: https://webgate.ec.europa.eu/chafea_pdb/health/projects/807392/summary [Accessed on: 05 April 2022]
[248] eu2018bg.bg (2018). FINAL REPORT: Conference "The Healthy Future of Europe: Healthy Nutrition for Children", Sofia, 6 February 2018, National palace of Culture. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5bc1c2b01&appId=PPGMS [Accessed on: 05 April 2022].

marketing, nutrient profiles, quality of foodstuffs). The discussion paper developed through the conference fed into the text of the Council conclusions by enabling contributions across Member States. Furthermore, this was the basis of the policy discussion paper, presented to the attention of the health ministers at an Informal Council on 22-23 April in Sofia. Finally, through **Best-ReMaP** there was a workshop on how to use, adapt and implement the EU harmonised nutrient profile model,[249] and a workshop on how to implement codes of practice to reduce unhealthy food marketing to children.[250] These events enabled shared learning.

Some wider and longer-term actions have been taken following the conclusion of **JANPA** related to **best practices**. In December 2017, the European Commission issued a call for tender for a feasibility study on a monitoring system on food reformulation initiatives for salt, sugars and fat.[251] This was reportedly done partly to meet a recommendation of JANPA, that is, deploying the tested monitoring system based on OQALI in several European countries.[252] Further, one of the best practices presented at the European Commission event titled "Marketplace workshop on nutrition and physical activities best practices" in 2018 was dedicated to the work of OQALI and JANPA WP5.[253] Further, according to the JANPA technical report[254] the work done in WP6 and WP7 to identify criteria to select good practices was part of a more global reflection of the Commission through the steering group on promotion and prevention to select best practices beyond the specific question of childhood obesity. The toolbox created by WP6 to share the best practices selected in the different countries proved to be innovative, easy to use and have a high potential.

Governmental Public Health Organisation stakeholders involved in **Best-ReMaP** who were interviewed for this study noted that there is a need to consider the differences between "best", "good", "emerging", and "promising" practices. Best-ReMaP are implementing promising or emerging practices rather than best or good practices, because there is not yet enough evidence to conclusively call them best or good practices. Further, in a 2022 debate on the topic of food marketing and children,[255] Amandine Garde (Professor of Law at the University of Liverpool, and EUPHA-LAW Section President) stated that the inclusion and promotion of best practices through **Best-ReMaP** stops short of what is needed in the area.[256]

As noted in the mid-term evaluation of the 3HP,[257] **JANPA** involved many actors across Member States and therefore lent itself to supporting and **promoting a**

[249] Best-ReMaP. (2021). EU Joint Action Best-ReMaP: Workshop on Nutrient Profiling Capacity Building to restrict unhealthy food marketing to children. Available from: https://bestremap.eu/wp-content/uploads/2022/08/M6.2-A-workshop-on-how-to-use-adapt-and-implement-the-EU-harmonised-nutrient-profile-model.pdf [Accessed on 08 August 2022].
[250] Best-ReMaP. (2022). Workshop on Food Marketing Codes of Practices—Process and Challenges. Available from: https://bestremap.eu/wp-content/uploads/2022/08/M6.4-Workshop-on-how-to-implement-Codes-of-Practice-to-reduce-unhealthy-food-marketing-to-children.pdf [Accessed on: 08 August 2022].
[251] http://ted.europa.eu/udl?uri=TED:NOTICE:516944-2017:TEXT:NL:HTML&tabId=1
[252] European Commission. (2018). Supporting the mid-term evaluation of the EU action plan on childhood obesity: The childhood obesity study. Available from: https://op.europa.eu/en/publication-detail/-/publication/7e0320dc-ee18-11e8-b690-01aa75ed71a1/language-en/format-PDF [Accessed on: 29 April 2022]
[253] European Commission. (2018). Marketplace workshop on nutrition and physical activities best practices. Available from: https://ec.europa.eu/health/other-pages/basic-page/marketplace-workshop-nutrition-and-physical-activities-best-practices_en#a [Accessed on: 29 April 2022]
[254] Janpa. (2018). Periodic Technical Report; CHAFEA Grant N°: 677063; Acronym: JANPA; Title: Joint Action on Nutrition and Physical Activity.
[255] European Public Health Alliance. (2022). Give Kids a Break! What next for EU action to protect children from harmful food marketing?. Information available from: https://epha.org/2022-events/eu-action-to-protect-children-from-harmful-food-marketing/
[256] This speaker stated that protecting children from unhealthy marketing is a human rights obligation, and therefore the EU should regulate organisations which infringe upon these rights.
[257] Coffey International Development, SQW, and Economisti Associati. (2017). Mid-term Evaluation of the Third Health Programme (2014 – 2020): Final report Annex B. Available from: https://ec.europa.eu/health/system/files/2017-10/2014-2020_evaluation_studyannexb_en_0.pdf [Accessed on: 29 April 2022].

coordinated approach across Member States to improve the situation of childhood overweight and obesity through the involvement of Member State health authorities. The European Commission's Childhood Obesity Study[258] stated that JANPA was considered to be a good example of collaborative action. Further, Professor Mojca Gabrijelčič Blenkuš, a public health specialist involved in the **Best-ReMaP** project was quoted as stating "*Best-ReMaP is not the work of one person or one country but something member states have been working towards for years*."[259] This coordinated approach could represent a longer-term impact of the action.

Within Bulgaria, the **Conference** inspired discussions at ministerial level on the topic during the Informal Meeting of Health Ministers held on 22 April 2018, in Sofia[260]. The Conference and the short movie produced for the conference entitled "The Healthy Future of Europe. Healthy Nutrition for Children" reportedly improved cooperation between the different sectors in that country (health, agriculture and food safety, education). The outcomes of the Conference were communicated through the website of the Ministry of Health[261].

In their final brochure[262], **JANPA** recommended that related to WP4 the developed costing model should be improved and written into open-source code, and further there should be improved co-ordination of national health information systems across the EU.

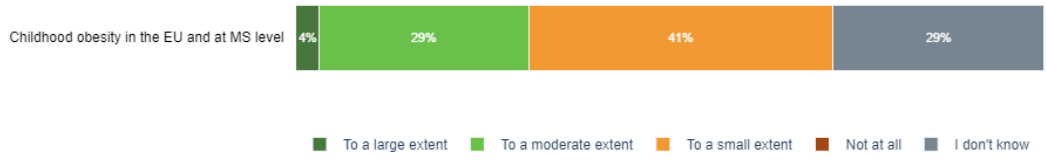
Overall, in an intermediate timescale it seems that best practices have been shared following the funded actions. This may be contributing towards longer-term comprehensive and uniform approaches in the EU, however it's not yet possible to conclude that the approach has been achieved. In order for the reported results of the funded actions to lead to the desired outcomes it will be crucial for the EU and Member State to take up the recommendations and tools produced by these funded actions. For example, policy makers should use the JANPA methodology to collect nutritional information, providing a way to compare the content of salt, sugar and fat easily and regularly in food sold in EU supermarkets. If these tools are not used, the impacts of the funded actions will be very limited.

EQ4b: To what extent has the programme contributed to improvements in childhood obesity in the EU and at Member State level?

A large proportion of respondents said the Programme contributed to improvements related to childhood obesity in the EU and at Member State level only to a small extent (41%), although note that nearly a third of respondents did not know (29%).

[258] European Commission. (2018). Supporting the mid-term evaluation of the EU action plan on childhood obesity: The childhood obesity study. Available from: https://op.europa.eu/en/publication-detail/-/publication/7e0320dc-ee18-11e8-b690-01aa75ed71a1/language-en/format-PDF [Accessed on: 29 April 2022]
[259] Federico. (2021). An interview with Professor Mojca Gabrijelčič Blenkuš. Stop Childhood Obesity. Available from: http://www.stopchildobesity.eu/an-interview-with-professor-mojca-gabrijelcic-blenkus/ [Accessed on: 29 April 2022]
[260] Information about the Conference was published in individual section "Priorities of the Ministry of Health under the Bulgarian Presidency of the Council of the EU" on the website of the Ministry of Health, including delivered speeches, conclusions and presentations.
[261] Information about the Conference was published in individual section "Priorities of the Ministry of Health under the Bulgarian Presidency of the Council of the EU" on the website of the Ministry of Health, including delivered speeches, conclusions and presentations.
[262] French Agency for Food, Environmental and Occupational Health & Safety (ANSES) (2017). TACKLING CHILDHOOD OVERWEIGHT AND OBESITY IN EUROPE: Lessons learnt and recommendations from the Joint Action on Nutrition and Physical Activity JANPA. Available from: https://www.anses.fr/fr/system/files/03ENG-LAYMAN-14nov2017_Print_Final.pdf [Accessed on: 06 April 2022].

Figure 51. To what extent has the Programme contributed to improvements in the following areas? (n=32)



A government policy maker reported that there were Joint Actions and studies on labelling and content of foods, but the work could have been more successful if the budget was larger to work across all the countries and to make meaningful assessments. The conclusions for these actions did not cover all countries. However, overall, another interviewed government policy maker indicated that activities in the field of nutrition addressing children and adolescents were very successful.

The funded actions seem to have led to some intermediate **awareness-raising** about the topics. The **Healthy Nutrition for Children conference** helped to focus attention on chronic diseases and the importance of adequate prevention policies, including as part of a health-in-all-policies approach.[263] The video produced as part of the conference has been used as the introduction to Council debates. It was also included in the program of Bulgarian official media as part of the national promotion campaign,[264] and raised awareness in the Bulgarian national context[265], which resulted in more discussions both within specialized TV programs and articles in the media. Further, according to the mid-term evaluation of the 3HP[266], the participation of **JANPA**'s consortium partners in other related actions means that they are well acquainted with the information available and recent research on the topic. **Best-ReMaP** is much less developed than the other funded actions, and the only detected awareness-raising undertaken as part of this project is an Instagram account[267] where they post useful information such as which vegetables are in season.

The **Healthy Nutrition for Children conference** inspired many of the findings and political messages in the Council Conclusions on Healthy Nutrition for Children: The Healthy Future of Europe.[268] These conclusions urge Member States and the Commission to take action to improve nutrition for children. Further, the Presidency devoted the meeting of the working party "Public health" in Bulgaria, to the topic of

[263] eu2018bg.bg (2018). FINAL REPORT: Conference "The Healthy Future of Europe: Healthy Nutrition for Children", Sofia, 6 February 2018, National palace of Culture. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5bc1c2b01&appId=PPGMS [Accessed on: 05 April 2022].
[264] CHAFEA. (n.d.). Presidency Conferences on Drug Shortages and on Healthy Nutrition for Children [DSHNCH CONFERENCES] [807392] - Presidential Conference. Available from: https://webgate.ec.europa.eu/chafea_pdb/health/projects/807392/summary [Accessed on: 05 April 2022]
[265] CHAFEA. (n.d.). Presidency Conferences on Drug Shortages and on Healthy Nutrition for Children [DSHNCH CONFERENCES] [807392] - Presidential Conference. Available from: https://webgate.ec.europa.eu/chafea_pdb/health/projects/807392/summary [Accessed on: 05 April 2022]
[266] Coffey International Development, SQW, and Economisti Associati. (2017). Mid-term Evaluation of the Third Health Programme (2014 – 2020): Final report Annex B. Available from: https://ec.europa.eu/health/system/files/2017-10/2014-2020_evaluation_studyannexb_en_0.pdf [Accessed on: 29 April 2022].
[267] https://www.instagram.com/best_remap/?hl=en
[268] European Union. (2018). NOTICES FROM EUROPEAN UNION INSTITUTIONS, BODIES, OFFICES AND AGENCIES: Council conclusions Healthy Nutrition for Children: The Healthy Future of Europe (2018/C 232/01). Official Journal of the European Union. Available from: https://www.ec.europa.eu/research/participants/documents/downloadPublic?documentIds=080166e5bbeb1aea&appId=PPGMS [Accessed on 05 April 2022].

nutrition for children to make sure that sectoral diplomats were kept abreast of and were actively involved in all discussions[269].

JANPA had a high level of Member States engagement, which enabled direct information dissemination and influence on public health and national authorities in the area of nutrition in the 26 countries directly involved in the joint action as well as the 3 Member States not directly involved in JANPA. Furthermore, it reportedly was part of JANPA's activities to develop a stakeholder database with a detailed analysis which enabled dissemination of JANPA's conclusions to a very targeted audience. Such factors may help ensure wide awareness of the results of JANPA. Indeed, several studies and publications have also **cited or used JANPA's findings**. A 2018 European Commission study on nutrition and health claims made on food with regard to nutrient profiles and health claims made on plants and their preparations cited JANPA results, including on sugar and fat content in cereals and soft drinks in three Member States. A JRC technical report from 2018[270] sought to estimate sugar content from 2015 data for sugar-sweetened beverages, breakfast cereals and dairy products. The study used a similar methodology to JANPA, and the study noted similar findings to JANPA, and cited several of JANPA's findings. Overall, this report lent additional support to JANPA's conclusions on the validity of nutrient label information and the importance of market share data. The European Commission's Childhood Obesity Study[271] described the main results and recommendations from JANPA as an example of EU action in this area.

In general, a Governmental Public Health Organisation stakeholder interviewed for the present study indicated that the 3HP's work on nutrition has been strong:

"what we have achieved in the area of nutrition under the 1st and the 2nd and the 3rd [health programmes] is really huge. That would not be achieved in the Member States, they would not be collaborating so closely."

The same stakeholder indicated that actions taken on the topic of nutrition are seen as very linked to each other, and **JANPA**, **Best-ReMaP**, and other joint actions are all linked:

"France has been testing the reformulation, monitoring in JANPA with three countries, and now it is disseminating it in Best-ReMaP to 21 Member States. That's really huge. And now in Best-ReMaP we are testing public procurement approaches in eight countries and...we are already in agreement with the Commission discussing that that the new joint action on health determinants we would be implementing this to as many Member States as they would like to join the public procurement in the next quarter. So it's rolling from joint action to joint action. And I think that this is really added value."

Further impacts of the projects on childhood obesity are anticipated, but it remains to be seen whether and to what degree these occur:

[269] Republic of Bulgaria: Ministry of Health. (2018). Final Technical Report: CHAFEA Operating Grant Nr: 807392; Acronym: DSHNCH CONFERENCES; Title: 'Presidency Conferences on Drug Shortages and on Healthy Nutrition for Children — DSHNCH CONFERENCES'.

[270] Robinson, M., Caldeira, S., & Wollgast, J. Sugars content in selected foods in the EU: A 2015 baseline to monitor sugars reduction progress. JRC Technical Reports. Available from: https://op.europa.eu/en/publication-detail/-/publication/8f9ef55b-d34a-11e8-9424-01aa75ed71a1/language-en/format-PDF [Accessed on: 29 April 2022].

[271] European Commission. (2018). Supporting the mid-term evaluation of the EU action plan on childhood obesity: The childhood obesity study. Available from: https://op.europa.eu/en/publication-detail/-/publication/7e0320dc-ee18-11e8-b690-01aa75ed71a1/language-en/format-PDF [Accessed on: 29 April 2022]

- The **tools developed by JANPA** may facilitate improvements in childhood obesity. According to the JANPA technical report,[272] the Joint Action allowed many concrete documents and tools to be produced, which were used by different types of stakeholders and particularly at European level as soon as they were produced, and before the end of JANPA. In their final brochure,[273] JANPA recommended that the OQALI tool be developed by public authorities in each European country to facilitate the nutritional food improvement requested by the European Council. This could potentially help citizens to make informed choices, support companies in launching healthier options and help authorities engage in supporting food reformulation. The toolbox developed in WP6 of JANPA could also enable more effective interventions in schools and kindergartens. A guide for elected officials and departmental services published by the French Government[274] recommended using the JANPA toolbox. An interviewed stakeholder from an international organisation also reported that they worked with Member States on **Best-ReMaP** to improve policy implementation on the ground.
- In the proposal for **Best-ReMaP**, an expected benefit of the project was that it could change the food environment for children in Europe by providing the first/second monitoring snapshot for food reformulation in participating Member States, assuring the Member States two snapshots within a reasonable timeframe in order to also assess trends in food reformulation.[275] The expected impacts of **Best-ReMaP** WP5 include that the European branded food database could allow comparisons and encourage the improvement of nutritional quality in the European food supply. Further, assessment of evolution in nutritional quality, identification of best reformulation practices, and assessment of the impact of processed food reformulation on nutrient intakes could allow European comparisons of processed food reformulations and processed food turnover. However, this action is in progress, and it is too early to assess impacts for this project.
- The work of **Best-ReMaP** WP6 could also impact **marketing of foods** to children, including that certain foods may stop being marketed to children and adolescents if the guidance produced by this action is followed. Further, a harmonised EU approach to monitoring marketing of unhealthy food to children could reduce such unhealthy marketing. If the recommendations and training produced by WP7 are followed, this could lead to achieve a higher quality menu in public institutions and schools. Again, this action is still in progress so these remain expected (rather than actual) impacts.

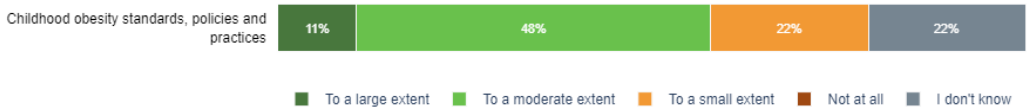
Overall, the funded actions have raised awareness and created useful tools, however it is not possible to assess whether or to what extent overweight and obesity will decrease among children following these actions. In order for the reported impacts of the funded actions to lead to the desired outcomes it will be crucial for the EU and Member State to take up the recommendations and tools produced by these funded actions.

[272] Janpa. (2018). Periodic Technical Report; CHAFEA Grant N°: 677063; Acronym: JANPA; Title: Joint Action on Nutrition and Physical Activity.
[273] French Agency for Food, Environmental and Occupational Health & Safety (ANSES) (2017). TACKLING CHILDHOOD OVERWEIGHT AND OBESITY IN EUROPE: Lessons learnt and recommendations from the Joint Action on Nutrition and Physical Activity JANPA. Available from: https://www.anses.fr/fr/system/files/03ENG-LAYMAN-14nov2017_Print_Final.pdf [Accessed on: 06 April 2022].
[274] Ministère des Solidarités et de la Santé. Départements et nutrition: améliorer la santé de la population par l'alimentation et l'activité physique: Guide à l'usage des élus et des services départementaux. Available from: https://solidarites-sante.gouv.fr/IMG/pdf/guide_pnnss_departement_new.pdf [Accessed on: 29 April 2022].
[275] European Commission. (2020). Proposal: Joint Action on implementation of validated best practices on nutrition (JA Best–ReMaP).

EQ4c: To what extent has the programme contributed to the EU's influence on childhood obesity standards, policies and practices at international level?

A majority of survey respondents reported that the Programme contributed to a large or moderate extent (11, 59%) to the EU's influence at the international level in the area of childhood obesity standards, policies and practices.

Figure 52. To what extent has the Programme contributed to EU's influence at international level in the following areas? (n=20, only public authorities)

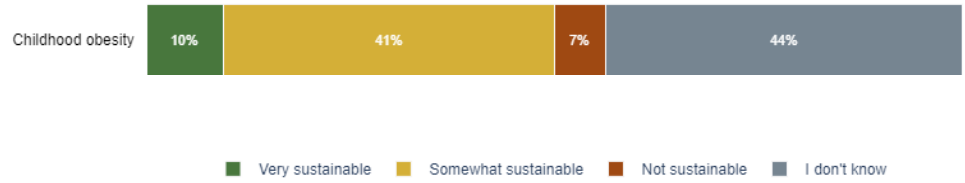


JANPA recommended that the toolbox developed in WP6 be extended to cover early interventions (WP7); if this happened it could contribute to the implementation of a European network and facilitate international transfer of the findings.[276] Further, according to the JANPA technical report,[277] the methodology developed by WP4 to estimate the future cost of childhood obesity was shared with the OECD team in charge to develop estimations of the cost of obesity.

EQ9a: To what extent are the programme results and effects in relation to childhood obesity likely to be sustainable?

In the survey, 41% of respondents felt work on childhood obesity is somewhat sustainable, however note that nearly half of respondents did not know (44%).

Figure 53. How sustainable do you think the Programme results and effects are in the specific fields of…? (n=32)



Overall, the brochure produced by **JANPA**[278] emphasized the need for further work and investment on the topics of the Joint Action: "Without further support from European institutions and particularly the European Commission, the work done so far will not be fruitful." During the Joint Action, the team for WP4[279] established close connections with the work of the OECD on the economics of public health and health promotion, with the aim of trying to obtain results for more European countries in the near future. Further work and investment such as this could help increase the sustainability of the actions, but it remains to be seen if this will occur.

[276] French Agency for Food, Environmental and Occupational Health & Safety (ANSES) (2017). TACKLING CHILDHOOD OVERWEIGHT AND OBESITY IN EUROPE: Lessons learnt and recommendations from the Joint Action on Nutrition and Physical Activity JANPA. Available from: https://www.anses.fr/fr/system/files/03ENG-LAYMAN-14nov2017_Print_Final.pdf [Accessed on: 06 April 2022].
[277] Janpa. (2018). Periodic Technical Report; CHAFEA Grant N°: 677063; Acronym: JANPA; Title: Joint Action on Nutrition and Physical Activity.
[278] French Agency for Food, Environmental and Occupational Health & Safety (ANSES) (2017). TACKLING CHILDHOOD OVERWEIGHT AND OBESITY IN EUROPE: Lessons learnt and recommendations from the Joint Action on Nutrition and Physical Activity JANPA. Available from: https://www.anses.fr/fr/system/files/03ENG-LAYMAN-14nov2017_Print_Final.pdf [Accessed on: 06 April 2022].
[279] République française, Anses (n.d.). European Joint Action on Nutrition and Physical Activity JANPA. Available from: https://www.anses.fr/en/content/european-joint-action-nutrition-and-physical-activity-janpa [Accessed on: 06 April 2022].

Further, Governmental Public Health Organisation stakeholders from **Best-ReMaP** indicated in an interview that the project will seek to add a full systems indicator to the European Semester indicators. Countries are checked against these indicators, so if implemented, the food environment in Europe would be monitored as a top priority. This would help offer an opportunity to monitor the impact of national regulations aimed at decreasing the salt, sugar and fat content of processed food. Furthermore, as stated above, the Joint Action aims to create a Food Information Database to ensure the sustainability of data collection on food reformulation (i.e. changing and regulating the food composition that can be offered on the market) at EU and national levels and of monitoring trends in food reformulation. The joint action was reportedly encouraged to take actions like this because of the requirement for joint actions to integrate sustainability in WP4. These outcomes from Best-ReMaP could lead to sustainable impacts. However, another indicator of Best-ReMaP was to report on the implementation of the project to the High-Level Group on Nutrition and Physical Activity, but it was confirmed in 2021 that this group had been abolished.[280] Therefore, the Joint Action cannot meet this objective.

While there are some opportunities for sustaining the results of the funded actions, there is not much evidence of high sustainability at present.

3.4. Conclusion

Overall, the EU has acted through the 3HP to improve nutrition policies and actions at Member State level. Specifically related to the sub-theme of childhood obesity with links to food reformulation, there have been three main actions through the 3HP: two joint actions and a conference. The conference seems to have had a surprisingly large impact compared to its cost, and the JANPA joint action has also provided a wealth of tools for policy makers wishing to enact policies to improve the nutrition of EU citizens. The Best-ReMaP joint action is yet to produce many outputs aside from a website.

Through these three actions, best practices have been shared among Member States and key stakeholders, in particular around the themes of nutrition and physical activity, as well as on ways to reduce unhealthy food marketing to children. The identification and exchanging of best practices is conducive to a more comprehensive and uniform approach to tackling childhood obesity in the EU; while it is not yet possible to conclude that such an approach has already been fully achieved, it can be assumed that cooperation and exchange of practices among Member States will likely contribute to achieving it in the long-term. Similarly, it is not possible to assess the contribution of EU action to decreasing childhood overweight and obesity across Europe, given that such a reduction is a longer-term impact whose realisation is dependent on a variety of factors. However, the above funded actions have raised awareness and created useful tools which will reasonably contribute to make progress in this area. It is important to note that in order for the reported results of the funded actions to lead to the desired outcomes in a sustainable way, it will be crucial for the EU and Member States to take up the recommendations and tools produced by these funded actions. If these tools are not used, the impacts of the funded actions will be very limited

Lastly, it does not seem that the Programme contributed to the EU's influence on childhood obesity standards, policies or practices at international level.

[280] Ryan, J.F. (2021). Closure of the EU Platform for Action on Diet, Physical Activity and Health. European Commission Directorate-General for Health and Food Safety. Available from: http://www.babymilkaction.org/wp-content/uploads/2021/08/Closure-of-the-EU-Platform-for-Action-on-Diet_signed.pdf

4. Case study: Evolution of the EUnetHTA Joint Actions

This case study presents work done under the 3rd Health Programme (3HP) related to health technology assessment (HTA) and focuses on the evolution of EUnetHTA Joint Actions, assessing the effectiveness and added value of 3HP actions in this area. This topic is explored through an in-depth examination of the European Network for Health Technology Assessment - Joint Action 3 (EUnetHTA JA3).

4.1. Introduction

4.1.1. Background

Health Technology Assessment (HTA) is a multidisciplinary process that aims to provide policymakers with evidence-based information on medical, social, economic and ethical issues related to the use of a health technology (e.g., medicinal products, medical devices, procedures, and measures for diagnosis, disease prevention or treatment). HTA is a tool to assess a new or existing technology and compare it with other health technologies, with the ultimate objective of informing health policies which are safe, effective, patient-focused and cost-effective.[281] A well-functioning HTA system can substantially contribute to the sustainability of health systems and the efficient allocation of resources in healthcare while also increasing business predictability for industry and encouraging innovation.[282]

EU-level collaboration on HTA has been a political priority for many years. The EU and its Member States have undertaken many activities in this field, from EU-funded projects and Joint Actions to the adoption of legislation, namely Directive 2011/24/EU on the application of patients' rights in cross-border healthcare. Despite the steps taken, major challenges have been identified that prevent Member States, economic operators, patients and healthcare professionals from realising the benefits of HTA, which can be summarised as follows:

- distorted market access caused by different national processes and methodologies;
- duplication of work; and
- unsustainability of current EU cooperation on HTA.

Considering these challenges, the EU has adopted Regulation (EU) 2021/2282 on HTA aiming to promote convergence in HTA procedures and methodologies, reduce duplication of work, ensure the uptake of joint outputs in Member States and the long-term sustainability of EU HTA cooperation.[283]

4.1.2. Rationale for selection and case study focus

The 3HP addresses HTA under Specific Objective 3 "Contribute to innovative, efficient, and sustainable health systems". It supports voluntary cooperation between Member States on health technology assessment and facilitates the uptake of the results stemming from research projects supported under the Seventh Framework Programme and Horizon 2020.

Actions taken under 3HP within this theme

The 3HP supported voluntary HTA collaboration through the European Network for Health Technology Assessment (EUnetHTA) Joint Action 3.[284] The Joint Action aimed to define and implement a sustainable model for scientific and technical cooperation on HTA between European countries.

[281] European Commission (2018), "Proposal for a Regulation on health technology assessment and amending Directive 2011/24/EU", Brussels.
[282] European Commission (2018), "Strengthening of the EU Cooperation on Health Technology Assessment (HTA)", Commission Staff Working Document, Brussels.
[283] European Union (2021), "Regulation (EU) 2021/2282 on health technology assessment", Brussels.
[284] EUnetHTA Joint Action 3

The EUnetHTA JA3 was the continuation of and built on the lessons of earlier EUnetHTA Joint Actions. From the group of 35 organisations across Europe who originally participated in the EUnetHTA Project (2006-2008),[285] the network has grown to 81 organisations from 29 countries working together for better access to health technologies for European citizens. The actions taken in the field of HTA since the EUnetHTA Project started in 2006 are illustrated in Table 13.

Table 13. Actions taken on HTA over time

Action	Timescale	EC Contribution (EUR)	Funding programme
Projects			
European Network for Health Technology Assessment [EUnetHTA][286]	01/01/2006 - 01/01/2009 (36 months; Finalised)	€ 1 620 000,00	First Programme of Community action in the field of public health (2003-2008)
Joint Actions			
European network for HTA Joint Action [EUnetHTA JA][287]	01/01/2010 - 01/02/2013 (37 months; Finalised)	€ 2 903 897,79	Second Programme of Community action in the Field of Health 2008-2013
European network for HTA Joint Action 2 [EUnetHTA JA2][288]	01/10/2012 - 01/04/2016 (42 months; Finalised)	€ 6 599 777,00	Second Programme of Community action in the Field of Health 2008-2013
European Network for Health Technology Assessment - Joint Action 3 [EUnetHTA JA3][289]	01/06/2016 - 31/05/2021 (48 months; Finalised)	€ 11 999 798,74	3rd Health Programme (2014-2020)

Case study subtheme: evolution of the EUnetHTA Joint Actions

The case study focuses on the evolution of the EUnetHTA Joint Actions and assesses the contribution of the 3HP to achieving EU objectives in this field.

Already recognised as a political priority in 2004,[290] HTA collaboration was targeted by the activities of the European Network for Health Technology Assessment through the project EUnetHTA in 2006-2009. The work of this project was continued with the establishment of the EUnetHTA Collaboration in 2009, and the subsequent EUnetHTA Joint Actions (JA1 2010-2012, JA2 2012-2015 and JA3 2016-2020).

In 2011, Directive 2011/24/EU on the application of patients' rights in cross-border healthcare laid down measures for cooperation on HTA. In particular, it established that the EU "shall support and facilitate cooperation and the exchange of scientific information among Member

[285] EUnetHTA Project (2006-2008)
[286] Health Programme DataBase - European Commission (europa.eu)
[287] Health Programme DataBase - European Commission (europa.eu)
[288] Health Programme DataBase - European Commission (europa.eu)
[289] See: Health Programme DataBase - European Commission (europa.eu); https://www.eunethta.eu/ja3-archive/; https://ec.europa.eu/health/system/files/2021-02/ev_20201027_co07_en_0.pdf
[290] Report from the High Level Group to the Employment, Social Affairs, Health and Consumer Protection Council on 6-7 December 2004

States within a voluntary network connecting national authorities or bodies responsible for health technology assessment".[291][292] The legislation identified as objectives of the network:

- To support cooperation between national authorities or bodies;
- To support Member States in the provision of information on health technologies and enable effective exchange of this information between national authorities or bodies;
- To support the analysis of the nature and type of information that can be exchanged; and
- To avoid duplication of assessments.

Building on the EUnetHTA Joint Action 1 (2010-2012) and the previous collaboration mechanisms, in October 2012 EUnetHTA Joint Action 2 launched its activities[293] aiming to strengthen HTA collaboration and establish a sustainable structure for HTA work in the EU according to the provisions of Directive 2011/24/EU.

The progress achieved under these projects has formed the basis for continued collaboration in the context of EUnetHTA Joint Action 3 (2016-2020) funded under the 3HP. The Joint Action aimed to establish a permanent HTA working structure for the EU and pave the way for an EU HTA system under the HTA Regulation.

EU cooperation in the field of HTA took a decisive turn in 2021, with the adoption of the HTA Regulation which entered into force in January 2022 and will apply as of January 2025.[294] The Regulation replaces the current system based on the voluntary network of national authorities (HTA Network), and the project-based cooperation (Joint Actions EUnetHTA) with a permanent framework for joint work.

Against this background, this case study assesses the contribution of EUnetHTA Joint Action 3 under the 3HP towards advancing a permanent sustainable European collaboration on HTA.

4.2. Intervention logic underpinning this study

The intervention logic illustrates the problems that EU action in the field of HTA seeks to address, the objectives, the inputs and activities undertaken, outputs of those activities and related outcomes and impacts.

The intervention logic developed for this case study includes the underlying problems that overall EU action seeks to address and the related EU operational objectives.[295] It then focuses specifically on the EUnetHTA Joint Action 3 to understand the contribution of the 3HP in the wider context of EU action in this area. As such, the intervention logic includes elements (i.e., general and specific objectives, inputs, activities, outputs and outcomes) which are directly linked to the EUnetHTA Joint Action 3.[296] Finally, the intervention logic illustrates the (desired) impacts of EU action on HTA which are linked to the establishment and smooth running of a well-functioning HTA system. Such a system has the potential to substantially contribute to the sustainability of health systems and the efficient allocation of resources in healthcare while also increasing business predictability for industry and encouraging innovation. Those desired impacts would, in turn, be expected to contribute to higher levels of human health protection over the long-term.

[291] Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare (Art. 15), Official Journal of the European Union

[292] The HTA Network set up by Directive 2011/24/EU gathers all Member States, Norway and Iceland and associates, as observers, stakeholders representing industry, payers, providers and patients. The Joint Action EUnetHTA provides the scientific and technical support to the Network.

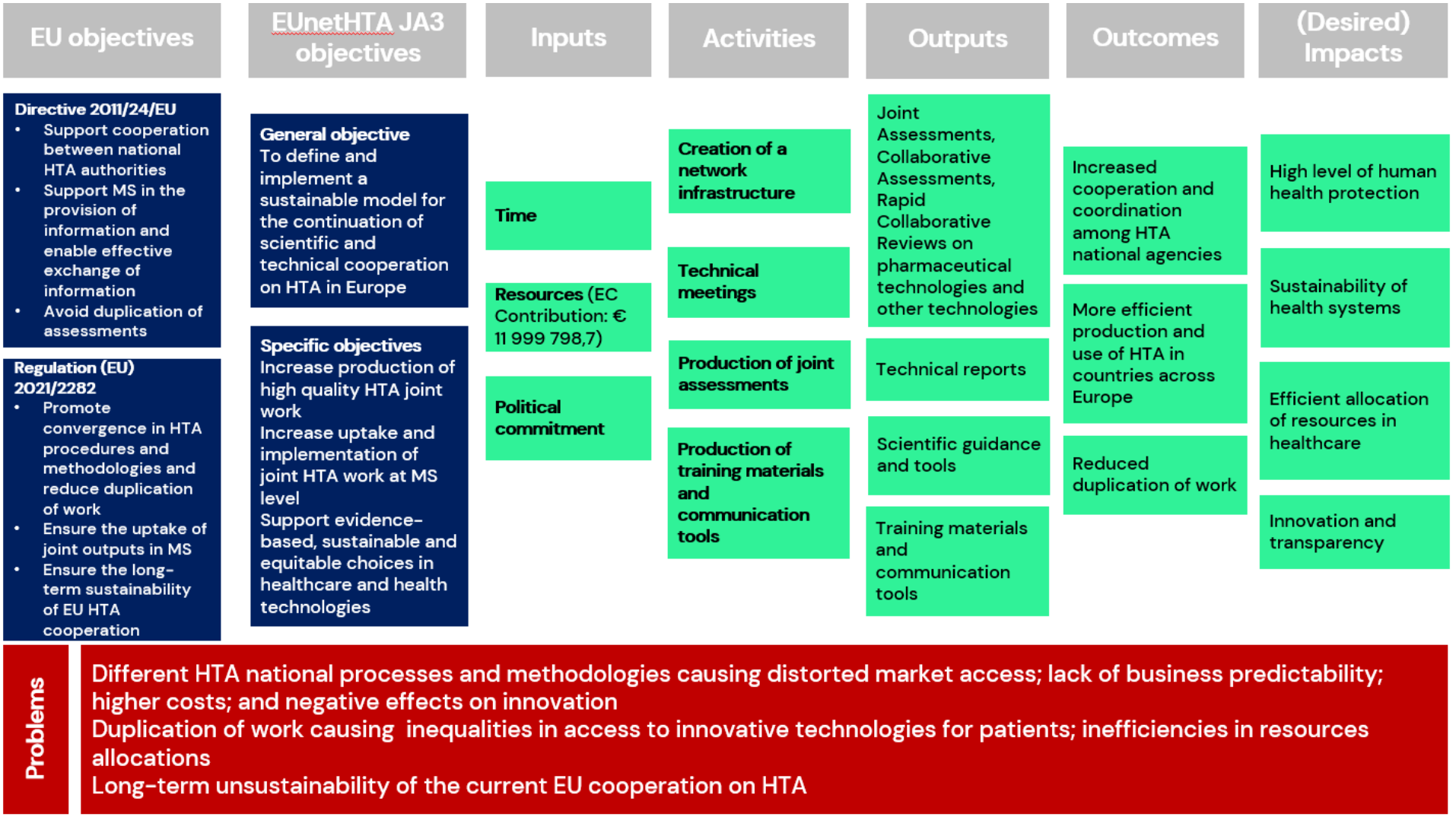
[293] Technical Annex1b of the EUnetHTA JA 2 Grant Agreement

[294] Regulation (EU) 2021/2282 of the European Parliament and of the Council of 15 December 2021 on health technology assessment and amending Directive 2011/24/EU.

[295] European Commission (2018), "Strengthening of the EU Cooperation on Health Technology Assessment (HTA)", Commission Staff Working Document, Brussels.

[296] See: https://www.eunethta.eu/ja3-archive/; https://ec.europa.eu/health/system/files/2021-02/ev_20201027_co07_en_0.pdf

Figure 54. Intervention logic outline



The pathway for impact of EU action in the field of HTA as outlined in Figure 54 includes a series of activities oriented to the creation of a sustainable cooperation and coordination mechanism benefitting the participating countries. The main activities include infrastructure development, meetings, production of joint assessments and other relevant materials and tools. These activities resulted in outputs in the form of Joint and Collaborative Assessments on pharmaceuticals and other technologies, technical reports, scientific guidance and training materials.

The outputs produced aimed to increase cooperation and coordination among HTA national bodies, reduce duplication of work and promote more efficient production and use of HTA across Europe.[297] The desired impact of such a pathway is the long-term sustainability of health systems, a more efficient allocation of resources in healthcare, a health technology ecosystem conducive to innovation and transparency and ultimately a high level of health protection.

4.3. Findings: pathway for impact

This section presents the findings of each step of the pathway for impact of EU action in the field of health technology assessment. It illustrates the problems that EU action seeks to address, and the objectives of the funded action examined in this case study. It then presents the inputs used to conduct the EUnetHTA Joint Action, the activities undertaken, and the outputs produced as part of this action. Lastly, this section discusses the observed outcomes, drawing from evidence collected from targeted desk research undertaken for this case study, coupled with evidence stemming from the consultation activities held as part of this study, and provides an assessment on the contribution that the funded action and its outputs had on expected outcomes and impacts in this area.

4.3.1. Drivers / problems

EU action on HTA seeks to address the major challenges mentioned in section 4.1.1:

- **Impeded and distorted market access**
- Different national processes and methodologies applied by national and regional HTA bodies contribute to impeded and distorted market access, which in turn leads to lack of business predictability, higher costs, and negative effects on innovation in the longer term.
- **Duplication of work for national HTA bodies**
- Health technologies are being assessed in parallel by HTA bodies in different Member States resulting in duplication of work and inefficient use of resources. This imposes a burden on national budgets and economic operators. Additionally, the duplication of work might result in different outcomes which negatively affect business predictability while also creating inequalities in access to innovative technologies for patients.
- **Unsustainability of HTA cooperation**
- EU-level cooperation on HTA is project-based and does not allow for long-term sustainability of the activities. This state of play is set to change when the permanent framework for joint work defined by the HTA Regulation is applied from 2025.

[297] The expected outcomes of EU action on HTA are reflected in the EU legislation on HTA (i.e., Directive 2011/24/EU and Regulations 2021/2282) as well as in the EUnetHTA Joint Action 3 objectives.

4.3.2. Objectives of the funded action

The overall objective of EUnetHTA Joint Action 3 was to define and validate the model for joint work on HTA to be continued after EU funding under 3HP ends.[298] Building on this overall objective, the Joint Action set as its specific objectives[299]:

- To increase production of high quality HTA joint work;
- To increase uptake and implementation of joint HTA work at the national, regional and local level; and
- To support evidence-based, sustainable and equitable choices in healthcare and health technologies.

4.3.3. Inputs

The inputs are the time and resources used to conduct the Joint Action. EUnetHTA was coordinated by the Dutch National Health Care Institute, while six partners from six countries led the Work Packages. Besides the project coordinator and the lead partners, the Joint Action benefitted from the participation of more than 80 partners from more than 30 countries across Europe. Partners were national, regional and non-profit agencies that produce or contribute to HTA. The EU contributed almost 12 million euros under 3HP, while the remaining resources were provided through Member State contributions. As noted in the 3HP mid-term evaluation the programme contribution to this action amounted to 22% of total spending in 2015, making it the single largest financed priority and action in any year.[300]

The Joint Action ran for 48 months, from June 2016 to May 2021 and its inputs are summarised in Table 14.

Table 14. Inputs related to the EUnetHTA Joint Action 3

Project Coordinator	Lead Partners	Timescale	Financing
Dutch National Health Care Institute (ZIN – NL))	Agencia de Evaluación de Tecnologías Sanitarias (AETS-ISCIII – ES) Dental and Pharmaceutical Benefits Agency (TLV – SE) The Norwegian Institute of Public Health (NIPHNO – NO) French National Authority for Health (HAS – FR) Institute for Quality and Efficiency in Health Care (IQWIG – DE) National Institute for Health and Care Excellence (NICE – UK)	01/06/2016 - 31/05/2021 (48 months; Finalised)	20 million euros total budget EC Contribution through 3HP: €11.999.798,74

Although generally stakeholders consulted as part of this study reported that the 3HP has sufficiently funded work on HTA, a theme within OPC consultations was that stakeholders felt more funding should be allocated in the next few years to support a

[298] Public Health Programme - Work Programme for 2015, Annex I; JA3 Archive (2016-2021) - EUnetHTA
[299] ev_20201027_co07_en_0.pdf (europa.eu)
[300] Mid-term Evaluation of the third Health Programme (2014 – 2020). Final Report.

smooth implementation of the HTA Regulation[301], especially for Member States with less experience in conducting HTAs.

4.3.4. Activities

The Joint Action was structured in three horizontal work packages (WP1-3), and four core work packages (WP4-7).

The three horizontal work packages managed the overall **coordination** of the Joint Action (WP1 – Network Coordination), its **dissemination** activities (WP2-Dissemination) and the **evaluation** of its implementation (WP3 – Evaluation). Activities included several meetings and conferences to set up the network infrastructure, the development of a communication model and tools to monitor uptake of EUnetHTA products at national, regional and local levels.

The four core work packages focused on the **joint production** of health technology assessments (WP4 - Joint Production), producing **robust evidence** for pharmaceutical and non-pharmaceutical health technologies (WP5 – Lifecycle Approach to improve Evidence Generation), **quality management** (WP6 – Quality Management, Scientific Guidance and Tools) and **national implementation** (WP7 – National Implementation and Impact). Activities included providing inputs for a sustainable model of collaboration on joint assessments, conducting dialogues, producing and disseminating scientific guidance and tools as well as providing technical support on implementation issues.

4.3.5. Outputs

The Chafea Health Programmes Database[302] lists 58 outputs of the EUnetHTA; however, not all of them are accessible for review. The Joint Action outputs are many and different in nature, ranging from the network infrastructure, the joint assessments, scientific guidance and tools.

The EUnetHTA produced 16 Joint Assessments and 4 Rapid Collaborative Reviews on pharmaceutical technologies, 2 Joint Assessments and 26 Collaborative Assessments on other technologies, all listed in the dedicated webpage.[303] It also produced a series of scientific reports and guidance tools to strengthen EU collaboration on HTA (some of them are available for download on the Chafea website).

Among the main project deliverables, it is worth noting some of the work packages final reports. In particular, WP2 final report includes strategies to support the development of a sustainable network in terms of communication; and WP3 final report which includes an analysis of how to bring the knowledge produced under EUnetHTA forward after 2020.

In addition, among other Joint Action deliverables, the Norwegian Institute of Public Health produced a report (not available for download) defining a system that facilitates the structural uptake of the joint assessments in national and regional settings.

[301] Regulation (EU) 2021/2282 of the European Parliament and of the Council of 15 December 2021 on health technology assessment and amending Directive 2011/24/EU. The 2022 EU4Health Work Programme includes an action that supports the implementation of the Regulation on health technology assessment – training of patient and clinical experts contributing to joint health technology assessment activities.
[302] Chafea Health Programmes Database
[303] https://www.eunethta.eu/rapid-reas/ [Accessed June 2022]

4.3.6. Outcomes and impacts / potential impacts

This section discusses the outcomes of EUnetHTA Joint Action 3 by relevant evaluation question.

The outcomes illustrated in the intervention logic are as follows:

- Increased cooperation and coordination among HTA national agencies;
- Reduced duplication of work; and
- More efficient production and use of HTA in countries across Europe.

The impacts illustrated in the intervention logic, namely the sustainability of health systems, a more efficient allocation of resources in healthcare, greater innovation and transparency, and a higher level of human health protection, are overall long-term desired impacts. Furthermore, the realisation of such impacts is dependent on a variety of factors and cannot be exclusively linked to the outcomes of one single action in the field of health policy and public policy at large. For these reasons, this case study focuses on the outcomes generated directly by the EUnetHTA Joint Action 3 and aims to characterise the pathway for change created by the action. The contribution of the outcomes to the (potential) impacts is considered to be an underlying assumption for the pathway for a change.

The mid-term evaluation of 3HP[304] identified Health Technology Assessments as a thematic area of strong EU added value, and the ESF and EGF impact assessment[305] similarly identified the development of common tools for integrated work (e.g., new HTA framework) and increase of capacity building actions (e.g. development of HTA capacity in Member States lacking it) as actions with highest added value. According to a European Parliament report[306], the EU network for HTA was considered a major achievement of the 3HP. Stakeholders consulted as part of this study also believed that work on HTA generated EU added value through facilitation of collaboration and knowledge exchange.

EQ4a: To what extent has the Joint Action funded under the programme, contributed to a more comprehensive and uniform approach to HTA in the EU?

The collaboration within EUnetHTA Joint Action 3 resulted in a large number of assessments on pharmaceutical and non-pharmaceutical technologies which have been used by national HTA agencies.

The final report of Work Package 7[307] describes the use in Joint Action 3 of joint assessments (JA) and collaborative assessments (CA) and compares this with use in Joint Action 2. Implementation data were available for 27 JA/CA published under Joint Action 3.[308] The report found 298 examples of reported use, of which 89 uses of the 7 pharmaceutical (PT) assessments and 209 uses of the 20 other technology (OT) assessments.

[304] Mid-term Evaluation of the third Health Programme (2014 – 2020). Final Report.
[305] European Commission., 2018. COMMISSION STAFF WORKING DOCUMENT: IMPACT ASSESSMENT: Accompanying the document: Proposal for a Regulation of the European Parliament and the Council on the European Social Fund Plus (ESF+); Proposal for a Regulation of the European Parliament and the Council on the European Globalisation Adjustment Fund (EGF). Available from: https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=SWD:2018:0289:FIN:EN:PDF [Accessed November 2021]
[306] The benefit of EU action in health policy: The record to date (2019) Niombo Lomba, European Added Value Unit, European Parliamentary Research Service.
[307] https://www.eunethta.eu/wp-content/uploads/2020/07/Final-Deliverable-7.2-report-after-consultation_FINAL.pdf?x69613
[308] The EUnetHTA dedicated webpage lists a total of 16 Joint Assessments and 4 Rapid Collaborative Reviews on pharmaceutical technologies, 2 Joint Assessments and 26 Collaborative Assessments on other technologies.

Pharmaceutical assessment use of JA/CA is usually part of a reimbursement and pricing process. For other technology assessments, a much more varied range of uses was reported, including in national HTA assessment procedures, and for monitoring the need to review an existing assessment. Furthermore, 19 countries reported using a Joint Action 3 JA/CA for pharmaceutical assessment activities. For other technology assessments, 20 countries reported using a Joint Action 3 JA/CA, mostly for assessment activities and to a lesser extent for dissemination purposes.

In terms of evolution between Joint Action 2 and Joint Action 3, the production and use of pharmaceutical assessments (both JA and CA) increased under Joint Action 3, whereas for other technologies there has been increased production of JA/CA. However, there is less use of JA/CA for other technologies under Joint Action 3 compared to Joint Action 2 in terms of total number of examples of use across countries. This lower number of examples of use of JA/CA for other technologies can partly be explained by limited national capacity and increased output under Joint Action 3, and by the fact that HTA processes for other technologies are not fully established in some countries. When looking at the number of countries that have used JA/CA, there is an increased number of countries that have used JA/CA under Joint Action 3 compared to Joint Action 2 for both pharmaceutical and other technologies.

Moreover, the European Parliament's review of European added value in health policy action (2019) listed the EUnetHTA as one of the 3HP's major achievements due to its 'contribution to the development of a common set of tools and standards, which strengthens European cooperation on creating, facilitating and promoting sustainable HTAs'.[309]

This points to a contribution of the outputs of EUnetHTA Joint Action 3 to the outcomes of increased cooperation and coordination among HTA national agencies and a more efficient production and (to a more limited extent) use of HTA in countries across Europe. The use of JA and CA at the national level, paired with the existing collaborative infrastructure and the produced practical tools and methodologies are elements conducive to a more comprehensive and uniform approach to HTA in the EU.

The findings described above are corroborated by this study's consultation activities. Increased cooperation on HTA at national level through the 3HP was reported by interviewed stakeholders. Actions around HTA were perceived to lead to the creation of national strategies, plans, and legislation. Three interviewed national policymakers reported that HTA was particularly successful in supporting national policy, and one national policymaker and a stakeholder from an organisation representing patients and service users felt that 3HP work on HTA also contributed to the new Regulation on HTA. Furthermore, a stakeholder interviewed from governmental public health institutions reported that the 3HP had effectively covered HTA, with a high number of participating countries.

Consulted stakeholders also noted that EU work on HTA contributed to a more comprehensive approach at EU level. A stakeholder from a governmental public health organisation and a government policymaker reported that within EUnetHTA, cooperation was good across institutions in all countries, and one government policymaker reported that networks were established at EU level. The European Parliament review of European added value in health policy action (2019) also

[309] European Parliament. (2019). 'The benefit of EU action in health policy: The record to date'. Available at https://www.europarl.europa.eu/RegData/etudes/STUD/2019/631729/EPRS_STU(2019)631729_EN.pdf, [accessed 07/09/2022].

reported that EUnetHTA led to cooperation across the EU in regard to evaluation and provision of expertise.[310]

Building on this. this study's survey responses show a more mixed picture. Most survey respondents (17 out of 32, 54%) believed that the Programme contributed to a more comprehensive and uniform approach on HTA (6 out of 32, 19% of respondents said this was the case to a large extent, and 11 out of 32, 35% of respondents said this was the case to a moderate extent); however, 19% (6 out of 32 respondents) felt that the Programme contributed to a more comprehensive and uniform approach to a small extent.[311]

Shortcomings and challenges are still present which prevent a comprehensive and uniform approach to HTA. Those shortcomings can be attributed to practical barriers and differences in national processes and methodologies which, among other things, contribute to persisting duplication of work.[312] However, these challenges are addressed by the HTA Regulation and its permanent framework for joint work.

EQ4b: To what extent has the Joint Action funded under the programme contributed to the creation of a well-functioning HTA system in Europe?

Building on the achievements of previous actions and projects in the field, the EUnetHTA Joint Action 3 has created a collaborative infrastructure used by national and local HTA authorities, produced practical tools and developed methods that form a solid foundation for close collaboration among over 80 agencies across Europe.[313]

Moreover, 57% of survey respondents (18 out of 32 respondents) reported that the 3HP contributed (at least to a moderate extent) to the creation of a well-functioning HTA system in Europe.[314] This largely positive response was echoed by stakeholders interviewed, who mentioned that HTAs were important for bolstering resilience of Member State healthcare systems.

The process of creating a well-functioning HTA system in Europe is on-going, not least considering the recent adoption of the HTA Regulation. Therefore, research undertaken for this case study does not provide enough information to assess the level of contribution of the Joint Action to the creation of a well-functioning HTA system.

EQ9a: To what extent are the results of the Joint Action in the field of HTA funded under the programme likely to be sustainable?

EU action on HTA has been further strengthened, in particular in 2021, with the adoption of the HTA Regulation which entered into force in January 2022 and will apply as of January 2025. The Regulation replaces the current system based on the voluntary network of national authorities and the project-based cooperation (Joint Actions EUnetHTA) with a permanent framework for joint work. The work developed

[310] European Parliament (2019) 'The benefit of EU action in health policy: The record to date' available from https://www.europarl.europa.eu/RegData/etudes/STUD/2019/631729/EPRS_STU(2019)631729_EN.pdf [accessed 13 September 2022)

[311] Survey question: To what extent has the Programme contributed to improvements in the area of Health Technology Assessment? (Respondents=32). Replies: 19% "to a large extent", 35% "to a moderate extent", 19% "to a small extent", 26% "I don't know".

[312] European Commission (2018), "Strengthening of the EU Cooperation on Health Technology Assessment (HTA)", Commission Staff Working Document, Brussels

[313] Judit Erdös et al. (2019), "European Collaboration in Health Technology Assessment (HTA): goals, methods and outcomes with specific focus on medical devices", Wien Med Wochenschr.

[314] Survey question: To what extent has the Programme contributed to improvements in the following areas? (Respondents=32). Replies: 13% "to a large extent", 44% "to a moderate extent", 16% "to a small extent", 28% "I don't know".

under EUnetHTA has strengthened the collaboration of national HTA agencies, promoting coordination and increasing production of HTA joint work. The activities of EUnetHTA have laid a strong foundation for sustainable cooperation which will be reflected in the permanent framework for joint work established by the HTA Regulation.[315]

Supporting this, EUnetHTA was identified as particularly sustainable by consulted stakeholders, due to its clear support for policy and legislative development. There were three Joint Actions on HTA which formed the basis of new EU legislation and contributed to the development of a regulation, and these Joint Actions supported its adoption with EU co-legislators, which was seen to ensure sustainability. According to this study's survey respondents, HTA was the policy field which achieved most sustainability of all surveyed fields, with 19 respondents out of 32 (59%) agreeing that results and effects produced through work on HTA in the 3HP were sustainable.[316]

Only 3% of surveyed stakeholders (1 out of 32 respondents) felt results from work on HTA were not sustainable, and one interviewed governmental stakeholder stated that work on HTA was less sustainable due to lack of cooperation after the end of the Joint Actions.

4.4. Conclusion

Overall, the EU has acted in the area of health technology assessment for many years to address the challenges that prevent Member States, economic operators, patients and healthcare professionals from realising the benefits of HTA. This case study analysed the European Network for Health Technology Assessment - Joint Action 3 (EUnetHTA JA3) which builds on the lessons of earlier EUnetHTA Joint Actions. The funded action conducted activities and produced a wealth of outputs for the benefit of policy makers and national HTA competent authorities.

Overall, those outputs have contributed to increased cooperation and coordination among HTA national agencies and have facilitated a more efficient production and (to a more limited extent) use of HTA in countries across Europe. Despite the progress achieved so far, shortcomings and challenges are still present which prevent a fully comprehensive and uniform approach to HTA at present. Those shortcomings can be attributed to still existing practical barriers and differences in national processes and methodologies. However, those challenges are addressed by the HTA Regulation and its permanent framework for joint work, whose adoption has largely benefited from the work done in the context of the different HTA Joint Actions.

Moreover, building on the achievements of previous actions and projects in this field, the EUnetHTA Joint Action 3 created a collaborative infrastructure used by national and local HTA authorities, including by producing practical tools and developing methods that form a solid foundation for close collaboration among over 80 agencies across Europe. Most consulted stakeholders also agreed that the 3HP (therefore, the EUnetHTA Joint Action 3) contributed to the creation of a well-functioning HTA system in Europe. However, it should be noted that the process of creating a well-functioning HTA system in Europe is still on-going, not least considering the recent adoption of the HTA Regulation. Therefore, research undertaken for this case study does not allow to

[315] Judit Erdös et al. (2019), "European Collaboration in Health Technology Assessment (HTA): goals, methods and outcomes with specific focus on medical devices", Wien Med Wochenschr.
[316] Survey question: How sustainable do you think the Programme results and effects are in the specific field of Health Technology Assessment? (Respondents=32). Replies: 25% "very sustainable", 34% "somewhat sustainable", 3% "not sustainable", 38% "I don't know".

fully assess the level of contribution of the Joint Action to the creation of a well-functioning HTA system.

As for the desired longer-term impacts (i.e., the sustainability of health systems, a more efficient allocation of resources in healthcare, greater innovation and transparency, and a higher level of human health protection), it is not possible to assess the 3HP contribution to their realisation as this is dependent on a variety of factors and not necessarily linked to the outcomes of one single action in the field of health policy. However, the increased cooperation and coordination among HTA national agencies, the collaborative infrastructure created by the EUnetHTA, and not least the production and use of HTAs, are potentially conducive to innovation and transparency, higher efficiency in the allocation of resources in healthcare and therefore increased sustainability of health systems. While those are longer-term impacts whose realisation is dependent on a variety of factors, it can be reasonably assumed that the outcomes achieved by the EU action on HTA, not least considering the adoption of the HTA Regulation, are likely to contribute to strengthened health systems sustainability, a more efficient resources allocation, innovation and transparency and subsequently a higher level of human health protection.

5. Case study: Anti-Microbial Resistance (AMR) Joint Action on AMR – EU-JAMRAI

This case study presents work done under the third health programme related to antimicrobial resistance. This topic is explored through an in-depth examination of the effectiveness of the European Joint Action on antimicrobial resistance and associated infections (EU-JAMRAI).

5.1. Introduction

5.1.1. Background

Antimicrobial resistance (AMR) occurs when microbes evolve to resist treatment. AMR constitutes a serious threat to public health and a major social and economic burden. Data collected in 2015 suggests that AMR is responsible for over 33,000 deaths per year in the European Union and these figures have increased over the last decade. Moreover, the estimated burden of antibiotic resistant infections in Europe is comparable to the combined burden of influenza, tuberculosis, and HIV.[317] In addition to the direct human suffering caused by resistant infections, AMR also hinders the performance of health systems more generally, and costs the EU an estimated €1.5 billion per year in healthcare costs and productivity losses.[318] Since antimicrobials are also used worldwide in agricultural practices and animal husbandry, AMR also reduces the ability to protect animal health and welfare, posing a threat to the food supply chain and the natural environment.[319]

Since the beginning of the 21st century the European Union has undertaken several initiatives to tackle the challenges posed by AMR, with the ultimate objective of preserving the effectiveness of treatment against infections both in humans and animals.

In 2001, a Community Strategy against AMR[320] was developed. It focused on key areas of action such as surveillance, prevention and infection control, including the prudent use of antimicrobial agents, research on new drugs and alternative treatments, and international cooperation. Actions have also been undertaken in the field of animal husbandry, such as the introduction of a ban on the use of antimicrobials for growth promotion in 2006.[321]

The 2001 Community Strategy was followed by the 2011-2016 AMR Action Plan, which aimed to reinforce existing measures and introduce new ones based on a holistic approach encompassing the different sectors relevant to AMR (e.g. human and veterinary medicine, agriculture and animal husbandry, environment and trade).[322] Building on the previous Action Plan (2011-2016) and considering the 2016 Council Conclusions on the next steps under a One Health[323] approach to combat antimicrobial resistance[324], the European Commission published in 2017 'A European One Health Action Plan against Antimicrobial Resistance'. This Communication identified as a key objective the need to make the EU a best practice region in the fight against AMR, to boost research and innovation, and to play a leading role globally on AMR. As part of its objective to achieve better coordination and implementation of EU rules to tackle AMR, the Action Plan

[317] Alessandro Cassini et al. (2018), "Attributable deaths and disability-adjusted life-years caused by infections with antibiotic-resistant bacteria in the EU and the European Economic Area in 2015: a population-level modelling analysis", The Lancet.
[318] ECDC (2009), The bacterial challenge: time to react.
[319] FAO. 2021. The FAO Action Plan on Antimicrobial Resistance 2021–2025. Rome. https://doi.org/10.4060/cb5545en
[320] https://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:52001DC0333&from=NL
[321] European Commission (2011), "Communication on Action plan against the rising threats from Antimicrobial Resistance"
[322] European Commission (2011), "Communication on Action plan against the rising threats from Antimicrobial Resistance"
[323] See definition of One Health: https://wedocs.unep.org/bitstream/handle/20.500.11822/37600/JTFOWU.pdf
[324] Council of the European Union (2016), "Council conclusions on the next steps under a One Health approach to combat antimicrobial resistance"

prioritised the launch of a joint action to support collaborative activities and policy development by Member States to tackle AMR and healthcare-associated infections.

To respond to other initiatives proposed in the Action Plan, EU action has been strengthened through different policy instruments. In particular, the Pharmaceutical Strategy for Europe put forward actions to address the lack of investment in antimicrobials and inappropriate use of antibiotics. The Farm to Fork Strategy set the objective of reducing the overall EU sales of antimicrobials for farmed animals and in aquaculture by 50% by 2030.

5.1.2. Rationale for selection and case study focus

The 3HP addresses AMR under specific objective 4 to "facilitate access to better and safer healthcare for Union citizens". Actions taken under the programme aim to improve the prudent use of antimicrobials; promote effective prevention; reduce the burden of resistant and healthcare-associated infections; and secure the availability of effective antimicrobials.

Actions taken under the 3HP within this theme

The 3HP supported between September 2017 to February 2021 Member State collaboration through the Joint Action on Antimicrobial Resistance and Healthcare-Associated Infections (JAMRAI). The Joint Action was launched with the intention to foster synergies among Member States, propose concrete steps to strengthen the implementation of One Health policies to tackle the rising threat of AMR and reduce Healthcare-Associated Infections (HCAIs).

Although JAMRAI represents the main action on AMR under the 3HP, operating grants under the European Public Health Alliance have addressed AMR and AMR-related issues. Two ministerial conferences focused on the issue were also organised under the Dutch and Romanian EU presidencies.

Case study subtheme: **Anti-Microbial Resistance (AMR) Joint Action on AMR – EU-JAMRAI**

The case study focuses on the Joint Action on AMR carried out under the 3HP. AMR is a complex and major public health challenge, driven by inappropriate use of antibiotics in humans and animals and insufficient infection control measures in healthcare settings, alongside the globalisation of markets and movements of people. AMR is a cross-cutting and cross-border challenge where collaboration and coordinated action is essential to tackle it. Against this background, JAMRAI aimed to bring together different networks of policymakers, experts, and stakeholders from across Europe and support EU Member States to design and implement public policies based on the 'One Health' approach encompassing human health, animal and plant health and the environment. It is therefore important to investigate the effectiveness of the Joint Action and the contribution it made to promote collaboration among Member States and strengthen national and EU responses against the AMR challenge in a holistic and comprehensive manner.

5.2. Intervention logic underpinning the case study

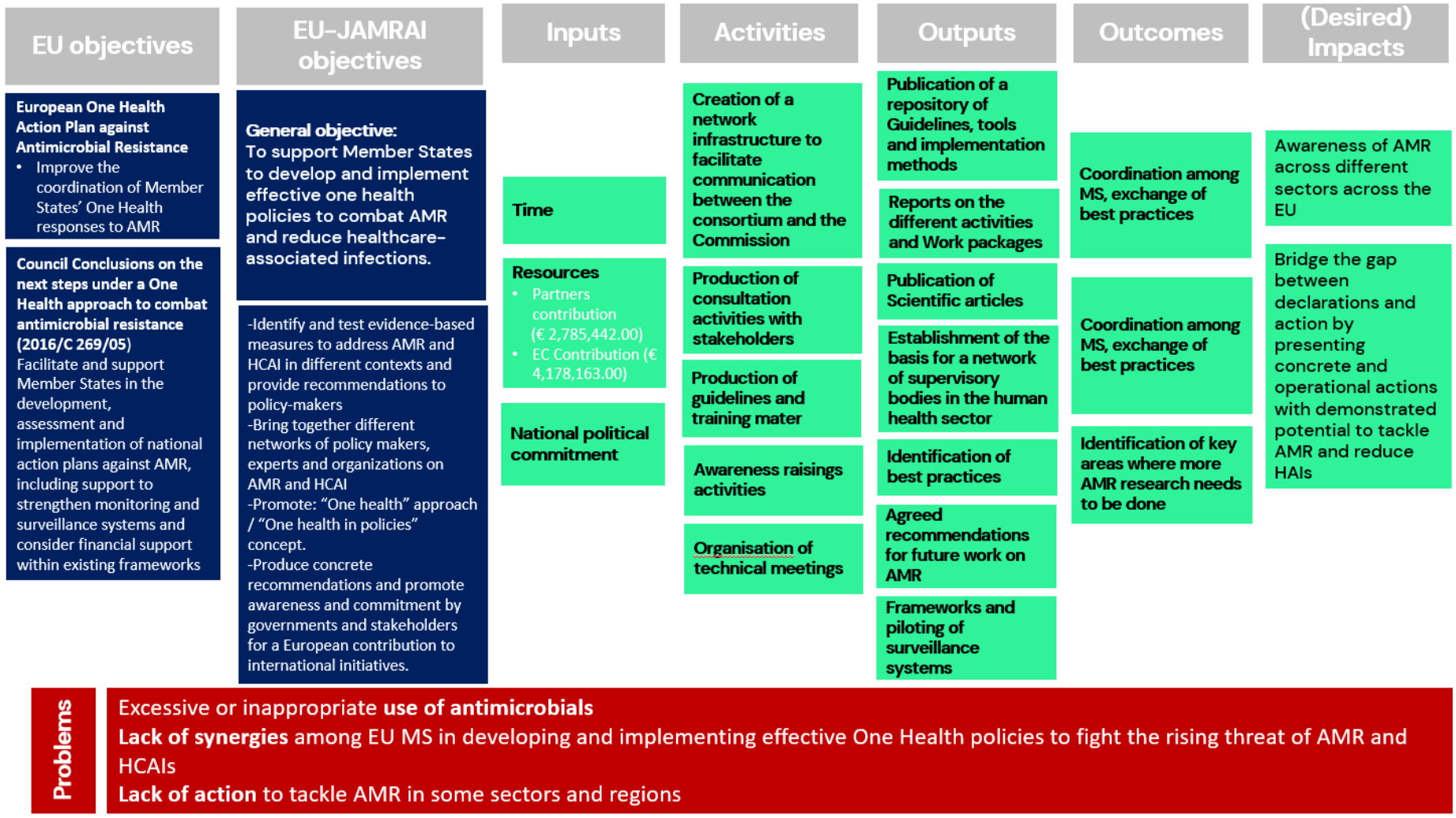
The intervention logic developed for this case study illustrates the underlying problems that overall EU action on AMR seeks to address and the related EU operational objectives that the Joint Action aims to achieve. Hence, the intervention logic focuses on EU-JAMRAI to understand how the 3HP contributed to the wider context of EU action in this area. The intervention logic includes elements directly linked to EU-JAMRAI (objectives, inputs,

activities, outputs and outcomes).[325] Finally, the intervention logic illustrates problems and (desired) impacts of EU-JAMRAI which are linked to increasing coordination and synergies to fight the rising threats of AMR and HCAIs.

The pathway for impact of EU action in the field of AMR as outlined in Figure 55 includes a series of activities carried out to foster a collaborative approach to policy developments and activities by Member States, in view of tackling the challenge of AMR and healthcare associated infections. These activities resulted in outputs in the form of country-to-country visits, voluntary self-assessments, technical meetings, communication activities and guidance, among others. These outputs would translate into increased cooperation and coordination among national officials working on AMR issues, agreed recommendations where more work is needed and in new or updated One Health National Action Plans. The desired impacts of the Action Plan are the increased awareness of AMR and its related challenges across different sectors and stakeholders in Europe and to bridge the gap between declarations and actions towards combating AMR and reducing HCAIs[326].

[325] See: https://eu-jamrai.eu/vision-mision/
[326] EU-JAMRAI (2021) EU-JAMRAI, Layman Report. Available from: EUjamrai_D2.2_LaymanReport_WP2_AEMPS_09.2021.pdf (eu-jamrai.eu)

Figure 55. Intervention logic outline



5.3. Findings: pathway for impact

This section presents the findings of each step of the pathway for impact of EU action on AMR through the EU-JAMRAI. It illustrates the problems that EU action seeks to address, and the objectives of the funded actions examined in this case study. It then presents the inputs used to conduct the actions, the activities undertaken, and the outputs produced as part of those actions. Lastly, this section discusses the observed outcomes, drawing from evidence collected from targeted desk research undertaken for this case study, coupled with evidence stemming from the consultation activities held as part of this study, and provides an assessment on the contribution that the funded actions and their outputs had on expected outcomes and impacts in this area.

5.3.1. Drivers / problems

AMR is a serious threat to public health and has a major social and economic burden. Death related to AMR are increasing every year. AMR is a cross-border and cross-cutting challenge where collaboration and coordination actions is needed. EU action on AMR relies on a multisectoral approach which aims to address:

- **Excessive or inappropriate use of antimicrobials**
- **Lack of synergies among EU Member States in the development and implementation of One Health policies**. AMR is a complex problem that requires a multisectoral approach. Multiple sectors and stakeholders covering human, animal and plant health, food production and the environment should be brought together to work in the design and implementation of policies, programmes, research.
- **Lack of action to tackle AMR** in some sectors and regions, leading to divergent levels and approaches to tackle AMR across the EU and around the world.

5.3.2. Objectives of the funded action

The overarching objective of EU-JAMRAI was to support EU Member States to develop and implement effective one health policies to combat AMR and reduce Healthcare-associated infections through the appropriate involvement of each stakeholder group in planned actions. Moreover, the Joint Action aimed at strengthening existing public health policies both at national and EU level, and contributing to achieve the objectives of:

- The WHO Global action plan on AMR published in 2016[327],
- The Council conclusions[328] on AMR as requested by the EU Member States, and
- EU One Health Action Plan against AMR adopted in 2017.[329]

Four general objectives were put forward in this Joint Action:

1) Identify and test evidence-based measures to address AMR and HCAIs in different contexts and provide recommendations to policy makers.

2) Bring together different networks of policy makers, experts and organisations on AMR and HCAIs.

[327] World Health Organisation (2016) Global action plan on antimicrobial resistance. Available at: https://www.who.int/publications/i/item/9789241509763

[328] Council of the EU (2016) Council conclusions on the next steps under a One Health approach to combat antimicrobial resistance. Available at: https://www.consilium.europa.eu/en/press/press-releases/2016/06/17/epsco-conclusions-antimicrobial-resistance/

[329] European Commission (2017) EU One Health Action Plan against AMR. Available at: https://health.ec.europa.eu/document/download/353f40d1-f114-4c41-9755-c7e3f1da5378_en?filename=amr_2017_action-plan.pdf

3) To promote the "One Health" approach and "One health in all policies"/ "Health in all policies" concept.

4) Produce concrete recommendations and promote awareness and commitment by governments and stakeholders for European contribution to international initiatives.

5.3.3. Inputs

The inputs are the time, resources and political commitment used to conduct the Joint Action. EU-JAMRAI was coordinated by the French National Institute of Health and Medical Research (INSERM) with six Work Package leaders: Spanish Agency of Medicines and Medical Devices (AEMPS), Instituto Superiore di Sanita (ISS), French Ministry of Solidarity and Health (MoH-FR), Dutch Ministry of Health, Welfare and Sport (VWS), Public Health Agency of Sweden (FOHM), Norwegian Institute of Public Health (FHI), and the National Public Health Organisation (NPHO).

In addition to the project coordinator and the work package leaders, the Joint Action benefited from the involvement of 44 partners and over 45 stakeholders across 26 Member States. Partners included ministries of health, national and regional public health, food and environmental agencies, hospitals, medicines agencies, civil society organisations, health professionals, patient associations, representatives from the animal health and environmental sectors, and companies.

The Joint Action had a budget of € 6,963,604, and the EU contributed 4,178,162.75 euros under the 3HP, while the remaining resources were provided through Member State contributions.

The Joint Action was launched in September 2017 and was completed in February 2021, lasting 42 months, although it was originally foreseen to last 36 months.

5.3.4. Activities

The Joint Action was structured in three horizontal work packages (WP 1-3), and six core work packages (WP 4-9).

The three horizontal work packages managed the overall **coordination** of the Joint Action, its **dissemination** activities and the evaluation of the Joint Action implementation. Activities were coordinated by the INSERM, AEMPS and ISS respectively.

Through the nine work packages, different activities were conducted to facilitate the implementation of national strategies for HCAI prevention at national and local levels, develop tools and guidelines for antimicrobial stewardship and surveillance of resistance in human and animals, identify challenges to national action plans and encourage discussion and uptake of action for improvement, while ensuring a One Health approach in all Member States. Additionally, the Joint Action activities focused on ensuring consistency between research programmes and identifying knowledge gaps. Different activities also focused on awareness raising on AMR and HCAIs, as well as disseminating the Joint Action results.

5.3.5. Outputs

The activities undertaken by EU-JAMRAI produced a range of outputs. The CHAFEA Health Programme Database[330] listed 35 outputs of EU-JAMRAI, however not all of

[330] See: https://webgate.ec.europa.eu/chafea_pdb/health/projects/761296/outputs

these outputs are accessible. Key outputs of these work packages and final reports are described below.

Coordinated by EU-JAMRAI, 13 participating countries completed several activities aiming at strengthening national responses against AMR. This included self-assessments, and external voluntary evaluation / country-to-country visits, these visits provided an opportunity to evaluate the National Action Plans (NAP) and the One Health strategy in the participating countries, and identify areas that need improvement a national level.[331] The results of the country visits were published in a report summarising these visits, which was followed by a report overviewing enforcement and recommendations. These processes were overseen by a network of supervisory bodies in the human health sector, established by EU-JAMRAI. As a result, EU-JAMRAI also established the basis for a network of supervisory bodies in the human health sector.

Regarding the prevention of HCAI, EU-JAMRAI through WP6 piloted the implementation of guidelines and frameworks to make infection prevention control (IPC) more effective through both a top-down (policies to prevent HCAI through the implementation of agreed infection control programmes and institutional behavioural change) and a bottom-up approach (improve health-care systems' infection control capacity from clinical practice to policy level). EU-JAMRAI implemented guidelines for prevention of Catheter Associated Urinary Tract Infections (CAUTI) and piloted these guidelines in 45 hospital wards in 11 countries (8 MS, 3 Non-EU).

The work carried out in WP7 proposed a repository of guidelines, tools for antibiotic stewardship to be used as a source of evidence for the implementation and revision of national stewardship guidelines for human health. Besides, under this WP a near-real time surveillance system for Antimicrobial Stewardship (AMS) and Antimicrobial Consumption was piloted in human health in 17 institutions from 11 countries. Additionally, the basis for a European Antimicrobial Resistance Surveillance network in Veterinary medicine (EARS-VET) was set up.

EU-JAMRAI produced a toolkit for awareness raising and behaviour change communication on AMR under WP8. Through the work of this work package, different awareness raising campaigns were developed (e.g., to promote appropriate antibiotic use (#DontLeaveItHalfway which was translated into 18 languages), a video game "Micro-Combat", and the creation of the first Global Antibiotic Symbol).

In WP9, EU-JAMRAI, in collaboration with seven volunteer countries, performed a mapping of the European research priorities and gaps on AMR.[332] The results of this work was the identification of key research priorities in the EU.

5.3.6. Outcomes and impacts / potential impacts

The outcomes of the EU-JAMRAI illustrated in the intervention logic (Figure 55) are the following:

- Coordination and exchange on best practices among Member States,
- New or updated One Health National Strategies, and
- Identification of key areas where more AMR research needs to be conducted.

The intervention logic illustrates the potential impacts that could be achieved as a result of the outcomes of the Joint Action. These are: increased awareness of AMR

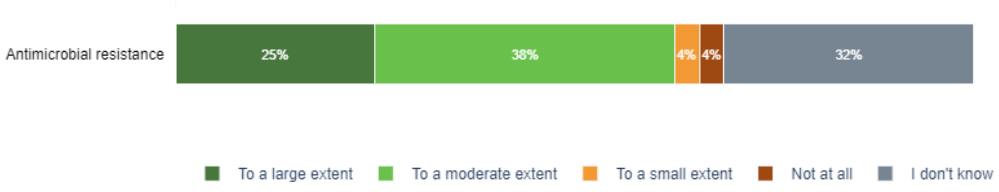
[331] EU-JAMRAI 2nd periodic and final Report (D1.2) not publicly available.
[332] EU-JAMRAI (2021) EU-JAMRAI Layman Report. Available at: https://eu-jamrai.eu/wp-content/uploads/2021/03/EUjamrai_D2.2_LaymanReport_WP2_AEMPS_03.2021.pdf

across the EU, and bridging the gap between declarations of intention and actions carried out by presenting concrete operational actions with demonstrated potential to tackle AMR and reduce HCAIs. These impacts depend on different factors and different activities taken at EU and national level. Therefore, these impacts are not solely attributable to one Joint Action. For these reasons, this case study focuses on the outcomes produced by the EU-JAMRAI and aims to characterise the pathway for change created by the action. How the outcomes of the Joint Action have contributed to these impacts is considered to be an underlying assumption for the pathway for a change.

EQ4a: To what extent has the joint action funded under the programme, contributed to a more comprehensive and uniform approach to tackling AMR in the EU?

The EU-JAMRAI was composed of 9 Work Packages, each run by a Member State, embodying the sentiment of cross-collaborative action central to the overall objective of the EU-JAMRAI. Moreover, the mission of EU-JAMRAI was to foster synergies among Member States and to propose concrete steps to strengthen the implementation of policies. Hence, the outcomes of the Joint Action relate to the increased collaboration and sharing of experiences and best practices among Member States. Moreover, this study's survey results show that public authorities considered that the 3HP contributed to the EU's influence at international level in relation to AMR standards, policies and practices. Similarly, surveyed stakeholders believed that the 3HP contributed to a more comprehensive and uniform approach to addressing health issues, such as antimicrobial resistance (20 of 32 respondents said this was true to at least a moderate extent, 63%) (see Figure 56).

Figure 56. To what extent has the Programme contributed to a more comprehensive and uniform approach to addressing health issues across the following policy areas? (n=32)



Three national policy makers interviewed as part of this study found EU-JAMRAI very useful and highlighted that the joint action supported more coordination and exchange across the EU.

Actions carried out in EU-JAMRAI had the potential to achieve a more comprehensive and uniform approach to tackle AMR in the EU. For example, through EU-JAMRAI, expert teams of 13 EU Member States visited peers in other EU countries to evaluate their AMR strategies. Country-to-country visits were undertake to support Member States (and other participating countries) in the implementation of some of the provisions under the council recommendations adopted in 2016 by the Council of the EU. The country-to-country visits aimed to facilitate exchange of best practices and discussion among policy makers with the aim to drive One Health AMR activities within the EU, and develop new National Action Plans on AMR and HCAIs or improve existing ones.

Several interviewed national policymakers reported that actions funded under the 3HP on AMR, such as EU-JAMRAI, influenced national strategies, helped establish national plans and create national legislation. Furthermore, an international organisations' stakeholder mentioned that the knowledge produced had benefitted EU countries designing national action plans on AMR. Similarly, a governmental public health stakeholder identified that the work on AMR within the 3HP influenced decision making at national and EU level. Some examples of these are the outcomes of country visits in the context of this Joint Action:

- The discussion between Greece and the visiting country (Romania) accelerated conversations on the finalisation of the One Health Greek National Plan on AMR. The National Plan was signed in 2019.
- Similarly, a Greek delegation visited Germany. This visit partially formed the base for their 5-year National Plan on AMR.

> These country-to-country visits were an effective collaborative working method that enabled identification of highly relevant common topics to discuss at EU level and to exchange policy views and experiences and discuss policy options with other countries that may have experienced the same challenge.[333] Some of these topics were common to most Member States, such as governance and coordination, or supervision and enforcement. The identification of these areas can be used for the prioritisation of future policies and activities at EU level on AMR and HCAI.[334]

Several meetings and consultation activities conducted by EU-JAMRAI highlighted the need for a network of supervisory bodies where Member States could exchange experiences and best practices regarding the implementation of their National Programmes, and to reinforce the AMR One Health Network. One of the results of EU-JAMRAI was establishing the basis for a network of supervisory bodies in the human health sector. This network is formed by competent national authorities, professional associations and other MS institutions responsible for undertaking activities to address AMR in the human health sector. As highlighted in a policy brief[335] produced by the Joint Action, this type of network has the potential to be used to facilitate collaboration and the exchange of views and best practices and to gather information about challenges, implementation of activities and compliance with legislation or guidelines at national level.

Additionally, the European Union coordinates AMR surveillance in the medical, animal and food sectors. However, it does not cover the surveillance of sick animals. Through EU-JAMRAI, a multidisciplinary group of experts together and in consultation with relevant stakeholders developed the EARS-Vet surveillance framework to complement and integrate with existing ECDC and EFSA monitoring, towards a truly One-Health strategy for surveillance of AMR.[336]

The findings of this case study point to the contribution of EU-JAMRAI outputs to the outcomes of enhanced cooperation and coordination efforts amongst Member States involved in public policy on AMR. Findings also show that EU-JAMRAI enabled the

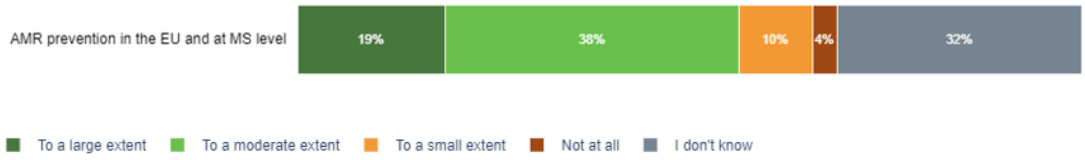
[333] Joint Action Antimicrobial Resistance and Healthcare-Associated Infections (2021) EU-JAMRAI, Layman Report. Available from: https://eu-jamrai.eu/wp-content/uploads/2021/03/EUjamrai_D2.2_LaymanReport_WP2_AEMPS_03.2021.pdf
[334] EU-JAMRAI 2nd periodic and final Report (D1.2) not publicly available.
[335] https://epha.org/wp-content/uploads/2021/01/eu-jamrai-pb-wp4-the-need-for-a-reinforced-amr-one-health-network.pdf
[336] EUjamrai_D2.2_LaymanReport_WP2_AEMPS_09.2021.pdf (eu-jamrai.eu)

sharing of existing good practices and development of cross-collaboration on a number of pertinent topics.

EQ4b: To what extent has the joint action funded under the programme contributed to efforts on AMR prevention in the EU and at Member State level?

Overall, 57% of this study's survey respondents (18 out of 32) said that the 3HP contributed to improvements in AMR prevention in the EU and at Member State level.

Figure 57. To what extent has the Programme contributed to improvements in the following areas? (n=32)



EU-JAMRAI developed guidelines and a framework to make Infection Prevention and Control (IPC) more effective following both a top-down and bottom-up approach[337]:

- EU-JAMRAI through a top-down approach developed a Universal Infection Control Framework (UICF) and six training tools through gap assessment and identification of priorities for each participating country's healthcare settings. To achieve this, EU-JAMRAI identified gaps in European IPC Programmes. The Framework was piloted in 17 healthcare settings in 4 different EU countries (AT, EL, ES, PT). After evaluating its implementation in these healthcare settings, the UICF was updated, published and shared with all EU Member States.[338] More than half of the responders (69%) used UICF despite the management of Covid-19 making this challenging. Regarding the response of hospital's administration related to the participation in the UIC pilot implementation, the satisfaction score of the health participants was only 3.7/5.0.[339] Almost all of the participants (92%) believe that UICF could have an impact in changing the behavioural culture of the healthcare setting[340], giving an score of UICF of 3.9/5.0.[341] EU-JAMRAI state that this tool can have an impact in changing Member States' behaviour culture regarding prevention and control of HCAIs.[342]
- Through a bottom-up approach a Breakthrough Series Model Improvement (BTS)[343] was used to implement guidelines for prevention of Catheter Associated Urinary Track Infections (CAUTI) in hospital wards. EU-JAMRAI developed guidance based on evidence-based guidelines and it was piloted in 27 wards in eight EU MS and three non-EU countries. This guidance was adapted to each country. Some of the piloted wards showed a decreased use of urinary catheters, increased compliance to standard procedures, procurement of closed collection systems and development of national guidelines on CAUTI prevention. Some of the results of this bottom-up approach went beyond the objective of this activity, as some participating countries developed a national plan to reduce HCAIs and IPC strategies. Additionally, guidelines for CAUTI

[337] EU-JAMRAI 2nd periodic and final Report (D1.2) not publicly available.
[338] EUjamrai_D2.2_LaymanReport_WP2_AEMPS_09.2021.pdf (eu-jamrai.eu) p16-17
[339] EUjamrai_MS32_Evaluation-of-UICF-implementation_WP6.1_EODY_280221.pdf (eu-jamrai.eu)
[340] EUjamrai_MS32_Evaluation-of-UICF-implementation_WP6.1_EODY_280221.pdf (eu-jamrai.eu)
[341] EUjamrai_MS32_Evaluation-of-UICF-implementation_WP6.1_EODY_280221.pdf (eu-jamrai.eu)
[342] EUjamrai_MS32_Evaluation-of-UICF-implementation_WP6.1_EODY_280221.pdf (eu-jamrai.eu)
[343] BTS is a model that aims at changing practices through quality work improvement.

> prevention in regional and local hospitals have been implemented, and this implementation model has been used in other wards and hospitals.[344]

The results of this work showed the potential that guidance on infection prevention and control, surveillance of HCAI, and proper education and training of health-care workers have in prevention of HCAIs. However, it is not clear from the results of these pilots whether the objectives have been achieved.

In order to shorten the time gap between AMR and AMC (antimicrobials' consumption) data collection and its assessment, a near-real time surveillance system was piloted within EU-JAMRAI for 2.5 years. The piloted near-real-time surveillance system included 41 indicators on AMR collected each trimester for AMC and AMR in hospital care (HC) and primary care (PC). Seventeen partners from eleven countries participated in the study. The surveillance system collected data from nearly 8 million hospital stays in HC, and from 45 million inhabitants primary care patients per trimester on average.

The outcomes presented in the JAMRAI report on a Tool on antibiotic use and resistance in humans showed that the implementation of near-real-time surveillance AMR and AMC surveillance system in the EU is possible, but it recognised that in order to make it work countries participating in the pitot recognised that they need: more institutional support, unified coordination of microbiological and antimicrobial consumption data sources, more homogeneous indicators, dedicated human resources, and modern and integrated IT systems.[345] The report found that this surveillance system could complement the current surveillance on AMR and AMC data in the EU/EEA, which are shared by Member States to the European Centre for Disease Prevention and Control (ECDC) and assessed on a yearly basis. Moreover, 53% (9 out of 17) of the partners involved in this exercise expressed interest in continuing to implement this quarterly surveillance in their hospitals/PC centres. However, both those participants who intend to continue, and those who indicated that they are not interested, reported the barriers and which hinder the effectiveness of the outcomes and identified needs to achieve the outcomes (more institutional support, unified coordination of microbiological and antimicrobial consumption data sources, more homogeneous indicators, dedicated human resources, and modern and integrated IT systems).

Additionally, through the work carried out in WP8, EU-JAMRAI developed a toolkit for awareness raising and behaviour change communication on AMR. This toolkit is available as a guide to support countries, partners and stakeholders in their efforts to raise awareness on AMR. A key feature of this tool is the Social Behaviour Change Communication Strategy (SBCC), which was developed as the main toolkit for national governments to guide their work. In addition to the strategy, the awareness raising activities were developed. These include the video series *#Don'tLeaveitHalfway,* highlighting the importance of following the prescription given. The series was translated to eighteen languages and reached 2.7 million people in one month through social medial channels and costing a total of €9,106.19. Other activities include the micro-combat game app, translated in 19 languages with 2,580 downloads reaching 2.2. million people through social media channels. The communication outputs might have produces outcomes in terms of awareness raising. However, it is not possible at this stage to assess whether they have been successful in achieve so. Further, it can be reasonably expected that materials have been used by its intended users.

[344] EUjamrai_D2.2_LaymanReport_WP2_AEMPS_09.2021.pdf (eu-jamrai.eu)
[345] EU-JAMRAI (2022) Report on JAMRAI tool on antibiotic use and resistance in humans

According to the indicators defined in a final evaluation of EU-JAMRAI, it is very difficult to assess the overall impact of the JA at month 42, because there has been very short time to ensure proper dissemination, uptake and application by the stakeholders of the main outputs. The available documentation on the joint action suggests that EU-JAMRAI introduced practical tools and methods that form a solid base for Member States to reinforce infection and prevention control programmes, surveillance, and awareness. Moreover, the outputs produced through EU-JAMRAI have the potential to contribute to the prevention of AMR; however, it is too soon to measure whether the implementation of all outputs can lead to the expected impacts.

EQ9a: To what extent are the results of the joint action in the field of AMR funded under the programme likely to be sustainable?

EU-JAMRAI delivered concrete measures with demonstrated potential to tackle AMR. The different outputs (e.g., tools, methods and recommendations) are publicly available on the EU-JAMRAI website and are organised by objectives in the results section[346] and also hosted on the websites of some stakeholders of the Joint Action to ensure that they are publicly available after the end of the joint action.

To foster sustainability of the different actions carried out under the Joint Action, the results of EU-JAMRAI were communicated to the European Commission in the form of policy briefs, as well as members from the European Parliament's Committee on Environment, Public Health and Food Safety in an attempt to get support from policy makers at EU level.

Many EU-JAMRAI activities targeted Member State authorities, beyond dissemination efforts. Country-to-country visits in WP5[347] and country visits in WP7 and WP9[348] acted as a strong driver to increase and continue work on AMR in the EU. Some results were taken up by Member States by updating or implementing National Action Plans against AMR or IPC guidelines. Additionally, the network created through the different activities has served as a basis to build a network of supervisory bodies in human health. Next steps to this network of supervisory bodies will be discussed in the AMR One Health Network.[349] This network is chaired by the European Commission and includes government experts from the human health, animal health and environmental sectors, EU agencies covering these different sectors and Commission experts. It serves as a platform to present national action plans and strategies, share best practices, and discuss policy options and how to enhance cooperation and coordination.

WP4 of EU-JAMRAI focused entirely on the sustainability of the Joint Action after its completion. Under this Work Programme a sustainability strategy was developed to consolidate and further develop EU-JAMRAI results. This strategy described which partner of EU-JAMRAI should focus on the sustainability of the different results. EU-JAMRAI was identified as particularly sustainable by stakeholders consulted as part of this study.

[346] https://eu-jamrai.eu/results/
[347] Country-to-country visits aimed to assess National Action Plans on AMR through a visit performed by officials from another MS, to reflect on policy options and make recommendations for improvements.
[348] Country visits were carried out as part of WP7 and WP9 to meet with relevant experts in a country and assess the practices, need and expectations of a country on a specific topic.
[349] Joint Action Antimicrobial Resistance and Healthcare-Associated Infections (2021) EU-JAMRAI, Layman Report. Available from: https://eu-jamrai.eu/wp-content/uploads/2021/03/EUjamrai_D2.2_LaymanReport_WP2_AEMPS_03.2021.pdf

Figure 58. How sustainable do you think the Programme results and effects are in the specific fields of…? (n=32)

Regarding sustainability, this study's survey respondents highlighted AMR to be one of the specific fields achieving the most sustainability. National policymakers said that the 3HP contributed to the EU's influence at international level in the following areas: AMR standards, policies and practices. Policy briefs covering the results of the Joint Action and recommendations were prepare and shared with relevant stakeholder to foster sustainability.[350] Moreover, in order to ensure sustainability of the activities started during EU-JAMRAI, the Joint Action consortia called for a follow-up Joint Action.[351] Such a follow-up action is now being prepared as part of theEU4Health's annual work programme 2022.

EU-JAMRAI was identified as a sustainable Joint Action by consulted stakeholders as part of this study, due to the clear support to the development of National Action Plans in the EU. The Joint Action has also been the basis for establishing exchange networks and developing common methods, and recommendations. However, as noted by some stakeholders, renewing an EU-Joint Action on AMR could bring higher sustainability as results from EU-JAMRAI would be taken up in a follow-up Joint Action, ensuring a minimum of resource-pooling, collaboration and building on the outcomes of the first Joint Action.

5.4. Conclusion

Overall, the EU has acted through the 3HP to address antimicrobial resistance by providing a significant amount of funding for Member State coordinated action. The case study analysed the European Joint Action on antimicrobial resistance and associated infections (EU-JAMRAI), which is also recognised as a key activity within the 2017 European One Health Action Plan against Antimicrobial Resistance. The funded action conducted activities and produced a wealth of outputs benefiting policy makers at national and EU level as well as other stakeholders.

Overall, the outputs have contributed to increased cooperation and coordination among Member States, the European Commission and its agencies, bringing the potential to avoid duplication across the EU. Furthermore, the funded action developed concrete recommendations to tackle AMR and HCAIs and enabled the sharing of existing good practices. Lastly, EU-JAMRAI produced sustainable results, especially when considering the support provided to Member States in terms of facilitating exchange and providing recommendations for action against AMR. Moreover EU-JAMRAI identified two main ways to ensure sustainability: ensure direct follow-up and cooperation between Member States and/or continue action at EU level, when and if necessary, using EU funding as an enabling mechanism. It is soon to assess the overall impact of EU-JAMRAI, given the limited time that involved actors have had to take up and apply the Joint Action's main outputs. However, it can be concluded that the outputs produced in the context of this Joint Action and the increased cooperation

[350] EU-JAMRAI 2nd periodic and final Report (D1.2) not publicly available.
[351] Ibid.

and coordination it facilitated are concrete achievements contributing to make progress in the fight against AMR.

6. Case study: Health inequalities affecting vulnerable groups

This case study presents work done under the 3rd Health Programme (3HP) related to health inequalities, specifically affecting vulnerable groups such as migrants and refugees and assesses the effectiveness of 3HP funded actions in this area. This topic is explored through an in-depth examination of six actions funded under the 3HP: one joint action (**Joint Action Health Equity Europe**), four projects (**AHEAD; Mig-HealthCare; MyHealth; SH-CAPAC**) and one operating grant (**European network to reduce vulnerabilities in health, Association Medecins du monde**).

6.1. Introduction

6.1.1. Background

Life expectancy has increased at a fairly rapid pace over the last two decades in Europe, due in large part to improvements in the performance of healthcare systems and medical innovation, amongst other factors. Overall, between 2002 and 2020, life expectancy at birth in the EU increased by 3.2 years for men, from 74.3 to 77.5 years, and by 2.3 years for women, from 80.9 to 83.2.[352] Healthy life expectancy, which indicates whether the gain in life expectancy is lived free of activity limitations due to health problems, has increased over the last decade. Between 2010 and 2020, healthy life years in the EU27 increased by 2.2 years for men, from 61.3 to 63.5 years, and by 2.3 years for women, from 62.2 to 64.5 years.[353]

Despite these positive trends, large differences in health status remain between and within EU countries. Data on life expectancy by educational level, for example, shows that inequalities are generally larger among men than women, and are particularly large in Central and Eastern Europe. In Slovakia, Poland and Hungary, 30-year-old men with a low level of education can expect to live more than 10 years less than those with a high level of education (2017 data).[354] There are also large differences between European countries, and between socioeconomic groups within countries, and in health-related behaviours, such as diet-related habits. Daily consumption of fruit and vegetables, for example, is higher in groups with higher education levels in northern and central European countries, but not necessarily in Southern Europe.[355]

In addition to an individual's genetics and lifestyle, health status is determined by a wide range of other factors, including social, economic and environmental aspects. Social determinants of health[356] including issues such as employment, income and social protection, education, housing and working life conditions and social inclusion play a role in determining health inequalities between EU countries and between population groups within these countries. Moreover, major disrupting events such as the COVID-19 pandemic or mass movements of migrants due to different causes (e.g., political instability, war, food crisis), can exacerbate the situation, especially in the most impacted regions.

The incidence of health inequalities across the EU raises serious concerns as it has negative consequences for health, cohesion and social and economic

[352] Eurostat, "Mortality and life expectancy statistics" (accessed 15.06.2022).
[353] OECD/European Union (2020), "Health at a Glance: Europe 2020: State of Health in the EU Cycle", OECD Publishing, Paris; and Eurostat Statistics Explained, "Healthy life years statistics" [Accessed 15.06.2022].
[354] OECD/European Union (2020), "Health at a Glance: Europe 2020: State of Health in the EU Cycle", OECD Publishing, Paris.
[355] European Parliamentary Research Service (2020), "Addressing health inequalities in the European Union", Brussels.
[356] WHO, Social determinants of health. [Accessed 31.10.2022]; Healthy People 2030, Social determinants of health. [Accessed 31.10.2022]

prosperity. A WHO Europe report (2017) estimated that the cost of health inequalities amounts to €980 billion per year in the EU.[357]

In 2009, the Commission published a communication - 'Solidarity in health: reducing health inequalities in the EU'[358] - stressing that reducing health inequalities was a crucial objective of the EU Health Strategy. Investing in an individual's good health helps foster the health of the population in general, while also improving employability and contributing to economic progress. Reducing health inequalities, especially among the most vulnerable groups in society, further contributes to social cohesion while fighting poverty and exclusion.[359]

Health equity is not only pursued through EU action in the field of health. Many other EU policies have integrated health equity considerations to address the determinants of health, including social, economic and environmental aspects. EU Cohesion Policy, the Common Agricultural Policy, the European Green Deal, and the European Pillar of Social Rights, the EU Youth Strategy, are all examples of policies that integrate health equity considerations and contribute to addressing the determinants of health.

6.1.2. Rationale for selection and case study focus

The 3HP has as its general objective the improvement of European citizens' health and the reduction of health inequalities, to be pursued through health promotion measures, innovation, health systems strengthening and the increased ability to respond to cross-border health threats.

Actions taken under 3HP within this theme

The 3HP addressed health inequalities as part of its general objective, and the theme is not linked to any specific 3HP objective or thematic priority. At the same time, 3HP funded many actions which relate to the broader theme of health inequalities. These measures were funded under different financial instruments such as framework partnership agreements, operating grants, projects and Joint Actions. Table 15 illustrates a sample of funded actions addressing the theme of health inequalities.

Table 15. Sample of funded actions in the field of health inequalities

Action	Examined as part of this case study	Timescale	EC Contribution (EUR)
Joint Actions			
InfAct (Information for Action)[360]		01/03/2018 – 31/05/2021 (36 months)	€ 3.999.191,48

[357] World Health Organisation, Regional Office for Europe (2017), "Investment for health and well-being: a review of the social return on investment from public health policies to support implementing the Sustainable Development Goals by building on Health 2020".
[358] European Commission (2009), "Communication on Solidarity in health: Reducing health inequalities in the EU", Brussels.
[359] See European Commission (2013), "Report on health inequalities in the European Union", Brussels; Council of the European Union (2019), "The Economy of Wellbeing Council Conclusions", Brussels.
[360] Health Programme DataBase - European Commission (europa.eu)

Action	Examined as part of this case study	Timescale	EC Contribution (EUR)
Joint Action Health Equity Europe [JAHEE]	✓	01/06/2018 – 30/11/2021 (36 months)	€ 2.499.997,02
Projects			
Action for Health and Equity - Addressing Medical Deserts (AHEAD)	✓	01/04/2021 – 31/05/2023 (26 months)	€ 397.748,00
Strengthen Community Based Care to minimize health inequalities and improve the integration of vulnerable migrants and refugees into local communities [Mig-HealthCare]	✓	01/05/2017 – 30/06/2020 (36 months)	€ 872.602,67
Models to engage Vulnerable Migrants and Refugees in their health, through Community Empowerment and Learning Alliance [MyHealth]	✓	01/04/2017 – 30/06/2020 (36 months)	€ 1.134.547,95
Supporting health coordination, assessments, planning, access to health care and capacity building in Member States under particular migratory pressure (SH-CAPAC)	✓	01/01/2016 – 31/12/2016 (12 months)	€ 537.044,34
Framework Partnership Agreements			
European network to reduce vulnerabilities in health [Vulnerability NW][361]		17/12/2014 – 16/12/2017 (36 months)	€ 294.664,00
Operating grants			
Promote health and reducing health inequalities for people with intellectual disability in Europe [SOEEFHealth][362]		01/01/2015 – 31/12/2015 (12 months)	€ 154.356,00
Saving lives by ending tobacco in Europe - from grassroots networking at EU countries level to the partnership with the Presidency of the Council of the EU [ENSP FY 2019][363]		01/01/2019 – 31/12/2019 (12 months)	€ 394.128,00

[361] Health Programme DataBase - European Commission (europa.eu)
[362] Health Programme DataBase - European Commission (europa.eu)
[363] Health Programme DataBase - European Commission (europa.eu)

Action	Examined as part of this case study	Timescale	EC Contribution (EUR)
European Network to reduce vulnerabilities in health [Vulnerability NW]	✓	01/01/2017 – 31/12/2017 (12 months)	€ 326.808,00

Case study subtheme: health inequalities affecting vulnerable groups including migrants and ethnic minorities

The subtheme of this case study is health inequalities in relation to vulnerable groups, including migrants and ethnic minorities, including Roma. As stated in the Commission Communication on health inequalities[364], across the EU a social gradient in health status exists whereby people further down the social ladder, with lower education, lower income or a lower occupational status run much higher risks of serious illness and premature death.

Vulnerable and socially excluded population groups such as people with a migrant background or belonging to an ethnic minority experience particularly poor average levels of health. As an example, it is estimated that the Roma population in Europe experiences considerably lower life expectancy compared to non-Roma (up to 20 years less), suffers higher rates of both infectious and chronic diseases, and has poorer access to primary care and preventative health services.[365]

Against this background and considering that the general objective of the 3HP is the improvement of European citizens' health and reduction of health inequalities, it is important to investigate the contribution of 3HP funded actions on the reduction of health inequalities affecting vulnerable groups.

To examine this subtheme in more detail, the study team focused on six actions:

- Joint Action Health Equity Europe (Joint Action, 2018-2021)[366]
- Action for Health and Equity - Addressing Medical Deserts (AHEAD) (Project, 2021-2023)[367]
- Strengthen Community Based Care to minimize health inequalities and improve the integration of vulnerable migrants and refugees into local communities (Mig-HealthCare) (Project 2017-2020)[368]
- Models to engage Vulnerable Migrants and Refugees in their health, through Community Empowerment and Learning Alliance (Myhealth) (Project, 2017-2020)[369]
- Supporting health coordination, assessments, planning, access to health care and capacity building in Member States under particular migratory pressure (SH-CAPAC) (Project, 2016)[370]

[364] European Commission (2009), "Communication on Solidarity in health: Reducing health inequalities in the EU", Brussels.
[365] See European Parliamentary Research Service (2020), "Addressing health inequalities in the European Union", Brussels; European Commission (2015), "Roma health report, health status of the Roma population: data collection in the Member States of the European Union: executive summary", Brussels, 2015.
[366] Health Programme Database - European Commission (europa.eu)
[367] Health Programme Database - European Commission (europa.eu)
[368] Health Programme Database - European Commission (europa.eu)
[369] Health Programme Database - European Commission (europa.eu)
[370] Health Programme Database - European Commission (europa.eu)

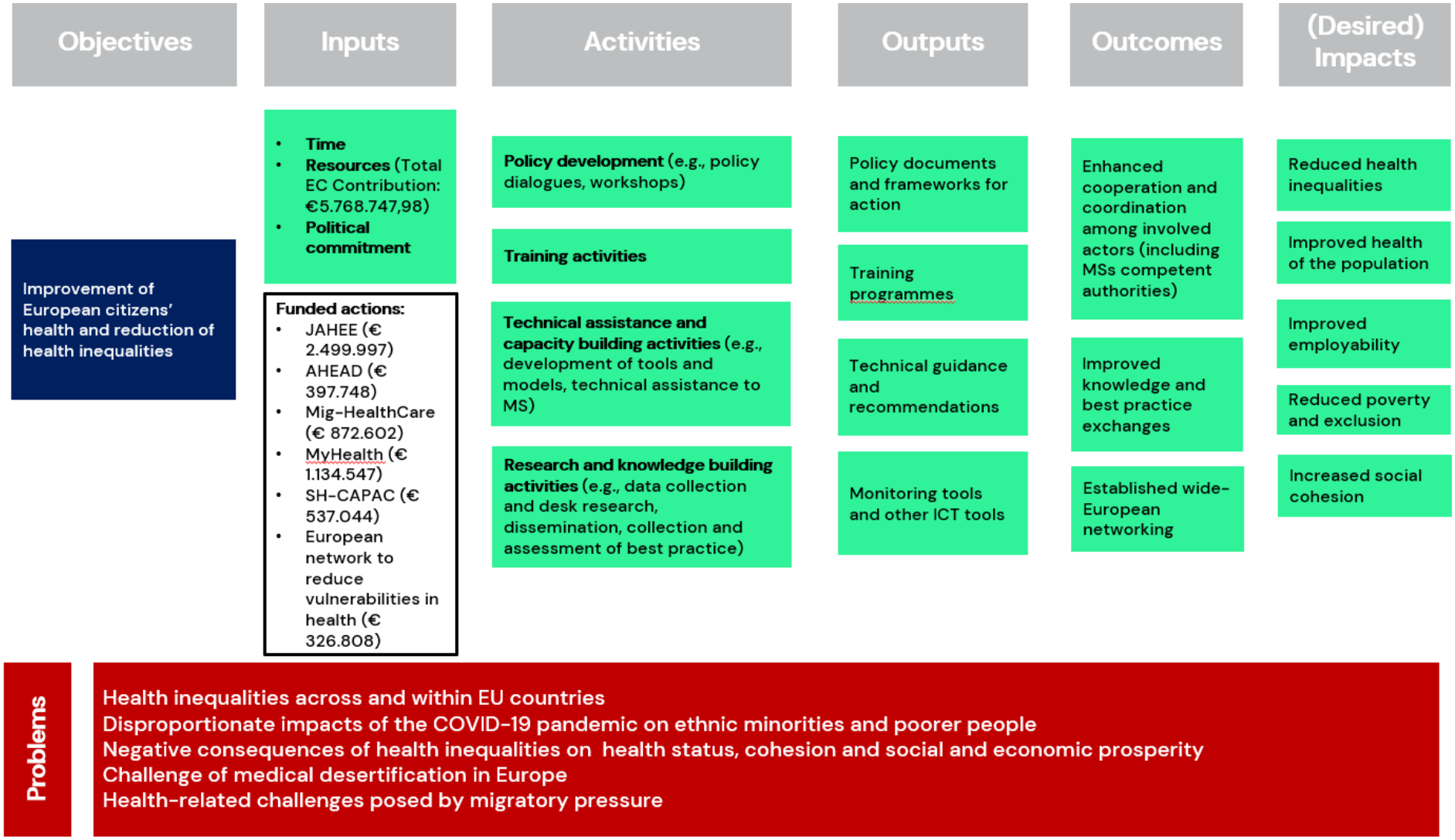
- European network to reduce vulnerabilities in health (Operating Grant, 2017)[371]

6.2. Intervention logic underpinning the case study

The intervention logic developed for this case study illustrates the problems that EU action seeks to address in the field of health inequalities, as well as the objectives, the inputs and activities undertaken, the outputs of those activities and the related outcomes and impacts. This underpins the findings of the case study, presented in section 1.3.

[371] Health Programme Database - European Commission (europa.eu)

Figure 59. Intervention logic outline



The pathway for impact of EU action in the field of health inequalities as outlined in the intervention logic includes a series of activities oriented towards increased cooperation and coordination across European countries and stakeholder groups (e.g., national and local authorities, civil society organisations) engaged in efforts to reduce health inequalities in Europe. The main activities include policy development activities, training, research and knowledge building activities, technical assistance and capacity building activities. These activities resulted in outputs in the form of policy documents and frameworks for action, technical guidance and recommendations, monitoring tools and other ICT tools, and training programmes.

The pathway for impact continues with outcomes resulting from those outputs. The funded actions examined in this case study overall aimed to enhance cooperation and coordination among involved actors (including Member State competent authorities), improve knowledge and exchange best practices, and establish Europe-wide networking. The desired long-term impacts of such a pathway are multifaceted. EU action aiming at reducing health inequalities in Europe is conducive to improving the health of the population, improving employability and reducing poverty and social exclusion, and strengthening social cohesion.[372]

6.3. Findings: pathway for impact

This section presents the findings of each step of the pathway for impact of EU action in the field of health inequalities. It illustrates the problems that EU action seeks to address, and the objectives of the funded actions examined in this case study. It then presents the inputs used to conduct the actions, the activities undertaken, and the outputs produced as part of those actions. Lastly, this section discusses the observed outcomes, drawing from evidence collected from targeted desk research undertaken for this case study, coupled with evidence stemming from the consultation activities held as part of this study, and provides an assessment on the contribution that the funded actions and their outputs had on expected outcomes and impacts in this area.

6.3.1. Drivers / problems

There are major health inequalities across and within EU countries, both in terms of health status and access to health services. Health inequalities have negative impacts on the health status of the population which in turn negatively affects cohesion and social and economic prosperity. Furthermore, vulnerable and socially excluded population groups such as people with a migrant background or belonging to an ethnic minority experience particularly poor average levels of health.

The landscape of health inequalities has recently been exacerbated by significant external pressure, namely the migratory crisis and more recently the COVID-19 pandemic.

6.3.2. Objectives of the funded actions

The funded actions examined in this case study pursued the overarching objective of reducing health inequalities.

In particular, the **Joint Action Health Equity Europe** aimed to improve health and well-being of EU citizens, achieve greater equity in health outcomes across all groups in society and reduce inter-country heterogeneity in tackling health inequalities. Activities mostly concentrated on socio-economic determinants of health and lifestyle related health inequalities. The Joint Action also included a specific focus on migrants and vulnerable groups.

[372] European Commission (2009), "Communication on Solidarity in health: Reducing health inequalities in the EU", Brussels.

The project **Action for Health and Equity - Addressing Medical Deserts (AHEAD)** aims to support national policy makers to define, design and implement evidence-based and context-specific reforms to counteract and/or prevent medical deserts thus helping reduce health inequalities.

The project **Strengthen Community Based Care to minimize health inequalities and improve the integration of vulnerable migrants and refugees into local communities (Mig-HealthCare)** aimed to promote effective community-based care models to improve physical and mental health care services, support the inclusion and participation of migrants and refugees in Europe and reduce health inequalities.

The project **Models to engage Vulnerable Migrants and Refugees in their health, through Community Empowerment and Learning Alliance (Myhealth)** aimed to improve the healthcare access of vulnerable immigrants and refugees newly arrived in Europe and focused on women and unaccompanied minors.

The project **Supporting health coordination, assessments, planning, access to health care and capacity building in Member States under particular migratory pressure (SH-CAPAC)** aimed to support Member States in coordinating, assessing and planning their public health response to the challenges posed by migratory pressure. By doing so, the project aimed to foster access to health care services for registered and unregistered refugees, asylum seekers and other migrants.

In particular, the **European network to reduce vulnerabilities in health** aimed to bring together NGOs and academic partners from different European countries and contribute to the reduction of EU-wide health inequalities and better equipped health systems to deal with vulnerability factors.

6.3.3. Inputs

Inputs are the time and resources used to conduct the actions. A detailed overview of the inputs of the examined funded actions is presented in Table 16, including timescale, project coordinators and partners, as well as the financial contribution provided under the 3HP.

Table 16. Inputs related to the funded actions in the field of health inequalities

Action	Project Coordinator	Lead Partners	Timescale	EC Contribution (EUR)
Joint Action Health Equity	Instituto Superiore Di Sanita (IT)	24 partners from 23 European countries	1/06/2018 - 30/11/2021 (36 months; finalised)	€ 2.499.997,02
Action for Health and Equity - Addressing Medical Deserts (AHEAD)	Stichting Wemos (NL)	5 partners from 5 European countries	01/04/2021 - 31/05/2023 (26 months; ongoing)	€ 397.748,00

Action	Project Coordinator	Lead Partners	Timescale	EC Contribution (EUR)
Strengthen Community Based Care to minimize health inequalities and improve the integration of vulnerable migrants and refugees into local communities (Mig-HealthCare)	Astiki Mikerdoskopiki Etaireia Prolipsis (GR)	13 partners from 10 European countries	01/05/2017 - 30/06/2020 (36 months; finalised)	€ 872.602,67
Models to engage Vulnerable Migrants and Refugees in their health, through Community Empowerment and Learning Alliance (Myhealth)	Fundacio Hospital Universitari Vall D'hebron - Institut de Recerca (ES)	12 partners from 7 European countries	01/04/2017 - 30/06/2020 (36 months; finalised)	€ 1.134.547,95
Supporting health coordination, assessments, planning, access to health care and capacity building in Member States under particular migratory pressure (SH-CAPAC)	Escuela Andaluza de Salud Pública (ES)	6 partners from 6 European countries	01/01/2016 - 31/12/2016 (12 months; finalised)	€ 537.044,34
European network to reduce vulnerabilities in health	Association Medecins du monde (BE)	NGOs & academic partners from 23 European countries	01/01/2017 - 31/12/2017 (12 months; finalised)	€ 326.808,00

6.3.4. Activities

In the context of the funded actions assessed in this case study, many different activities have been conducted, which can be categorised as follows:

- Policy development activities (e.g. policy dialogues and workshops);
- Training activities;
- Research and knowledge building activities (e.g. data collection and desk research, dissemination activities, and collection, assessment and exchange of best practices); and
- Technical assistance and capacity building activities (e.g., development of tools and models, technical assistance to Member States).

The **Joint Action Health Equity Europe** conducted a wide range of activities, including a series of events (e.g. policy dialogues and workshops) and policy development activities. It also undertook research and knowledge building activities such as identification of national strategies and policy practice gaps, and formulation of regional, local and national strategies. As part of the activities, technical assistance

was also provided to Member States, including for engaging cross-sectoral stakeholders and developing monitoring systems on health inequalities adapted to national contexts.

The project **AHEAD** conducted desk research activities, multi-stakeholder consensus building dialogues, and high-level policy dialogues at national and EU level. It also conducted dissemination activities of the projects' knowledge products and best practices.

The project **Mig-HealthCare** conducted focus groups, interviews and surveys, data collection and assessment of best practices. The project also focused on the development of an algorithm and prediction model, pilot implementation and the creation of evidence-based guidance and recommendations.

The project **Myhealth** mostly focused on research and data collection activities. In particular, a mapping exercise of existing initiatives on health for vulnerable migrants and refugees was conducted, as well as a pilot survey. The project also focused on pilot identification and implementation, as three pilots of models based on a community health approach were carried out in different countries.

The project **SH-CAPAC** conducted training and dissemination activities, offered technical assistance to Member States through country missions, and carried out regional advocacy and capacity building activities.

The **European network to reduce vulnerabilities in health** conducted a data collection exercise through medical and social surveys and organised two exchanges of best practices between participants.

6.3.5. Outputs

The activities resulted in a range of different outputs, which fall under four overarching output categories:

- policy documents and frameworks for action;
- technical guidance and recommendations;
- monitoring and other ICT tools, and
- training programmes.

Policy briefs, reports and frameworks for action were produced in the context of the **Joint Action Health Equity Europe** and the project **SH-CAPAC**. In particular, the Joint Action Health Equity Europe produced two policy briefs on COVID-19 and health inequalities, and policy frameworks for action on different themes (i.e., on monitoring health inequalities, healthy living environments, migration and health, access to care for those left behind, health and equity in all policies).[373] In the context of the project SH-CAPAC, a health coordination framework was produced aiming to support Member States developing or strengthening a coordination mechanism that brings together all actors involved in the health response to the influx of migrants, including refugees and asylum seekers.[374]

The project **Myhealth** produced an interactive map[375] including the main health issues, actors and stakeholders, and reference sites dealing with vulnerable migrants and refugees across Europe. The interactive map also included legal and organizational information on healthcare systems of the involved countries, and the

[373] The documents produced in the context of the Joint Action are available at: https://jahee.iss.it/documents/.
[374] SH-CAPAC project, Coordination framework for addressing the health needs of the recent influx of refugees, asylum seekers and other migrants into the European union (EU) countries.
[375] MyHealth project, Collaborative Migrants Health Resources Map.

information and communications technology (ICT) tools available in them.[376] The project **AHEAD** produced an interactive mapping tool visualising national indicators related to different aspects of desertification.[377]

The project **Mig-HealthCare** produced scientific articles and conference presentations, an on-line database[378] with mapping results of existing services and health profiles, a roadmap and a toolbox including an index of best practices, recommendations and training material.[379]

Lastly, the project **SH-CAPAC** also produced an online training course titled *Improving the health response to refugees, asylum seekers and other migrants* targeting health managers, healthcare service providers and administrative staff working in health facilities.[380]

6.3.6. Outcomes and impacts / potential impacts

This section discusses the outcomes of the funded actions by relevant evaluation question. The outcomes illustrated in the intervention logic are as follows:

- Enhanced cooperation and coordination among actors involved in reducing health inequalities (including Member State competent authorities);
- Improved knowledge and best practice exchanges; and
- Established Europe-wide networking infrastructure.

It is important to note that the impacts illustrated in the intervention logic, namely the reduction of health inequalities, improved health of the population, improved employability, reduced poverty and exclusion, and increased social cohesion are overall long-term desired impacts. The realisation of these impacts is dependent on a variety of factors and cannot be exclusively linked to the outcomes of any single action in the field of health policy. For those reasons, we focus on the outcomes generated by the examined funded actions and aim to gain a better understanding of the pathway for change created by them. The contribution of the outcomes is an underlying assumption for the pathway to impact.

EQ4a: To what extent has the Programme contributed to a more comprehensive and coordinated approach to health inequalities affecting vulnerable groups?

Most respondents to this study's survey (held as part of targeted consultations with various stakeholder groups) reported that the 3HP contributed to a more comprehensive and uniform approach to addressing health inequalities affecting vulnerable groups (17 out of 32, 55% to a moderate extent and 2 out of 32, 7% to a large extent).

However, a relatively large proportion of respondents (compared to other policy areas) believed that the 3HP only did so to a small extent (7 out of 32, 23%) or did not contribute at all to a more comprehensive and uniform approach (2 out of 32, 7%),

In the focus group on Joint Actions, a stakeholder emphasised the relevance of the Joint Action Health Equity Europe (JAHEE) for certain countries in terms of awareness related to the pandemic, as they were working with '*other cultures much further*

[376] MyHealth project, Work package 4: Mapping on Health and Vulnerable Migrants and Refugees. D4.2 Interactive map
[377] AHEAD project, Medical Deserts Diagnostic Tool (MDDT)
[378] Mig-HealthCare project, Interactive map
[379] Mig-HealthCare project, e-Library: Project results.
[380] SH-CAPAC project, Report on the design, development and evaluation of the online training course.

ahead like Finland or Sweden' creating *'an intersectional table to talk about the issue of health policies and how all the sectors could work together'*.

Activities and outputs of the funded actions (i.e., Mig-HealthCare, MyHealth and SH-CAPAC) contributed to increased collaboration among actors involved in reducing health inequalities, as well as better exchange of knowledge and best practices, as described below.

In particular, the SH-CAPAC project conducted technical advice missions to beneficiary countries to introduce, disseminate and discuss the frameworks, methodologies and tools developed in the context of the project.[381] The missions to support coordination and coherence, for example, allowed for discussions with multiple national and local stakeholders involved in the health response to refugees, and explored the possibilities for improving coordination and coherence in the response. As part of the missions and in addition to technical assistance, the participating countries benefitted from exchange of knowledge produced in the context of the project as well as training activities.

In the context of the Mig-HealthCare project, a comprehensive roadmap for the implementation of community-based care models was developed and disseminated to policy makers at national, regional and local levels. These included service providers, migrant and refugee representative bodies, scientific organisations and universities. Training sessions were delivered at country level and community-based care models and integrated services were disseminated and promoted among key stakeholders and policy makers at national, regional and local levels.[382]

The findings point to a contribution of the outputs of the funded actions to the outcomes of enhanced cooperation and coordination among actors involved in reducing health inequalities and improved knowledge and best practice exchanges. Those elements are conducive to a more comprehensive and coordinated approach to health inequalities affecting vulnerable groups.

However, it should not be overlooked that almost a third of survey respondents reported that the 3HP contribution in this area was little (7 out of 32 respondents 23%, said that the 3HP contributed to a small extent while 2 out of 32 respondents, 7%, said it did not contribute at all). These findings might be partly explained by the fact that health inequalities represented a cross-cutting issue addressed by the 3HP[383], rather than being explicitly integrated in the 3HP specific objectives and thematic priorities, and thus stakeholders might be less aware of the role of the 3HP in addressing them.

EQ4b: To what extent has the Programme contributed to improvements in health status and access to care of vulnerable groups?

The available documentation on the funded actions reviewed as part of this case study suggests that some of the funded actions (namely, the MyHealth project) contributed to improvements in the health status and access to care of vulnerable groups.

[381] See for example: SH-CAPAC, "Reports on technical advice missions to support coordination and coherence, Deliverable 1.2" and SH-CAPAC "Reports on technical advice missions to support action planning at country level. Deliverable 3.2", available at Health Programme DataBase - European Commission (europa.eu).
[382] Alejandro Gil Salmerón, Anastasios Rentoumis, Jorge Garcés Ferrer (2020), "Mig-HealthCare: Strengthen Community Based Care to minimize health inequalities and improve the integration of vulnerable migrants and refugees into local communities, Final Evaluation Report", available at Health Programme DataBase - European Commission (europa.eu).
[383] The general objective of the 3HP, as stated in the Regulation No 282/2014 establishing it, is to complement, support and add value to the policies of the Member States to improve the health of Union citizens and reduce health inequalities.

- The final evaluation of the MyHealth project explored the project's effectiveness and collected respondents' perceptions of how well the project achieved its objectives. Overall, most respondents agreed that the outputs and outcomes of the project improved the health of vulnerable migrant women and unaccompanied minors. Respondents also agreed that the project met the needs of these vulnerable groups.[384]

However, the findings emerging from the consultation activities held as part of this study overall point to a small contribution of the 3HP in the area of health status and access to care of vulnerable groups.

Only 4% (1 out of 32 respondents) of this study's survey respondents reported that the 3HP largely contributed to improvements in the health status and access to care of vulnerable groups in the EU and at Member States level. Most survey respondents (14 out of 32, 46%) noted that the 3HP did so to a moderate extent, while a large proportion of respondents (12 out of 32, 39%) believed that the 3HP contributed only to a small extent.

The relatively small contribution perceived by stakeholders in the area of health status and access to care of vulnerable groups (as compared to other areas) might be explained by changes which occurred in the European landscape in terms of health needs related to increased migration. Although the 3HP overall remained relevant to health needs linked to migration, some consulted stakeholders reported that refugee and migrant health was not a topic adequately addressed by the 3HP.

Different consulted stakeholders did not feel the 3HP adequately addressed needs related to health inequalities. Four respondents to this study's OPC noted that health inequalities were not sufficiently addressed throughout the 3HP's specific objectives and thematic priorities, and an interviewed governmental public health organisation reported that health inequalities could have been included more in all actions. Two stakeholders from an organisation representing patients and services users also reported the work on access to healthcare and health inequalities was not done comprehensively, particularly related to patient empowerment. Two interviewed academics reported that the 3HP did not adequately address disparities within and across countries. They noted that there is a need for a stronger focus on health inequalities: the 3HP emphasis on health promotion has been positive, but healthcare access should have been more addressed (specifically for those in lower economic groups) as well as health inequalities, particularly in relation to migration.

Further, one OPC respondent felt that the 3HP could have shed more light on the systems and processes that widen the health inequalities gap across the social gradient and along the life course and use this knowledge to move towards more sustainable and innovative health systems. The same respondent also felt the 3HP could have made a much stronger impact on progressing social rights and the right to health by providing for actions on poverty (especially in childhood), income and living conditions, by prioritising investments in building capacities, applying equity impacts assessments, and building partnerships across the sectors and disciplines to address inequalities in health in a more holistic and integrated manner.

The findings of this case study point to a limited contribution of the 3HP to improving the health status and access to care of vulnerable groups. Specific actions funded under the 3HP, notably the MyHealth project, have been successful in this area and

[384] MYHEALTH Consortium (2017), "Models to engage Vulnerable Migrants and Refugees in their health, through Community Empowerment and Learning Alliance. Work Package 2: Evaluation. D2.2 Final Evaluation Report", available at Health Programme DataBase - European Commission (europa.eu).

the 3HP has managed to remain relevant over time to health needs linked to migration. However, it remains unclear whether the 3HP has comprehensively contributed to improving the health status and access to care of vulnerable groups.

EQ9a: To what extent are the Programme results and effects on health inequalities likely to be sustainable?

A majority of survey respondents believed that the 3HP results and effects in the field of health inequalities were somewhat sustainable (14 out of 32, 44%) or very sustainable (3 out of 32, 10%).

The final evaluation of the MyHealth project explored the sustainability of the project's effects and its future potential. The consortium members agreed that the MyHealth project practices resulted in the adaptation and adoption of new methods. Furthermore, the project generated new ways of thinking and promoted public awareness of migrant health risks.[385] These elements are conducive to the sustainability of the project's effects beyond the lifetime of the project itself. However, as noted in the final evaluation of the Mig-HealthCare project,[386] the long-term sustainability of project effects is dependent on a series of actions, including expanding the network of stakeholders beyond the core of the consortium partners, incorporating the tools developed in the context of the project in the everyday activities of the relevant stakeholders.

Therefore, given the available information, it could be concluded that some of the funded actions have the potential to be impactful beyond their lifetime as they lay down the foundation for further action; however, this sustainability needs to be supported with relevant activities and wide-spread dissemination and use of the produced outputs.

Overall contribution of the funded actions to the expected outcomes

The evidence discussed above allows for some reflections on the contribution that the funded actions and their outputs had on expected outcomes in this area.

- The findings point to a contribution of the outputs of the funded actions to the outcomes of enhanced cooperation and coordination among actors involved in reducing health inequalities and improved knowledge and best practice exchanges. This is particularly the case for the Joint Action Health Equity Europe (JAHEE), and the Mig-HealthCare, MyHealth and SH-CAPAC projects.
- While the reviewed actions are deemed to have been successful in fostering cooperation and coordination, improving knowledge and promoting best practice exchange, it remains unclear whether the 3HP has overall contributed to improving the health status and access to care of vulnerable groups. The reviewed action MyHealth was deemed to be effective in improving the health of vulnerable migrant women and unaccompanied minors; however, several consultees did not feel that the 3HP adequately addressed the theme of health inequalities, including linked to migrants' health.
- Similarly, while the Joint Action JAHEE managed to enhance collaboration and coordination across Member States, it remains unclear whether it has contributed, alongside other funded actions, to establishing a Europe-wide networking infrastructure.

[385] MYHEALTH Consortium (2017), "Models to engage Vulnerable Migrants and Refugees in their health, through Community Empowerment and Learning Alliance. Work Package 2: Evaluation. D2.2 Final Evaluation Report", available at Health Programme DataBase - European Commission (europa.eu).
[386] Alejandro Gil Salmerón, Anastasios Rentoumis, Jorge Garcés Ferrer (2020), "Mig-HealthCare: Strengthen Community Based Care to minimize health inequalities and improve the integration of vulnerable migrants and refugees into local communities, Final Evaluation Report", available at Health Programme DataBase - European Commission (europa.eu).

6.4. Conclusion

Overall, the EU has acted through the 3HP to address health inequalities affecting vulnerable groups. This case study has analysed three funded projects specifically related to vulnerable migrants and refugees (MyHealth, Mig-HealthCare, and SH-CAPAC); the Joint Action Health Equity Europe which, among other objectives, also focused on migrants and vulnerable groups; the AHEAD project and the European network to reduce vulnerabilities in health (managed through an operating grant) which addressed challenges linked more broadly to health inequalities. The examined actions have conducted activities and produced a wealth of outputs for the benefit of policy makers, health and social care professionals and beneficiaries (e.g. vulnerable individuals and communities).

Those outputs have contributed to enhancing cooperation and coordination among actors involved in reducing health inequalities and improved knowledge and best practice exchanges. It remains unclear whether they have contributed to establishing a Europe-wide networking infrastructure addressing health inequalities affecting vulnerable groups.

Despite the positive results emerging from the examined funded actions (i.e., enhanced cooperation and coordination between different actors and improved knowledge and best practice exchanges) and the significant resources invested by the 3HP on this policy area, overall, consulted stakeholders do not believe that the theme of health inequalities was sufficiently addressed by the 3HP. In fact, almost a third of this study's survey respondents reported that the 3HP contribution in this area was little (7 out of 32 respondents 23%, said that the 3HP contributed to a small extent while 2 out of 32 respondents, 7%, said it did not contribute at all). This finding might be partly explained by the fact that reducing health inequalities was a general objective of the 3HP and represented a cross-cutting issue addressed by the Programme, rather than being explicitly integrated in the 3HP specific objectives and thematic priorities. Therefore, stakeholders might be less aware of the role of the 3HP in addressing health inequalities.

As for the desired longer-term impacts (i.e., reduction of health inequalities, improved health of the population, improved employability, reduced poverty and exclusion and increased social cohesion), it is not possible to isolate and assess the 3HP contribution to their realisation as this is dependent on a variety of factors and not necessarily linked to the outcomes of one single action in the field of health policy. However, based on this case study results, it can be reasonably concluded that the increased cooperation and coordination between different actors, alongside with the improved knowledge and exchange, could in the long-term contribute to build capacity and create infrastructures able to address health inequalities and the social determinants of health.

7. Case study: European response to the challenges related to vaccination

This case study presents actions funded under the 3HP related to vaccinations and assesses the effectiveness of 3HP actions in this area. This topic is explored through an in-depth examination of five actions funded under the 3HP: one joint action (Joint Action on Vaccination- EU-JAV), three projects (Improving Immunisation cooperation in the European Union- IMMUNION; Common approach for refugees and other migrants' health-CARE; Strengthen Community-based care to minimise health inequalities and improve the integration of vulnerable migrants and refugees into local communicates- Mig-HealthCare) and one direct grant (to the International Organisation for Migration- IOM).

7.1. Introduction

7.1.1. Background

Vaccines are one of the most successful and cost-effective public health interventions ever produced.[387] Thanks to the widespread availability of vaccination some diseases have been eradicated or almost eliminated.[388] According to the World Health Organisation (WHO) and European Centre for Disease Prevention and Control (ECDC), vaccination prevents an estimated 2-3 million deaths worldwide each year and vaccination against COVID-19 alone is estimated to have saved 470,000 lives of those aged 60 and older since the start of the pandemic in Europe.[389]
Successful immunisation positively impacts healthcare systems as it reduces costs related to vaccine-preventable diseases that require medical visits, hospitalisation, and use of treatments, which means that resources can be deployed to address other health problems.

However, some EU and neighbouring countries have experienced outbreaks of vaccine preventable diseases due to insufficient vaccination coverage rates (e.g., measles and seasonal influenza). For example, in 2017 Europe experienced outbreaks of infectious diseases measles (14,000 cases) and rubella (696 cases). Ensuring herd immunity[390] is a major challenge for public health. However, some factors prevent sufficient vaccination coverage. These factors are accessibility to vaccines, vaccine shortages, waning public confidence in vaccinations, and increasing misinformation about vaccines.

Vaccination is a national competency in the EU, however, the European Commission assists the Member States in coordinating and funding policies and actions in this area. The EU allocates funds and promotes research and innovation of new vaccines through different funding mechanisms (e.g., Horizon Europe[391], IHI[392]), facilitates cooperation and exchange of information between national authorities, and helps to improve coordination on vaccine procurement (e.g., COVID-19).

Additionally, the European Commission, based on European Medicines Agency (EMA) recommendations, authorises vaccines to use based on the evidence of their safety and

[387] Ehreth J. (2003). The global value of vaccination. Vaccine, 21(7-8), 596–600. https://doi.org/10.1016/s0264-410x(02)00623-0
[388] European Centre for Disease Prevention and Control (ECDC) Vaccine-preventable diseases. Accessed on 20.09.2022. Available at: https://www.ecdc.europa.eu/en/immunisation-vaccines/facts/vaccine-preventable-diseases#:~:text=Smallpox,only%20reservoir%20was%20infected%20humans.
[389] Meslé, M. M., Brown, J., Mook, P., Hagan, J., Pastore, R., Bundle, N., Spiteri, G., Ravasi, G., Nicolay, N., Andrews, N., Dykhanovska, T., Mossong, J., Sadkowska-Todys, M., Nikiforova, R., Riccardo, F., Meijerink, H., Mazagatos, C., Kyncl, J., McMenamin, J., . . . Pebody, R. G. (2021). Estimated number of deaths directly averted in people 60 years and older as a result of COVID-19 vaccination in the WHO European Region, December 2020 to November 2021. *Eurosurveillance*, *26*(47). https://doi.org/10.2807/1560-7917.es.2021.26.47.2101021
[390] Herd immunity occurs when a high percentage of the community is immune to a disease. Herd immunity can be reached through vaccination or prior illness. Herd immunity then makes the spread of a disease from person to person unlikely.
[391] Horizon Europe: It is a key funding programme for research and innovation.
[392] IHI: Innovative Health Initiative: It is a EU public-private partnership funding health research and innovation. Vaccines are among its health priorities, and addressed in IHI projects.

efficacy. To ensure the highest safety standards of marketed vaccines, the EMA supervises the post-authorisation of vaccines through pharmacovigilance, by assessing and monitoring their safety.

In 2014, Council Conclusions (2014/C 438/04) identified vaccination as an effective public health tool whilst noting some challenges and specifying ways forward. The Conclusions called on Member States and the European Commission to develop a joint action to share best practices on vaccination policies.[393]

In December 2018, Health Ministries from EU Member adopted a Council Recommendation on strengthened cooperation against vaccine-preventable diseases, calling for a large number of actions to be carried out by the Commission, its agencies, Member States and stakeholders to increase vaccination uptake across Europe in a life-course perspective. Actions within this policy initiative aim to cooperate on vaccine procurement, support for research and innovation, and approaches to tackle vaccine hesitancy. A roadmap for the implementation of these actions was recently updated to show progress in the achievements[394]; this roadmap covers some of the actions on vaccination that are also covered in this case studies.

In 2020, the European Commission presented the EU Vaccine Strategy. The objectives of this strategy are to ensure quality, safety and efficacy of vaccines, secure timely access across the EU, ensure equitable and affordable access to vaccines, and make sure that countries are ready to deploy vaccines when necessary. Vaccination is also part of wider EU health objectives: for example, the value of vaccination is recognised in supporting cancer prevention through the Europe Beating Cancer Plan[395] and infection prevention in the AMR Action Plan.

7.1.2. Rationale for selection and case study focus

The 3HP's addresses vaccination under Specific Objective 2 "protect citizens from serious cross-border health threats". 3HP action in the area of vaccination supports voluntary cooperation between Member States to develop and implement coherent approaches to vaccination in view of strengthening health systems' ability to respond to the vaccination challenges.

Case study subtheme: European response to the challenges related to vaccination.

The subtheme of this case study is the European response- through the 3HP- to the challenges related to vaccination, and it assesses the contribution of 3HP activities with a focus on vaccination.

3HP actions in this area were diverse and included supporting Member States' health authorities and other stakeholders to improve access to immunisation; awareness-raising; and mobilising support to respond to the needs of EU citizens in protecting them from vaccine preventable diseases.

The 3HP has also focused on strengthening cooperation and communication across the EU as well as funding the implementation of best practices on vaccine policy interventions. These measures were funded using different financial instruments such as Joint Actions, operating grants, project grants, direct grants or procurement contracts. Table 17 illustrates a sample of funded actions addressing the theme of vaccination.

[393] Council of the European Union, 2014, Council conclusions on vaccination as an effective tool in public health (2014/C 438/04).
[394] Roadmap for the implementation of actions by the European Commission based on the commission communication and the council recommendation on strengthening cooperation against vaccine preventable diseases. Available at: https://health.ec.europa.eu/system/files/2022-07/2019-2022_roadmap_en.pdf
[395] The Europe Beating Cancer Plan actions on vaccine-preventable cancers include, among others, proposing a Council Recommendation on vaccine-preventable cancers and updating the European Code against Cancer.

Table 17. Sample of funded actions in the field of vaccinations.

Action	Examined as part of this case study	Time scale	EU Contribution (EUR)
Joint Action			
European Joint Action on Vaccination (EU-JAV)[396]	✓	August 2018 – March 2022 (42 months)	3.530.232 €
Project Grants			
Improving IMMunisation cooperation in the European UNION (IMMUNION)[397]	✓	01/04/2021-31/03/2023 (24 months)	999.338,00 €
Common Approach for REfugees and other migrants' health (CARE)[398]	✓	01/04/2016 – 31/03/2017 (12 months)	1.689.045,11 €
Strengthen Community Based Care to minimize health inequalities and improve the integration of vulnerable migrants and refugees into local communities (Mig-HealthCare)[399]	✓	01/05/2017 – 30/06/2020 (36 months)	872.602,67 €
Innovative Immunisation Hubs (ImmuHubs)[400]		01/05/2021 - 30/04/2024 (36 months)	989 104,39 €
Reaching the hard-to-reach: Increasing access and vaccine uptake among prison population in Europe (RISE-Vac)[401]		01/05/2021-30/04/2024 (36 months)	951.120,03 €
Increased Access To Vaccination for Newly		01/05/2021-30/04/2024 (36 months)	994.393,00 €

[396] CHAFEA (n.d.). European Joint Action on Vaccination [EU-JAV] [801495] - Joint Actions. Available from: https://webgate.ec.europa.eu/chafea_pdb/health/projects/801495/summary
[397] CHAFEA (n.d.) Improving IMMunisation cooperation in the European UNION [IMMUNION] [101018210] – Project. Available at: https://webgate.ec.europa.eu/chafea_pdb/health/projects/101018210/summary
[398] http://careformigrants.eu/the-project/
[399] CHAFEA (n.d.). Strengthen Community Based Care to minimize health inequalities and improve the integration of vulnerable migrants and refugees into local communities [Mig-HealthCare] [738186] - Project. Available at: https://webgate.ec.europa.eu/chafea_pdb/health/projects/738186/summary
[400] CHAFEA (n.d.). Innovative Immunisation Hubs [ImmuHubs] - [101018282] – Project. Available at: https://webgate.ec.europa.eu/chafea_pdb/health/projects/101018282/summary
[401] CHAFEA (n.d.). Reaching the hard-to-reach: Increasing access and vaccine uptake among prison population in Europe [RISE-Vac] [101018353] – Project. Available at: https://webgate.ec.europa.eu/chafea_pdb/health/projects/101018353/summary

Action	Examined as part of this case study	Time scale	EU Contribution (EUR)
Arrived Migrants (AcToVax4NAM)[402]			
Direct Grants			
IOM Re-Health[403]	✓	July 2017 – October 2018	2.484.885 €
UNICEF RM-Child Health[404]		May 2020-August 2022 (28 months)	4.300.000 €
Operating Grants			
European Public Health Association (EUPHA)		2019	300.539 €
European Public Health Alliance (EPHA)		2017, 2018, 2019, 2020	662.661 € (2017), 584.206,40 € (2018), 554.996 € (2019), 585.800 € (2020)
Procurement			
Study to examine the feasibility of developing a common vaccination card for EU citizens		2019 - 2021	2.220.000 €
Study exploring the feasibility of and identifying options for physical stockpiling of vaccines		2019 -2021	Cancelled

After performing initial desk research for all the listed actions above, five actions were selected and examined in detail to inform this case study: the Joint Action on Vaccination (**EU-JAV**)[405], three projects: 'Improving IMMunisation cooperation in the European UNION (**IMMUNION**)', 'Common Approach for REfugees and other migrants' health (**CARE**)' and 'Strengthen Community Based Care to minimize health inequalities and improve the integration of vulnerable migrants and refugees into local communities (**Mig-HealthCare**)' and the direct grant to the International Organisation for Migration (IOM) (**Re-Health**). Some of these actions focus directly on vaccination (i.e., EU-JAV and IMMUNION). The remaining actions (i.e., CARE, Mig-HealthCare, and Re-Health), while

[402] CHAFEA (n.d.). Increased Access To Vaccination for Newly Arrived Migrants [AcToVax4NAM] [101018349] – Project. Available at: https://webgate.ec.europa.eu/chafea_pdb/health/projects/101018349/summary
[403] https://eea.iom.int/re-health2
[404] https://www.unicef.org/eca/rm-child-health-safeguarding-health-refugee-and-migrant-children-europe
[405] CHAFEA. (n.d.). European Joint Action on Vaccination [EU-JAV] [801495] - Joint Actions. Available from: https://webgate.ec.europa.eu/chafea_pdb/health/projects/801495/summary

relating to other thematic priorities, also cover vaccination in their scope, albeit not being the direct focus.

The other 3HP actions listed in the table above were not examined in detail as the initial desk research showed that not enough information on outputs or outcomes was available (i.e., the procurement contracts, and the UNICEF RM-Child project), vaccination was not the only topic addressed in detail through the action (i.e., EUPHA, EPHA operating grants) or the relevant activities started only recently, therefore few results have been produced (i.e., the projects ImmuHubs, RISE-Vac and ActToVAx4NAM which started in 2021). Despite not being covered in detail, the available information related to some of these actions (i.e., the procurement contracts) is discussed in the outcomes section (see 7.3.6).

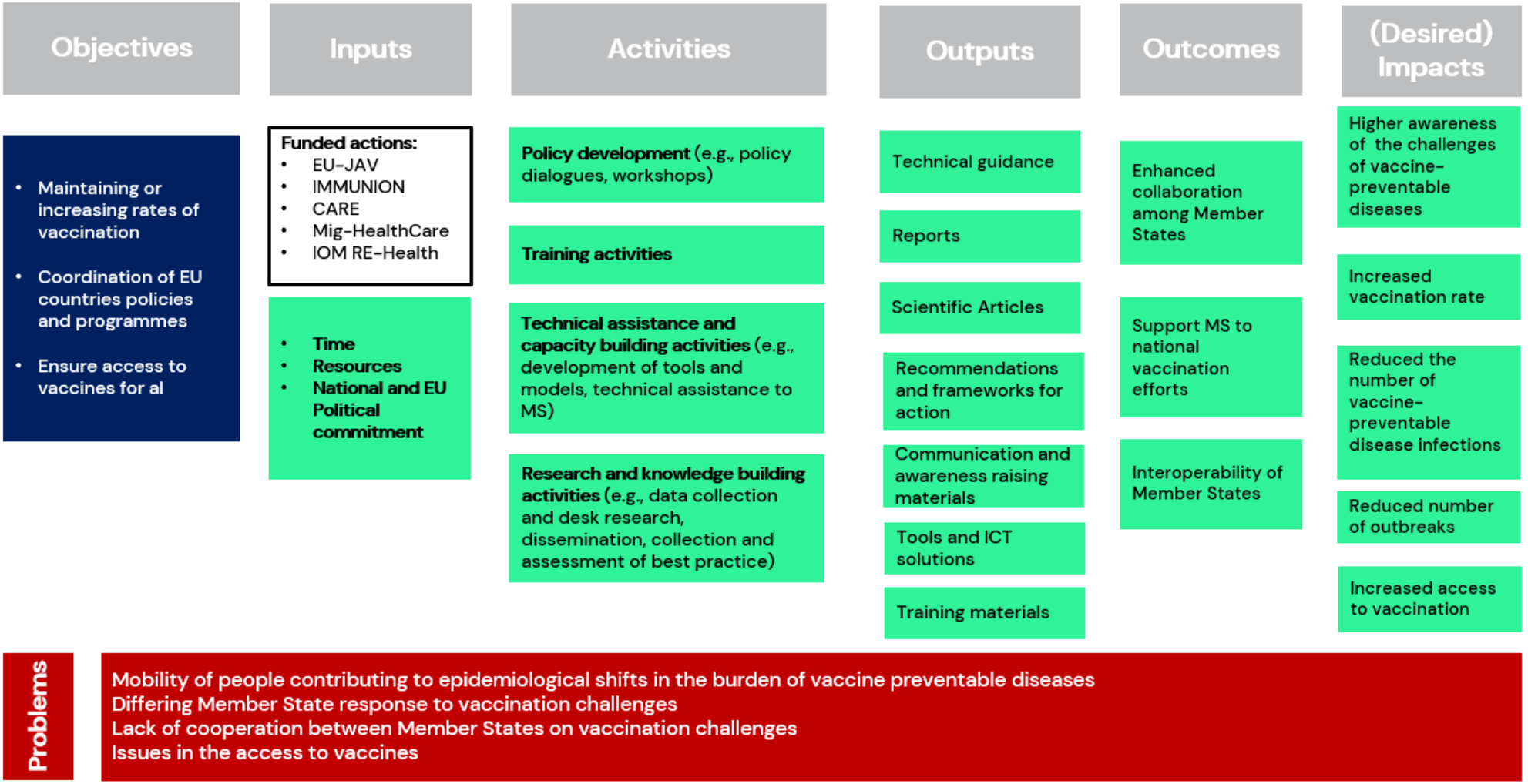
7.2. Intervention logic

The intervention logic illustrates the problems that EU Action on vaccination seeks to address, as well as the objectives, and the inputs and activities undertaken. The intervention logic also depicts the outputs of those activities and their related outcomes and impacts. In terms of financial inputs, the intervention logic does not include a total 3HP contribution on vaccination. The reason is that vaccination has only been the central focus of some actions covered under this case study (e.g., European Joint Action on Vaccination, IMMUNION). Other actions covered in the case study only partially focused on vaccination (e.g., Mig-HealthCare). Therefore, it would be misleading to allocate the entire funding of those actions to vaccination.

The pathway for impact of EU Action in the field of vaccination as outlined in the intervention logic includes a series of activities oriented towards increased cooperation and coordination across European countries and stakeholder groups (e.g., national and local authorities, non-governmental organisations, Civil Society Organisations (CSOs), etc.) engaged in efforts to increase vaccination against communicable diseases and support Member States in responding to vaccination efforts. These activities resulted in outputs in the form of recommendations, technical guidance, ICT tools, training programmes, reports, and events.

The pathway for impact then continues with outcomes resulting from those outputs. The funded actions examined through this case study aimed at coordinating Member State responses to vaccination challenges (e.g., access to vaccination), through enhancing collaboration and supporting national vaccination efforts, and supporting the interoperability between Member States on different aspects of vaccination, e.g., vaccine shortages. The desired long-term impacts are to raise awareness of the challenges posed by vaccine-preventable diseases, increase vaccination rates, increase access to vaccination and reduce the number of vaccine-preventable diseases infections and outbreaks.

Table 18. Intervention logic outline



7.3. Findings: pathway for impact

This section presents the findings of each step of the pathway for impact of EU action in the field of vaccination. It illustrates the problems that EU action seeks to address, and the objectives of the funded actions examined in this case study. It then presents the inputs used to conduct the actions, the activities undertaken, and the outputs produced as part of those actions. Lastly, this section discusses the observed outcomes, drawing from evidence collected from targeted desk research undertaken for this case study, coupled with evidence stemming from the consultation activities held as part of this study, and provides an assessment on the contribution that the funded actions and their outputs had on expected outcomes and impacts in this area.

7.3.1. Drivers / Problems

There are major problems related to vaccination in Europe in terms of access to vaccines and uptake. This negatively affects the potential to protect EU citizens from cross border health threats. Additionally, the mobility of people in and within Europe is contributing to epidemiological shifts in the burden of vaccine-preventable diseases. These issues are worsened due to the insufficient cooperation between Member States on vaccination challenges.

The COVID-19 pandemic, although out of scope of the ex-post evaluation of the 3HP, also played an important role in how Member States responded to cross-border health threats and has reaffirmed the need for further coordination of the work on vaccination across Europe.

7.3.2. Objectives of the funded action#

The funded actions examined in this case study pursued the overarching objective of supporting vaccination efforts in Europe through different activities and mechanisms.

The **Joint Action on Vaccination (EU-JAV)** aimed to stimulate long-lasting EU cooperation against vaccine-preventable diseases. It aimed to build concrete tools to **strengthen national responses to vaccination challenges in Europe** and therefore improve public health. EU-JAV complemented and supported the Commission Communication regarding vaccine preventable diseases[406] and the Council Recommendation on strengthened cooperation against vaccine-preventable diseases[407], in particular as many of the actions carried out by the EU-JAV feed into the vaccination roadmap, as well as the Joint Procurement of medical countermeasures initiative.[408]

Innovative Immunisation Hubs (**ImmuHubs**) is a project funded under the 3HP with the objective to support EU efforts to improve vaccine uptake by strengthening joint efforts with the Coalition for Vaccination[409] and other stakeholders (i.e., media, national public

[406] The Council of the European Union (2018) Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on Strengthened Cooperation against Vaccine Preventable Diseases of April 2018. Available at: Council Recommendation of 7 December 2018 on strengthened cooperation against vaccine-preventable diseases (europa.eu)

[407] European Commission (2018) COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE COUNCIL, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS Strengthened Cooperation against Vaccine Preventable Diseases COM(2018) 245 final, Brussels. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=COM:2018:245:FIN

[408] European Commission (2014) Commission Decision C(2014) 2258 final on approval of the Joint Procurement Agreement to procure medical countermeasures pursuant to Decision 1082/2013/EU. Available at: Commission Decision C(2014) 2258 final (europa.eu)

[409] The Coalition for Vaccination is formed by European associations of healthcare professionals and relevant student associations in the field. More information can be found at https://coalitionforvaccination.com/.

health authorities) to deliver better vaccine education to health professionals and better information to the public.

The project **Common Approach for REfugees and other migrants' health (CARE)** aimed to promote and sustain a good health status among migrants and local populations in five Member States experiencing strong migration pressure: Italy, Greece, Malta, Croatia and Slovenia.

The project **MIG-HealthCare** aimed to promote effective community-based care models to improve physical and mental health care services, support the inclusion and participation of migrants and refugees in Europe and to reduce health inequalities, including access to vaccination. This project is covered in detail in the Health Inequalities' case study.

The IOM direct grant for **Re-Health** aimed to support EU Member States in improving healthcare provision for migrants and contribute to the integration of newly arrived migrants and refugees in EU Member State health systems.

7.3.3. Inputs

Inputs included the time and resources used to conduct the actions. The section below presents an overview of the timescale of each project, the financial contribution the 3HP provided (for those actions that entirely focus on vaccinations), and the number of partners involved in each action.

The **Joint Action on Vaccination (EU-JAV)** was coordinated by INSERM (France) and the Ministry of Solidarity and Health (France), and ran from August 2018 to March 2022. The overall budget of the Joint Action was € 5.800.000 and the 3HP contribution amounted to € 3.530.232. The partnership was formed by 20 countries (17 Member States and 3 non-EU countries) and it included public health authorities, such as health ministries, public health institutes, medicines agencies and biomedical research institutions.

ImmuHubs is being coordinated by Eurohealthnet and received € 989.104,39 of funding through the 3HP and it is set to last two years (01/04/2021-31/03/2023).

The actions listed below had a component focusing on vaccination. However, the proportion of the vaccination focus within these actions is not quantifiable. Therefore, the EU funding received through the 3HP should not be aggregated with the above two actions that focused entirely on vaccination.

The **CARE** project was coordinated by the Italian Institute for Health, Migration and Poverty (INMP), it lasted 12 months (April 2016 to March 2017). The partnership was formed by Public Health Authorities, healthcare providers and NGOs.

MIG-HealthCare coordinated by Astiki Mikerdoskopiki Etaireia Prolipsis (GR), lasted 36 months (May 2017 to June 2020). 13 partners from 10 European countries participated in the project as lead partners.

Re-Health coordinated by the International Organisation for Migration (IOM) lasted 15 months (July 2017 to October 2018).

7.3.4. Activities

Different activities were carried out for each action, and can be categorised as follows:

- Training activities;

- Proposal of technical assistance (e.g., development of tools and models, technical assistance to Member States);
- Research and knowledge building activities (e.g., data collection and desk research, dissemination activities, collection, assessment and exchange of best practices, consultation activities); and
- Developing recommendations, and roadmaps for action.

The Joint Action on Vaccination (EU-JAV) was composed of eight work packages. Three work packages oversaw horizontal activities (coordination, dissemination of the results and communication, evaluation, and sustainability). The vertical work packages 5 to 8 focused on key domains (e.g., better understanding the factors behind vaccine hesitancy and increasing vaccine acceptance; strengthening vaccine supply and preparedness in the EU) and on building concrete tools useful for EU and non-EU country health authorities aimed at strengthening cooperation in Europe in the field of vaccination. A wide range of actions were taken under the different work packages, from communications actions, to developing policy initiatives, or working on developing tools and platforms to support vaccination efforts in Europe.

Activities in the **IMMUNION** project, which aim to support the Coalition for Vaccination, cover the development of a platform to bring to bring together training and resource materials for health professionals, developing national toolboxes to increase vaccine uptake in target communities in four countries (EL, IT, LV, RO), and the organisation of trainings and workshops.

The work carried out through work package 5 of the **CARE** project aimed to strengthen capacity in preventing and detecting communicable disease in newly arrived migrant populations a month after their arrival. Six countries participated (IT, EL, MT, HR, SI, PT) in two cross-sectional studies. To support this objective, the activities carried out included a survey on national policies concerning vaccination to migrants, and a second survey at local level to explore how national immunisation policies offered to newly arrived migrants in participating countries are applied. The survey was conducted to develop a cross sectional study to assess the policy and standards on ad hoc vaccination targeting newly arrived migrants in different European countries. Tools supporting the monitoring and surveillance of migrants' health status related to communicable diseases were piloted, adapted (existing ones) or developed (new approaches) as part of this project.

The consortium coordinating the **MIG-HealthCare** project has used the results of surveys and focus groups to guide the development of roadmaps and toolboxes to respond to the health issues found to be most important for migrants and refugees. Vaccination was among the ten most important issues identified. Therefore, one of the roadmaps and toolboxes focused on vaccination. A pilot was carried out based on the preferences and needs of each Member State. In one country (Bulgaria) training on vaccination for migrants/refugees was piloted.

Re-Health carried out the piloting of an electronic health database and its electronic Personal Health Record (e-PHR) to construct the health history of newly arrived migrants to identify health needs, including vaccinations. This was piloted in four countries across Europe (HR, EL, IT, SI).

7.3.5. Outputs

The different activities described above resulted in a range of different outputs, most notably:

- technical guidance and recommendations;
- monitoring tools and other ICT tools;
- training programmes;
- communication an awareness raising materials ; and
- and frameworks for action.

The Joint Action on Vaccination (EU-JAV) delivered concrete activities and tools for stronger national responses to vaccination challenges. The outputs include websites containing all information about the project and the deliverables produced, organising meetings and events (i.e., information days, and two Member State committee meetings), the development of communication materials such as leaflets and a booklet, and creating different social media channels. EU-JAV outputs also include the publication of scientific publications/journal articles. Different tools were developed and piloted, including training tools, online platforms to share best practices, establishing a vaccine network (Vaccine Hesitancy and Uptake Network), a vaccine barometer to measure the need for training of Health care workers (HCW) and students in healthcare studies, reports summarising the results of each action implemented under the Joint Action. Besides the EU-JAV produced and recommended frameworks for action such as on vaccine stockpiles and supply, and research priorities.

The **IMMUNION** project is still ongoing, however, some outputs have already been delivered, for example, an online dashboard provides access to communication toolboxes and community engagement resources to increase vaccine uptake. These toolboxes provide videos, factsheets, communication materials and other documents to health professionals and health authorities raise awareness about the importance of vaccination and increase vaccine uptake. These are available in several languages (EN, IT, EL, RO, LV) and different formats (e.g., banner, video), applicable to different diseases (e.g., measles, seasonal influenza) and target audiences (e.g., children, migrants)

The **CARE** project produced significant outputs, mainly based on the production and adoption of common tools for migrant health assistance, monitoring of communicable diseases, training of health and non-health operators and communication materials for migrants and the general public. In the participating countries, these tools have been used by the CARE partners for the implementation of actions based on a common strategy, with adjustments to different local contexts.

MIG-HealthCare produced scientific articles and conference presentations, an on-line database with mapping results of existing services and health profiles, a roadmap and a toolbox including an index of best practices, recommendations and training material on vaccination.

The 3HP supported **Re-Health** in the development of an electronic health database to collect data from Personal Health Records (PHR) collected from newly arrived migrants to construct/reconstruct the medical history of arriving migrants, thereby establishing their health status and medical needs. This allowed the record of subsequent provision of preventive measures such as vaccination.

7.3.6. Outcomes

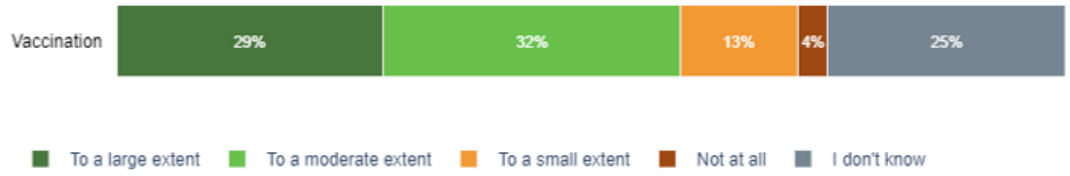
This section discusses the outcomes of the funded actions by evaluation question. The outcomes illustrated in the intervention logic are as follows:

- Coordination among Member States, including the exchange of best practices;
- Support to Member States' efforts on vaccination.

EQ4a: To what extent has the programme contributed to a more comprehensive and coordinated approach to vaccinations in the EU?

Overall, half of respondents to this study's survey (held as part of targeted consultations with various stakeholder groups) felt the 3HP contributed to a more comprehensive and uniform approach to addressing health issues related to vaccination to a large or moderate extent (61%).

Table 19. To what extent has the Programme contributed to a more comprehensive and uniform approach to addressing health issues across the following policy areas? (n=32)



Moreover, available documentary information on some of the funded actions suggests that the activities covered contributed to *an increased collaboration and coordination among Member State officials* allowing exchange of knowledge and best practices and the development of common tools. Concretely, the available documentation for two projects (CARE, Re-Health) indicated that activities and outputs related to vaccination issues increased coordination across Member States in response to vaccination needs related to the migration crisis. For instance, through the CARE project common tools tailored to local contexts were developed to respond to the needs related to migrant health assistance. CARE partners actively promoted these tools and project activities in the context of other projects addressing health needs of migrants which were conducted simultaneously at national or EU level. This streamlining process aimed to strengthen the project activities and avoid overlaps with other projects. Hence, outputs and materials were made available to those who wanted to implement similar projects/activities. In addition, coordination with other 3HP projects[410] was assured through inter-coordination meetings promoted by CHAFEA. In this framework, tools and materials produced by CARE were made available to public institutions and private entities who wanted to implement similar projects and activities. An example of coordination with another project addressing health needs of migrants was the Re-Health project also covered in this case study.

Results from an OPC carried out as part of this study showed that respondents who believed that 3HP actions led to general improvements in health considered EU-JAV as an example of an action contributing to greater cooperation between Member States, and a more effective implementation of the Programme's priorities. Hence, the work of the Joint Action was delivered using cooperative methods. A vaccine network was set up at the beginning of the EU-JAV bringing together officials in charge of vaccination policy and health services in their countries. Additionally, a stakeholder forum was created to gather all stakeholders involved in vaccines in Europe (e.g., EPHA). Cooperation was also achieved with other EU institutions. An agreement was signed

[410] Projects funded by CHAFEA in the framework of the HP-HA_2015 call for proposal (8 NGOs in 11 countries, Re-Health, SH-CAPAC and EUR-HUMAN)

between the EU-JAV and ECDC to ensure efficient cooperation. In the context of EU-JAV, many activities were carried out aiming to collect and exchange best practices. Moreover, EU-JAV results, tools and recommendations were presented to Member States during several meetings of the Member States Committee. Member States declared that they would take in account these recommendations and would implement these tools at the national level.[411] Additionally EU-JAV produced a report on the possibility of establishing a strengthened cooperation structure between National Immunization Technical Advisory Groups (NITAGs)[412] after working in close collaboration with the ECDC, as this agency initiated a pilot collaboration between EU/EEA experts working with or supporting national NITAGs.

A stakeholder interviewed as part of this study who represented a governmental public health organisation reported that EU-JAV supported collaboration across European agencies in a clear, practical way, allowing 'differences to be identified and ironed out'. The same stakeholder found that results from vaccine programmes contributed to decision making at EU/national level. EU-JAV is a clear example of an action set up through the 3HP to deliver and share concrete tools to help strengthen national responses to vaccination challenges. To support that, the coordinator of EU-JAV stated that the joint action focused on identifying technical requirements, operational structures, and mechanisms for cooperation to bridge gaps and maximise synergies between experts and policy makers.[413]

In the final report of the EU-JAV, the consortium stated that the joint action developed multilateral and durable systemic cooperation to build concrete tools useful for EU and non-EU Member State health authorities. These tools/concepts include efficient mechanisms for interoperability of digital vaccine-related databases, robust methods of monitoring immunisation programmes, accurate forecasting of vaccine needs through a concept of repository supply and demand data, priority-setting of vaccine research and development, and an instrument to monitor vaccine confidence through social media, as well as a platform collecting and disseminating best practices and interventions to improve vaccine confidence.

Similar collaboration is occurring in the ongoing IMMUNION project. The central objective of this project is to improve vaccination uptake across Europe through strengthening collaboration between Coalition for Vaccination member associations and other stakeholders to deliver better vaccine education to health professionals and better information to the public.[414] Hence, close collaboration with the Coalition for Vaccination[415] serves as a forum for key stakeholders involved in education and trainings and it also allows materials to be developed and reach their targeted audience (healthcare professionals on the ground as well as students). Building on collaboration in the context of EU-JAV, IMMUNION used the vaccine barometer developed within EU-JAV as the basis for the IMMUNION WP4 survey. Additionally, EU-JAV's vaccinology curriculum has been the foundation of IMMUNION WP5 training, how the two projects connect is further expanded and discussed under EQ9 as it speaks to the sustainability of the EU-JAV results. A main focus of IMMUNION is on dissemination and sharing of the outputs produced. However, this project is still ongoing and some of the results are recent or have not been concluded.

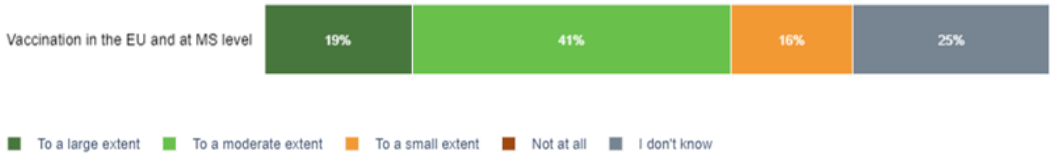
[411] EU-JAV (2022) Periodic Technical Report) Not publicly available.
[412] NITAGs are multidisciplinary bodies of national experts that provide evidence-based recommendations to policy-makers and immunization programme managers.
[413] Genevieve Chene coordinator of EU-JAV on behalf of INSERM In EU Health programme Conference 30 November 2019
[414] Improving IMMunisation cooperation in the European UNION (IMMUNION) (2022) Periodic Technical Report. Not publicly available
[415] The Coalition for Vaccination brings together European associations of healthcare professionals and relevant student associations in the field.

The findings from the above actions show that outcomes relate primarily to sharing best practices and coordination efforts in developing tools and outputs. While consulted stakeholders indicated that outputs have supported coordination and collaborative efforts through the 3HP in the field of vaccination, in order to reach the desired outcomes and have an impact it will be crucial for the EU and Member State to take up the recommendations and tools produced by these funded actions and to sustain them. Some tools and recommendations have been already used, either in other funded projects or following the surge of the COVID-19 pandemic. If these tools are not used, the impacts of the funded actions will be very limited.

EQ4b: To what extent has the programme contributed to improvements in vaccination efforts in the EU and at Member State level?

Results from a survey show that 60% of respondents believed that the programme contributed to improvements in vaccination in the EU and at Member State level.

Table 20. To what extent has the Programme contributed to improvements in the following areas? (n=32)



The CARE project produced a report identifying critical aspects of immunisation delivery and providing possible solutions targeting newly arrived migrants in different countries. In addition, tools and training were delivered through this project to support stakeholders in contact with newly arrived migrants. The Re-Health project developed an electronic health database to collect data from personal health records (PHR) collected from newly arrived migrants. The objective of this approach was to construct/reconstruct the medical history of arriving migrants, thereby establishing their health status and medical needs. This has the potential to support healthcare providers to record the provision of preventive measures such as vaccination to migrants. Hence migrants can follow their vaccination schedules and avoid receiving repeated vaccinations. Moreover, an interviewed stakeholder from DG SANTE mentioned that the work conducted in the context of the 3HP and undertaken by international institutions in the area of health inequalities (migration vaccination) including training programmes on vaccination and micro tools was very useful.

Some of the funded actions lead to awareness-raising about vaccination topics. This is the main focus of IMMUNION and partly the focus of EU-JAV. Both projects focused on dissemination, communication or awareness raising as their main objective.

Furthermore, Joint Actions organised under the 3HP, like EU-JAV bring the potential to accelerate the adoption of tools and best practices at national level, as the outputs of these joint actions result from cooperation among EU and national policy makers. For example, through the EU-JAV, a "vaccine barometer" to measure the need for training of health care workers and students in health was delivered and evaluated. The results from this action have the potential to be used in response to vaccination challenges or have served as the basis for additional projects under the 3HP on vaccination (e.g., the focus on training in IMMUNION or in reaching disadvantaged and socially excluded groups). In response to the pandemic, policy reforms at EU level have been initiated, these include revising the mandate of ECDC, EMA and establishing DG HERA. The details of these policy texts will be further expanded and discussed under EQ9 as it

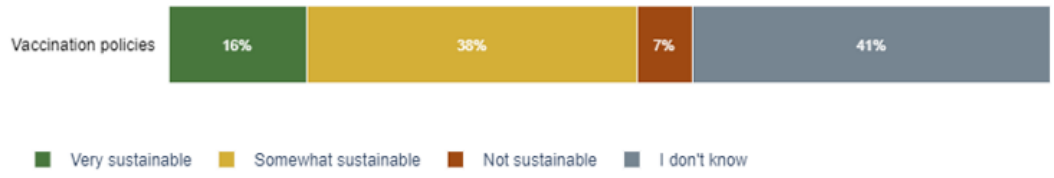
speaks to the sustainability of the EU-JAV results. More importantly, an analysis conducted as part of EU-JAV on the proposed legislative texts showed that COVID-19 illustrated how relevant the areas of work of EU-JAV was to tackle the different challenges of this crisis. The clear alignment between the gaps identified and the objectives of the EU-JAV underline the relevance of the strategic focus of the Joint Action, presenting opportunities for the EU-JAV outputs to contribute strengthening EU's response to vaccination challenges.

The available documentation on the funded actions reviewed as part of this case study suggest that some of the funded actions (i.e. RE-health, CARE) have the potential to improve the health status and access to care of vulnerable groups. Available documentation on the EU-JAV and IMMUNION, shows the great potential that the developed tools have in improving vaccination coverage and strengthening national immunisation programmes and the response to vaccinations challenges in the UE. However, it is not yet possible to conclude that outputs of the funded actions have led to improvements in vaccination efforts in the EU an at Member State level. However, results show that there is potential to reach these outcomes if the recommendations and tools produced by these funded actions are taken up comprehensively.

EQ9a: To what extent are the programme results and effects in relation to vaccination likely to be sustainable?

Over half of survey respondents (54%) felt that work on vaccination policies was very or somewhat sustainable. Moreover, survey respondents highlighted that vaccination policies were one of the fields having the most sustainability by way of action (5 respondents, 16%).

Figure 60. *How sustainable do you think the Programme results and effects are in the specific fields of…? (n=32)*



The EU-JAV developed multilateral and durable cooperation to build concrete tools useful for EU and non-EU Member States' health authorities.[416][417] Furthermore, numerous EU-JAV partners are involved in other projects funded under the 3HP focusing on vaccination. Hence, outputs of the EU-JAV are being used in the implementation of such actions, for example the work produced in WP4 and WP5 of EU-JAV has served as the basis for the work of IMMUNION. The emergence of the COVID-19 pandemic showed the importance of the EU-JAV work. Gaps identified from ten early lessons from COVID-19 identified by the European Commission[418] clear alignment between the gaps identified and the objectives of the EU-JAV underline the relevance of the strategic focus of this Joint Action. Moreover, new regulations to

[416] Non-EU member states were involved in the different workstreams of the Joint Action: Bosnia and Herzegovina, Norway and Serbia.

[417] These tools include efficient mechanisms for interoperability of digital vaccine-related databases, robust methods of monitoring immunisation programmes, accurate forecasting of vaccine needs through a repository of vaccine supply and demand data, priority-setting of vaccine research and development, an instrument to monitor vaccine confidence in social media, as well as a platform collecting and disseminating best practices and interventions to improve confidence.

[418] European Commission (2021) Communication from the commission to the European parliament, the European Council, the Council, the European economic and social committee and the committee of the regions. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52021DC0380&from=EN

strengthen the mandates of the ECDC, EMA and the establishment of DG HERA and the new Pharmaceutical Industry show an opportunity for the EU-JAV to participate in strengthening the EU's preparedness. Moreover, an analysis conducted to link EU-JAV outputs to the gaps in the above regulations. From the analysis it became apparent that ECDC extended competences are central to the EU-JAV (Healthcare workers' training, research priorities, promotion of surveillance standards). The mandates of EMA and HERA relate to commit with monitoring stocks and supplies of medical countermeasures to avoid shortages and include a focus on electronic monitoring system therefore relating to work performed on the prevention of vaccine shortages and the analysis conducted on vaccine exchanges mechanisms during the EU-JAV.

Furthermore, regarding the work undertaken in response to the migration crisis, as noted in the final evaluation of the Mig-HealthCare project,[419] the long-term sustainability of project effects is dependent on a series of actions, including expanding the network of stakeholders beyond the core of the consortium partners, incorporating the tools developed in the context of the project in the everyday activities of the relevant stakeholders.

Regarding Re-health, the actions started through this project were continued in a follow-up project (Re-Health2). This continuation was led by the evidence provided and the need for further support by Member States. In addition, Re-health2's scope was enlarged to include two additional countries (Serbia and Cyprus).[420]

Moreover, as discussed in the previous section, work supported by the 3HP undertaken by international institutions in the area of health inequalities (migration vaccination) including training programmes on vaccination and micro tools were perceived as very useful and sustainable- examples provided by stakeholders consulted as part of this study confirmed this, citing that certain results are still in place and in active use (e.g., some results of these projects are being used to respond to the incoming migration due to the crisis in Ukraine).

In the roadmap on vaccination[421] the European Commission considered as one of its key actions on vaccination to examine the feasibility of developing a common vaccination card/passport for EU citizens that is compatible with electronic immunisation information systems and recognised for use across borders, without duplicating work at national level. A feasibility study for the development of a common EU vaccine card was procured (publication pending). The emerging results of this procurement action on the EU vaccination card were praised by EU stakeholders in a focus group conducted as part of this study. Moreover, the European Commission considers this action to be materialised in the format of a Commission proposal for Regulation on the European Health Data Space.[422]

In conclusion, given the available information, it can be stated that some of the funded actions are impactful beyond their lifetime, as they laid down the foundation for other actions (funded through the 3HP) to continue working on the same themes.

[419] Alejandro Gil Salmerón, Anastasios Rentoumis, Jorge Garcés Ferrer (2020), "Mig-HealthCare: Strengthen Community Based Care to minimize health inequalities and improve the integration of vulnerable migrants and refugees into local communities, Final Evaluation Report", available at Health Programme DataBase - European Commission (europa.eu).
[420] International Organization for Migration (IOM) (2017) Final Public Report. Available at: https://eea.iom.int/sites/g/files/tmzbdl666/files/inline-files/rh_final-public-report_final.pdf
[421] Roadmap for the implementation of actions by the European Commission based on the commission communication and the council recommendation on strengthening cooperation against vaccine preventable diseases. Available at: https://health.ec.europa.eu/system/files/2022-07/2019-2022_roadmap_en.pdf
[422] European Commission (2022) Roadmap on vaccination. Available at: https://health.ec.europa.eu/system/files/2022-07/2019-2022_roadmap_en.pdf

However, to achieve this sustainability, commitment from relevant stakeholders and wide spread of the outputs need to be considered.

7.4. Conclusion

Overall, the EU has acted through dedicated 3HP funding to address vaccination issues. This case study analysed five funded actions, two specifically directed to vaccination challenges (EU-JAV and IMMUNION) and three projects directed towards improving the access to healthcare (including vaccination) of migrants and refugees (CARE, Mig-HealthCare, RE-health). The examined actions have conducted a wide range of activities engaging with stakeholders and a wealth of outputs have been produced for the benefit of policy makers, health and social care professionals and other stakeholders, including technical guidance, monitoring tools, training programmes and awareness raising materials.

Those outputs have contributed to enhancing cooperation and collaboration among actors involved in the challenges associated with vaccination and improved knowledge and best practices exchanges.

The desired long-term impacts of such outputs and outcomes have been identified as increased vaccination rates and increased access to vaccination across Europe, reduced number of vaccine-preventable diseases and higher awareness of the challenges linked to those. It is not possible to assess the 3HP contribution to achieving those long-term impacts, given that their realisation depends on a variety of factors not necessarily linked to the outcomes of a single action in the field of health policy. However, the outputs and outcomes of the examined 3HP funded actions (e.g., the produced tools, the increased coordination among Member States and cooperation among the different actors involved) have the potential to improve vaccination efforts in Europe by strengthening national immunisation programmes and therefore are likely to contribute to the achievement of the above mentioned long-term impacts.

. Questionnaires, topic guides and facilitation plans used in the field phase

A4.1 OPC

PUBLIC CONSULTATION ON THE FINAL EVALUATION OF THE THIRD HEALTH PROGRAMME 2014-2020

Fields marked with * are mandatory.

Introduction

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 Commission is conducting a final evaluation of the 3rd Health Programme. Its purpose is to monitor, evaluate and report on the implementation of the actions of the 3HP in relation to its objectives and indicators (time period: 2014-2020). The evaluation will cover the following criteria: Effectiveness, Efficiency, Relevance, Coherence, and EU-added value.

This consultation is a part of a series of consultations (public consultation, targeted stakeholder surveys, stakeholder interviews, focus groups), foreseen in the stakeholder strategy.

Your insights will help us to assess the successes and areas for improvement of the Programme. You can contribute to this consultation by filling in the online questionnaire. If you are unable to use the online questionnaire, please contact us using the email address below.

Questionnaires are available in all official EU languages. You can submit your responses in any official EU language.

Depending on your role in the programme this questionnaire may prompt you to participate in a targeted consultation, organised by ICF, contracted by the Commission to perform a study in support of this evaluation.

For reasons of transparency, organisations and businesses taking part in public consultations are asked to register in the EU's Transparency Register.
In case you wish to contact the Unit responsible for the open public consultation, please send an email to: SANTE-3HP-FINAL-EVALUATION@ec.europa.eu.

If you have any issues with completing the survey you can contact the study team here: 3hpstudy@icf.com

About you

* 1 Language of my contribution

- Bulgarian
- Croatian
- Czech
- Danish
- Dutch
- English
- Estonian
- Finnish
- French
- German
- Greek
- Hungarian
- Irish
- Italian
- Latvian
- Lithuanian
- Maltese
- Polish
- Portuguese
- Romanian
- Slovak
- Slovenian
- Spanish
- Swedish

* 2 I am giving my contribution as

- Academic/research institution
- Business association
- Company/business organisation
- Consumer organisation
- EU citizen
- Environmental organisation
- Non-EU citizen
- Non-governmental organisation (NGO)

- Public authority
- Trade union
- Other

* 3 Please specify further

- Central government/ministry of health
- Public health authority or agency

* 4 Please specify further

- International organisation (e.g. WHO, OECD)
- Healthcare service provider
- Organisation representing healthcare service providers
- Healthcare professionals' association
- Independent expert

* 5 First name

* 6 Surname

* 7 Email (this won't be published)

* 8 Scope

- International
- Local
- National
- Regional

* 9 Level of governance

- Local Authority
- Local Agency

* 10 Level of governance

- Parliament

- Authority
- Agency

* 11 Organisation name

255 character(s) maximum

* 12 Organisation size

- Micro (1 to 9 employees)
- Small (10 to 49 employees)
- Medium (50 to 249 employees)
- Large (250 or more)

13 Transparency register number

255 character(s) maximum

Check if your organisation is on the transparency register. It's a voluntary database for organisations seeking to influence EU decision-making.

* 14 Country of origin

Please add your country of origin, or that of your organisation.

- Afghanistan
- Åland Islands
- Albania
- Algeria
- American Samoa
- Andorra
- Angola
- Anguilla
- Antarctica
- Antigua and Barbuda
- Djibouti
- Dominica
- Dominican Republic
- Ecuador
- Egypt
- El Salvador
- Equatorial Guinea
- Eritrea
- Estonia
- Eswatini
- Libya
- Liechtenstein
- Lithuania
- Luxembourg
- Macau
- Madagascar
- Malawi
- Malaysia
- Maldives
- Mali
- Saint Martin
- Saint Pierre and Miquelon
- Saint Vincent and the Grenadines
- Samoa
- San Marino
- São Tomé and Príncipe
- Saudi Arabia
- Senegal
- Serbia
- Seychelles

Argentina	Ethiopia	Malta	Sierra Leone
Armenia	Falkland Islands	Marshall Islands	Singapore
Aruba	Faroe Islands	Martinique	Sint Maarten
Australia	Fiji	Mauritania	Slovakia
Austria	Finland	Mauritius	Slovenia
Azerbaijan	France	Mayotte	Solomon Islands
Bahamas	French Guiana	Mexico	Somalia
Bahrain	French Polynesia	Micronesia	South Africa
Bangladesh	French Southern and Antarctic Lands	Moldova	South Georgia and the South Sandwich Islands
Barbados	Gabon	Monaco	South Korea
Belarus	Georgia	Mongolia	South Sudan
Belgium	Germany	Montenegro	Spain
Belize	Ghana	Montserrat	Sri Lanka
Benin	Gibraltar	Morocco	Sudan
Bermuda	Greece	Mozambique	Suriname
Bhutan	Greenland	Myanmar/Burma	Svalbard and Jan Mayen
Bolivia	Grenada	Namibia	Sweden
Bonaire Saint Eustatius and Saba	Guadeloupe	Nauru	Switzerland
Bosnia and Herzegovina	Guam	Nepal	Syria
Botswana	Guatemala	Netherlands	Taiwan
Bouvet Island	Guernsey	New Caledonia	Tajikistan
Brazil	Guinea	New Zealand	Tanzania
British Indian Ocean Territory	Guinea-Bissau	Nicaragua	Thailand
British Virgin Islands	Guyana	Niger	The Gambia
Brunei	Haiti	Nigeria	Timor-Leste

- Bulgaria
- Burkina Faso
- Burundi
- Cambodia
- Cameroon
- Canada
- Cape Verde
- Cayman Islands
- Central African Republic
- Chad
- Chile
- China
- Christmas Island
- Clipperton
- Cocos (Keeling) Islands
- Colombia
- Comoros
- Congo
- Cook Islands
- Costa Rica
- Côte d'Ivoire
- Croatia
- Cuba
- Curaçao
- Cyprus
- Heard Island and McDonald Islands
- Honduras
- Hong Kong
- Hungary
- Iceland
- India
- Indonesia
- Iran
- Iraq
- Ireland
- Isle of Man
- Israel
- Italy
- Jamaica
- Japan
- Jersey
- Jordan
- Kazakhstan
- Kenya
- Kiribati
- Kosovo
- Kuwait
- Kyrgyzstan
- Laos
- Latvia
- Niue
- Norfolk Island
- Northern Mariana Islands
- North Korea
- North Macedonia
- Norway
- Oman
- Pakistan
- Palau
- Palestine
- Panama
- Papua New Guinea
- Paraguay
- Peru
- Philippines
- Minor Outlying Islands
- Pitcairn Islands
- Poland
- Portugal
- Puerto Rico
- Qatar
- Réunion
- Romania
- Russia
- Rwanda
- Saint Barthélemy
- Togo
- Tokelau
- Tonga
- Trinidad and Tobago
- Tunisia
- Turkey
- Turkmenistan
- Turks and Caicos Islands
- Tuvalu
- Uganda
- Ukraine
- United Arab Emirates
- United Kingdom
- United States
- United States
- Uruguay
- US Virgin Islands
- Uzbekistan
- Vanuatu
- Vatican City
- Venezuela
- Vietnam
- Wallis and Futuna
- Western Sahara
- Yemen

- Czechia
- Democratic Republic of the Congo
- Lebanon
- Lesotho
- Saint Helena Ascension and Tristan da Cunha
- Saint Kitts and Nevis
- Zambia
- Zimbabwe

- Denmark
- Liberia
- Saint Lucia

* 15 How would you describe your knowledge of the 3rd Health Programme?

- Detailed in-depth knowledge
- Some knowledge
- Only very basic knowledge
- No knowledge at all

* 16 Have you or the organisation / institution you represent ever applied directly or indirectly for funding from the 3rd Health Programme?

Indirect application refers to support to or partnering with an organisation which has directly applied for funding from the 3rd Health Programme

- Yes
- No
- Not aware of
- Not applicable

17 As part of your involvement in the 3rd Health Programme, what type of funding instruments did you come across?

- Project grants
- Operating grants
- Direct grants to international organisations
- Joint actions
- Procurement contracts
- Health Policy Platform & Health Award/Health Prize

* 18 What is the main reason that you or your organisation did not apply for funding from the 3rd Health Programme?

- Available funding amount was not suitable
- Did not feel prepared to apply for funding
- Did not have staff or resource capacity to apply
- The topic of the calls did not correspond to our profile
- I was not aware of/informed of the existence of the programme
- Other

19 If other, please state

* 20 Have you or the organisation / institution you represent ever received funding from the 3rd Health Programme?

- Yes
- No
- I don't know

21 What type of funding instrument you benefitted from?

- Project grants
- Operating grants
- Direct grants to international
- organisations Joint actions
- Procurement contracts
- Health Policy Platform & Health Award/Health Prize

* 22 What is your background in relation to the 3rd Health Programme?

- Stakeholder directly involved in the **programme design**
- Stakeholder directly involved in the **programme implementation**
- Stakeholder directly involved in the **programme evaluation**
- Stakeholder who **benefitted from the programme**
- Stakeholder who **has interest in the programme**

Thank you – based on your profile and experience of the 3rd Health Programme, we would recommend you to take part in our targeted surveys. The link for the targeted survey is: https://icfconsulting.qualtrics.com/jfe/form/SV_5u24ltZglpOMfOe.

* 23 As part of your involvement in the 3rd Health Programme, what type of funding instruments were you aware of?

- Project grants

- ☐ Operating grants
- ☐ Direct grants to international
- ☐ organisations Joint actions
- ☐ Procurement contracts
- ☐ Health Policy Platform & Health Award/Health Prize

The Commission will publish all contributions to this public consultation. You can choose whether you would prefer to have your details published or to remain anonymous when your contribution is published. **Fo r the purpose of transparency, the type of respondent (for example, 'business association, 'consumer association', 'EU citizen') country of origin, organisation name and size, and its transparency register number, are always published. Your e-mail address will never be published.**
Opt in to select the privacy option that best suits you. Privacy options default based on the type of respondent selected

* 24 Contribution publication privacy settings

The Commission will publish the responses to this public consultation. You can choose whether you would like your details to be made public or to remain anonymous.

○ **Anonymous**

The type of respondent that you responded to this consultation as, your country of origin and your contribution will be published as received. Your name will not be published. Please do not include any personal data in the contribution itself.

○ **Public**

Your name, the type of respondent that you responded to this consultation as, your country of origin and your contribution will be published.

* 25 Contribution publication privacy settings

The Commission will publish the responses to this public consultation. You can choose whether you would like your details to be made public or to remain anonymous.

○ **Anonymous**

Only organisation details are published: The type of respondent that you responded to this consultation as, the name of the organisation on whose behalf you reply as well as its transparency number, its size, its country of origin and your contribution will be published as received. Your name will not be published. Please do not include any personal data in the contribution itself if you want to remain anonymous.

○ **Public**

Organisation details and respondent details are published: The type of respondent that you responded to this consultation as, the name of the organisation on whose behalf you reply as well as its transparency number, its size, its country of origin and your contribution will be published. Your name will also be published.

☐ I agree with the personal data protection provisions

RELEVANCE

This section invites you to assess whether the priorities and objectives of the 3rd Health Programme address needs and problems in society.

Health and healthcare needs and problems in the EU at the time of the programme's development (2014)

The mid-term evaluation of the 3rd Health Programme identified a set of health and healthcare needs and problems at the time when the Programme was established in 2014:

- An ageing population, threatening the financial sustainability of health systems and causing health workforce shortages;
- A fragile economic recovery, limiting the availability of resources to invest in healthcare;
- An increase in health inequalities between and within Member States; An increase in the prevalence of chronic disease;
- Pandemics and emerging cross-border health threats; The rapid development of health technologies; Increase in mental health problems (particularly among the young);
- Other specific emergency situations which expose EU health professionals to unprecedented challenges (for example, dealing with the repercussions of the influx of refugees);
- and Threats to environmental health such as air quality and pollution monitoring

* 26 To what extent did the 3rd Health Programme correctly identify the health and healthcare needs and problems at the time of the development?

○ To a large extent
○ To a moderate extent
○ To a small extent
○ Not at all
○ I don't know

27 Please

explain

* 28 In your view, were there any relevant problems or needs that were not identified by the 3rd Health Programme at the time of its development?

- Yes
- No

29 Please explain

The 3rd Health Programme has 4 specific objectives as listed in question 11 below. These specific objectives are further broken down into 23 thematic priorities as listed in question 12 below.

Citizens' perceptions of key health issues in the EU

More than half of the citizen from the 27 Member States consider that the overall quality of health care in their countries in fairly good. Moreover, only 7% mentioned having a very bad quality of health care in their countries.

In terms of their perceptions of key health issues in the EU, citizens consider that:

- Unnecessary use of antibiotics makes them become ineffective.
- Not getting vaccinated can lead to serious health issues.
- The main health risks in the future will be related to diseases and epidemics, ageing population and pollution.
- Possible risks of contracting a disease (e.g., HIV, hepatitis, etc.) when treated with donated blood, cells, or tissues.

30 In your view, how relevant are the 3rd Health Programme's specific objectives in relation to EU health needs?

	1 - Not at all relevant	2	3	4	5 - Very relevant	I don't know
* Promote health, prevent disease and foster supportive environments for healthy lifestyles						

* Protect Union citizens from serious cross border health threats						
* Contribute to innovative, efficient and sustainable health systems						
* Facilitate access to better and safer healthcare for Union citizens						

31 Please provide details about your responses in the question above:

32 Please rate the relevance of each of the 3rd Health Programme priorities on a scale of 1 to 5 (1 is not at all relevant and 5 is very relevant).

1. Promote health, prevent disease and foster supportive environments for healthy lifestyles

	1 - Not at all relevant	2	3	4	5 - Very relevant	I don't know
* 1.1 Risk factors such as use of tobacco and passive smoking, harmful use of alcohol, unhealthy dietary habits and physical inactivity						
* 1.2 Drugs-related health damage, including information and prevention						
* 1.3 HIV/AIDS, tuberculosis and hepatitis						
* 1.4 Chronic diseases including cancer, age-related diseases and neurodegenerative diseases						
* 1.5 Tobacco legislation						
* 1.6 Health information and knowledge system to contribute to evidence-based decision making						

33 2. Protect Union citizens from serious cross border health threats

	1 - Not at all relevant	2	3	4	5 - Very relevant	I don't know
* 2.1 Risk assessment 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						

34 3. Contribute to innovative, efficient, and sustainable health systems

	1 - Not at all relevant	2	3	4	5 - Very relevant	I don't know
* 3.1 Health Technology Assessment - HTA						
* 3.2 Innovation and e-health						
* 3.3 Health workforce forecasting and planning						
* 3.4 Setting up a mechanism for pooling expertise at Union level						
* 3.5 European Innovation Partnership on Active and Healthy Ageing						
* 3.6 Implementation of Union legislation in the field of medical devices, medicinal products and cross-border healthcare						
* 3.7 Health information and knowledge system including support to the Scientific Committees set up in accordance with Commission Decision 2008 /721/EC						

35 4. Facilitate access to high quality, safe healthcare for EU citizens

	1 - Not at all relevant	2	3	4	5 - Very relevant	I don't know
* 4.1 European Reference Networks						
* 4.2 Rare diseases						
* 4.3 Patient safety and quality of healthcare						
* 4.4 Measures to prevent Antimicrobial resistance and control healthcare-associated infections						
* 4.5 Implementation of Union legislation in the fields of tissues and cells, blood, organs						

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

36 Please provide details about your responses in the question above:

EFFECTIVENESS

This section invites you to assess how successful the 3rd Health Programme has been in achieving or progressing towards its stated objectives. The specific objectives and thematic priorities for the Programme are listed below:

Specific Objectives:

1) Promote health, prevent disease and foster supportive environments for healthy lifestyles; 2) Protect Union citizens from serious cross border health threats; 3) Contribute to innovative, efficient and sustainable health systems; 4) Facilitate access to better and safer healthcare for Union citizens.

Thematic priorities:

1.1. Risk factors such as use of tobacco and passive smoking, harmful use of alcohol, unhealthy dietary habits and physical inactivity; **1.2** Drugs-related health damage, including information and prevention; **1.3** HIV / AIDS, tuberculosis and hepatitis; **1.4** Chronic diseases including cancer, age-related diseases and neurodegenerative diseases; **1.5** Tobacco legislation; **1.6** Health information and knowledge system.
2.1 Risk assessment 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
3.1 HTA; **3.2** Innovation and e-health; **3.3** Health workforce forecasting and planning; **3.4** Setting up a mechanism for pooling expertise at Union level; **3.5** European Innovation Partnership on Active and Healthy Ageing; **3.6** Implementation of Union legislation in the field of medical devices, medicinal products and cross-border healthcare; **3.7** Health information and knowledge system including support to the Scientific Committees set up in accordance with Commission Decision 2008/721/EC
4.1 European Reference Networks; **4.2** Rare Diseases; **4.3** Patient safety and quality of healthcare; **4.4** Measures to prevent Antimicrobial resistance and control healthcare-associated infections; **4.5** Implementation of Union legislation in field of tissues and cells, blood, organs; **4.6** Health information and knowledge system.

* 37 To what extent have measures implemented by Member States overall been aligned with the specific objectives and thematic priorities of the 3rd Health Programme?

- To a large extent
- To a moderate extent
- To a small extent
- Not at all
- I don't know

38 Please explain

* 39 To what extent have programme actions led to general improvements in health and healthcare in the EU and at MS level?

- To a large extent
- To a moderate extent
- To a small extent
- Not at all
- I don't know

40 Please list which actions you consider to have led to improvements in health and health care in the EU and at MS level:

The EU complements national health policies by supporting national governments of the EU Member States to achieve common objectives, pool resources and overcome shared challenges. In addition, the EU also formulates EU-wide laws and standards for health products and services, and provides funding for health projects across the EU.

EU health policy focuses on protecting and improving health, giving equal access to modern and efficient healthcare for all Europeans, and coordinating any serious health threats involving more than one EU country. Disease prevention and response play a big part in the EU's public health focus. Prevention touches many areas such as vaccination, fighting antimicrobial resistance, actions against cancer and responsible food labelling.

EU health priorities and actions.

41 To what extent is the 3rd Health Programme able to strengthen the impact of EU health policy?

	To a large extent	To a moderate extent	To a small extent	Not at all	I don' t know
* Complementing national policies					
* Encouraging cooperation between Member States					
* Formulating EU-wide laws and standards for health products and services					
* Coordinating cross-border health threats					
* Disease prevention and response					
Other					

EFFICIENCY

This section invites you to assess the relationship between the resources used by the 3rd Health Programme and the changes it generated.

42 To what extent do you believe costs associated with the 3rd Health Programme are reasonable and kept to the minimum necessary in order to achieve the expected results?

	1 - Not at all	2	3	4	5 - To a large extent	I don't know
* Programme operational costs (design & implementation)						
* Management costs for funding						
* Administrative costs for applicants						
* Administrative costs for Chafea						
* Monitoring & reporting costs for Member States and the Commission						

EU ADDED VALUE

In this section we would like you to indicate changes which can reasonably be argued to be due to the 3rd Health Programme, over and above what could reasonably have been expected from national actions alone.

* 43 What has been the Programme's contribution, beyond what Member States could have achieved acting alone?

- It provided high added value
- It provided moderate added value
- It provided negligible/marginal added value
- It did not provide any added value
- I don't know

* 44 Which of the 7 EU value added criteria, listed below do you consider the most important? Please select up to three criteria

- Exchanging good practices between Member States
- Supporting networks for knowledge sharing or mutual learning
- Addressing cross-border threats to reduce their risks and mitigate their consequences
- Addressing issues relating to the internal market to ensure high-quality solutions across Member States
- Unlocking the potential of innovation in health
- Actions that could lead to a system for benchmarking to allow informed decision-making at Union level
- Improving efficiency by avoiding waste of resources due to duplication and optimising use of financial resources
- Other

* 45 If other, please specify

COHERENCE

This section invites you to indicate the extent to which the 3rd Health Programme, complemented and created synergies with other EU Programmes and with national initiatives.

* 46 To what extent did the 3rd Health Programme complement and/or create synergies with other EU programmes or with wider EU policies?

Examples of other EU programmes include, but are not limited to: The Horizon 2020 Programme for Research and Innovation, EU Structural Funds, the European Social Fund, the European Fund for Strategic Investments (EFSI), Asylum, Migration and Integration Fund, Citizens, Equality, Rights and Value Programme, COSME, …)

- To a large extent
- To a moderate extent
- To a small extent
- Not at all
- I don't know

47 Please explain:

* 48 To what extent did the 3rd Health Programme complement and/or create synergies with national initiatives and/or programmes ?

- To a large extent
- To a moderate extent
- To a small extent
- Not at all
- I don't know

49 Please explain

Closing Questions

50 Thank you for your answers.

If you have any more information you want to share, please enter it in the box below, or upload it.

51 Please upload your file(s)

Only files of the type pdf,txt,doc,docx,odt,rtf are allowed

A4.2 Targeted survey

J330300868 FINAL Targeted Survey

Survey Flow

EmbeddedData
Full nameValue will be set from Panel or URL.
OrganisationValue will be set from Panel or URL.

Standard: Introduction questions 1 (2 Questions)

Branch: New Branch
If
If Do you agree that... You consent voluntarily to be a participant in this survey
You understand that personal information collected about you, such as your name, will not be shared beyond the study team over the duration of the assignment and beyond
You understand that the information you provide will be used in reports and other deliverables to DG SANTE to help inform the evaluation of the 3rd Health Programme. I understand that no specific attribution will be made to me or my organisation in reporting - No Is Selected

EndSurvey: Advanced - Screen-Out

Standard: Introduction questions 2 (3 Questions)

Branch: New Branch
If
If If other, please select from the options below: EU citizen Is Selected

EndSurvey: Advanced - Screen-Out

Standard: Introduction questions 3 (7 Questions)
Standard: Relevance (20 Questions)
Standard: Effectiveness (41 Questions)
Standard: Efficiency (22 Questions)
Standard: EU Added Value (10 Questions)
Standard: Coherence (5 Questions)
Standard: Concluding remarks (7 Questions)

Page Break

Start of Block: Introduction questions 1

Introduction 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.

ICF is conducting an evaluation (running from July 2021- Summer 2022) of the 3rd Health Programme. The purpose of the study is to monitor, evaluate and report on the implementation of the actions of the 3HP in relation to its objectives and indicators (time period: 2014-2020). The main evaluation areas we are focusing on are the following: Effectiveness, Efficiency, Relevance, Coherence, and EU-added value.

Part of this study is a series of targeted consultations (Open public consultation, targeted stakeholder surveys, stakeholder interviews, focus groups). Your insights will help us to assess the successes and areas for improvement of the Programme.

If you have any questions related to this survey, or the issues we discuss here, you can contact the ICF study team via the following email: 3hpstudy@icf.com. In case you wish to contact the DG SANTE unit responsible for the survey, please send an email to: SANTE-3HP-FINAL-EVALUATION@ec.europa.eu

For more information about how your data will be used please see our privacy statement.

Q1 **Do you agree that...**

You consent voluntarily to be a participant in this survey You understand that personal information collected about you, such as your name, will not be shared beyond the study team over the duration of the assignment and beyond		
You understand that the information you provide will be used in reports and other deliverables to DG SANTE to help inform the evaluation of the 3rd Health Programme. I understand that no specific attribution will be made to me or my organisation in reporting (1)	○ Yes (1)	○ No (2)

End of Block: Introduction questions 1

Start of Block: Introduction questions 2

Q2 I am giving my contribution as a representative of a[n]:

- Public authority (1)
- Academic / research organisation (3)
- Non-governmental organisation (4)
- Consumer organisation (5)
- Company / business association (6)
- Other (7)

Display This Question:

If Q2 = Public authority

Q2_i Please specify which of the below you represent

- Central government/ministry of health (1)
- Public health authority or agency (2)

Display This Question:

If Q2 = Other

Q2_A If other, please select from the options below:

- ○ International organisation (e.g. WHO, OECD) (1)
- ○ International organisation (EU instituitions) (2)
- ○ Healthcare service provider (3)
- ○ Organisation representing healthcare service providers (4)
- ○ Healthcare professionals' association (5)
- ○ Independent thematic experts (6)
- ○ EU citizen (7)

End of Block: Introduction questions 2

Start of Block: Introduction questions 3

Q3 Where is your institution / organisation's headquarters?

- ○ Austria (1)
- ○ Belgium (2)
- ○ Bulgaria (3)
- ○ Croatia (4)
- ○ Cyprus (5)
- ○ Czechia (6)
- ○ Denmark (7)
- ○ Estonia (8)
- ○ Finland (9)
- ○ France (10)
- ○ Germany (11)
- ○ Greece (12)
- ○ Hungary (13)
- ○ Ireland (14)
- ○ Italy (15)
- ○ Latvia (16)
- ○ Lithuania (17)
- ○ Luxembourg (18)
- ○ Malta (19)
- ○ Netherlands (20)
- ○ Poland (21)
- ○ Portugal (22)
- ○ Romania (23)

- ○ Slovakia (24)
- ○ Slovenia (25)
- ○ Spain (26)
- ○ Sweden (27)
- ○ United Kingdom (28)
- ○ Other (29)

Display This Question:

If Q3 = Other

Q4 If other, please specify

_____

Page Break

Q5 Does your organisation work mainly in ${Q3/ChoiceGroup/SelectedChoices}, or is it Pan-European or international organisation which works across other countries as well?

- My organisation's work is focused on ${Q3/ChoiceGroup/SelectedChoices}. (1)
- My organisation's work has a Pan-European or international focus broader than ${Q3/ChoiceGroup/SelectedChoices}. (2)

Q6 What is your background in relation to the 3rd Health Programme?

- Stakeholder directly involved in the **programme design** (1)
- Stakeholder directly involved in the **programme implementation** (2)
- Stakeholder directly involved in the **programme evaluation** (3)
- Stakeholder who **benefitted from the programme** (4)
- Stakeholder who **has an interest in the programme** (5)

Display This Question:

If Q6 = Stakeholder who has an interest in the programme

Q7 Thank you – based on your profile and experience of the 3rd Health Programme, we would recommend that you take part in our Open Public Consultation rather than this survey. The link for the Open Public Consultation is: https://ec.europa.eu/eusurvey/runner/ThirdHealthProgramme. If you still wish to continue answering this survey, please press "Next"

Display This Question:

If Q6 = Stakeholder directly involved in the programme design

Or Q6 = Stakeholder directly involved in the programme implementation

Or Q6 = Stakeholder directly involved in the programme evaluation

Or Q6 = Stakeholder who benefitted from the programme

Q8 As part of your involvement in the 3rd Health Programme, what type of funding instruments are you aware of?

(Select all that apply)

- ☐ Project grants (1)
- ☐ Operating grants (2)
- ☐ Direct grants to international organisations (3)
- ☐ Joint actions (4)
- ☐ Procurement contracts (5)
- ☐ Health Policy Platform & Health Award/Health Prize (6)

Q9 Have you been involved in the management and administration of an action from the 3rd Health Programme (e.g. filled in an application form)?

- ○ Yes (1)
- ○ No (2)

End of Block: Introduction questions 3

Start of Block: Relevance

TEXT1 **RELEVANCE**

This section invites you to assess whether, and how, the priorities and objectives of the 3rd Health Programme address needs to problems in society.

Q10
Please see the attached guidance document for information about the health and healthcare needs and problems in the EU at the time of the programme's development.

In your view, how relevant were the 3rd Health Programme's specific objectives in relation to

EU health needs at the time of the Programme's development:

	Not at all relevant (1)	To a small extent (2)	To a moderate extent (6)	To a large extent (7)	Very relevant (3)	I don't know (5)
Promote health, prevent disease and foster supportive environments for healthy lifestyles (1)	○	○	○	○	○	○
Protect Union citizens from serious cross border health threats (2)	○	○	○	○	○	○
Contribute to innovative, efficient and sustainable health systems (3)	○	○	○	○	○	○
Facilitate access to better and safer healthcare for Union citizens (4)	○	○	○	○	○	○

Page Break

Display This Question:

If Q10 = Not at all relevant

Or Q10 = To a small extent

Q11 You said the following objectives were not relevant or relevant to a small extent

Please explain below

Display This Choice:

If Q10 = Promote health, prevent disease and foster supportive environments for healthy lifestyles [Not at all relevant]

Or Q10 = Promote health, prevent disease and foster supportive environments for healthy lifestyles [To a small extent]

○ Promote health, prevent disease and foster supportive environments for healthy lifestyles (1) _____

Display This Choice:

If Q10 = Protect Union citizens from serious cross border health threats [Not at all relevant]

Or Q10 = Protect Union citizens from serious cross border health threats [To a small extent]

○ Protect Union citizens from serious cross border health threats (2) _____

Display This Choice:

If Q10 = Contribute to innovative, efficient and sustainable health systems [Not at all relevant]

Or Q10 = Contribute to innovative, efficient and sustainable health systems [To a small extent]

○ Contribute to innovative, efficient and sustainable health systems (3) _____

Display This Choice:

If Q10 = Facilitate access to better and safer healthcare for Union citizens [Not at all relevant]

Or Q10 = Facilitate access to better and safer healthcare for Union citizens [To a small extent]

○ Facilitate access to better and safer healthcare for Union citizens (4) _____

TEXT2 Please see the attached guidance document for information about the 4 specific objectives and 23 thematic priorities of the 3rd Health Programme.

This guidance document also includes information about health and healthcare problems and needs in the EU throughout the programme implementation.

Q12 To what extent have the 3rd Health Programme's objectives (and associated actions) remained relevant?

	This objective has become less relevant over time (1)	This objective remained as relevant over time as at the time of the 3rd Health Programme's development (2)	This objective has become more relevant over time (3)	I don't know (4)
Promote health, prevent disease and foster supportive environments for healthy lifestyles (1)	○	○	○	○
Protect Union citizens from serious cross border health threats (2)	○	○	○	○
Contribute to innovative, efficient and sustainable health systems (3)	○	○	○	○
Facilitate access to better and safer healthcare for Union citizens (4)	○	○	○	○

Page Break

Display This Question:

If Q12 = This objective has become more relevant over time

Q13 You said the following objectives have become more relevant over time. In your view, what factors could explain this trend?

Display This Choice:

If Q12 = Promote health, prevent disease and foster supportive environments for healthy lifestyles [This objective has become more relevant over time]

Display This Choice:

If Q12 = Protect Union citizens from serious cross border health threats [This objective has become more relevant over time]

Display This Choice:

If Q12 = Contribute to innovative, efficient and sustainable health systems [This objective has become more relevant over time]

Display This Choice:

If Q12 = Facilitate access to better and safer healthcare for Union citizens [This objective has become more relevant over time]

	Science and technological progress in the area of health and healthcare (1)	Solutions developed at national level by national governments or public bodies (2)	Solutions developed by private actors (3)	Solutions developed by not-for-profit actors (4)	Solutions or funding developed at the EU level (5)	Changes in citizens' opinions or perspectives on health systems (6)	Changes in prevalence & severity of non-communicable diseases (7)	Changes in prevalence & severity of communicable diseases (8)	Changes in rates of health behaviours e.g. changes in smoking or exercise rates or diet (9)	New and emerging cross-border health threats during the time of the 3rd Health Programme (note Covid-19 is not in the scope of this evaluation) (10)	Demographic context affecting health and sustainability of health systems (11)	Other (please specify) (12)

Display This Choice:

If Q12 = Promote health, prevent disease and foster supportive environments for healthy lifestyles [This objective has become more relevant over time]

Promote health, prevent disease and foster supportive environments for healthy lifestyles (1)

Display This Choice:

If Q12 = Protect Union citizens from serious cross border health threats [This objective has become more relevant over time]

Protect Union citizens from serious cross border health threats (2)

Display This Choice:

If Q12 = Contribute to innovative,

efficient and sustainable health systems [This objective has become more relevant over time]

Contribute to innovative, efficient and sustainable health systems (3)

Display This Choice: If Q12 = Facilitate access to better and safer health care for Union citizens [This objective has beco

me more relevant over time]	
Facilitate access to better and safer healthcare for Union citizens (4)	

Display This Question:

If Q12 = This objective has become more relevant over time

Q14 Please explain

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Page Break

Display This Question:

If Q12 = This objective has become less relevant over time

Q15 You said the following objectives have become less relevant over time. In your view, what factors could explain this trend?

Display This Choice:

If Q12 = Promote health, prevent disease and foster supportive environments for healthy lifestyles [This objective has become less relevant over time]

Display This Choice:

If Q12 = Protect Union citizens from serious cross border health threats [This objective has become less relevant over time]

Display This Choice:

If Q12 = Contribute to innovative, efficient and sustainable health systems [This objective has become less relevant over time]

Display This Choice:

If Q12 = Facilitate access to better and safer healthcare for Union citizens [This objective has become less relevant over time]

	Science and technological progress in the area of health and healthcare (1)	Solutions developed at national level by national governments or public bodies (2)	Solutions developed by private actors (3)	Solutions developed by not-for-profit actors (4)	Solutions or funding developed at the EU level (5)	Changes in citizens' opinions or perspectives on health systems (6)	Changes in prevalence & severity of non-communicable diseases (7)	Changes in prevalence & severity of communicable diseases (8)	Changes in rates of health behaviours e.g. changes in smoking or exercise rates or diet (9)	New and emerging cross-border health threats during the time of the 3rd Health Programme (note Covid-19 is not in the scope of this evaluation) (10)	Demographic context affecting health and sustainability of health systems (11)

Display This Choice: If Q12 = Promote health, prevent disease and foster supportive environments for healthy lifestyles [This objective has become less relevant over time]

Promote health, prevent disease and foster supportive environments for healthy lifestyles (1)

Display This Choice: If Q12 =

Protect Union citizens from serious cross border health threats [This objective has become less relevant over time]

Protect Union citizens from serious cross border health threats (2)

Display This Choice: If Q12 = Contribute to innovative, efficient and sustainable health systems [This objective has become less relevant over time]

Contribute to innovative, efficient and sustainable health systems (3)

Display This Choice : If Q12 = Facilitate access to better and safer health care for Union citizens [This objective has become less relevant over time]

Facilitate access to better and safer health care for Union citizens (4)

Display This Question:

If Q12 = This objective has become less relevant over time

Q16 Please explain

_____

_____

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_____

Page Break

TEXT3 Please see the attached guidance document for information about the 4 specific objectives and 23 thematic priorities of the 3rd Health Programme.

Q17
To what extent were the 3rd Health Programme's funded actions aligned with the Programme's thematic priorities?

	Not at all (1)	To a small extent (2)	To a moderate extent (5)	To a large extent (3)	I don't know (4)
Promote health, prevent disease and foster supportive environments for healthy lifestyles (1)	○	○	○	○	○
Protect Union citizens from serious cross border health threats (2)	○	○	○	○	○
Contribute to innovative, efficient and sustainable health systems (3)	○	○	○	○	○
Facilitate access to better and safer healthcare for Union citizens (4)	○	○	○	○	○

Page Break

Display This Question:

If Q17 = Not at all

Or Q17 = To a small extent

Q18 You said the following objectives were not relevant or relevant only to a small extent. Please explain why.

Display This Choice:

If Q17 = Promote health, prevent disease and foster supportive environments for healthy lifestyles [Not at all]

Or Q17 = Promote health, prevent disease and foster supportive environments for healthy lifestyles [To a small extent]

○ Promote health, prevent disease and foster supportive environments for healthy lifestyles (1) _____

Display This Choice:

If Q17 = Protect Union citizens from serious cross border health threats [Not at all]

Or Q17 = Protect Union citizens from serious cross border health threats [To a small extent]

○ Protect Union citizens from serious cross border health threats (2) _____

Display This Choice:

If Q17 = Contribute to innovative, efficient and sustainable health systems [Not at all]

Or Q17 = Contribute to innovative, efficient and sustainable health systems [To a small extent]

○ Contribute to innovative, efficient and sustainable health systems (3) _____

Display This Choice:

If Q17 = Facilitate access to better and safer healthcare for Union citizens [Not at all]

Or Q17 = Facilitate access to better and safer healthcare for Union citizens [To a small extent]

○ Facilitate access to better and safer healthcare for Union citizens (4) _____

Page Break

TEXT4 Please see the attached guidance document for information about the main priorities of the Commission during the implementation of the 3rd Health Programme.

Please also see the guidance document for information about the 4 specific objectives and 23 thematic priorities of the 3rd Health Programme.

Q19 To what extent were the thematic priorities relevant to the Commission's wider priorities over the implementation of the 3rd Health programme?

	Not at all (1)	To a small extent (2)	To a moderate extent (3)	To a large extent (4)	I don't know (5)
Europe 2020 strategy for smart, sustainable and inclusive growth (1)	○	○	○	○	○
A new boost for jobs, growth and investment in the EU (2)	○	○	○	○	○
A deeper and fairer internal market with a strengthened industrial base (5)	○	○	○	○	○
A balanced and progressive trade policy to harness globalisation (6)	○	○	○	○	○
Promoting our European Way of Life (8)	○	○	○	○	○
The European Green Deal (7)	○	○	○	○	○

Page Break

Display This Question:

If Q19 = Not at all

And Q19 = To a small extent

Q20 You said the following objectives were not relevant or relevant only to a small extent. Please explain.

Display This Choice:

If Q19 = Europe 2020 strategy for smart, sustainable and inclusive growth [Not at all]

Or Q19 = Europe 2020 strategy for smart, sustainable and inclusive growth [To a small extent]

○ Europe 2020 strategy for smart, sustainable and inclusive growth (8)

_____

Display This Choice:

If Q19 = A new boost for jobs, growth and investment in the EU [Not at all]

Or Q19 = A new boost for jobs, growth and investment in the EU [To a small extent]

○ A new boost for jobs, growth and investment in the EU (9)

_____

Display This Choice:

If Q19 = A deeper and fairer internal market with a strengthened industrial base [Not at all]

Or Q19 = A deeper and fairer internal market with a strengthened industrial base [To a small extent]

○ A deeper and fairer internal market with a strengthened industrial base (10)

_____

Display This Choice:

If Q19 = A balanced and progressive trade policy to harness globalisation [Not at all]

Or Q19 = A balanced and progressive trade policy to harness globalisation [To a small extent]

○ A balanced and progressive trade policy to harness globalisation (11)

_____

Display This Choice:

If Q19 = Promoting our European Way of Life [Not at all]

Or Q19 = Promoting our European Way of Life [To a small extent]

○ Promoting our European Way of Life (12)

_____

Display This Choice:

If Q19 = The European Green Deal [Not at all]

Or Q19 = The European Green Deal [To a small extent]

○ The European Green Deal (13)

_____

Page Break

TEXT5 Please see the attached guidance document for information about citizen's perceptions of key health issues in the EU.

Please also see the guidance document for information about the 4 specific objectives and 23 thematic priorities of the 3rd Health Programme.

Q21 To what extent are the thematic priorities relevant in light of citizens' perceptions of key health issues in the EU?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Display This Question:

If Q21 = Not at all

Or Q21 = To a small extent

Q21_A Please explain

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_____

_____

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_____

Q22 In your opinion, to what extent has the 3rd Health Programme responded to citizens' health needs?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Display This Question:

If Q22 = Not at all

Or Q22 = To a small extent

Q22_A Please explain:

_____

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_____

End of Block: Relevance

Start of Block: Effectiveness

TEXT6 **EFFECTIVENESS**
This section invites you to assess how successful the 3rd Health Programme has been in achieving or progressing towards its stated objectives (i.e. looking at the effects of the 3rd Health Programme, and the extent to which the observed effects can be linked to it).

Display This Question:

If Q2 = Public authority

Or Q2 = Academic / research organisation

Or Q2 = Non-governmental organisation

Or Q2 = Company / business association

Or Q2 = Consumer organisation

Or Q2_A = Healthcare service provider

Or Q2_A = Healthcare professionals' association

Or Q2_A = Independent thematic experts

Or Q2_A = Organisation representing healthcare service providers

Q23 To what extent…

	Not at all (1)	To a small extent (2)	To a moderate extent (3)	To a large extent (4)	I don't know (5)
…have measures implemented by Member States been aligned with the 3rd Health Programme? (1)	○	○	○	○	○
…have national programmes and actions reflected evidence and evidence-based approaches developed through Programme funding? (2)	○	○	○	○	○
…has health data been more robust, timely and comparable across EU countries? (3)	○	○	○	○	○

Display This Question:

If Q2 = Public authority

Or Q2 = Academic / research organisation

Or Q2 = Non-governmental organisation

Or Q2 = Consumer organisation

Or Q2 = Company / business association

Or Q2_A = Healthcare service provider

Or Q2_A = Organisation representing healthcare service providers

Or Q2_A = Healthcare professionals' association

Or Q2_A = Independent thematic experts

Q24 To what extent has the 3rd Health Programme contributed to a more comprehensive and uniform approach to health in the following policy areas?

	Not at all (1)	To a small extent (2)	To a moderate extent (3)	To a large extent (4)	I don't know (5)
Alcohol marketing (1)	○	○	○	○	○
Antimicrobial resistance (2)	○	○	○	○	○
Health inequalities affecting vulnerable groups (3)	○	○	○	○	○
Childhood obesity (4)	○	○	○	○	○
Health Technology Assessment (5)	○	○	○	○	○
Vaccination (6)	○	○	○	○	○

Display This Question:

If Q24 , Not at all Is Displayed

Q25 Please elaborate

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Display This Question:

If Q2 = Public authority

Or Q2 = Academic / research organisation

Or Q2 = Non-governmental organisation

Or Q2 = Consumer organisation

Or Q2 = Company / business association

Or Q2_A = Healthcare service provider

Or Q2_A = Organisation representing healthcare service providers

Or Q2_A = Healthcare professionals' association

Or Q2_A = Independent thematic experts

Q26 To what extent…

	Not at all (1)	To a small extent (2)	To a moderate extent (3)	To a large extent (4)	I don't know (5)
…have programme actions led to new knowledge and evidence which have been used in the development of policy and decision-making? (1)	○	○	○	○	○
…have programme actions led to general improvements	○	○	○	○	○

in health and healthcare in the EU and at MS level? (2)	

Display This Question:

If Q2 = Public authority

Or Q2 = Academic / research organisation

Or Q2 = Non-governmental organisation

Or Q2 = Consumer organisation

Or Q2 = Company / business association

Or Q2_A = Healthcare service provider

Or Q2_A = Organisation representing healthcare service providers

Or Q2_A = Healthcare professionals' association

Or Q2_A = Independent thematic experts

Q27 To what extent has the 3rd Health Programme contributed to improvements in the following areas?

	Not at all (1)	To a small extent (2)	To a moderate extent (3)	To a large extent (4)	I don't know (5)
AMR prevention in the EU and at MS level (1)	○	○	○	○	○
Health status and access to care of vulnerable groups in the EU and at MS level (2)	○	○	○	○	○
Childhood obesity in the EU and at MS level (3)	○	○	○	○	○
The creation of a well-functioning HTA system in Europe (4)	○	○	○	○	○

Vaccination in the EU and at MS level (5)	○	○	○	○	○

Display This Question:

If Q27 , Not at all Is Displayed

Q28 Please elaborate:

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Display This Question:

If Q2 = Public authority

Or Q2_A = International organisation (e.g. WHO, OECD)

Or Q2_A = International organisation (EU instituitions)

Q29 To what extent…

	Not at all (1)	To a small extent (2)	To a moderate extent (3)	To a large extent (4)	I don't know (5)
…have programme outputs (e.g., establishment of Joint Actions and ERNs, evaluations and studies, establishment of EU-wide data systems) been used at an	○	○	○	○	○

international level? (1)					
…has the EU's coordination with international bodies in the field of health been strengthened in Programme priority areas? (2)	○	○	○	○	○

Display This Question:

If Q2 = Public authority

Or Q2_A = International organisation (e.g. WHO, OECD)

Or Q2_A = International organisation (EU instituitions)

Q30 To what extent has the 3rd Health Programme contributed to EU's influence at international level in the following areas?

	Not at all (1)	To a small extent (2)	To a moderate extent (3)	To a large extent (4)	I don't know (5)
AMR standards, policies and practices (1)	○	○	○	○	○
Childhood obesity standards, policies and practices (2)	○	○	○	○	○
Immunisation programmes (3)	○	○	○	○	○

Display This Question:

If Q30 , Not at all Is Displayed

Q31 Please elaborate:

_____

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_____

_____

Q32 To what extent have the funded actions you have been involved in contributed to achieving the objectives of the 3rd Health Programme?

	Not at all (1)	To a small extent (2)	To a moderate extent (3)	To a large extent (4)	I don't know (5)
Operating grant (1)	○	○	○	○	○
Project (2)	○	○	○	○	○
Framework Partnership Agreement (3)	○	○	○	○	○
Joint Aciton (4)	○	○	○	○	○
Presidential Conference (5)	○	○	○	○	○

TEXT7 Please see the attached guidance document for information about the exceptional utility criterion.

Display This Question:

If Q2 = Public authority

Q33 Has your Member State applied for funding under the exceptional utility criterion?

- Yes (1)
- No (2)
- I don't know (3)

Display This Question:

If Q33 = Yes

Q34 To what extent has your country's participation been incentivized by the criterion?

- Not at all (1)
- To a small extent (2)
- To a moderate extent (3)
- To a large extent (4)
- I don't know (5)

Display This Question:

If Q33 = Yes

Q35 Have any of the following wider factors contributed to your country's participation?

				Please elaborate
	Yes (1)	No (2)	I don't know (3)	(1)
Securing co-financing (1)	○	○	○	•

Administrative capacity to manage actions in the MS (2)	○	○	○	•
Availability of information about the 3rd Health Programme support (3)	○	○	○	•
Language skills (4)	○	○	○	•

Display This Question:

If Q33 = No

Q36 Have any of the following factors determined the decision to not apply for funding under the exceptional utility criterion?

				Please elaborate
	Yes (1)	No (2)	I don't know (3)	(1)
Difficulties in securing co-financing (1)	○	○	○	•

Lack of administrative capacity to manage actions in the MS (2)	○	○	○	•
Administrative burden (once project is up and running) (3)	○	○	○	•
Complexity of application process (4)	○	○	○	•
Challenges in coordination between Member States (e.g., identifying partners, agreeing on roles, language barriers) (5)	○	○	○	•
Lack of language skills (6)	○	○	○	•

Display This Question:

If Q2 != Public authority

Q38 To your knowledge, have any of the following wider factors influenced the participation of low GNI countries?

	Yes (3)	No (4)	I don't know (5)
Securing co-financing (1)	○	○	○
Administrative capacity to manage actions in the MS (2)	○	○	○
Administrative burden (once project is up and running) (3)	○	○	○
Complexity of application process (4)	○	○	○
Challenges in coordination between Member States (e.g. identifying partners, agreeing on roles, language barriers) (5)	○	○	○
Availability of information about the 3rd Health Programme support (6)	○	○	○
Lack of language skills (7)	○	○	○

Page Break

Display This Question:

If Q38 = Yes

Or Q38 = No

Q38A Please elaborate

Display This Choice:

If Q38 = Securing co-financing [Yes]

Or Q38 = Securing co-financing [No]

○ Securing co-financing (4) _____

Display This Choice:

If Q38 = Administrative capacity to manage actions in the MS [Yes]

Or Q38 = Administrative capacity to manage actions in the MS [No]

○ Administrative capacity to manage actions in the MS (5)
_____

Display This Choice:

If Q38 = Administrative burden (once project is up and running) [Yes]

Or Q38 = Administrative burden (once project is up and running) [No]

○ Administrative burden (once project is up and running) (6)
_____

Display This Choice:

If Q38 = Complexity of application process [Yes]

Or Q38 = Complexity of application process [No]

○ Complexity of application process (7)
_____

Display This Choice:

If Q38 = Challenges in coordination between Member States (e.g. identifying partners, agreeing on roles, language barriers) [Yes]

Or Q38 = Challenges in coordination between Member States (e.g. identifying partners, agreeing on roles, language barriers) [No]

○ Challenges in coordination between Member States (e.g. identifying partners, agreeing on roles, language barriers) (8)
_____

Display This Choice:

If Q38 = Availability of information about the 3rd Health Programme support [Yes]

Or Q38 = Availability of information about the 3rd Health Programme support [No]

○ Availability of information about the 3rd Health Programme support (9)
_____

Display This Choice:

If Q38 = Lack of language skills [Yes]

Or Q38 = Lack of language skills [No]

○ Lack of language skills (10) _____

Page Break

TEXTT Please see the attached guidance document for information about simplification measures.

Display This Question:

If Q2 = Public authority

Q37 To what extent did the simplification measures related to the exceptional utility criteria reduce administrative costs?

- Not at all (1)
- To a small extent (2)
- To a moderate extent (3)
- To a large extent (4)
- I don't know (5)

Display This Question:

If Q2 != Public authority

Q39 To your knowledge, to what extent did the simplification measures related to the exceptional utility criteria reduce administrative costs for applicants and Chafea?

- Not at all (1)
- To a small extent (2)
- To a moderate extent (3)
- To a large extent (4)
- I don't know (5)

Q40 To what extent do you have access to publications resulting form the Programme's actions/outcomes/results?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Display This Question:

If Q40 , Not at all Is Displayed

Q40_A Please explain

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TEXT8 See the attached guidance document for information about areas of greatest added value to the EU identified in the mid-term evaluation.

The Commission mid-term evaluation indicated the added value of the 3HP in areas such as capacity building against health threats, pooling expertise and resources across the EU to reduce health inequalities, collaboration in the field of HTA and eHealth, exchange and implementation of best practice for promoting health and preventing diseases.

Q41 To what extent do you think DG SANTE has prioritised and acted upon areas of greatest added value to the EU (i.e., above what could reasonably have been expected from actions at the national level)?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Display This Question:

If Q41 , Not at all Is Displayed

Q41_A Please explain:

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TEXT9 See the attached guidance document for information about the Commission's general priorities.

Q42 To what extent has DG SANTE strengthened and built links between the 3rd Health Programme and wider Commission & EU policy agenda to maximise impact?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Display This Question:

If Q42 , Not at all Is Displayed

Q42_A Please explain:

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Display This Question:

If Q9 = Yes

TEXT10 Please see the attached guidance document for information about the seven added-value criteria used in the 3rd Health Programme.

Display This Question:

If Q9 = Yes

Q43 To what extent did you understand the EU added value criteria and how to apply them (prior to undertaking this survey)?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Display This Question:

If Q9 = Yes

Q44 To what extent have the EU added value criteria improved the application process?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Display This Question:

If Q9 = Yes

Q44_A Please explain:

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Display This Question:

If Q9 = Yes

Q45 To what extent have the EU added value criteria been used by DG SANTE & Chafea (now HaDEA) in a more integrated way in the application process?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Display This Question:

If Q9 = Yes

Q45_A Please explain:

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Q46
Multi-annual planning, which provides for spending across several years, was introduced in the 3rd Health Programme to incorporate a more holistic, longer-term mind-set into the programming process.

To what extent has DG SANTE integrated multi-annual planning with existing programme processes (i.e. establishing the Annual Work Programmes)?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Q47 To what extent have DG SANTE & Chafea (now HaDEA) developed a broader strategy to increase participation from lower-income MS & underrepresented organisations (e.g., underrepresented patients' organisations, NGOs, etc.) (distinct from the exceptional utility criterion)?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Q48 Please explain

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JS

Q49 How sustainable do you think the results of the 3rd Health Programme (and its funded actions) are?

- ○ Very sustainable (please elaborate) (1) _____
- ○ Somewhat sustainable (please elaborate) (2) _____
- ○ Not sustainable (please elaborate) (3) _____
- ○ I don't know (4)

Q50 How sustainable do you think the 3rd Health Programme results and effects are in the specific fields of:

	Very sustainable (5)	Somewhat sustainable (6)	Not sustainable (7)	I don't know (8)
AMR (1)	○	○	○	○
Health inequalities (2)	○	○	○	○
Childhood obesity (3)	○	○	○	○
Health Technology Assessments (HTA) (4)	○	○	○	○
Vaccination policies (5)	○	○	○	○

Page Break

Display This Question:

If Q50 = Very sustainable

Or Q50 = Somewhat sustainable

Or Q50 = Not sustainable

Q50A Please elaborate

Display This Choice:

If Q50 = AMR [Very sustainable]

Or Q50 = AMR [Somewhat sustainable]

Or Q50 = AMR [Not sustainable]

○ AMR (4) _____

Display This Choice:

If Q50 = Health inequalities [Very sustainable]

Or Q50 = Health inequalities [Somewhat sustainable]

Or Q50 = Health inequalities [Not sustainable]

○ Health inequalities (5) _____

Display This Choice:

If Q50 = Childhood obesity [Very sustainable]

Or Q50 = Childhood obesity [Somewhat sustainable]

Or Q50 = Childhood obesity [Not sustainable]

○ Childhood obesity (6) _____

Display This Choice:

If Q50 = Health Technology Assessments (HTA) [Very sustainable]

Or Q50 = Health Technology Assessments (HTA) [Somewhat sustainable]

Or Q50 = Health Technology Assessments (HTA) [Not sustainable]

○ Health Technology Assessments (HTA) (7) _____

Display This Choice:

If Q50 = Vaccination policies [Very sustainable]

Or Q50 = Vaccination policies [Somewhat sustainable]

Or Q50 = Vaccination policies [Not sustainable]

○ Vaccination policies (8) _____

End of Block: Effectiveness

Start of Block: Efficiency

TEXT11 **EFFICIENCY**

This section invites you to assess the relationship between the resources used by the 3rd Health Programme and the changes it generated.

Display This Question:

If Q9 = Yes

Q51 To what extent do you consider costs associated with the 3rd Health Programme are reasonable and kept to the minimum necessary in order to achieve the expected results?

	Not at all (1)	To a small extent (2)	To a moderate extent (3)	To a large extent (4)	I don't know (5)
Programme operational costs (design & implementation) (1)	○	○	○	○	○
Management costs for funding (2)	○	○	○	○	○
Administrative costs for applicants & Chafea (3)	○	○	○	○	○
Monitoring & reporting costs for MS and the Commission (4)	○	○	○	○	○

Q52 In your view, to what extent the following factors may have influenced any disparities between Programme funded actions costs and the expected results?

	Not at all (1)	To a small extent (2)	To a moderate extent (3)	To a large extent (4)	I don't know (5)
Additional costs for personnel (1)	○	○	○	○	○

Additional costs associated with preparation, coordination, administration and programme delivery (2)	○	○	○	○	○
Additional costs for materials (3)	○	○	○	○	○
Other (Please elaborate) (4)	○	○	○	○	○

Q53 In your view, what internal factors might have influenced the 3rd Health Programme's results, in addition to costs?

	Positive influence (1)	No influence (2)	Negative influence (3)	I don't know (4)
Collaboration between Member States (1)	○	○	○	○
Development of guidance to assist funding applicants (2)	○	○	○	○
Facilitation / coordination of the Programme by DG SANTE / Chafea (3)	○	○	○	○
Other (please specify) (4)	○	○	○	○

Q54 In your view, what external factors might also have influenced the 3rd Health Programme's results, beyond what the Programme funding could have achieved?

	Positive influence (1)	No influence (2)	Negative influence (3)	I don't know (4)
Science and technological progress in the area of health and healthcare (1)	○	○	○	○
Solutions developed at national level, or by private or non-for-profit actors (2)	○	○	○	○
Other solutions or funding developed at the EU level (3)	○	○	○	○
Changes in citizens' opinions or perspectives on health systems (4)	○	○	○	○
Changes in prevalence & severity of non-communicable diseases (5)	○	○	○	○
Changes in prevalence & severity of communicable diseases (6)	○	○	○	○
Changes in rates of health behaviours e.g. changes in smoking or exercise rates or diet (7)	○	○	○	○
New and emerging cross-border health	○	○	○	○

threats during the time of the 3rd Health Programme (note Covid-19 is not in the scope of this evaluation) (8)				
Demographic context affecting health and sustainability of health systems (9)	○	○	○	○
Other (please specify) (10)	○	○	○	○

Q55 In your view, how have the following factors influenced the efficiency with which achievements were attained?

	Fostered efficiency (1)	No specific impact (2)	Hindered efficiency (3)	I don't know (4)
Available financial and human resources for the 3rd Health Programme (1)	○	○	○	○
Definition of the specific and operational objectives (2)	○	○	○	○
Thematic priority structure of the 3rd Health Programme (3)	○	○	○	○
Multi-annual planning process (4)	○	○	○	○
Types of funding mechanisms used	○	○	○	○

in the 3rd Health Programme (5)				
Extent to which actions are well-designed (6)	○	○	○	○
Extent to which actions are outcome-focused (7)	○	○	○	○
Other factors linked to the design and implementation of the 3rd Health Programme (please specify) (8)	○	○	○	○

Display This Question:

If Q2 = Academic / research organisation

Or Q2 = Non-governmental organisation

Or Q2_A = International organisation (EU instituitions)

Or Q2_A = International organisation (e.g. WHO, OECD)

Q56 Have there been any differences between participating countries in the following:

	Large differences (1)	Minor differences (2)	No differences (3)	I don't know (4)
Costs incurred by Member States in the implementation of the 3rd Health Programme (1)	○	○	○	○
Benefits accrued by Member States in the implementation of the 3rd Health Programme (2)	○	○	○	○

Display This Question:

If Q56 = Large differences

Or Q56 = Minor differences

Q57 Please explain/provide examples

Display This Choice:

If Q56 = Costs incurred by Member States in the implementation of the 3rd Health Programme [Large differences]

Or Q56 = Costs incurred by Member States in the implementation of the 3rd Health Programme [Minor differences]

○ Costs incurred by Member States in the implementation of the 3rd Health Programme (1) _____

Display This Choice:

If Q56 = Benefits accrued by Member States in the implementation of the 3rd Health Programme [Large differences]

Or Q56 = Benefits accrued by Member States in the implementation of the 3rd Health Programme [Minor differences]

○ Benefits accrued by Member States in the implementation of the 3rd Health Programme (2) _____

Display This Question:

If Q2 = Academic / research organisation

Or Q2 = Non-governmental organisation

Or Q2_A = International organisation (e.g. WHO, OECD)

Or Q2_A = International organisation (EU instituitions)

Q58 In your view, how have the following factors impacted the differences in costs and benefits between countries?

	Reduced differences (1)	No specific impact (2)	Led to more differences (3)	I don't know (4)
Administrative burden of applying for and receiving funding (1)	○	○	○	○
Countries' public health capacity to	○	○	○	○

apply for and manage funding (2)				
Awareness about the 3rd Health programme (3)	○	○	○	○
Organisational capacity to deliver funded actions (4)	○	○	○	○
Scope of the "exceptional utility" criterion (which provides for a higher level of co-funding for actions that include a certain proportion of members from low-GNI countries) (5)	○	○	○	○
Other (please specify) (6)	○	○	○	○

TEXT12 Please see the attached guidance document for information about simplification measures.

Q59 To what extent did the simplification measures reduce administrative costs for applicants and Chafea?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Display This Question:

If Q59 = To a large extent

Or Q59 = To a moderate extent

Q60 Please indicate which of the simplification measures helped reduce administrative costs.

_____

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_____

Q61 To what extent is there scope to further reduce costs?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Display This Question:

If Q61 = To a large extent

Or Q61 = To a moderate extent

Q62 Please provide suggestions on how to further reduce costs.

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Page Break

Display This Question:

If Q9 = Yes

TEXT13
It is important to understand the extent to which the monitoring processes of the 3rd Health Programme were efficient.

Monitoring occurred in the 3rd Health Programme at several points. At lower levels, direct monitoring of implementation occurred (for example, funded actions are monitored to determine how many actions have been launched under each of the finding instruments, and how much budget has been consumed for co-funding the actions.

At an intermediary or medium level, outputs and outcomes of actions were monitored in terms of results achieved by the actions and actions to disseminate these results to encourage their wider uptake.

Finally, there was higher level of monitoring which consists of assessing the impact of the actions, of a group of actions or a feature of an entire programme. The high-level monitoring system includes a set of indicators which contribute to assessing overall performance of the Programme.

Display This Question:

If Q9 = Yes

Q63 In your view, how have the following factors influenced the efficiency of the monitoring processes outlines above?

	Enabled efficiency (1)	No specific impact (2)	Restricted efficiency (3)	I don't know (4)
Level of clarity of indicators (1)	○	○	○	○
Comprehensiveness of indicators (2)	○	○	○	○
Relevance of indicators (3)	○	○	○	○
Way information is stored and organised (4)	○	○	○	○
Other (please specify) (5)	○	○	○	○

Display This Question:

If Q9 = Yes

Q64 Please describe the monitoring costs you have experienced in the context of the management and administration of an action from the 3rd Health Programme

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Display This Question:

If Q9 = Yes

Q65 To what extent do you consider the monitoring costs are reasonable and kept to the minimum necessary in order to achieve the expected results?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Display This Question:

If Q9 = Yes

Q66 As part of the 3rd Health Programme, there are regular reporting requirements for each funded action e.g. documenting and reporting on project activities, outputs, outcomes and impacts.

Display This Question:

If Q9 = Yes

Q67 In your view, what benefits have resulted from this reporting system?

- ☐ Allowing programme participants to track actions' progress against their original plan (1)
- ☐ Allowing programme participants to identify risks early on and taking mitigation actions in time (2)
- ☐ Allowing programme participants to manage actions' budget more effectively (3)
- ☐ Increasing the visibility of the 3rd Health Programme and its actions (4)
- ☐ Highlighting good practice and challenges faced while implementing actions, and, in turn, informing/improving future actions (5)
- ☐ Other (please specify) (6) _____
- ☐ ⊗ I don't know (7)

Display This Question:

If Q9 = Yes

Q68 To what extent do you believe the costs of the reporting system are reasonable and kept to the minimum necessary, in order to achieve the expected results?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Display This Question:

If Q9 = Yes

JS

Q69 In your view, are there any ways in which the reporting system could be more effectively implemented?

- ☐ Simplifying the reporting procedure (reducing administrative burden, time and efforts required) (Please explain) (1)

_____

- ☐ Increasing the frequency of reporting requirements (2)
- ☐ Reducing the frequency of reporting requirements (3)
- ☐ Improving the 3rd Health Programme indicators (Please explain) (4)

_____

- ☐ Other (please specify) (5)

_____

- ☐ ⊗ I don't know (6)

End of Block: Efficiency

Start of Block: EU Added Value

TEXT13 **EU ADDED VALUE**

This section invites you to indicate changes which can reasonably be argued to be due to the 3rd Health Programme, over and above what could reasonably have been expected from national actions alone.

The EU complements national health policies by supporting national governments of the EU Member States to achieve common objectives, pool resources and overcome shared challenges. In addition, the EU also formulates EU-wide laws and standards for health products and services and provides funding for health projects across the EU.

EU health policy focuses on protecting and improving health, giving equal access to modern and efficient healthcare for all Europeans, and coordinating any serious health threats involving more than one EU country. Disease prevention and response play a big part in the EU's public health focus. Prevention touches many areas such as vaccination, fighting antimicrobial resistance, actions against cancer and responsible food labelling.

Display This Question:

If Q2 = Academic / research organisation

Or Q2 = Non-governmental organisation

Or Q2 = Consumer organisation

Or Q2 = Company / business association

Or Q2_A = International organisation (e.g. WHO, OECD)

Or Q2_A = International organisation (EU instituitions)

Or Q2_A = Healthcare service provider

Or Q2_A = Organisation representing healthcare service providers

Or Q2_A = Healthcare professionals' association

Or Q2_A = Independent thematic experts

Q70 The 3rd Health Programme is an important part of EU level action in the field of health. The Commission mid-term evaluation indicated that the 3rd Health Programme added value in areas such as capacity building against health threats, pooling expertise and resources across the EU to reduce health inequalities, collaboration in the field of HTA and eHealth, exchange and implementation of best practice for promoting health and preventing diseases.

To what extent do you believe the Programme provided added -value, beyond what Member States could have achieved acting alone?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Display This Question:

If Q2 = Public authority

Q71 The 3rd Health Programme is an important part of EU level action in the field of health. The Commission mid-term evaluation indicated that the 3rd Health Programme added value in areas such as capacity building against health threats, pooling expertise and resources across the EU to reduce health inequalities, collaboration in the field of HTA and eHealth, exchange and implementation of best practice for promoting health and preventing diseases.

To what extent do you believe the Programme provided added -value, beyond what Member States could have achieved acting alone?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ Not at all (5)

Display This Question:

If Q2 = Public authority

Q72 To what extent do you think Member State actions have been helped or incentivised by the 3rd Health Programme?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

TEXT14 Please see the attached guidance document for information about the seven added-value criteria .

Display This Question:

If Q9 = Yes

Q74 To what extent were the seven added value criteria used in funding decisions?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Display This Question:

If Q74 , Not at all Is Displayed

Q75 Please explain

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Display This Question:

If Q9 = Yes

Q76 To what extent have the seven added value criteria been well-defined in funding proposals?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Display This Question:

If Q9 = Yes

Q77 To what extent have the added value criteria remained relevant to what you see as key health needs and priorities during 2014-2020?

- Not at all (1)
- To a small extent (2)
- To a moderate extent (3)
- To a large extent (4)
- I don't know (5)

JS

Q78 To what extent should the added value criteria be retained in future health programmes?

- Criteria should be retained as they are (1)
- Criteria should be modified somewhat (please elaborate) (2) _____
- Criteria should be significantly modified (please elaborate) (3) _____
- Criteria should be fully removed or replaced (please elaborate) (4) _____
- I don't know (5)

End of Block: EU Added Value

Start of Block: Coherence

TEXT15 **COHERENCE**

This section invites you to indicate the extent to which the 3rd Health Programme complemented and created synergies internally and with other actions outside of the

Programme. Specifically, we focus on the internal coherence of the 3rd Health Programme and its coherence with national health priorities and initiatives during the Programme period.

Q79 To what extent did the 3rd Health Programme's thematic priorities enable consistent and coherent funding decisions across actions during the Programme period?

	To a large extent: Funding decisions are very coherent (e.g. there are synergies between actions which improve overall performance) (1)	To a moderate extent: Funding decisions are moderately coherent with each other (2)	To a small extent: Funding decisions are coherent with each other only to a small extent (3)	Not at all: Funding decisions are not at all coherent (e.g. there are inconsistencies between actions, gaps, duplications or contradictions, which lead to inefficiencies) (4)	I don't know (5)
Promote health, prevent disease and foster supportive environments for healthy lifestyles (1)	○	○	○	○	○
Protect Union citizens from serious cross border health threats (2)	○	○	○	○	○
Contribute to innovative, efficient and sustainable health systems (3)	○	○	○	○	○
Facilitate access to better and safer healthcare for Union citizens (4)	○	○	○	○	○

Page Break

Display This Question:

If Q79 = To a small extent: Funding decisions are coherent with each other only to a small extent

Or Q79 = Not at all: Funding decisions are not at all coherent (e.g. there are inconsistencies between actions, gaps, duplications or contradictions, which lead to inefficiencies)

Q80 In your view, where there has been a lack of coherence (e.g. inconsistencies between actions, gaps, duplications or contradictions), what has caused this?

Display This Choice:

If Q79 = Promote health, prevent disease and foster supportive environments for healthy lifestyles [To a small extent: Funding decisions are coherent with each other only to a small extent]

Or Q79 = Promote health, prevent disease and foster supportive environments for healthy lifestyles [Not at all: Funding decisions are not at all coherent (e.g. there are inconsistencies between actions, gaps, duplications or contradictions, which lead to inefficiencies)]

Display This Choice:

If Q79 = Protect Union citizens from serious cross border health threats [To a small extent: Funding decisions are coherent with each other only to a small extent]

Or Q79 = Protect Union citizens from serious cross border health threats [Not at all: Funding decisions are not at all coherent (e.g. there are inconsistencies between actions, gaps, duplications or contradictions, which lead to inefficiencies)]

Display This Choice:

If Q79 = Contribute to innovative, efficient and sustainable health systems [To a small extent: Funding decisions are coherent with each other only to a small extent]

Or Q79 = Contribute to innovative, efficient and sustainable health systems [Not at all: Funding decisions are not at all coherent (e.g. there are inconsistencies between actions, gaps, duplications or contradictions, which lead to inefficiencies)]

Display This Choice:

If Q79 = Facilitate access to better and safer healthcare for Union citizens [To a small extent: Funding decisions are coherent with each other only to a small extent]

Or Q79 = Facilitate access to better and safer healthcare for Union citizens [Not at all: Funding decisions are not at all coherent (e.g. there are inconsistencies between actions, gaps, duplications or contradictions, which lead to inefficiencies)]

	Structure of the 3rd Health Programme (e.g. definition of the scope and of the priorities) (1)	Relationships between different actors / beneficiaries (2)	Programme management and communication with core stakeholders (3)	Other (please specify) (4)	I don't know (5)
Display This Choice: If Q79 = Promote health, prevent disease and foster supportive environments for healthy lifestyles [To a	○	○	○	○	○

small extent: Funding decisions are coherent with each other only to a small extent] *Or Q79 = Promote health, prevent disease and foster supportive environments for healthy lifestyles [Not at all: Funding decisions are not at all coherent (e.g. there are inconsistencies between actions, gaps, duplications or contradictions, which lead to inefficiencies)]*					
Promote health, prevent disease and foster supportive environments for healthy lifestyles (1)					
Display This Choice: *If Q79 = Protect Union citizens from serious cross border health threats [To a small extent: Funding decisions are coherent with each other only to a small extent]* *Or Q79 = Protect Union citizens from serious cross border health*	○	○	○	○	○

threats [Not at all: Funding decisions are not at all coherent (e.g. there are inconsistencies between actions, gaps, duplications or contradictions, which lead to inefficiencies)]					
Protect Union citizens from serious cross border health threats (2)					
Display This Choice: *If Q79 = Contribute to innovative, efficient and sustainable health systems [To a small extent: Funding decisions are coherent with each other only to a small extent]* *Or Q79 = Contribute to innovative, efficient and sustainable health systems [Not at all: Funding decisions are not at all coherent (e.g. there are inconsistencies between actions, gaps, duplications or contradictions, which lead to inefficiencies)]*	○	○	○	○	○
Contribute to innovative, efficient and					

sustainable health systems (3)					
Display This Choice: *If Q79 = Facilitate access to better and safer healthcare for Union citizens [To a small extent: Funding decisions are coherent with each other only to a small extent]* *Or Q79 = Facilitate access to better and safer healthcare for Union citizens [Not at all: Funding decisions are not at all coherent (e.g. there are inconsistencies between actions, gaps, duplications or contradictions, which lead to inefficiencies)]* Facilitate access to better and safer healthcare for Union citizens (4)	○	○	○	○	○

Display This Question:

If Q2 = Public authority

Q81 Please see the attached guidance document for information about the health and healthcare needs and problems in the EU at the time of the programme's development.

To what extent has the 3rd Health Programme been aligned with and addressed national health priorities during the Programme period?

- ○ Not at all (1)
- ○ To a small extent (2)
- ○ To a moderate extent (3)
- ○ To a large extent (4)
- ○ I don't know (5)

Display This Question:

If Q81 = To a small extent

Or Q81 = Not at all

Q82 In your view, where there has been a lack of alignment, what has caused this?

- ○ Structure of the 3rd Health Programme (e.g., definition of the scope and of the priorities) (1)
- ○ Changing needs and priorities in health during the Programme period (2)
- ○ Programme management and communication with core stakeholders (3)
- ○ Other (please specify) (4) _____

End of Block: Coherence

Start of Block: Concluding remarks

TEXT16

CONCLUDING REMARKS

We may wish to discuss some of the issues you have raised further. If you would be happy for us to contact you for a brief interview on this issue, we would be grateful if you could provide your contact details below. Personal information will be handled and stored securely and shall not be shared with anyone beyond the study team, nor for any other purposes outside of this study.

Q83 First name:

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Q84 Surname:

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Q85 Organisation name:

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Q86 Job title:

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Q87 Email:

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Q88 Telephone number:

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End of Block: Concluding remarks

A4.3 Interview topic guides per stakeholder group

Interview topic guides per stakeholder group

Topic guide- Academic and Research Organisations

Introduction

Stakeholder background and involvement in the Programme

1. **What is your understanding of what the 3rd health Programme set out to achieve?**

Relevance

1. From the perspective of the stakeholder group you represent, what were the **main healthcare needs** during the Programme period?
    a. **Did the 3HP sufficiently address those needs?**
        i. If yes, **in what ways? What specific actions addressed these healthcare needs?** [NOTE FOR INTERVIEW TO RECORD THESE AND EXPLORE LATER IN INTERVIEW]
        ii. If no, **why not?**
2. Were there any **healthcare needs that were not sufficiently addressed** by the Programme?
    a. What were they?
    b. Are you aware of why they were not included in the Programme?
4. Have there been changes in **public needs** over time in relation to the Programme priorities?
5. Is there variance between countries in terms of **citizen engagement** with the Programme?
6. How aligned were the **funded actions** with the thematic priorities set out by the Programme?
7. Do you feel the way the Programme was implemented was relevant given the needs and context at the time of implementation?

Effectiveness

Success factors of the Programme

8. **What, in your opinion, were the main success factors of the 3rd Health Programme?**
9. **As part of our case study work, we will be exploring a number of areas in-depth. In your opinion, which specific initiatives funded under the following areas of the 3HP were particularly successful? Why? Can you think of any**

examples of particularly innovative initiatives under these areas?

- Alcohol
- Anti-Microbial Resistance
- Health Inequalities
- Nutrition
- Health Technology Assessment
- Vaccination

Barriers to effectiveness

10. **What, in your opinion, were the main challenges in the implementation of the 3rd Health Programme?**

11. Are you aware of any **guidance** provided under the 3rd Health Programme, which detailed how actions **generate added value**?
    a. Did you use this guidance?
    b. If so, to what extent did you find this useful?

THE FOLLOWING QUESTIONS EXPLORE ANSWERS TO 4.5.1 and 4.5.2 IN MORE DEPTH

Effectiveness of funded actions

12. For actions that you were involved in and/or aware of, were the activities **implemented as planned**? If not, why not?

13.

Effectiveness of Programme outputs, outcomes and impacts

Programme outputs

14. Which **Programme outputs were particularly effective** from your point of view?

Programme outcomes

15. Which **Programme outcomes were particularly effective** from your point of view?
    a. In what ways were they effective?
    b. To whom were they most useful for?

Programme impacts

16. What **key impacts** have you observed as a result of the Programme?

17. **Which Programme outcomes were particularly effective** in leading to impacts from your point of view?

Sustainability of funded actions

18. **How sustainable are the results of the Programme likely to be?**

a. What opportunities are there for individuals or organisations to continue activities beyond the life of the Programme?

b. Were any institutions set up to continue the activities funded under the Programme?

19. What are the **barriers and enablers of sustainability** for these actions?
20. Were there any **unintended consequences** of the Programme which will **last beyond the funding period**? (E.g. stakeholder relationships, knowledge, capacity building)
21.

Best practice examples

22. To what extent were **best practices from the Programme implemented by Member States**? To what extent was this achieved in a **coordinated** way?
23. Are you aware of any **changes in EU policy and practice** that have resulted from the Programme?
24. What would have been achieved in the absence of the Programme?

Efficiency

This section is applicable to stakeholders who have experience of implementing and running actions and/or developing supporting budgets.

Interviewer to explore opinions from specific stakeholders on:

25. The extent to which Programme actions were cost-effective and the factors that impacted this
26. Factors impacting the funding allocations and results of funded actions
27. Evolution of funding instruments in terms of simplification, cost effectiveness and ultimately funding of actions
28. What worked and did not work in terms of reporting systems

Looking forward

29. (EQ1b) To which extent is there still a need to focus on each of the Programme's thematic areas?

Government and policy makers topic guide

Stakeholder background and involvement in the Programme

1. **What is your understanding of what the 3rd health Programme set out to achieve?**

Relevance

1. How aligned were the **funded actions** with the thematic priorities set out by the Programme?

2. We observed that over the 3HP implementation period, national priorities have been largely aligned with 3HP priorities that received most funding, in particular in the field of health promotion and patient safety and quality of healthcare. Do you agree that national health priorities in your country largely aligned with the 3HP objectives?

Effectiveness

Success factors of the Programme

4. **What, in your opinion, were the main success factors of the 3rd Health Programme?**
5. **As part of our case study work, we will be exploring a number of areas in-depth. In your opinion, which specific initiatives funded under the following areas of the 3HP were particularly successful? Why? Can you think of any examples of particularly innovative initiatives under these areas?**

    - Alcohol
    - Anti-Microbial Resistance
    - Health Inequalities
    - Nutrition
    - Health Technology Assessment
    - Vaccination

Barriers to effectiveness

6. **What, in your opinion, were the main challenges in the implementation of the 3rd Health Programme?**
7. **Were any objectives of the Programme not met?**

Implementation of Programme

1. **What is your opinion about and/or experience with the funding mechanisms supporting the 3rd Health Programme? What worked well? What could be improved?**
2. We observed that the distribution of funding and actions has not been even across participating countries, with some countries coordinating more funded actions and receiving more funding than other countries.

    a. Do you think these differences in the distribution of funding and coordination of funded actions have led to differences in benefits or costs across Member States?

    b. In your opinion, what factors resulted in these differences?
3. What was your experience of the **monitoring and reporting of results** of 3HP?

    a. Have you observed efforts to **improve the monitoring and reporting** of results of 3HP over the Programme period?

4. What actions were taken by your organisation or more widely to **disseminate the results** of 3HP funded actions?

    a. Could anything have been improved in terms of disseminating the results of the Programme?

    b. Have you observed efforts to improve the dissemination of results of 3HP over the Programme period?

5. How **effective was the exceptional utility criteria** in terms of attracting participation from low gross national income (GNI) countries?

    a. Did the effectiveness of the exceptional utility criteria change over time?

    b. What barriers are there for low GNI countries to participate in the Programme?

    c. Could any improvements have been made to attracting participation from low GNI countries?

    d. (**For stakeholders from MS leading projects**) In your opinion, what are the main barriers for low GNI countries to participate in the Programme under the exceptional utility criteria?

6. To what extent was there **cooperation** between 3rd Health Programme and **other relevant EU financial instruments**?

7. Are you aware of any **guidance** provided under the 3rd Health Programme, which detailed how actions **generate added value**?

    a. Did you use this guidance?

    b. If so, to what extent did you find this useful?

Effectiveness of funded actions

8. For actions that you were involved in and/or aware of, were the activities **implemented as planned**? If not, why not?

Effectiveness of Programme outputs, outcomes and impacts

Programme outcomes

9. Do you feel the Programme met the **targets of Member States** in the area of health defined during the implementation of the 3HP?

Programme impacts

10. What **key impacts** have you observed as a result of the Programme?

Sustainability of funded actions

11. **How sustainable are the results of the Programme likely to be?**

a. What opportunities are there for individuals or organisations to continue activities beyond the life of the Programme?

b. Were any institutions set up to continue the activities funded under the Programme?

12. What are the **barriers and enablers of sustainability** for these actions?
13. Were there any **unintended consequences** of the Programme which will **last beyond the funding period**? (E.g. stakeholder relationships, knowledge, capacity building)

Best practice examples

14. To what extent were **best practices from the Programme implemented by Member States**? To what extent was this achieved in a **coordinated** way?
15. To what extent have studies, reports and evidence produced through the Programme contributed to **decision making at EU or national level**?
16. What would have been achieved in the absence of the Programme?

Efficiency

This section is applicable to stakeholders who have experience of implementing and running actions and/or developing supporting budgets.

Questions will be specified relating to:

17. The extent to which Programme actions were cost-effective and the factors that impacted this
18. Factors impacting the funding allocations and results of funded actions
19. Evolution of funding instruments in terms of simplification, cost effectiveness and ultimately funding of actions
20. (If applicable) What worked and did not work in terms of reporting systems?

EU Added value

21. In your opinion, what would have been achieved in the thematic areas of the Programme in the absence of the 3rd Health Programme?
22. Were any other factors more influential on outcomes and impacts achieved in the thematic areas of the Programme than the Programme itself?

Coherence

23. In your opinion, have the Programme priorities been aligned with other EU-level policies in the field of health over time and up to 2020?
24. In your opinion, have the Programme priorities been aligned with national priorities in the field of health over time and up to 2020?
25. Do you believe there have been areas where 3HP priorities and national priorities have not been aligned?

Looking forward

26. What is your understanding of the scope and focus of EU4Health?
    a. Is this in line with your expectations?

27. Looking forward and considering the main areas of evaluation, what are the main factors to take into account for the new funding period (EU4Health)?

28. To which extent is there still a need to focus on each of the Programme's thematic areas?

Topic Guide - Governmental Public Health Organisations

Introduction

Stakeholder background and involvement in the Programme

1. **What is your understanding of what the 3rd health Programme set out to achieve?**

Relevance

2. From the perspective of the stakeholder group you represent, what were the **main healthcare needs** during the Programme period?

    a. **Did the 3HP sufficiently address those needs?**

        i. If yes, **in what ways? What specific actions addressed these healthcare needs?**

        ii. If no, **why not?**

3. Were there any **healthcare needs that were not sufficiently addressed** by the Programme?

    a. What were they?

    b. Are you aware of why they were not included in the Programme?

4. How aligned were the **funded actions** with the thematic priorities set out by the Programme?

5. Do you feel the way the Programme was implemented was relevant given the needs and context at the time of implementation?

Effectiveness

Success factors of the Programme

6. **What, in your opinion, were the main success factors of the 3rd Health Programme?**

7. **As part of our case study work, we will be exploring a number of areas in-depth. In your opinion, which specific initiatives funded under the following areas of the 3HP were particularly successful? Why? Can you think of any examples of particularly innovative initiatives under these areas?**

- Alcohol
- Anti-Microbial Resistance
- Health Inequalities
- Nutrition
- Health Technology Assessment
- Vaccination

Barriers to effectiveness

8. **What, in your opinion, were the main challenges in the implementation of the 3rd Health Programme?**

9. **Were any objectives of the Programme not met?**

- Where objectives have not been met, interview to explore factors which contributed to this.

Implementation of Programme

20. **What is your opinion about and/or experience with the funding mechanisms supporting the 3rd Health Programme? What worked well? What could be improved?**

21. We observed that the distribution of funding and actions has not been even across participating countries, with some countries coordinating more funded actions and receiving more funding than other countries.

- Do you think these differences in the distribution of funding and coordination of funded actions have led to differences in benefits or costs across Member States?
- In your opinion, what factors resulted in these differences?

22. What was your experience of the **monitoring and reporting of results** of 3HP?

a. Have you observed efforts to **improve the monitoring and reporting** of results of 3HP over the Programme period?

23. What actions were taken by your organisation or more widely to **disseminate the results** of 3HP funded actions?

a. Could anything have been improved in terms of disseminating the results of the Programme?

b. Have you observed efforts to improve the dissemination of results of 3HP over the Programme period?

24. Are you aware of any **guidance** provided under the 3rd Health Programme, which detailed how actions **generate added value**?

a. Did you use this guidance?

b. If so, to what extent did you find this useful?

Effectiveness of Programme outputs, outcomes and impacts

Programme outputs

25. Which **Programme outputs were particularly effective** from your point of view? Follow-on questions to be asked.

Programme outcomes

26. Which **Programme outcomes were particularly effective** from your point of view? Follow-on questions to be asked.

27. Do you feel the Programme met the **targets of Member States** in the area of health defined during the implementation of the 3HP?

Programme impacts

28. What **key impacts** have you observed as a result of the Programme?

29. **Which Programme outcomes were particularly effective** in leading to impacts from your point of view?

Sustainability of funded actions

30. **How sustainable are the results of the Programme likely to be?** (PROMPT: interviewer to select a number of relevant examples)

a. What opportunities are there for individuals or organisations to continue activities beyond the life of the Programme?

b. Were any institutions set up to continue the activities funded under the Programme?

31. What are the **barriers and enablers of sustainability** for these actions?

32. Were there any **unintended consequences** of the Programme which will **last beyond the funding period**? (E.g. stakeholder relationships, knowledge, capacity building)

Best practice examples

33. To what extent were **best practices from the Programme implemented by Member States**? To what extent was this achieved in a **coordinated** way?

34. To what extent have studies, reports and evidence produced through the Programme contributed to **decision making at EU or national level**?

35. What would have been achieved in the absence of the Programme?

Efficiency

This section is applicable to stakeholders who have experience of implementing and running actions and/or developing supporting budgets.

Interviewer to explore opinions from specific stakeholders on:

36. The extent to which Programme actions were cost-effective and the factors that impacted this

37. Factors impacting the funding allocations and results of funded actions

38. Evolution of funding instruments in terms of simplification, cost effectiveness and ultimately funding of actions

39. What worked and did not work in terms of reporting systems?

EU Added value

40. In your opinion, what would have been achieved in the thematic areas of the Programme in the absence of the 3rd Health Programme?

41. Were any other factors more influential on outcomes and impacts achieved in the thematic areas of the Programme than the Programme itself?

Coherence

42. In your opinion, have the Programme priorities been aligned with other EU-level policies in the field of health over time and up to 2020?

43. In your opinion, have the Programme priorities been aligned with national priorities in the field of health over time and up to 2020?

44. Do you believe there have been areas where 3HP priorities and national priorities have not been aligned?

Looking forward

45. What is your understanding of the scope and focus of EU4Health?

a. Is this in line with your expectations?

46. Looking forward and considering the main areas of evaluation, what are the main factors to take into account for the new funding period (EU4Health)?

47. To which extent is there still a need to focus on each of the Programme's thematic areas?

Topic Guide - Healthcare Professionals' Associations

Introduction

Stakeholder background and involvement in the Programme

1. **What is your understanding of what the 3rd health Programme set out to achieve?**

Relevance

2. From the perspective of the stakeholder group you represent, what were the **main healthcare needs** during the Programme period?

a. **Did the 3HP sufficiently address those needs?**

i. If yes, **in what ways? What specific actions addressed these healthcare needs?** [NOTE FOR INTERVIEW TO RECORD THESE AND EXPLORE LATER IN INTERVIEW]

ii. If no, **why not?**

3. How aligned were the **funded actions** with the thematic priorities set out by the Programme?

4. Do you feel the way the Programme was implemented was relevant given the needs and context at the time of implementation?

Effectiveness

Success factors of the Programme

5. **What, in your opinion, were the main success factors of the 3rd Health Programme?**

6. **As part of our case study work, we will be exploring a number of areas in-depth. In your opinion, which specific initiatives funded under the following areas of the 3HP were particularly successful? Why? Can you think of any examples of particularly innovative initiatives under these areas?**

- Alcohol
- Anti-Microbial Resistance
- Health Inequalities
- Nutrition
- Health Technology Assessment
- Vaccination

Barriers to effectiveness

7. **What, in your opinion, were the main challenges in the implementation of the 3rd Health Programme?**

THE FOLLOWING QUESTIONS EXPLORE ANSWERS TO 7.5.1 and 7.5.2 IN MORE DEPTH

Implementation of Programme

8. **What is your opinion about and/or experience with the funding mechanisms supporting the 3rd Health Programme? What worked well? What could be improved?**

9. What was your experience of **applying to the Programme**?

a. What level of administrative burden was there on your organisation when applying to and participating in the Programme?

b. Do you feel there have been improvements in the **administrative burden** of participating in the Programme since 2016?

10. Are you aware of any **guidance** provided under the 3rd Health Programme, which detailed how actions **generate added value**?

a. Did you use this guidance?

b. If so, to what extent did you find this useful?

Effectiveness of funded actions

11. For actions that you were involved in and/or aware of, were the activities **implemented as planned**? If not, why not?

Effectiveness of Programme outputs, outcomes and impacts

Programme outputs

12. Which **Programme outputs were particularly effective** from your point of view? Follow-on questions to be asked.

Programme outcomes

13. Which **Programme outcomes were particularly effective** from your point of view?

a. In what ways were they effective?

b. To whom were they most useful for?

Programme impacts

14. What **key impacts** have you observed as a result of the Programme?

15. **Which Programme outcomes were particularly effective** in leading to impacts from your point of view? Follow on questions to be asked.

Best practice examples

16. What **opportunities** were there to share **best practices** through the Programme?

17. What would have been achieved in the absence of the Programme?

Efficiency

This section is applicable to stakeholders who have experience of implementing and running actions and/or developing supporting budgets.

Interviewer to explore opinions from specific stakeholders on:

18. The extent to which Programme actions were cost-effective and the factors that impacted this

19. Factors impacting the funding allocations and results of funded actions

20. Evolution of funding instruments in terms of simplification, cost effectiveness and ultimately funding of actions

21. What worked and did not work in terms of reporting systems

Looking forward

22. To which extent is there still a need to focus on each of the Programme's thematic areas?

Topic guide - Healthcare service providers and organisations representing them

Introduction

Stakeholder background and involvement in the Programme

1. **What is your understanding of what the 3rd health Programme set out to achieve?**

Relevance

2. From the perspective of the stakeholder group you represent, what were the **main healthcare needs** during the Programme period?

a. **Did the 3HP sufficiently address those needs?**

i. If yes, **in what ways? What specific actions addressed these healthcare needs?** [NOTE FOR INTERVIEW TO RECORD THESE AND EXPLORE LATER IN INTERVIEW]

ii. If no, **why not?**

3. Have there been changes in **public needs** over time in relation to the Programme priorities?

4. How aligned were the **funded actions** with the thematic priorities set out by the Programme?

17. Do you feel the way the Programme was implemented was relevant given the needs and context at the time of implementation?

Effectiveness

Success factors of the Programme

6. **What, in your opinion, were the main success factors of the 3rd Health Programme?**

7. **As part of our case study work, we will be exploring a number of areas in-depth. In your opinion, which specific initiatives funded under the following areas of the 3HP were particularly successful? Why? Can you think of any examples of particularly innovative initiatives under these areas?**

- Alcohol
- Anti-Microbial Resistance
- Health Inequalities
- Nutrition
- Health Technology Assessment
- Vaccination

Barriers to effectiveness

22. **What, in your opinion, were the main challenges in the implementation of the 3rd Health Programme?**

THE FOLLOWING QUESTIONS EXPLORE ANSWERS TO 6.5.1 and 6.5.2 IN MORE DEPTH

Implementation of Programme

9. **What is your opinion about and/or experience with the funding mechanisms supporting the 3rd Health Programme? What worked well? What could be improved?**

10. What was your experience of **applying to the Programme**?

a. What level of administrative burden was there on your organisation when applying to and participating in the Programme?

b. Do you feel there have been improvements in the **administrative burden** of participating in the Programme since 2016?

11. Are you aware of any **guidance** provided under the 3rd Health Programme, which detailed how actions **generate added value**?

a. Did you use this guidance?

b. If so, to what extent did you find this useful?

Effectiveness of funded actions

12. For actions that you were involved in and/or aware of, were the activities **implemented as planned**? If not, why not?

Effectiveness of Programme outputs, outcomes and impacts

Programme outputs

13. Which **Programme outputs were particularly effective** from your point of view?

Programme outcomes

14. Which **Programme outcomes were particularly effective** from your point of view?

a. In what ways were they effective?

b. To whom were they most useful for?

Programme impacts

15. What **key impacts** have you observed as a result of the Programme?

16. **Which Programme outcomes were particularly effective** in leading to impacts from your point of view?

Best practice examples

17. What **opportunities** were there to share **best practices** through the Programme?

18. What would have been achieved in the absence of the Programme?

Efficiency

This section is applicable to stakeholders who have experience of implementing and running actions and/or developing supporting budgets.

Interviewer to explore opinions from specific stakeholders on:

19. The extent to which Programme actions were cost-effective and the factors that impacted this

20. Factors impacting the funding allocations and results of funded actions

21. Evolution of funding instruments in terms of simplification, cost effectiveness and ultimately funding of actions

22. What worked and did not work in terms of reporting systems

Looking forward

23. To which extent is there still a need to focus on each of the Programme's thematic areas?

Topic Guide - International Organisations

Introduction

Stakeholder background and involvement in the Programme

1. **What is your understanding of what the 3rd health Programme set out to achieve?**

Relevance

2. How aligned were the **funded actions** with the thematic priorities set out by the Programme?

3. To what extent did the Programme **align with wider Commission priorities, strategies or programmes**?

Effectiveness

Success factors of the Programme

4. **What, in your opinion, were the main success factors of the 3rd Health Programme?**

5. **As part of our case study work, we will be exploring a number of areas in-depth. In your opinion, which specific initiatives funded under the following areas of the 3HP were particularly successful? Why? Can you think of any examples of particularly innovative initiatives under these areas?**

- Alcohol
- Anti-Microbial Resistance
- Health Inequalities
- Nutrition
- Health Technology Assessment
- Vaccinations

Barriers to effectiveness

6. **What, in your opinion, were the main challenges in the implementation of the 3rd Health Programme?**

7. **Were any objectives of the Programme not met?**

THE FOLLOWING QUESTIONS EXPLORE ANSWERS TO 3.5.1 and 3.5.2 IN MORE DEPTH

Implementation of Programme

8. What was your experience of the **monitoring and reporting of results** of 3HP?

a. Have you observed efforts to **improve the monitoring and reporting** of results of 3HP over the Programme period?

9. What actions were taken by your organisation or more widely to **disseminate the results** of 3HP funded actions?

a. Could anything have been improved in terms of disseminating the results of the Programme?

b. Have you observed efforts to improve the dissemination of results of 3HP over the Programme period?

10. How **effective was the exceptional utility criteria** in terms of attracting participation from low gross national income (GNI) countries?

a. Did the effectiveness of the exceptional utility criteria change over time?

b. What barriers are there for low GNI countries to participate in the Programme?

c. Could any improvements have been made to attracting participation from low GNI countries?

11. To what extent was there **cooperation** between 3rd Health Programme and **other relevant EU financial instruments**?

12. Are you aware of any **guidance** provided under the 3rd Health Programme, which detailed how actions **generate added value**?

a. Did you use this guidance?

b. If so, to what extent did you find this useful?

Effectiveness of funded actions

Programme impacts

13. What **key impacts** have you observed as a result of the Programme?

14. When looking at the progress of the 3HP towards meeting its objectives, we observed a positive trend for most key performance indicators (e.g., deployment of patient summaries data and e-prescriptions, establishment of European Reference Networks), while others have lagged behind.

a. In your opinion, which 3HP objectives were only partially met or unmet?

b. What are the factors hindering the achievement of the 3HP objectives?

Sustainability of funded actions

15. **How sustainable are the results of the Programme likely to be?** (PROMPT: interviewer to select a number of relevant examples)

a. What opportunities are there for individuals or organisations to continue activities beyond the life of the Programme?

b. Were any institutions set up to continue the activities funded under the Programme?

16. What are the **barriers and enablers of sustainability** for these actions?

17. Were there any **unintended consequences** of the Programme which will **last beyond the funding period**? (E.g. stakeholder relationships, knowledge, capacity building)

Best practice examples

18. Are you aware of any **changes in EU policy and practice** that have resulted from the Programme?

19. What would have been achieved in the absence of the Programme?

20. Do you think the Programme contributed to the EU's influence on standards, policies and practices at global level (WHO, SDGs)?

a. If so, in which policy areas and to what extent?

b. If not, what have been the barriers?

Efficiency

This section is applicable to stakeholders who have experience of implementing and running actions and/or developing supporting budgets.

Interviewer to explore opinions from specific stakeholders on:

21. The extent to which Programme actions were cost-effective and the factors that impacted this

22. Factors impacting the funding allocations and results of funded actions

23. Distribution of funding across different funding mechanisms and how it has impacted the efficiency of the funded actions

24. Efficiency of resource allocation across thematic areas

25. Evolution of funding instruments in terms of simplification, cost effectiveness and ultimately funding of actions

26. Usefulness of the reporting system and potential barriers to its effective implementation

27. What worked and did not work in terms of reporting systems

EU Added value

28. In your opinion, what would have been achieved in the thematic areas of the Programme in the absence of the 3rd Health Programme?

29. Were any other factors more influential on outcomes and impacts achieved in the thematic areas of the Programme than the Programme itself?

Coherence

30. In your opinion, to what extent has the Programme been aligned with wider international initiatives and obligations in the field of health?

Looking forward

31. What is your understanding of the scope and focus of EU4Health?

a. Is this in line with your expectations?

32. Looking forward and considering the main areas of evaluation, what are the main factors to take into account for the new funding period (EU4Health)?

33. To which extent is there still a need to focus on each of the Programme's thematic areas?

Topic guide - Non-governmental Organisations

Introduction

Stakeholder background and involvement in the Programme

1. **What is your understanding of what the 3rd health Programme set out to achieve?**

Relevance

2. From the perspective of the stakeholder group you represent, what were the **main healthcare needs** during the Programme period?

   a. **Did the 3HP sufficiently address those needs?**

      i. If yes, **in what ways? What specific actions addressed these healthcare needs?**

      ii. If no, **why not?**

3. Were there any **healthcare needs that were not sufficiently addressed** by the Programme?

   a. What were they?

   b. Are you aware of why they were not included in the Programme?

4. Have there been changes in **public needs** over time in relation to the Programme priorities?

5. Is there variance between countries in terms of **citizen engagement** with the Programme?

6. How aligned were the **funded actions** with the thematic priorities set out by the Programme?

7. Do you feel the way the Programme was implemented was relevant given the needs and context at the time of implementation?

Effectiveness

Success factors of the Programme

8. **What, in your opinion, were the main success factors of the 3rd Health Programme?**

9. **As part of our case study work, we will be exploring a number of areas in-depth. In your opinion, which specific initiatives funded under the following areas of the 3HP were particularly successful? Why? Can you think of any examples of particularly innovative initiatives under these areas?**

- Alcohol
- Anti-Microbial Resistance
- Health Inequalities
- Nutrition
- Health Technology Assessment
- Vaccination

- In your opinion, was EU action under the 3HP successful in fostering cooperation and coordination across Member States in the field of vaccination?

Barriers to effectiveness

10. **What, in your opinion, were the main challenges in the implementation of the 3rd Health Programme?**

THE FOLLOWING QUESTIONS EXPLORE ANSWERS TO 5.5.1 and 5.5.2 IN MORE DEPTH

Implementation of Programme

11. **What is your opinion about and/or experience with the funding mechanisms supporting the 3rd Health Programme? What worked well? What could be improved?**

12. What was your experience of **applying to the Programme**?

a. What level of administrative burden was there on your organisation when applying to and participating in the Programme?

b. Do you feel there have been improvements in the **administrative burden** of participating in the Programme since 2016?

35. Are you aware of any **guidance** provided under the 3rd Health Programme, which detailed how actions **generate added value**?

a. Did you use this guidance?

b. If so, to what extent did you find this useful?

c.

Effectiveness of funded actions

14. For actions that you were involved in and/or aware of, were the activities **implemented as planned**? If not, why not?

15.

Effectiveness of Programme outputs, outcomes and impacts

Programme outputs

16. Which **Programme outputs were particularly effective** from your point of view?

Programme outcomes

17. Which **Programme outcomes were particularly effective** from your point of view?

a. In what ways were they effective?

43. To whom were they most useful for?

Programme impacts

18. What **key impacts** have you observed as a result of the Programme?

19. **Which Programme outcomes were particularly effective** in leading to impacts from your point of view?

20.

Best practice examples

21. What **opportunities** were there to share **best practices** through the Programme?

47. What would have been achieved in the absence of the Programme?

Efficiency

This section is applicable to stakeholders who have experience of implementing and running actions and/or developing supporting budgets.

Interviewer to explore opinions from specific stakeholders on:

23. The extent to which Programme actions were cost-effective and the factors that impacted this

24. Factors impacting the funding allocations and results of funded actions

25. Evolution of funding instruments in terms of simplification, cost effectiveness and ultimately funding of actions

26. What worked and did not work in terms of reporting systems

Coherence

27. In your opinion, have the Programme priorities been aligned with other EU-level policies in the field of health over time and up to 2020?

28. In your opinion, have the Programme priorities been aligned with national priorities in the field of health over time and up to 2020?

29. Do you believe there have been areas where 3HP priorities and national priorities have not been aligned?

Looking forward

30. To which extent is there still a need to focus on each of the Programme's thematic areas?

Topic guide - Organisations representing patients and services users

Introduction

Stakeholder background and involvement in the Programme

1. **What is your understanding of what the 3rd health Programme set out to achieve?**

Relevance

2. From the perspective of the stakeholder group you represent, what were the **main healthcare needs** during the Programme period?

   a. **Did the 3HP sufficiently address those needs?**

      i. If yes, **in what ways? What specific actions addressed these healthcare needs?** [NOTE FOR INTERVIEW TO RECORD THESE AND EXPLORE LATER IN INTERVIEW]

      ii. If no, **why not?**

3. Were there any **healthcare needs that were not sufficiently addressed** by the Programme?

   a. What were they?

   b. Are you aware of why they were not included in the Programme?

4. Have there been changes in **public needs** over time in relation to the Programme priorities?

5. Is there variance between countries in terms of **citizen engagement** with the Programme?

6. How aligned were the **funded actions** with the thematic priorities set out by the Programme?

7. Do you feel the way the Programme was implemented was relevant given the needs and context at the time of implementation?

Effectiveness

Success factors of the Programme

8. **What, in your opinion, were the main success factors of the 3rd Health Programme?**

9. **As part of our case study work, we will be exploring a number of areas in-depth. In your opinion, which specific initiatives funded under the following areas of the 3HP were particularly successful? Why? Can you think of any examples of particularly innovative initiatives under these areas?**

- Alcohol
- Anti-Microbial Resistance
- Health Inequalities
- Nutrition
- Health Technology Assessment
- Vaccination

10. In your opinion, was EU action under the 3HP successful in fostering cooperation and coordination across Member States in the field of vaccination?

Barriers to effectiveness

11. **What, in your opinion, were the main challenges in the implementation of the 3rd Health Programme?**

THE FOLLOWING QUESTIONS EXPLORE ANSWERS TO 8.5.1 and 8.5.2 IN MORE DEPTH

Implementation of Programme

12. **What is your opinion about and/or experience with the funding mechanisms supporting the 3rd Health Programme? What worked well? What could be improved?**

13. What was your experience of **applying to the Programme**?

a. What level of administrative burden was there on your organisation when applying to and participating in the Programme?

b. Do you feel there have been improvements in the **administrative burden** of participating in the Programme since 2016?

14. Are you aware of any **guidance** provided under the 3rd Health Programme, which detailed how actions **generate added value**?

a. Did you use this guidance?

b. If so, to what extent did you find this useful?

Effectiveness of funded actions

15. For actions that you were involved in and/or aware of, were the activities **implemented as planned**? If not, why not?

Effectiveness of Programme outputs, outcomes and impacts

Programme outputs

16. Which **Programme outputs were particularly effective** from your point of view? Follow-on questions to be asked.

Programme outcomes

17. Which **Programme outcomes were particularly effective** from your point of view?

a. In what ways were they effective?

b. To whom were they most useful for?

Programme impacts

18. What **key impacts** have you observed as a result of the Programme?

19. **Which Programme outcomes were particularly effective** in leading to impacts from your point of view? Follow-on questions to be asked.

Best practice examples

20. What **opportunities** were there to share **best practices** through the Programme?

21. What would have been achieved in the absence of the Programme?

Efficiency

This section is applicable to stakeholders who have experience of implementing and running actions and/or developing supporting budgets.

Interviewer to explore opinions from specific stakeholders on:

22. The extent to which Programme actions were cost-effective and the factors that impacted this

23. Factors impacting the funding allocations and results of funded actions

24. Evolution of funding instruments in terms of simplification, cost effectiveness and ultimately funding of actions

25. What worked and did not work in terms of reporting systems

Coherence

1. In your opinion, have the Programme priorities been aligned with other EU-level policies in the field of health over time and up to 2020?

Looking forward

26. To which extent is there still a need to focus on each of the Programme's thematic areas?

A4.4 Facilitation Plans for Focus Groups

Facilitation plan

Focus Group on 'Project Grants and gaps from findings'

Date: TBD

Time: 9.00 – 12.00 CET

Place: Online (MS Teams)

Link to Teams meeting: To be added

Study team: 2 x facilitators, 2 note-takers

Focus Group objectives: The objective of the focus group is to consult with organisations who have received Project Grants, under the 3rd Health Programme, to: (a) discuss the effectiveness and coherence of this specific type of funding (Project Grants); (b) explore current research gaps identified by the study team.

Participants will be provided with a concept note in advance of the focus group which will contain the following elements: (a) agenda of the meeting; (b) general description of the 3rd Health Programme and the objectives of the study and (c) high-level findings of the study to date which will underpin the discussions.

Time	Item/title of session	Topic and Key questions
9.00 - 9.15	Registration/Virtual coffee	N.a.
9.15 - 9.25	Welcome and introduction Introduction to the topic: The objectives of the Focus group and overall topics to be addressed	Facilitator one: - To welcome participants; present the goals of the meeting (agenda); introduce organisers and facilitators. **- Run through Slido questions as a starter** **Facilitator 2 to do – add link in chat box** - To ask Slido introductory questions - Slido event code: #379271 - Link: https://app.sli.do/event/9bppRwBJjj7YNYuS3DXfm4
9.25 – 9.50	Presentation of the Programme and main preliminary results of the study	○ Objectives of the 3rd Health Programme, main results of the evaluation study, questions to be addressed, and gaps identified. ○ Specific mention of the project grants which relate to the case study themes that we will be asking more detailed questions on for relevant participants.
9.25-B10.15	**First topic -** Funding mechanism: Project grants	Questions on funding mechanism Project Grants: 5. How were Project Grants designed? 6. How do they work? (Slido question 6)

		• 6a. (EQ13) To what extent was the funding in line with EU health priorities? a. Were the right funding instruments used for the right objectives? b. Were the funding instruments used strategically? 7. (EQ13) How was the funding (within this mechanism) split among different thematic areas? (Slido question 7) a. What are your views on the split of funding between funding mechanisms, and how has this impacted the efficiency of the funded actions in practice? b. Were Project Grants cost- effective in your view? 8. (Q5) To what extent was this funding mechanism useful to achieve results (distribution credits)? (Slido question 8 and 9)
10:15-10:20	**Break**	
~~10:15-12:00~~10.20-12.00	**Move to breakout rooms**	
10.20~~15~~–12.00	**Second topic (gaps from study): Two Break Out Groups**	N.a
10.20 – 12.00	**Group 1**	**Gaps from Evaluation study:** ○ Slido event code: #334570 ○ Link: **https://app.sli.do/event/t5ukWtBJPBWMKj55MKUg7U**
		Relevance 2. To what extent have the Programme's scope, including its objectives and priorities been relevant to health needs across the EU, considering their evolution over the evaluation period? (Slido question 2) 3. To which extent were the Programme's thematic priorities sufficiently covered by the funded actions to achieve the Programme's objectives and Commission's wider priorities? (Slido question 3 and 4) 5. Were some objectives or thematic priorities more relevant than others? (Slido question 5)

		Effectiveness
		6. What, in your opinion, were the main success factors of the 3rd Health Programme? (Slido question 6) e. What have been the (quantitative and qualitative) effects of the Programme? 7. To what extent have the Programme's objectives (general and specific) been met? To what extent can factors influencing the observed achievements be linked to the EU intervention? (Slido question 7) f. To what extent has the Programme contributed to the EU's influence on health and healthcare standards, policies and practices at international level? g. What objectives were partially met or unmet, if any? 8. What factors hindered the achievement of progress towards each general and specific objectives? What, in your opinion, were the main challenges in the implementation of the 3rd Health Programme? (slido question 8) 9. For actions that you were involved in and/or aware of, were the activities implemented as planned? If not, why not? (slido question 9) 10. How effective was the "exceptional utility" criteria in allowing/increasing the participation of low GNI (Gross National Income) countries? (Slido question 10) 11. To what extent were the results of 3HP are being used by stakeholders? (slido question 11) 12. Were the recommendations from previous evaluations implemented? (slido question 12)
		Questions related to Case Studies: **11.15 – 12.00?**

		13. ~~5.~~ In your opinion, was EU action under the 3HP successful in reducing health inequalities affecting vulnerable groups? (slido question 13~~5~~) 14~~6~~. In your opinion, was EU action under the 3HP successful in tackling overweight and obesity among children? (Slido question 14~~6~~) 15~~7~~. In your opinion, was EU action under the 3HP successful in fostering cooperation and coordination across Member States in the field of vaccination?[1](slido question 15~~7~~)
		Looking forward
		16. What is your understanding of the scope and focus of EU4Health? Is this in line with your expectations? (slido question 13) 17. Looking forward and considering the main areas of the evaluation, what are the main factors to take into account for the new funding period (EU4Health)? (slido question 14)
		~~**Questions related to Case Studies**:~~
		~~15. In your opinion, was EU action under the 3HP successful in reducing health inequalities affecting vulnerable groups? (slido question 15)~~ ~~16. In your opinion, was EU action under the 3HP successful in tackling overweight and obesity among children? (Slido question 16)~~ ~~17. In your opinion, was EU action under the 3HP successful in fostering cooperation and coordination across Member States in the field of vaccination?[2](slido question 17)~~
10.45 - 12.00	**Group 2**	**Gaps from Evaluation study:** ○ Slido code: #494541 ○ Event link: https://app.sli.do/event/68WXYqCrv25pQDRGv1tWNJ
		Efficiency
		2. To what extent the Programme results, and effects are likely to be sustainable? Is there any evidence of this? (slido question 2) 3. Were there any specific instances where spending deviated from plans? (slido question 3)

		4. Were Programme's costs associated with proportionate benefits? (slido question 4) 5. To what extent have simplification measures led to a reduction in the administrative costs for applicants, and could improvements be made to further simplify procedures and reduce costs? (slido question 5 and 6) 7. What are your views on the monitoring processes of the programme? (slido question 7) 8. What were the weaknesses of the Programme as described in previous evaluations? (slido question 8)
		EU Added Value
		9. What is the additional value resulting from the Programme, compared to what could reasonably have been expected from Member States acting at national and/or regional levels, and compared to what the EU would have achieved without the Programme? (Impact of 3HP on MSs action – view and evidence) (slido question 9)
		Coherence
		10. Are the actions implemented under the 3rd Health Programme coherent with its objectives? How has the coherence of the Programme influenced its effectiveness? (slido question 10) 11. To which extent have the priorities of the Programme led to more synergy, focus and coherence between the EU-funded actions in delivering on similar objectives? Did the health Programme encourage cooperation with the European Structural and Investment Funds and other EU financial instruments? To which extent is the Programme coherent with wider EU policy and with international obligations? (slido question 11) 12. To which extent has the Programme proved complementary to other EU or Member States targets/interventions/initiatives in the field of health? (slido question 12 and 13)
		Looking Forward
		14. What is your understanding of the scope and focus of EU4Health? Is this in line with your expectations? (slido question 14)

		• Looking forward and considering the main areas of evaluation, what are the main factors to take into account for the new funding period (EU4Health)?
		~~**Questions related to Case Studies**~~
		~~15. In your opinion, was EU action under the 3HP successful in reducing health inequalities affecting vulnerable groups? (slido question 15)~~ ~~16. In your opinion, was EU action under the 3HP successful in tackling overweight and obesity among children? (slido question 16)~~ ~~17. In your opinion, was EU action under the 3HP successful in fostering cooperation and coordination across Member States in the field of vaccination?[3] (slido question 17)~~
12:00 - 12:15	*Break*	*n.a.*
12:15 – 12.45	**Plenary session**	a. Event code: #231790 b. Link of the event: https://app.sli.do/event/q1MBaxz3Vq1vFgyj5TjWiM 1. Discussion, general observations from participants (concluding questions, Slido) 2. Concluding remarks (5 minutes) and next steps (Facilitator one) **~~N~~ext steps in the evaluation, follow-on interviews, advertising the o partner organisations if possible (6 May).**

Facilitation Plan

Focus Group on Operating Grants and gaps from findings' (no sub-groups)

Date: 18 of May 2022

Time: 10.00 – 13.00 CET

Place: Online (MS Teams)

Link to Teams meeting: To be added

Study team:

1. **Facilitator 1 (Facilitator 2 to present results of the Study)**
2. **Technical support and note-takers: Facilitator 3 (and Facilitator 2 at the beginning only)**

Focus Group objectives: The objective of the focus group is to consult with organisations who have received Operating Grants, under the 3rd Health Programme, to: (a) discuss the effectiveness and coherence of this specific type of funding (Operating Grants); (b) explore current research gaps identified by the study team.

Participants will be provided with a concept note in advance of the focus group which will contain the following elements: (a) agenda of the meeting; (b) general description of the 3rd Health Programme and the objectives of the study and (c) high-level findings of the study to date which will underpin the discussions.

Time	Item/title of session	Topic and Key questions
10.00 - 10.15	**Registration**/Virtual coffee	N.a.
10.15 - 10.25	**Welcome and introduction** Introduction to the topic: The objectives of the Focus group and overall topics to be addressed	**Facilitator 1:** - To welcome participants; present the goals of the meeting (agenda); introduce organisers and facilitators. - **Run through Slido questions as a starter** **Facilitator 2 to do – add link in chat box** - To ask Slido introductory questions - Slido event code: #379272 - Link: https://app.sli.do/event/wiFteLWUQZFMaQmvLPkiht Ask (Facilitator 1) participants introduce their organisation and type of work the operating grant contributed to? (to be asked verbally after Sli.do question 1)
10.25 – 10.40	**Presentation of the Programme and main preliminary results** of the study	○ Objectives of the 3rd Health Programme, main results of the evaluation study, questions to be addressed, and gaps identified.
10.40 - 11.20	**First topic -** Funding mechanism: Operating grants	**Questions on funding mechanism Operating Grants:** 4. How were Operating Grants designed? (Slido question 4) 5. How do they work? (Slido question 5) 5a. (EQ13) To what extent was the funding in line with EU health priorities? (For right objective/strategically) 6. (EQ13) How was the funding (within this mechanism) split among different thematic areas? (Slido question 6) a. What are your views on the split of funding between funding mechanisms, and how has this impacted the efficiency of the funded actions in practice?

		b. Were Operating Grants cost- effective in your view? 7. (Q5) To what extent was this funding mechanism useful to achieve results (distribution of credits)? (Slido question 7 and 8)[1]
11.20 – 11.30	**Break**	
11.30 – 12.50	**Discussion about gaps**	
		Relevance 2. What are your views of the Commission's wider priorities at the time of the 3HP implementation? (Slido question 2) [Use discussion to get feedback on whether there were links between 3HP and wider Commission priorities in the field of health and beyond]. 2.1 To what extent have the Programme's scope, including its objectives and priorities been relevant to health needs across the EU, considering their evolution over the evaluation period? (Slido question 2.1) 3. 3a) How relevant are the 3HP objectives? (slido question 3) 4. Were some objectives of the Programme more relevant than others? (Slido question 4) [This relates to the link between the thematic priorities of the Programme in relation to the wider health needs during the implementation of the 3HP] 5. What was the impact of the funding on Operating Grants in your view? (Slido question 5) 6. What outputs/results were achieved through the Operating Grants? (slido question 6) 7. What would have happened without this funding? [Probe discussion further if not mentioned]: Do you think another funding source have come along? Would key activities have been cut? What progress would not have happened? (Slido question 7)
		Effectiveness 8. What, in your opinion, were the **main success factors** of the 3rd Health Programme? (Slido question 8) [First, ask slido question 8 and then have a discussion if relevant.] 9a. How effective was the **application process** for the Programme? What worked well and what didn't? (Slido question 9a) 9b. How effective was the **monitoring process** for the Programme? What worked well and didn't? (slido question 9b, 9c)

		10. What factors hindered the achievement of progress towards each general and specific objective of the 3HP? (slido question 10) 11. What, in your opinion, were the main challenges in the implementation of the 3rd Health Programme? (Slido question 11 and 12)[Please keep slide with the objectives in hand to show for discussion] 12. How have results of Operating Grants -been used? Could you provide specific examples of results used? (no slido question)[to be asked after slido question 12]
		Efficiency 13. Were there any specific instances where spending deviated from plans? (slido question 13)[2] 14. Were Programme's costs associated with proportionate benefits? (slido question 14) 15. To what extent have simplification measures[3] led to a reduction in the administrative costs for applicants, and could improvements be made to further simplify procedures and reduce costs? (slido question 15a and 15b) (Show slides with simplification measures) 16. What were the weaknesses of the Programme in terms of efficiency in your view?(slido question 16)
		EU Added Value 17. What is the additional value resulting from the Programme, compared to what could reasonably have been expected from Member States acting at national and/or regional levels, and compared to what the EU would have achieved without the Programme? (Impact of 3HP on MSs action) (Slido question 17)

		Coherence 19. Are the actions implemented under the 3rd Health Programme coherent with its objectives? (slido question 18) 20~~19~~.To which extent have the priorities of the Programme led to more synergy, focus and coherence between the EU-funded actions in delivering on similar objectives? To which extent is the Programme coherent with wider EU policy and with international obligations? (slido question 19 and 20) 21~~0~~.To which extent has the Programme proved complementary to other EU or Member States targets/interventions/initiatives in the field of health? (slido question 21)
12:50 – 13.00	**Plenary session**	a. Event code: #231791 b. Link of the event: https://app.sli.do/event/qNha5W3nCFqx7yZHzmz2d3 1. General observations from participants (concluding questions, Slido) 2. Concluding remarks (5 minutes) and next steps (Facilitator 1) **Next steps in the evaluation, follow-on interviews, advertising the o partner organisations if possible (date).**

Facilitation Plan

Focus Group on Procurement Contracts and gaps from findings'

Date: 19th of May 2022

Time: 10.00 – 13.00 CET

Place: Online (MS Teams)

Link to Teams meeting: https://teams.microsoft.com/l/meetup-join/19%3ameeting_YjIzZTU4NDYtOTk5Ni00ZmE5LTllOWItZWUxZWI1OTkwYjg0%40thread.v2/0?context=%7b%22Tid%22%3a%22cf90b97b-be46-4a00-9700-81ce4ff1b7f6%22%2c%22Oid%22%3a%2205039bfb-278e-41aa-82b5-7af4a465f6f2%22%7d

Study team:

1. **Facilitators: 1 and 2**
2. **Technical support and note-takers: Facilitator 3**

Focus Group objectives: The objective of the focus group is to consult DG SANTE and HaDEA on their views of **Procurement contracts** under the 3rd Health Programme, in

order to: (a) discuss the effectiveness, coherence and efficiency of this specific type of funding; (b) explore current research gaps identified by the study team.

Participants will be provided with the list of key questions in advance of the focus group.

Time	Item/title of session	Topic and Key questions
10.00 - 10.15	**Registration**/Virtual coffee	N.a.
10.15 - 10.25	**Welcome and introduction** Introduction to the topic: The objectives of the Focus group and overall topics to be addressed	**Facilitator 1:** - To welcome participants; present the goals of the meeting (agenda); introduce organisers and facilitators. - **Run through Slido questions as a starter** **Facilitator 3 – add link in chat box** - To ask Slido introductory questions - Slido event code:#379273 - Link: https://app.sli.do/event/o6WxDjHDvtm4Hs8SfC477n Ask (Facilitator 1) participants introduce their Unit and type of work the Procurement contract(s) contributed to? (to be asked verbally after Sli.do question 1) Ask (if pp not talking much): *Is there a topic relating to Operating Grants that you particularly look forward to discussing today? (Word cloud)* For Slido Q4 Check List of procurement contracts shared by SANTE (Saved in here)
10.25 – 10.35	Presentation of the 3HP evaluation and main preliminary results	a. Main objectives and results of the evaluation study (so far), questions to be addressed, and gaps identified.
10.35 - 11.25	**First topic -** Funding mechanism: **Procurement contracts**	**Questions on funding mechanism Procurement contracts:** **(Areas of success relating to procurement Contracts, and challenges/areas for improvement)** 1. How was the **Procurement contracts** funding mechanism initially designed? 2. 6a. (EQ13) How was the funding (within this mechanism) split among different thematic areas? (Slido question 7) (distribution of credits) a. What are your views on the split of funding between funding mechanisms, and how has this impacted the efficiency of the funded actions in practice? (distribution of credits)[1]

		b. Were Procurement contracts cost- effective in your view? 3. (EQ5) To what extent was this funding mechanism useful to achieve results ?
11.25 – 11.35	**BREAK**	
11.35 – 12.35	**Gaps from study**	N.a
11.35 – 12.35	**Topic 1** **12 Qs – 60 mins**	**Gaps from Evaluation study**
		Relevance: 1. How relevant were Procurement contracts within the Third Health Programme?
		Effectiveness: *Procurement contracts' **application process and monitoring process:*** 2. In case you were involved in reviewing applications, was the **application process** effective in your view? What worked well? What was challenging? 2a. Were there any changes or improvements in the application process over the programme period? 3. How effective has the **monitoring process** been? What worked well? What was challenging? 3a. Were there any changes or improvements in the monitoring process over the programme period? 4. Were the recommendations of the midterm evaluation implemented? ***Success factors*** 5. What, in your opinion, were the **main success factors** of the 3rd Health Programme? ***Effects / results / impact of the procurement contracts*** 6. What have been the (quantitative and qualitative) effects of the Programme? 7. [If not mentioned before] To what extent did the Programme contribute to the EU's influence on health and healthcare standards, policies and practices at international level? 8. For the Procurement contracts that you were involved in and/or aware of, were the activities

		implemented as planned in your view? If not, why not? 9. What factors hindered the achievement of progress towards each general and specific objectives? What, in your opinion, were the main challenges in the implementation of the 3rd Health Programme? 4. To what extent did the Programme results and effects demonstrate evidence of being continued regardless of Programme funding (sustainability of results and effects)?
	Topic 3 Topic 2	**Gaps from Evaluation study**
		Coherence: 5. Were the Procurement contracts ~~implemented under the 3rd Health Programme~~ coherent with the objectives of the 3HP~~its objectives~~? 6. To which extent have the priorities of the Programme led to more synergy, focus and coherence between Procurement contracts in delivering on similar objectives?
		EU Added Value: 7. Was there any EU-added value arising from the procurement contracts you were involved with?
		If time, we can discuss the case studies questions:
12:35 - 12:45	*Break*	*n.a.*
12:45 – 13.15		**Efficiency** ***Planning and budgeting*** 17. Were there any specific instances where spending deviated from plans? Why? 18. In your view how did the split of funding between mechanisms impact the efficiency of procurement contracts? 19. Our results so far show that the funding wasn't allocated equally between the 4 priority areas; was the funding given to areas with more added value in your view? (Ask in particular about Procurement contracts funding) ***Costs incurred by SANTE and HaDEA*** 20. What specific types of costs were incurred within SANTE relating to procurement contracts. *E.g. administrative, legal, monitoring, personnel, equipment, IT, time etc.* 21. Did the simplification measures lead to a reduction in the administrative costs for SANTE and

		HaDEA? Could improvements be made to the simplification measures to further reduce costs? 22. [If not mentioned] How cost-effective were the monitoring processes (procurement contracts)? 23. Were there any other factors impacting the efficiency of Procurement contracts? **Closing/Concluding remarks:** a. Event code: #231792 b. Link of the event: https://app.sli.do/event/fyU9euE5TW833WS561kmv4 1. Discussion, general observations from participants (Florencia to share concluding questions from Slido) 2. Concluding remarks (5 minutes) and next steps (Facilitator 1) **Next steps in the evaluation, follow-on interviews, advertising the partner organisations if possible (date).**

Facilitation Plan

Focus Group on Joint Actions and gaps from findings'

Date: 23 of May 2022

Time: 10.00 – 13.00 CET

Place: Online (MS Teams)

Link to Teams meeting: To be added

Study team:

1. **Facilitators: 1, 2, and 3**
2. **Technical support and note-takers: Facilitators 4 and 5**

Focus Group objectives: The objective of the focus group is to consult with organisations who have participated in Joint Actions, under the 3rd Health Programme, to:

(a) discuss the effectiveness and coherence of this specific type of funding (Joint Actions); (b) explore current research gaps identified by the study team.

Participants will be provided with a concept note in advance of the focus group which will contain the following elements: (a) agenda of the meeting; (b) general description of the 3rd Health Programme and the objectives of the study and (c) high-level findings of the study to date which will underpin the discussions.

Time (Brussels CEST)	**Item/title of session**	**Topic and Key questions**
10.00 - 10.15	**Registration**/Virtual coffee	N.a.
10.15 - 10.20	**Welcome and introduction** Introduction to the topic: The objectives of the Focus group and overall topics to be addressed	**Facilitator 1:** - To welcome participants; present the goals of the meeting (agenda); introduce organisers and facilitators. - **Run through Slido questions as a starter** **Facilitator 3 to do – add link in chat box** - To ask Slido introductory questions - Slido event code: # 379273 - Link: https://app.sli.do/event/mR1B3JtWgBqSU9ogmyi5Ra **Facilitator 1** - Ask participants to introduce their organisation and type of work the Joint Action contributed to? (to be asked verbally after Sli.do question 1 as in a **Tour de Table**)
10.20 – 10.35	**Presentation of the Programme and main preliminary results** of the study	○ Objectives of the 3rd Health Programme, main results of the evaluation study, questions to be addressed, and gaps identified. ○ Specific mention of the Joint Actions which relate to the case study themes. We will be asking more detailed questions on these later in the FG.
10.35-11.30	**First topic -** Funding mechanism: Joint Actions	**Questions on funding mechanism Joint Actions – Open questions** 3. How were Joint Actions designed? (Slido question 3) 4. How do they work? (Slido question 4) 4a. (For discussion after sli.do Q) (EQ13) To what extent was the funding allocated to Joint Actions in line with EU health priorities? a. Was the funding instrument (Joint Action) used strategically? 5. (EQ13) How was the funding (within this mechanism) split among different thematic areas? (Slido question 5)

		a. (For discussion after sli.do question) What are your views on the split of funding between funding mechanisms, and how has this impacted the efficiency of the funded actions in practice? (no slid.do question) b. Were Joint Actions cost- effective in your view? (no sli.do question) 6. (Q5) To what extent was this funding mechanism useful to achieve results? (Slido question 6 and 7) PROBE for: the extent to which the Programme contributed to the EU's influence on health and healthcare standards, policies and practices at international level PROBE for: the extent to which the results were published or made accessible to the wider scientific and health community and to the public **Barriers to dissemination of results** PROBE for: results being used at Member State level.
11.30-11.40	**Break**	
11.40-12.40	**Move to breakout rooms**	
11.40–12.40	**Second topic (gaps from study): Two Break Out Groups**	N.a
11.40 – 12.40	**Group 1**	
	3 questions, 15 min?	**Relevance** [1. Please type the name of your organisation (only in slido)] 2. To what extent were the Joint Actions relevant considering health needs across the EU? (sli.do Q2) 3. To what extent were the Programme's objectives and thematic priorities sufficiently covered by the Joint Actions? (sli.do Q3) a. (Follow-up question after sli.do) Were some objectives/thematic priorities of the Programme more relevant than others? 4. In your view, to what extent were the funded actions linked to these three levels: (slido Q4)

		3. Commission's wider priorities 4. 3HP objectives 5. 3HP thematic priorities
	12 questions, 30 min?	**Effectiveness** ***Joint Actions application process and monitoring process*** 5a. How effective was the funding **application process**? (Slido question 5a) 6. (For discussion after slido Q) What worked well and what didn't? 5b. (For those involved in different Joint Actions over multiple years) Were there any changes or improvements in the application process over the programme period? (slido question 5b) 5c. How effective have the **monitoring processes** been? (slido question 5c) 7. (For discussion after slido Q) What worked well and didn't? 5d. Were there any changes or improvements in the monitoring process over the programme period? (slido question 5d) 5e. Were the recommendations of the midterm evaluation implemented? (slido question 5e) ***Success factors*** 6a. What, in your opinion, were the main success factors of the 3rd Health Programme? (Slido question 6a) [First, ask slido question 6a and then have a discussion if relevant.] [Include options of success factors in PPT] 8. (For discussion after sli.do Q) What were the main success factors of the Joint Actions you were involved in? ***Effects and Sustainability*** 7a. What are in your opinion the main effects of the Joint Actions you were involved in? (no sli.do Q) 7b. To what extent were the results of the Joint Actions published and disseminated? (slido question 7b) 7c. To what extent were the 3HP results and effects linked to Joint Actions likely to be sustainable? Is there any evidence of this? (slido question 7c) ***Barriers to effectiveness*** 8a. For the Joint Actions you were involved in, were the activities implemented as planned in your view? (slido question 8a) 9. If not, why not? 8b. What, in your opinion, were the main challenges in the implementation of the 3rd Health Programme? (no sli.do

		Q)[Please keep slide with the objectives in hand to show for discussion] 10. What were the main challenges in the implementation of the Joint Action you were involved in? ***Participation*** 9. How effective was the "exceptional utility" criteria in allowing/increasing the participation of low GNI (Gross National Income) countries? (Slido question 9)
	5/10 minutes **Questions are to be asked only to participants from the Joint Actions looked at in the case studies**	**Questions related to Case Studies [Open discussion, no Sli.do Qs)** **Health inequalities** [For those involved in JAHEE – Joint Action Health Equity Europe] • To what extent has the Joint Action contributed to a more comprehensive and coordinated approach to health inequalities affecting vulnerable groups? • Do you think the projects/activities you were involved into contributed to improvements in health status and access to care of vulnerable groups? • Do you think the project's results and effects on health inequalities are likely to be sustainable (beyond the project life cycle)? **Nutrition** [For those involved in Best-ReMaP – Joint Action on Implementation of Validated Best Practices in Nutrition] • To what extent have the projects/activities you were involved into contributed to a more comprehensive and coordinated approach to childhood obesity? • To what extent have you coordinated with actors involved in the JANPA joint action, or the ongoing Best-ReMaP joint action? • To what extent have the results/ outputs of JANPA or Best-ReMaP been useful to your projects/activities? **Vaccination** • To what extent has the Joint Action contributed to a more comprehensive and coordinated approach to vaccination? • Do you think the projects/activities you were involved into contributed to improvements in vaccination rates? • Do you think the projects/activities you were involved into contributed to improvements in access to vaccination services for vulnerable groups?

		Looking forward – Open discussion, no sli.do Qs
	2 question, 5/10 min?	10.What is your understanding of the scope and focus of EU4Health? Is this in line with your expectations? 11.Looking forward and considering the main areas of the evaluation, what are the main factors to take into account for the new funding period (EU4Health)?
11.40 - 12.40	**Group 2**	**Gaps from Evaluation study:** a. Slido code: #494542 b. Event link: https://app.sli.do/event/9ThpaP1jU8v1wYd6fxuDPh
		Introductory questions ***Success factors and challenges*** b. What, in your opinion, were the main success factors of the 3rd Health Programme? c. Were there any barriers to the Programme's success? d. What were the main results of your Joint Actions? PROBE for: use of results at MS level. e. What were the main success factors of the Joint Actions you were involved in? f. Were there any barriers to achieving success in your Joint Actions?
		Efficiency
	6 questions, 30 min?	[1. Please type name of organisation (only inslido] 2. Were there any specific instances where spending deviated from what was planned? (slido question 2) [Show sli.do Q then discuss instances] 3. Were the Programme's costs associated with proportionate benefits? (slido question 3) 4. To what extent have simplification measures led to a reduction in the administrative costs for applicants, and could improvements be made to further simplify procedures and reduce costs? (slido question 4a and 4b) [Show simplification measures in

		slide] [If respondents say further changes are needed, ask what changes] 5. What are your views on the monitoring processes of the programme linked to Joint Actions? (slide with description of monitoring) (slido question 5) 6. What are your views on the reporting system of the programme linked to Joint Actions (slido question 6) 7. Were there any other factors impacting the efficiency of Joint Actions? (no slid.do Q)
	1 question, 5/10 minutes For Selma: participants are normally eager to discuss EU added value, and also it is important to get MS views on this, so please try and engage with everyone on this question	**EU Added Value** 8. What is the additional value resulting from the Programme (especially from the Joint Actions), compared to what could reasonably have been expected from Member States acting at national and/or regional levels? (Impact of 3HP on MSs action) (Slido question 7)
	4 questions, 15 minutes For Selma: these questions are not specifically related to the Joint Actions, however as follow-up questions and to steer the discussion if participants do not specifically mention Joint Actions in their answers, please do ask after sli.do questions 10, 11 and 12 whether the Joint Actions in particular have contributed to more synergies/coherence	**Coherence** 9. Were the actions implemented under the 3rd Health Programme coherent with its objectives? (slido question 8) 10. How well has the coherence of the Programme influenced its effectiveness? (Slido question 9) 11. To which extent have the priorities of the Programme led to more synergy, focus and coherence between the EU-funded actions in delivering on similar objectives? Did the health Programme encourage cooperation with the European Structural and Investment Funds and other EU financial instruments? To which extent is the Programme coherent with wider EU policy and with international obligations? (slido question 10 and 11) g. [For discussion, no need to include in PPT]: In particular, do you think the Joint Actions you were involved in led to more synergy, focus and coherence between the EU-funded actions? Were they coherent with wider EU policy and with international obligations? 12. To which extent has the Programme proved complementary to other EU or Member States targets/interventions/initiatives in the field of health? (slido question 12) h. [For discussion, no need to include in PPT]: In particular, do you think the Joint

		Actions you were involved in were complementary to other EU or Member State initiatives in the field of health?
	2 questions, 5/10 minutes	**Looking Forward – Open discussion, no sli.do Qs** 13. What is your understanding of the scope and focus of EU4Health? Is this in line with your expectations? (slido question 11) 14. Looking forward and considering the main areas of the evaluation, what are the main factors to take into account for the new funding period (EU4Health)? (slido question 12)
12:40 – 13.00	**Plenary session**	a. Event code: # 231793 b. Link of the event: https://app.sli.do/event/2DpmfJPPB8DW6fziybQGrj 1. Discussion, general observations from participants (concluding questions, Slido) 2. Concluding remarks (5 minutes) and next steps (Hayley) i. **Next steps in the evaluation, follow-on interviews [ask to suggest colleagues] , advertising the o partner organisations if possible (date).**

Facilitation Plan

Focus Group on All funding mechanism and gaps from findings'

Date: 24th of May 2022

Time: 10.00 – 13.00 CET

Place: Online (MS Teams)

Link to Teams meeting:

Study team:

1. **Facilitators: 1 and 2**
2. **Technical support and note-takers: Facilitator 3**

Focus Group objectives: The objective of the focus group is to consult DG SANTE and HaDEA on their views of **All funding mechanisms** under the 3rd Health Programme, in order to: (a) discuss the effectiveness, coherence and efficiency of the different funding mechanisms; (b) explore current research gaps identified by the study team.

Time	Item/title of session	Topic and Key questions
10.00 - 10.15	**Registration**/Virtual coffee	N.a.
10.15 - 10.25	**Welcome and introduction** Introduction to the topic: The objectives of the Focus group and overall topics to be addressed	**Facilitator 1:** - To welcome participants; present the goals of the meeting (agenda); introduce organisers and facilitators. Ask participants introduce their Unit and type of work they contributed to? (Only if different participants from Procurement Contracts FG)
10.25-11.25	**First topic -** Funding mechanism: **All funding mechanisms**	**Questions on all funding mechanisms :** **(Areas of success /areas for improvement)** 1. How were the different funding mechanism designed and what purpose~~s~~ did they have? 2. (EQ13) How was the funding split among different thematic areas? (Slido question 7) (distribution of credits) [ICF ~~to~~ should show the specific objectives table with the thematic priorities underneath & ask what benefits there were to allocate funding more in some areas than others] 3. To what extent was each funding mechanism cost- effective in your view? 4. (EQ5) To what extent were the different funding mechanisms useful to achieve results~~-~~? Please specify in which way each funding mechanism contributed to this. PROBE for: key results from each funding mechanism 5. Can you summarise key successes of the Programme?
11.25 – 11.35	**BREAK**	
11.35 – 12.35	**Topic 1**	**Gaps from Evaluation study**

	12 Qs – 60 mins	**Relevance:** 6. To what extent have the 3HP Programme's scope, including its objectives and priorities been relevant to health needs across the EU, considering their evolution over the evaluation period? 7. Has the 3HP addressed the health needs from non-EU countries who took part in the programme in your view? 8. Have some objectives or thematic priorities been more relevant than others ? Why? 9. Could you provide an assessment of the alignment between: • the funded actions and the Programme's thematic priorities? • the funded action and the wider Commission priorities?
		Effectiveness: 10. What were the effects (both quantitative and qualitative) of the Programme? *Per funding mechanism.* 11. What objectives (general and specific) were partially met or unmet in your view? 12. For the objective that were not (fully) met, what factors hindered their achievement? 13. To what extent was the exceptional utility criteria effective? *Applicable to Joint Actions, Project Grants and Operating Grants.* 14. To what extent were Programme results published (e.g. by Commission services and Programme beneficiaries)? Were publications made accessible to the wider scientific and health community and to the public? 15. Do you have any data on the resources allocated to Programme monitoring? *[Internal note: information not provided in the Annual Implementation Reports -*

		Portion of the budget category "Horizontal activities"] ***Effects / results / impact of all funding mechanisms*** 16. For the funded actions that you were involved in and/or aware of, were the activities implemented as planned in your view? If not, why not?
	Topic 3 Topic 2	**Gaps from Evaluation study**
		Coherence: 17. Have the actions implemented under the Programme been coherent with the objectives of the Programme? 18. Was there any coordination between the 3HP and other EU financial instruments? Were the 3HP and the other funding mechanism complementary in your view (e.g. the European Structural and Investment Funds)? If yes, how? 19. Was the 3HP coherent and aligned with wider EU policies? 20. To what extent have the priorities of the Programme led to more synergy, focus and coherence between the different funding mechanisms in delivering on similar objectives?
		EU Added Value: 21. What was the added value of the 3HP and its funding? 22. What was the impact of the Programme on Member States' actions? Can you provide some examples?
12:35 - 12:45	*Break (if on time)*	*n.a.*
12:45 – 13.15		**Efficiency** ***Costs incurred by SANTE and HaDEA*** 23. What specific types of costs were incurred within SANTE relating to managing the 3HP? *E.g.*

		administrative, legal, monitoring, personnel, equipment, IT, time etc. 24. [If not mentioned] How cost-effective were the monitoring processes (all funding mechanism)? 25. Were there any other factors impacting the efficiency of the different funding ~~mechanims~~mechanism? **Looking forward** 26. Is the scope and focus of EU4Health in line with your expectations? 27. Looking forward and considering the main areas of the evaluation, what are the main factors to take into account for the new funding period (EU4Health) **Closing/Concluding remarks:** 28. Discussion, general observations from participants (Ask if any other relevant points to make, that were not coeverd during the discussion) 29. Concluding remarks (5 minutes) and next steps (Facilitator 1) • **Next steps in the evaluation, follow-on interviews – Suggestions for colleagues that we could interview are welcome.**

Annex 5 Additional relevant information, data files, tables and figures to supplement the analysis in the previous chapters.

A5.1 Supplementary information for Q1

Baseline assessment

- **Baseline (2014):** The second health programme's (2HP) objectives and funded actions largely covered the health needs in the Member States. However, evidence shows the scope for the programme was very broad in practice: "With the way the 2nd HP's objectives were defined, nearly any topic related to public health in Europe could be considered relevant"[423]. This meant it was difficult for some stakeholders to understand what the objectives of the 2HP were, or to what extent actions addressed needs in the topic areas. Further, it was noted[424] that the Programme may effectively address an important public health issue, however it does not necessarily follow from this that action at the EU level is the best way to tackle the underlying problems. Therefore, it is important for relevance to coincide with EU added value. Previous evaluations recommended a tighter focus and better concentration of resources available on issues where they can add the most value. The 3HP was designed to address these issues by setting more specific objectives, which cover a slightly reduced scope of public health issues, and by introducing a focus on how progress was to be achieved.
- **Mid-point (2017):** 3HP's "valid and appropriate objectives" allowed it to support focused actions which address existing issues while generating EU added value. In the mid-term evaluation, there was some suggestion that 3HP was not adequately addressing mental health needs.

Health needs during the period of programme implementation

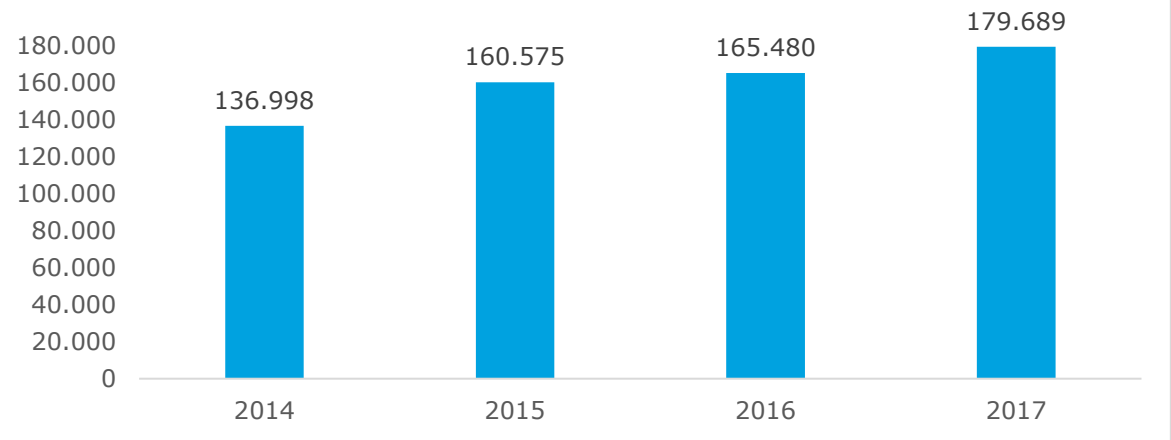
The text below provides further information on the specific health needs and trends in the participating countries, which is presented under Q1. This includes incorporating trends from key European datasets (Eurobarometer and Euromonitor)[425].

Objective 1: Health promotion

As shown in Figure 61, in the EU between 2014 and 2017 deaths from mental and behavioural diseases increased by 31.2%[426]. This included deaths from dementia, mental and behavioural disorder due to drug dependence, harmful alcohol use, and other behavioural and mental health disorders[427].

[423] Coffey International Development., 2015. Ex-post Evaluation of the Health Programme (2008-2013) Final report [online]. Available from: https://ec.europa.eu/health/system/files/2016-11/ex-post_ev-hp-2008-13_final-report_0.pdf [Accessed November 2020].
[424] As detailed in the introduction, the primary source for the baseline assessment is the ex-post evaluation of the second health programme and the primary source for the mid-point assessment is the mid-term report of the 3HP.
[425] Note that the Eurobarometer and Eurostat indicators examined here only include EU Member States, therefore trends in the United Kingdom (Data for the UK has been removed from analysis to ensure comparability with the present EU-27), Bosnia and Herzegovina, Iceland, Moldova, Norway, and Serbia are not captured. Further, EU data trends were not found related to the following thematic priorities: 1.3, 1.6, 2.1, 2.3, 3.1, 3.3 to 3.7, 4.1 and 4.2. See Annex 2 for further information on these datasets.
[426] Data is only available from 2014 until 2017. Data found for the years 2018 and 2019 is incomplete and cannot be used to compare information across the 27 Member States.
[427] Eurostat, [online data code: HLTH_CD_ARO]. *Causes of death - deaths by country of residence and occurrence.* Available from: Statistics | Eurostat (europa.eu) [Accessed October 2021]

Figure 61. Deaths from Mental and Behavioural Disorders by million people in 27 member states.



- *Source: Eurostat, [online data code: HLTH_CD_ARO]. Causes of death – deaths by country of residence and occurrence*

Thematic priority **1.1** (risk factors such as use of tobacco and passive smoking, harmful use of alcohol, unhealthy dietary habits and physical inactivity) seemed to represent a large health need in the EU.

According to the World Health Organisation (WHO)- Europe, across the 53 European countries some of the main challenges during the years of the implementation of the 3rd health programme were tobacco consumption, poor nutrition, and physical inactivity[428].

Across the 27 member states, most of the citizens do not smoke tobacco products. However, from those people that smoke, their daily smoking consumption has slightly decreased between 2014 and 2019[429]. However, more than half of these smokers have never tried to stop smoking. Passive smoking has also decreased across the 27 Member States due to the limitations on smoking in certain environments, including public places and inside eating or drinking establishments (prohibited in most Member States[430]). In terms of alcohol use, the frequency of weekly alcohol consumption has slightly increased in all 27 member states between 2014 and 2019.[431,432,433]

In relation to risk factors associated with unhealthy dietary habits and physical inactivity, almost half of the citizens (46%) from the 27 Member States never exercise or play a sport.[434] The main physical activity carried out by citizens involves walking to and from a place (79.4%). Furthermore, 54.7% of the citizens from the 27 member states consume between 1 to 4 portions of fruits and vegetables a day.

[428] World Health Organisation. Core health indicators in the European Region. Retrieved from: https://www.euro.who.int/en/data-and-evidence/evidence-resources/core-health-indicators-in-the-who-european-region
[429] Eurostat, [online data code: HLTH_EHIS_SK3E]. Daily smokers of cigarettes by sex, age and educational attainment level. Retrieved from: Statistics | Eurostat (europa.eu)
[430] There is a full ban on using traditional products for smoking indoors in restaurants and eating establishments in 16 countries, and a partial ban in a further 14. See DG SANTE. 2021. Final Report: Study on smoke-free environments and advertising of tobacco and related products. Available from: https://op.europa.eu/en/publication-detail/-/publication/68ce81fc-5d55-11ec-9c6c-01aa75ed71a1/language-en
[431] Eurobarometer, 2015. *Special Eurobarometer 429: Attitudes of Europeans towards tobacco 2015.* Retrieved from: https://data.europa.eu/data/datasets/s2033_82_4_429_eng?locale=en
[432] Eurobarometer, 2017. *Special Eurobarometer 458: Attitudes of Europeans towards tobacco and electronic cigarettes 2017.* Retrieved from: https://data.europa.eu/data/datasets/s2146_87_1_458_eng?locale=en
[433] Eurobarometer, 2021. Special Eurobarometer 506: Attitudes of Europeans towards tobacco and electronic cigarettes 2021. Retrieved from: https://data.europa.eu/data/datasets/s2240_506_eng?locale=en
[434] Eurobarometer, 2018.*Sport and physical activity 2018*. Retrieved from: https://data.europa.eu/data/datasets/s2164_88_4_472_eng?locale=en

Such risk factors also seemed to be a common theme amongst Member States' priorities; taken together it seems that Thematic priority 1.1 represents a key health issue in the EU.

Thematic priority **1.2** concerns drug-related health damage, including information and prevention. When it comes to accessing information on drug use, EU citizens rarely ask the police, a telephone helpline, or someone from school or work to provide them with this information. Data indicates that most young Europeans aged 15 to 24 from the 27 Member States seek information about illicit drug use and drug use in general from school prevention programmes (32%), the internet (37%), and media campaigns (33%).

Thematic priority **1.4** concerns chronic diseases including cancer, age-related diseases and neurodegenerative diseases.

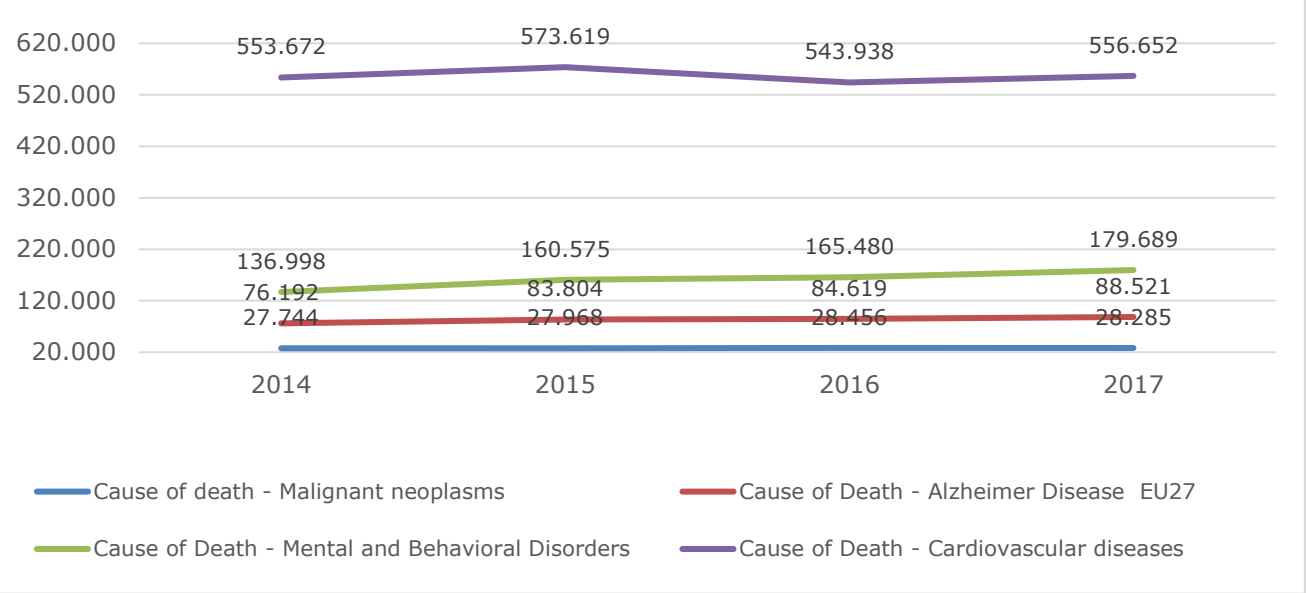
This was a common theme which emerged amongst Member State priorities. More specifically, the following conditions or diseases were included in Member States' priorities: Cancer (nine Member States: CY; DK; EL; LT; MT; SK; UK (England); UK (Northern Ireland); UK (Scotland)); Alzheimer's, Dementia, or related conditions (four: CY; CZ; EL; UK (England)); Diabetes (three: CY; MT; PL); Cardiovascular diseases (two: LV; PL); General non-communicable diseases (two: LV; SI); Respiratory diseases including COPD (two: ES; PL); Haemophilia and Related Haemorrhagic Diseases (one: PL); Conditions of the osteoarticular system (one: PL); and Rheumatic diseases (one: CY).

Young Citizens from the 27 Member States with a long-standing illness or health problem has slightly increased between 2014 and 2019.[435] Also, the number of citizens reporting to have a chronic disease has also slightly increased across these years, except for chronic lower respiratory diseases which haven't changed during this timeframe[436].

Moreover, in the 27 Member States the number of deaths of chronic diseases, aged-related diseases and neurodegenerative diseases increased. Figure 62 shows that between 2014 and 2017 mental and behavioural disorders increased by 31.2%, deaths from Alzheimer disease increased by 16.2%, and deaths from cancer increased by 1.9%[437]. On the other hand, self-reported breast examinations show a slight decrease in the percentage of people in the 27 Member States who reported their last breast examination to be between 1-2 years ago[438]. With an increase in chronic diseases, coordinated preventive measures should be implemented, prioritizing those diseases with the highest burden on health and society[439].

[435] Eurostat, [Online data code: HLTH_SILC_11]. People having a long-standing illness or health problem, by sex, age and income quintile. Retrieved from: Statistics | Eurostat (europa.eu)
[436] Eurostat, [Online data code: HLTH_EHIS_CD1E]. Persons reporting a chronic disease, by disease, sex, age and educational attainment level. Retrieved from: Statistics | Eurostat (europa.eu)
[437] Eurostat, [online data code: HLTH_CD_ARO]. *Causes of death - deaths by country of residence and occurrence.* Retrieved from: Statistics | Eurostat (europa.eu)
[438] Eurostat, [online data code: HLTH_EHIS_PA7E]. Self-reported last breast examination by X-ray among women by age and educational attainment level. Retrieved from: https://ec.europa.eu/eurostat/databrowser/view/hlth_ehis_pa7e/default/table?lang=en
[439] European Commission, 2014.*The 2014 EU Summit on Chronic Diseases: Conference conclusions.* Retrieved from:ev_20140403_mi_en.pdf (europa.eu)

Figure 62. Causes of death by chronic diseases by million people in 27 European member states.[440]



Source: Eurostat, [online data code: HLTH_CD_ARO]. Causes of death – deaths by country of residence and occurrence

Table 21. Health needs under objective 1

Health needs
1.1 (Risk factors): Our document review indicated that risk factors such as use of tobacco and passive smoking, harmful use of alcohol, unhealthy dietary habits and physical inactivity (thematic priority 1.1) represented a large health need in eligible countries. For example, according to the World Health Organisation (WHO), across the 53 European countries some of the main challenges during the years of the implementation of the 3HP were tobacco consumption, poor nutrition, and physical inactivity[441]. There were also some trends indicating increased smoking prevalence, increased harmful alcohol consumption, and poor dietary habits and physical activity within the EU. These risk factors were also a common theme amongst participating countries' priorities.
1.2 (Drugs-related damage): The desk review also indicated prevalent health needs concerning drug-related health damage, including information and prevention. When it comes to accessing information on drug **use**, EU citizens did not often turn to reliable sources such as the police, a telephone helpline, or someone from school or work.[442]
1.3 (HIV/AIDS, tuberculosis and hepatitis): A stakeholder from an organisation representing patients and services users reported the main healthcare needs included a lack of accessibility of PrEP (a preventative drug for HIV), and a need to reduce stigma and discrimination related to HIV and AIDS.
1.4 (Chronic diseases): Chronic diseases including cancer, age-related diseases and neurodegenerative diseases were common themes among the participating countries' priorities[443], and further the number of EU citizens reporting to have a chronic disease has also

[440] Data on deaths from cardiovascular diseases include the following indicators: Ischaemic heart diseases, acute myocardial infarction including subsequent myocardial infarction, other ischaemic heart diseases, and other heart diseases.
[441] World Health Organisation.,(n.d). Core health indicators in the European Region. Available from: https://www.euro.who.int/en/data-and-evidence/evidence-resources/core-health-indicators-in-the-who-european-region [Accessed December 2021]
[442] Eurostat, [online data code: HLTH_CD_ARO]. *Causes of death - deaths by country of residence and occurrence.* Available from: Statistics | Eurostat (europa.eu) [Accessed October 2021]
[443] More specifically, the following conditions or diseases were included in Member States' priorities: Cancer (nine Member States: CY; DK; EL; LT; MT; SK; UK (England); UK (Northern Ireland); UK (Scotland)); Alzheimer's, Dementia, or related

slightly increased across these years, except for chronic lower respiratory diseases which have not changed during this timeframe[444]. Moreover, in the 27 Member States the number of deaths due to chronic diseases, aged-related diseases and neurodegenerative diseases increased. Combatting such NCDs and chronic diseases was also seen as a key health need by some interviewees, including an academic / research stakeholder. A few governmental public health organisations mentioned that an ageing population was a key health challenge in the EU, which was linked by the interviewees to NCDs such as cancer. A stakeholder from a healthcare professionals' organisation spoke specifically about challenges related to childhood cancer: there has not been much market-driven innovation for new medicines for childhood cancer.[445] Further, there was reportedly a need for more longer-term surveillance and secondary prevention for those with childhood cancer.

Objective 3: Health systems

Many of the health needs in the EU related to objectives 1 and 4, however there were also some identified needs under objective 3 (**health systems**). Consulted stakeholders reported some specific key health needs in this area. These needs included a lack of training in certain procedures or conditions or about health inequalities (academic / research stakeholder; healthcare professionals' organisation) and a lack of capacity to monitor and/or respond to serious cross-border health threats (academic / research stakeholder; governmental public health organisation). Other needs reported included: long waiting lists for treatments (academic / research stakeholder), a need for stronger primary healthcare (governmental public health organisation), a need for early treatment (governmental public health organisation), a need for biomedical technology (governmental public health organisation), and a need to stabilise health systems (healthcare professionals' organisation). Finally, an organisation representing healthcare service providers reported there are needs related to spending for healthcare systems: EU countries are trying to find solutions on how it is possible to manage spendings and to achieve better results with less money.

Relating to priority **3.5** (European Innovation Partnership on Active and Healthy Ageing), the Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases (SGPP) consider that ageing is an important health and healthcare problem at EU level. They identify ageing societies with an expansion of chronic diseases as the main social challenges. To tackle these issues, the highlight the importance of modernizing the health and social systems. They argue that more investment and innovation would help adapt the current health system towards integrative care and continuity of care [446].

Table 22. Health needs under objective 3

Health needs
3.3 (Health workforce): A key need reported by a healthcare professionals' organisation was a need to have an adequate health workforce.
3.5 (European Innovation Partnership on Active and Healthy Ageing): The reviewed literature also indicated there is a need to ensure active and healthy ageing. The Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases

conditions (four: CY; CZ; EL; UK (England)); Diabetes (three: CY; MT; PL); Cardiovascular diseases (two: LV; PL); General non-communicable diseases (two: LV; SI); Respiratory diseases including COPD (two: ES; PL); Haemophilia and Related Haemorrhagic Diseases (one: PL); Conditions of the osteoarticular system (one: PL); and Rheumatic diseases (one: CY).For example, priorities covered Dementia (CY, UK), cancer (CY, DK, MT), and diabetes (CY, MT).

[444] Eurostat, [Online data code: HLTH_EHIS_CD1E]. Persons reporting a chronic disease, by disease, sex, age and educational attainment level. Available from: Statistics | Eurostat (europa.eu) [Accessed October 2021]

[445] According to this stakeholder, many medicines are adult medicines which are used off-label; this is effective for some childhood cancers but in this setting there is a lack of innovation specifically targeting children.

[446] Eurobarometer, 2014. *Special Eurobarometer 419: Public perceptions of science, research and innovation.* Retrieved from: https://data.europa.eu/data/datasets/s2047_81_5_419_eng?locale=en **;** European Commission, 2014.*The 2014 EU Summit on Chronic Diseases: Conference conclusions.* Retrieved from:ev_20140403_mi_en.pdf (europa.eu)

(SGPP) considered that ageing is an important health and healthcare problem at EU level. They identified ageing societies with an expansion of chronic diseases as the main social challenges, and to tackle these issues, the SGPP highlight the importance of modernizing health systems. They argue that more investment and innovation would help adapt current health systems towards integrative care and continuity of care.[447]

3.6 (legislation on medical devices, medicinal products and cross-border healthcare): No participating countries had a priority on this topic. However, one stakeholder from a governmental public health organisation mentioned they needed support in their country to implement health regulations related to medical devices and medicine regulation.

Objective 4: Better and safer healthcare

Priority **4.3** (Patient safety and quality of healthcare) was the most common priority which emerged from the Member State priority mapping. This is unsurprising given that health systems and healthcare are a national competency. Examples of priorities within this theme were "Enhancing efficiency of the service (e.g. simplification, introduction of IT system, introduction of performance targets)" (DK), "Ensuring universal access to quality care" (EL), and "Better organisation of care for patients, guarantee equality of access on the basis of a territorial approach" (FR).

Finally, EU citizens reported information regarding the thematic priority **4.6** (Health information and knowledge system to contribute to evidence-based decision making). When it comes to using the internet to access general information on health-related topics and ways to improve health, almost all citizens from the 27 EU Member States use internet search engines as their main source of information.

Table 23. Health needs under objective 4

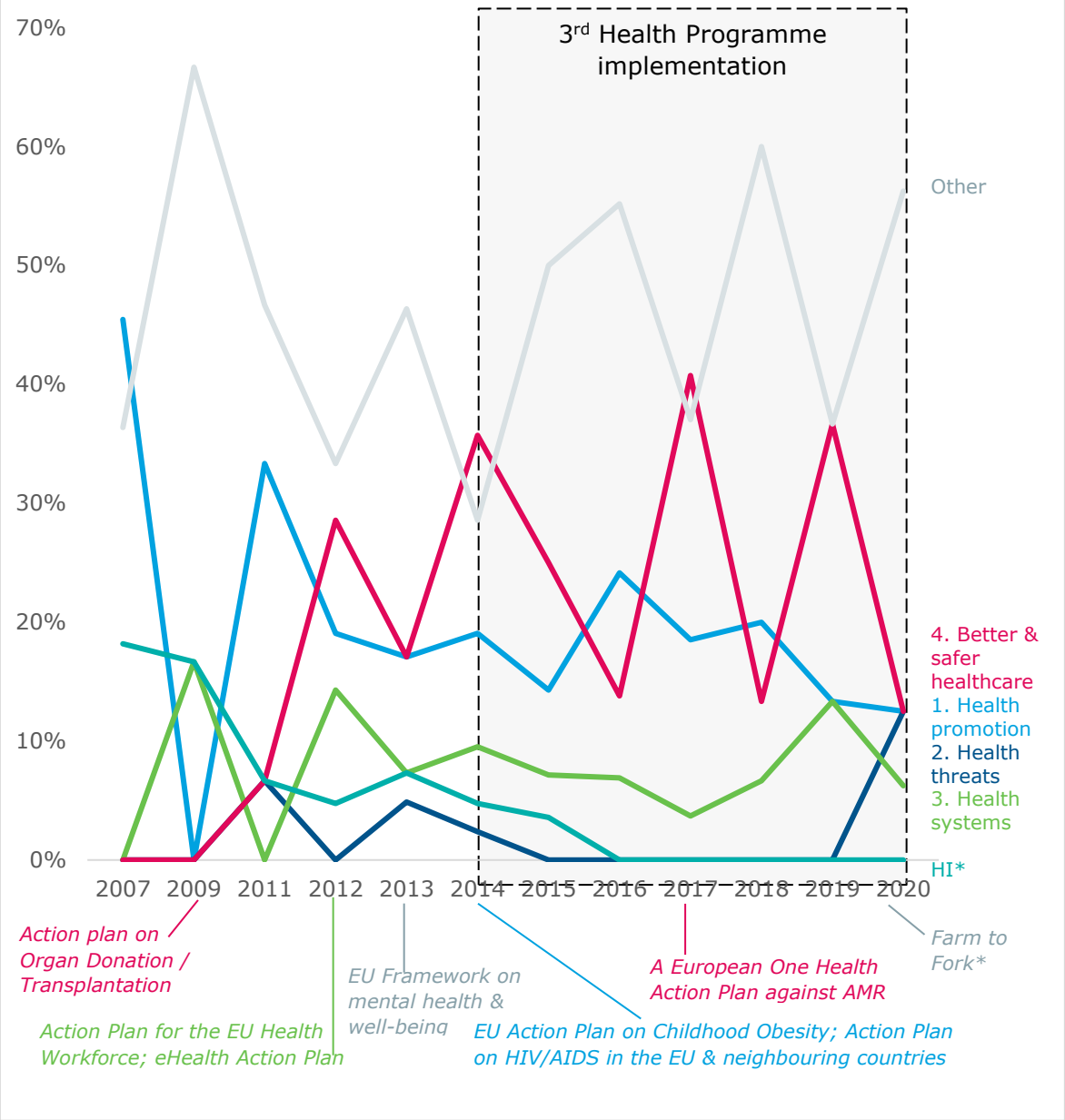
Health needs
4.2 (Rare diseases): This thematic priority represented 3% of participating countries' priorities. An academic / research stakeholder reported that particularly the visibility of rare diseases was a key healthcare need. There was no hospital codification system for rare diseases, so rare diseases were not visible in information systems leading to issues in recognition and quality of care and proper diagnostics.
4.3 (Safety and quality of healthcare): Patient safety and quality of healthcare represented an urgent and crucial health need: this was the single most common priority which emerged from the Member State priority mapping.[448] This is unsurprising given that health systems and healthcare are a national competency. Some consulted stakeholders[449] also mentioned that improving patient care, treatment, and safety is a key need in the EU.
4.4 (Preventing AMR and healthcare-associated infections): This was a very common priority which emerged from the Member State priority mapping.

Trends in health needs over time

The graph below displays the percentage of priorities from the participating countries which aligned to each objective in each year. Key EU-level plans or strategies which may have been related to trends in strategy focuses are also mapped in the figure.

[447] European Commission. The 2014 EU Summit on Chronic Diseases. Conference Conclusions. Retrieved from: https://ec.europa.eu/health/system/files/2016-11/ev_20140403_mi_en_0.pdf
[448] Examples of priorities within this theme were "Enhancing efficiency of the service (e.g. simplification, introduction of IT system, introduction of performance targets)" (DK), "Ensuring universal access to quality care" (EL), and "Better organisation of care for patients, guarantee equality of access on the basis of a territorial approach" (FR).
[449] Stakeholders from a Healthcare Professionals' Association and an organisation representing patients and services users.

Figure 63. Percentage of priorities from the participating countries which aligned to each objective: by year the strategy began

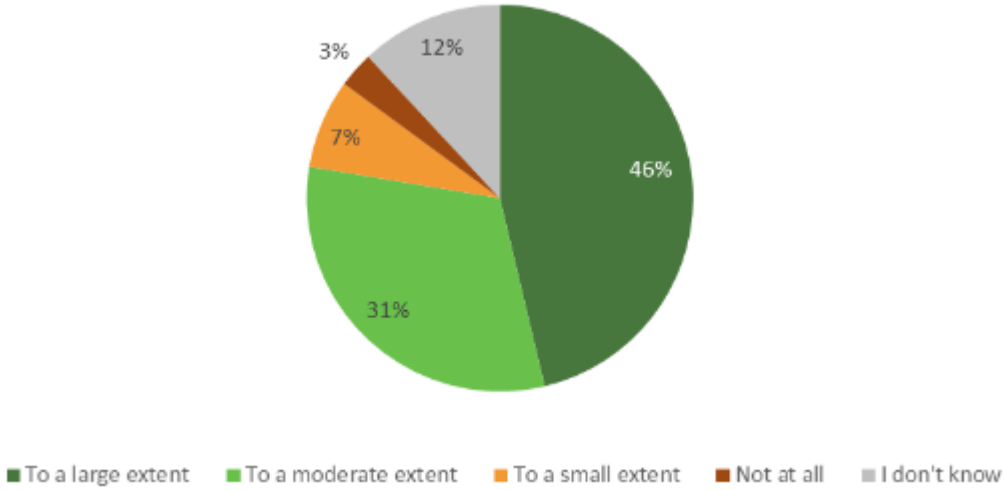


- *Source: ICF analysis of eligible countries' health strategies. *Health inequalities / Determinants of health **A Farm to Fork Strategy for a fair, healthy and environmentally friendly food system*

Trends in priorities over time may have been related to EU-level plans or strategies. For example, a spike in "other" priorities in 2013 may have been due to a focus on mental health following the EU Framework on mental health & well-being, and similarly a positive trend in Objective 3 following 2012 may have been due to two new plans: the Action Plan for the EU Health Workforce and the eHealth Action Plan. Desk research shows that other EU plans and strategies are less associated with trends in Member State priorities (although it is not possible to determine causation). Other trends in the participating countries may have also impacted priorities; for example, health threats as a strategic priority had generally remained low throughout the implementation period of 3HP, however it began to increase in 2020, likely due to the major health threat of the Covid-19 pandemic.

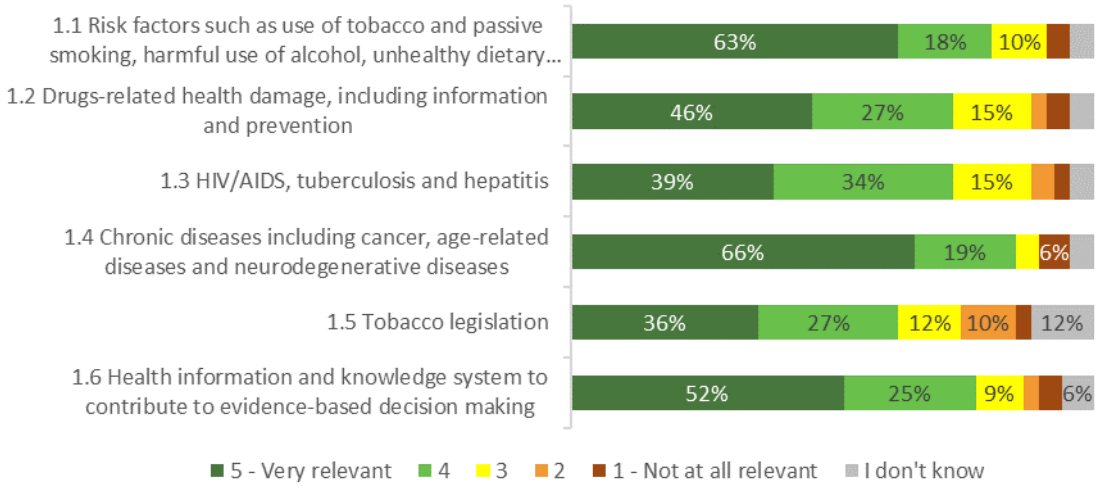
Further information about the relevance of specific thematic priorities.

Figure 64. To what extent did the 3rd Health Programme correctly identify the health and healthcare needs and problems at the time of its development[450]? (n=67)



8.

Figure 65. OPC: Please rate the relevance of each of the 3rd Health Programme priorities on a scale of 1 to 5 (1 is not at all relevant and 5 is very relevant) (n=67)



9.

1.1 (Risk factors): Two thirds of OPC respondents (63%) reported that priority 1.1 was "very relevant". Some interviewed stakeholders (including a stakeholder from a healthcare professionals' organisation) reported that the 3HP was relevant to health needs in this area. An NGO reported that the EU has also taken action on prevention, in that information from 3HP contributed to national prevention agreements and action plans related to alcohol, tobacco, and overweight. However, in the OPC some respondents added that the Programme should have put a stronger focus on issues related to unhealthy lifestyles, and could have better tackled the role of food in health (e.g., reducing

[450] Some examples of needs and problems were provided to survey respondents. E.g.: An ageing population, threatening the financial sustainability of health systems and causing health workforce shortages; A fragile economic recovery, limiting the availability of resources to invest in healthcare; An increase in health inequalities between and within Member States; An increase in the prevalence of chronic disease; Pandemics and emerging cross-border health threats; The rapid development of health technologies; Increase in mental health problems (particularly among the young); Other specific emergency situations which expose EU health professionals to unprecedented challenges (for example, dealing with the repercussions of the influx of refugees); and Threats to environmental health such as air quality and pollution monitoring.

junk food and shifting towards more plant-based food), and could have done more in terms of encouraging physical activity.

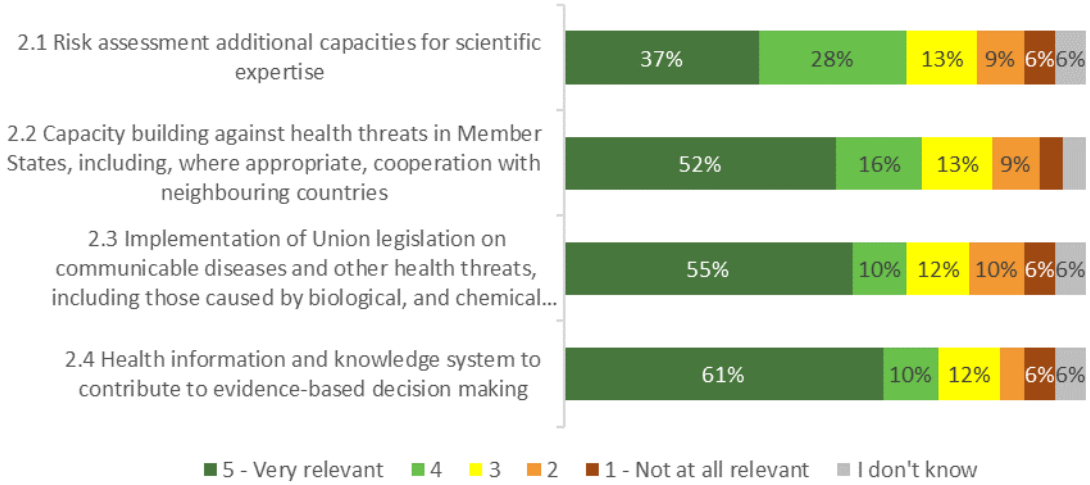
1.2 (Drugs-related damage): In an interview, a stakeholder from an healthcare professionals' organisation stated that useful work has been done through priority 1.2, and an NGO reported that the 3HP funded operating grants so NGOs could address issues in the area of drug use. In contrast, OPC respondents reported that the Programme should have better recognised addictions as a health problem. They added that insufficient resources were invested to comprehensively and holistically address the spread of illicit drug use as well as the non-medical use of controlled substances for medical use and alcohol. Respondents reported that there is no provision for an approach to prevent the harm that these substances cause to the health — both physical and mental — of individuals and to the development of society as a whole, including the social and economic aspects that have a major negative impact.

1.3 (HIV/AIDS, tuberculosis and hepatitis): As seen in Figure 3 above, thematic priority 1.3 represented 6% of participating countries' priorities, and received 4% of 3HP funding, indicating high alignment between the participating countries and the 3HP. A stakeholder from an organisation representing patients and services users expressed that there have been difficulties making health Programme changes happen at the Member State level, for example there is unequal access to PrEP across Member States.

1.4 (Chronic diseases): Two thirds of OPC respondents (66%) reported that priority 1.4 was "very relevant". A stakeholder from an healthcare professionals' organisation provided examples whereby the 3HP helped address needs related to childhood cancer. A particular action which addressed their organisation's needs was the JA on rare cancers; this enabled development of evidence-based policy recommendations on how to best organise delivery and research for childhood cancers. Further, through the JA they were able to hold important workshops to develop expertise from the ground, and were able to formulate informed recommendations. Another key action to addressing this organisation's priorities was ERN PaedCan which created a virtual network linking specialist centres across Europe, so that no matter where a child lives, they can immediately get access (in theory) to pan-European expertise. 3HP enabled them to start this essential and instrumental project. One academic / research stakeholder felt the 3HP did not adequately address included needs related to NCDs.

1.6 (Health information/knowledge): This priority was not identified within any participating countries' priorities, and similarly it only received 2% of 3HP funding. This may indicate that this was not a key health need in the participating countries, and therefore was not prioritised by the 3HP. Nevertheless, half of OPC respondents (63%) reported that priority 1.6 was "very relevant".

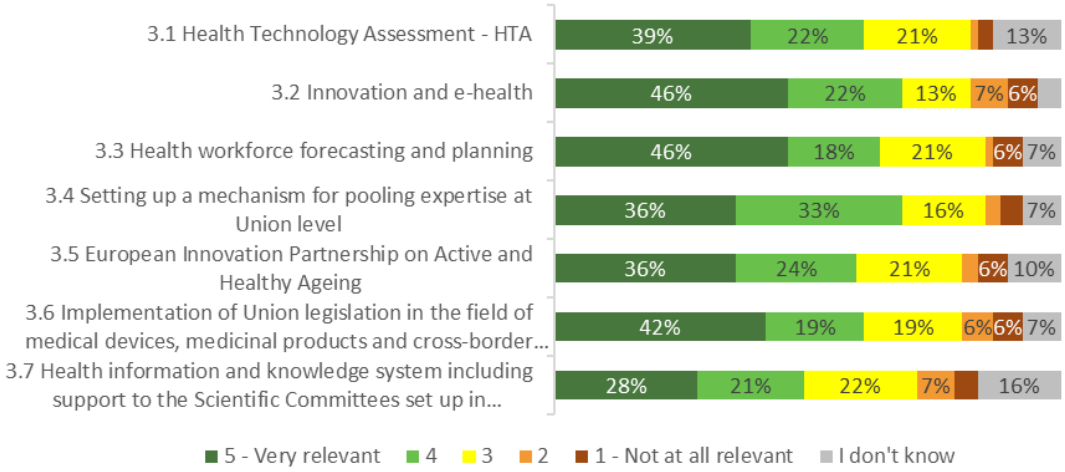
Figure 66. OPC: Please rate the relevance of each of the 3rd Health Programme priorities on a scale of 1 to 5 (1 is not at all relevant and 5 is very relevant) (n=67)



10.

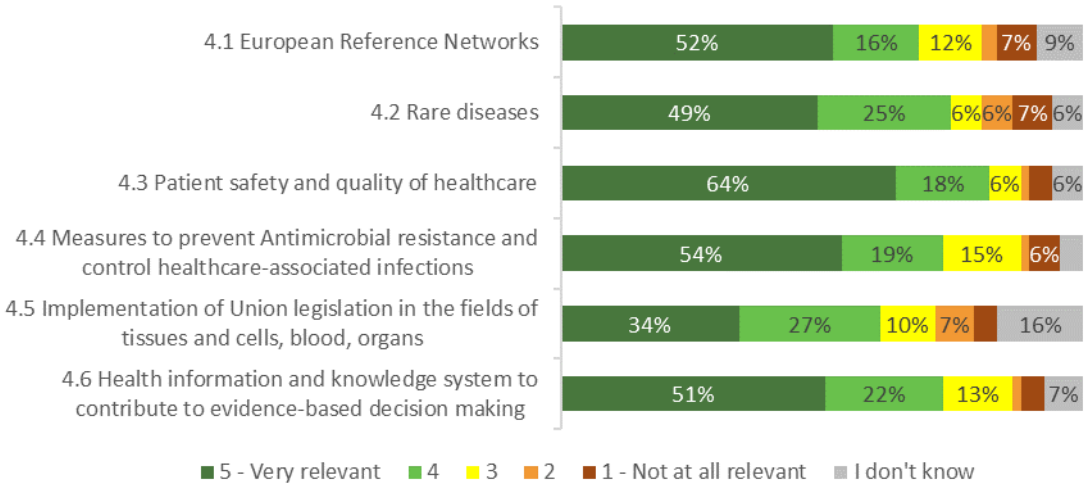
In the targeted survey organised as part of this study, one academic/research organisation having benefitted from the Programme said objectives 1 and 2 were relevant only to a small extent. The respondent explained that it requires strong multidisciplinary action that needs to be promoted systemically at a central level by all EU countries. However, the respondent judged this to be "hardly possible", especially as many countries have a high heterogeneity in the management of health services and a consequent mismatch at country level. They added that the process of cultural change in prevention is a long one and requires Joint Action at all levels.

Figure 67. OPC: Please rate the relevance of each of the 3rd Health Programme priorities on a scale of 1 to 5 (1 is not at all relevant and 5 is very relevant) (n=67)



11.

Figure 68. OPC: Please rate the relevance of each of the 3rd Health Programme priorities on a scale of 1 to 5 (1 is not at all relevant and 5 is very relevant) (n=67)



12.

A few respondents raised some concerns related to the 3HP's relevance related to objective 4. For instance, an EU public authority involved in the Programme design said that means and tools were not appropriate to meet this specific objective. A national public authority involved in the Programme implementation added that they could see no impact of the Programme on the health of their country's citizens (rather that benefits were experienced by other EU countries). Finally, an academic/research organisation having benefitted from the Programme said that the extent to which a population "gains access" to better and safer healthcare depends on a number of factors (e.g. financial, organisational, social or cultural barriers) which may in some way limit the use of services. Therefore, availability of services and barriers to access must be considered in the context of the different perspectives, health needs, and material and cultural backgrounds of different groups in society. However, competencies related to health services largely fall under Member State competence.

How 3HP addressed lack of healthcare workforce across Europe

A stakeholder from a healthcare professionals' organisation stated that the 3HP addressed their organisation's needs under thematic priority 3.3. However, a stakeholder from a healthcare professionals' organisation and an academic stakeholder reported that 3HP did not address the lack of healthcare workforce across Europe. An interviewee did state that this is a complex issue which DG SANTE is not in a position to solve through the Health Programmes. Further, a governmental public health organisation reported there has been a large migration of medical professionals, which was not addressed in the 3HP.

Limiting factors to relevance

One somewhat commonly reported limitation to the relevance of the 3HP was insufficient funding. An NGO reported that more support for NGOs was needed, and it would have been useful to include civil society organisations working the field to ensure the involvement of stigmatised communities. A stakeholder from a healthcare professionals' organisation reported the 3HP did enable planting the "seeds" for change to start, but there is still more work that needs to be done, and more funding should be available.

"We were involved in only two projects, which are very important projects that did address all of this these three priority areas...but ultimately I would say that at the end of the day, the funds were insufficient to really appropriately make a tangible change."

Most stakeholders consulted in the focus group on project grants considered that the thematic priorities of the 3HP were too broad. An NGO stakeholder said that there are too many serious issues under each thematic area that need to be addressed and funded, and another stakeholder representing a Government Public health organisation mentioned that they are not sufficiently granular as to develop critical strategic developments in the in the progress for better health in Europe.

An academic / research stakeholder reported that there should have been an overall objective which was quantifiable and measurable (e.g., improvement in healthy life expectancy – quantifiable health goals and measurable indicators). The stakeholder urged that there should be quantifiable health goals at the EU level.

A stakeholder from an organisation representing patients and services users stated the eligibility criteria of grant applicants and the involvement of patient organisations in Joint Actions caused issues around under-representation.

Other health needs not covered by the programme

Other topics which may not have been adequately covered by the 3HP include **child health** and **infant health**. In a February 2016 meeting of the Health Programme Committee[451], a Member State did note that the action "Support to the report to the Council on the implementation of the Action Plan on Childhood Obesity" is one of the few actions in the Annual Work Programme for that year where child healthcare is addressed and that the next Annual Work Programme should take the theme of child health more prominently into account. OPC respondents noted the importance of sexual and child abuse, which they said may lead to poorer health in the long run than other issues supported by the Programme's projects.

OPC respondents provided other examples of problems or needs that were not identified by the Programme, such as antimicrobial resistance as a global health threat, and other health threats linked to the development of the internal market and EU trade policies (noting and addressing the role of commercial determinants in the development and prevalence of (preventable) chronic diseases in the EU), and emerging diseases due to climate change (including Lyme disease).

Some of these topics were addressed in previous HPs, for example "Health effects of wider environmental determinants" was a sub-priority in the 2HP[452] (although it only received 1% of 2HP funding). Examination of other Health Programmes is outside the scope of this evaluation.

A5.2 Supplementary information for Q2

Baseline assessment

- **Baseline (2014):** No specific information available.
- **Mid-point (2017):** Overall the thematic priorities were "relevant and valid", and consolidated actions under coherent thematic priorities, while focusing on specific high-priority / value areas. However, we found that some thematic priorities (e.g. 2.4 and 4.6 which cover "fostering a health information and knowledge system") did not lead to any funded actions, potentially because this priority was mainly served by the ECDC's mission. Further, the priorities could be streamlined or refined to increase coherence, and thematic priorities that were more closely linked to EU legislation (e.g. European Reference Networks) were more precise than those related to wider policy areas (e.g. chronic diseases).

[451] European Commission. (2016). Health Programme Committee: Draft minutes of the Committee meeting of 4 February 2016.
[452] Coffey International Development., 2015. Ex-post Evaluation of the Health Programme (2008-2013) Final report [online]. Available from: https://ec.europa.eu/health/system/files/2016-11/ex-post_ev-hp-2008-13_final-report_0.pdf [Accessed November 2020].

Alignment of funded actions with thematic priorities

A stakeholder from a healthcare professionals' organisation mentioned several funded actions which were in line with the thematic priorities of the Programme which also helped address the needs of their organisation. For example, this interviewee mentioned that a substantial amount of funding went to CPE, and similarly a large amount of funding went to refugee related actions (Joint Action ORAMMA). A stakeholder from an international public health organisation reported that reducing health inequalities was included across the four specific objectives.

In the focus group on Joint Actions, a coordinator from the EU reported that the Programme's objectives were almost totally covered by the Joint Actions:

> *"in our JA, we had 6 specific objectives and more than 30 deliverables which is probably too much, and retrospectively when considering things after doing them, we felt it would be better not to allocate the same volume. Regarding immunization systems for surveillance, we should not have allocated the funds on so many topics or allocated them differently. At the end, the topic was covered but not with the same intensity in the different fields"*

Alignment between 3HP funded actions and the Commission's wider priorities: evidence from European Commission policy documentation

Table 24. Commission priorities and DG SANTE's specific objectives 2014-2015

Relevant Commission priorities	→	DG SANTE's specific objectives related to the 3HP spending
Europe 2020 priorities: - Smart growth - Sustainable growth - Inclusive growth	The overarching framework for EU action in health over the period 2014-2015 acknowledges the importance of investing in health, as a healthy population and functioning and financially sustainable health systems across Europe are pre-conditions to achieve a smart, sustainable and inclusive growth.	1. Promote health, prevent diseases, and foster supportive environments for healthy lifestyles
		2. Protect citizens from serious cross-border health threats
		3. Support public health capacity building and contribute to innovative, efficient and sustainable health systems
		4. Facilitate access to better and safer healthcare for Union citizens

Source: ICF analysis of European Commission policy documentation, including strategic documents and DG SANTE's annual management plans and activity reports

Table 25. Commission priorities and DG SANTE's specific objectives 2016-2019

Relevant Commission priorities (2016-2019)	→	DG SANTE's specific objectives related to the 3HP spending (2016-2019)
1. A new boost for jobs, growth and investment in the EU	DG SANTE's Strategic Plan for 2016-2020 reiterates the intrinsic value of health and its positive effect on the economy. Policies supporting access to care and health promotion, the modernisation of health systems	1.1 Better preparedness, prevention and response to human, animal and plant health threats
		1.3 Cost-effective health promotion and disease prevention

	and preparedness and response against global health challenges play a key role in creating an environment conducive to jobs, growth and investment in the EU.	1.4 Effective, accessible and resilient healthcare systems in the EU
		1.5 Increased access to medical expertise and information for specific conditions
2. A deeper and fairer internal market with a strengthened industrial base	DG SANTE's Strategic Plan for 2016-2020 recognises that EU action in the health sector, in particular in the field of pharmaceutical products, contributes to the functioning of the internal market and encourages innovation in the health sector.	2.1 Effective EU assessment of medicinal products and other treatment
		2.2 Stable legal environment and optimal use of current authorisation procedures for a competitive pharmaceutical sector and patients' access to safe medicines
		2.3 Common Member States' tools and methodologies used for EU health systems performance assessments
3. A balanced and progressive trade policy to harness globalisation[453]	DG SANTE's action in health contributes to shape the free trade agreement with the US resulting in more trade possibilities for pharmaceutical products without compromising the EU's high safety standards.	3.2 A balanced agreement with the US on pharmaceutical products and in SPS area

Source: ICF analysis of European Commission policy documentation, including strategic documents and DG SANTE's annual management plans and activity reports.

Table 26. Commission priorities and DG SANTE's specific objectives 2020

Relevant Commission priorities	→	DG SANTE's specific objectives related to the 3HP spending[454]
1. The European Green Deal	In 2020 3HP spending was not allocated to any activity under this Commission priority. However, the European Green Deal, and in particular the Farm to Fork Strategy, contributes to the overall objective of promoting good health in the EU.	No specific objective related to 3HP spending
2. Promoting our European Way of Life	DG SANTE's Strategic Plan for 2020-2024 stresses that health	2.1 Diminishing the impact of cancer in Europe

[453] This general objective has been adjusted in 2017 to expand the previous focus on the free trade agreement with the U.S. to a wider political priority on trade policy.
[454] DG SANTE 2020 activity report indicates that health outputs for 2020 are related to EU4Health and the 3HP.

	and healthcare are a fundamental part of the social fabric of the European Union, as also reflected in the European Pillar of Social Rights. Fostering a healthy population and well-functioning health systems are key elements contributing to the promotion of the European Way of Life.	2.2 Patients' access to safe, innovative and affordable medicines and medical devices
		2.3 Effective response coordination of serious cross-border health threats
		2.4 More effective, accessible and resilient health systems

Source: ICF analysis of European Commission policy documentation, including strategic documents and DG SANTE's annual management plans and activity reports.

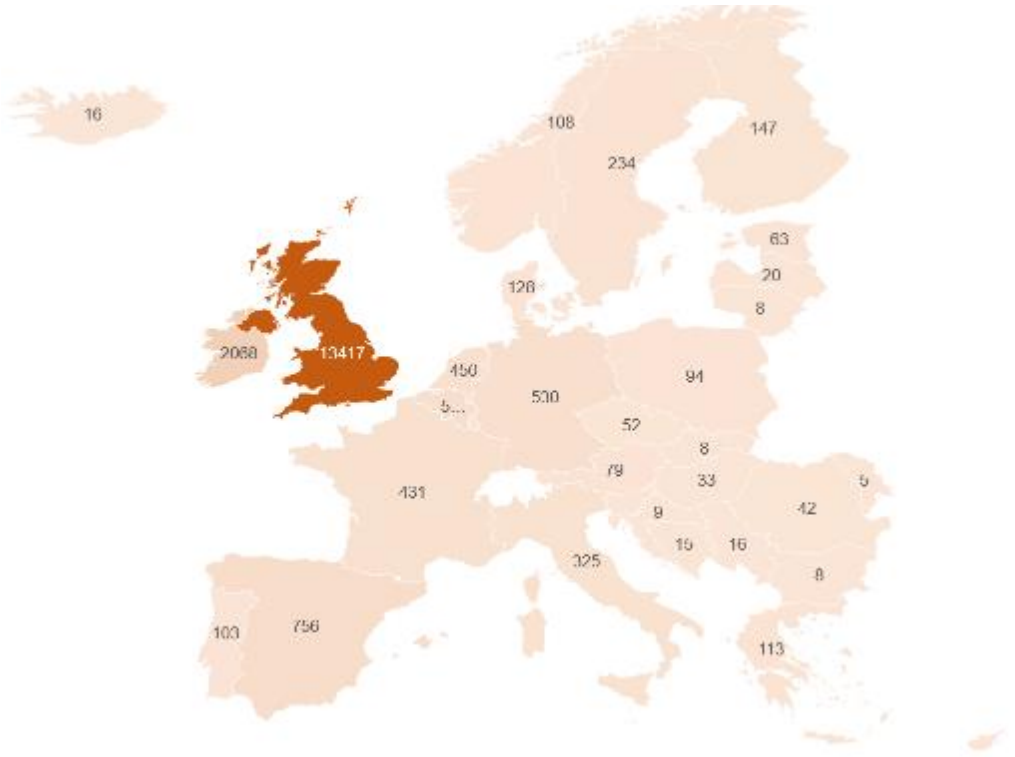
A5.3 Supplementary information for Q3

Baseline assessment

- **Baseline (2014):** As discussed in Q1, 2HP's objectives and funded actions largely aligned with the needs and priorities in the Member States. However, there was a lack of structure and prioritisation, which the 3HP sought to address.
- **Mid-point (2017):** The individual actions remained relevant due to the 3HP's structure of objectives and thematic priorities. The actions largely corresponded to public health needs, both in terms of existing needs (e.g. chronic diseases) and emerging challenges (e.g. an ageing population and cross-border health threats). However, as discussed in Q1, some other pertinent needs, such as addressing mental health, were not fully met.

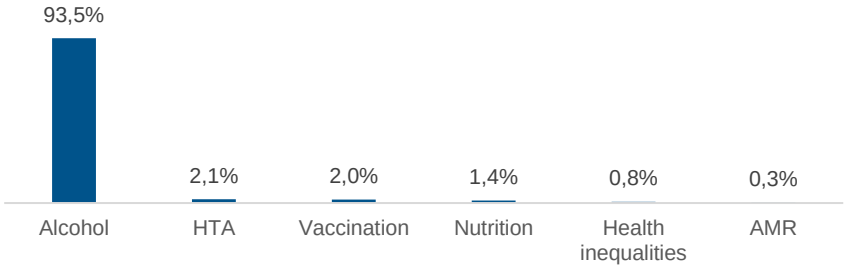
Due to the large volume of data that the search garnered, a sample of 20,000 tweets was used. Tweets were extracted from all the target countries, however, 67% of the tweets were from users located in the UK, followed by 10% in Ireland. Whilst hashtags are often not translated and tweets were extracted in multiple languages, the search terms being in English likely resulted in an English language bias.

Figure 69. Map of tweets collected July 2020-July 2022 by location



Across the topic areas, the alcohol topic made up the majority of tweets (93.5%). The topic area which had the lowest proportion of coverage was AMR (0.3%).

Figure 70. Proportion of tweets by topic area



Alcohol

Discussions around alcohol on Twitter peaked between December 2021 – February 2022. The main driver of this peak was a report about the UK government, which criticised alcohol consumption in professional environments. Other topics discussed during this peak were: alcohol as a leading risk factor in the UK for preventable ill health, illness in 40-year-olds in the UK due to excessive and chronic consumption of alcohol, the increase in alcohol price in Ireland to try to improve health.

Tweets sent from users in Spain included: the promotion of a study on alcohol consumption and mortality, how marketing terms about 'responsible' levels of alcohol consumption can be misleading, alcoholic liver disease in youth, and new waves of bars serving only non or low alcoholic drinks.

Posts from users in Belgium focused principally on alcohol and cancer which were driven from EU commission posts on the new #EUCancerPlan for cancer prevention by tackling cancer risks factors such as alcohol. A secondary story was the Eurocare alcohol policy conference.

Tweets sent from users in the Netherlands included the promotion of different studies looking at alcohol consumption and varying health impacts, such as alcohol and sleep and alcohol's impact on the brain, and the role of alcohol in violence against women.

The wide variety of discussion around alcohol across the targeted countries indicates the topic as an area of high public interest.

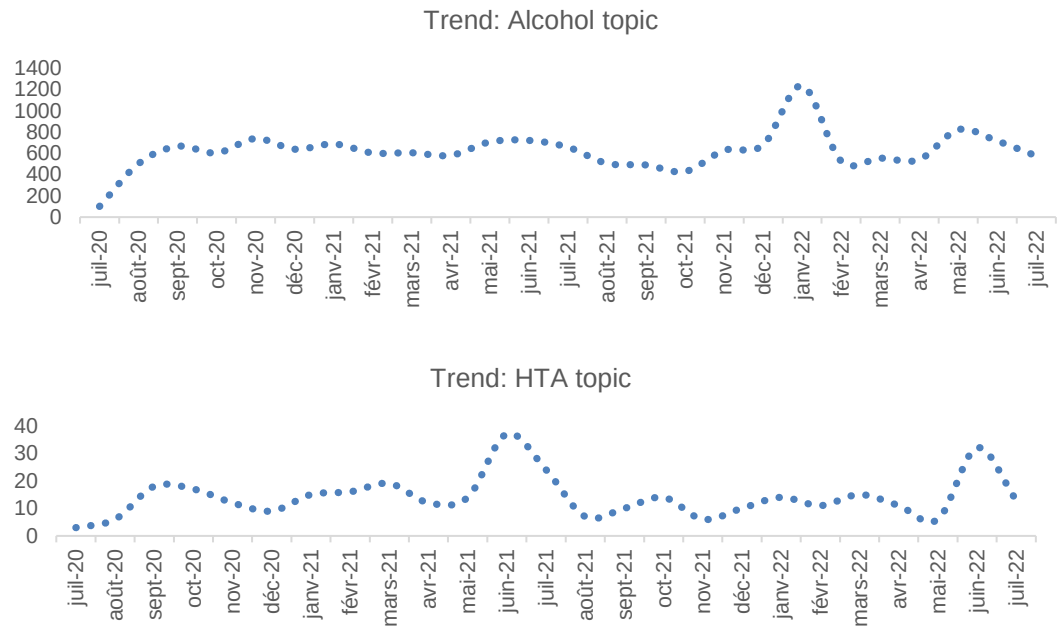
HTA

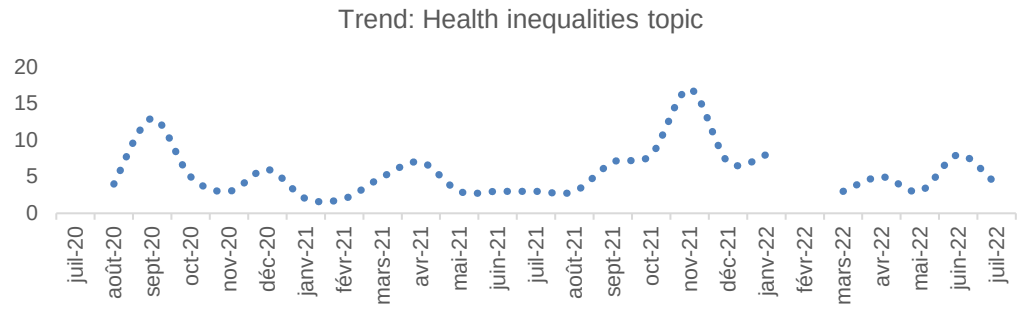
Discussions around HTA peaked in June 2021 and June 2022. The first peak was driven by the provisional agreement on the increased cooperation of Member States on HTA at EU level. The majority of tweets at this time and around this topic garnered positive sentiment, for example "*We need more innovative health technologies. The political agreement on the Health Technology Assessment (HTA) Regulation by @Europarl_EN & @EUCouncil is good news"*. The second peak was driven by posts on the regulation of HTA and promotions to audiences to learn more about what HTA is.

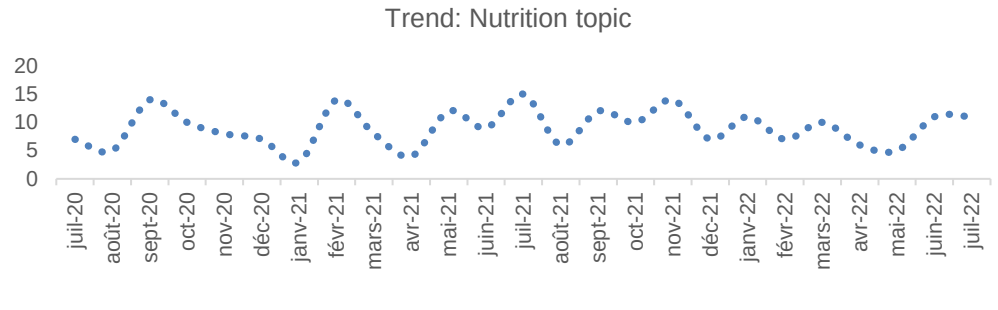
Vaccination

Both the AMR and vaccination topics saw a decrease in activity in the third quarter of 2021 which continued to the end of the monitoring period. Vaccination was the only topic where tweets from Belgium exceeded tweets from the UK. Tweets on this topic focused on access to vaccinations for Covid-19 with the highest reaching tweet being from Moldova: *"I had a very productive meeting with @vonderleyen today. We discussed the possibility of faster access to #vaccination for healthcare workers, of more medical equipment, #EU assistance, and #Moldova's European integration path and reforms. Thank you for your trust and support"*

Figure 71. Trend by topic area




Trend: Health inequalities topic
20
15
10
5
0
juil-20
août-20
sept-20
oct-20
nov-20
déc-20
janv-21
févr-21
mars-21
avr-21
mai-21
juin-21
juil-21
août-21
sept-21
oct-21
nov-21
déc-21
janv-22
févr-22
mars-22
avr-22
mai-22
juin-22
juil-22


Trend: Nutrition topic
20
15
10
5
0
juil-20
août-20
sept-20
oct-20
nov-20
déc-20
janv-21
févr-21
mars-21
avr-21
mai-21
juin-21
juil-21
août-21
sept-21
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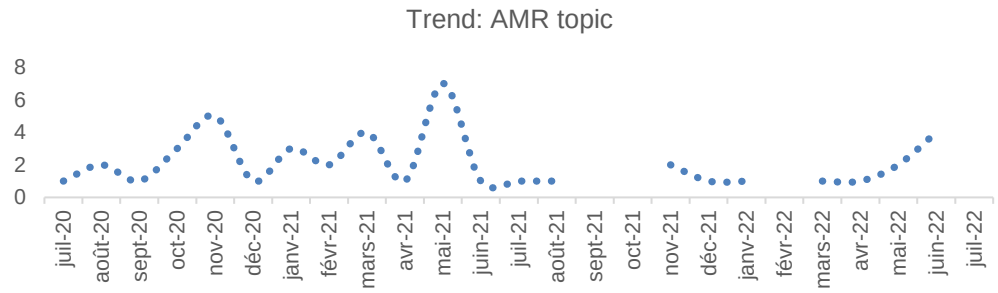
févr-22
mars-22
avr-22
mai-22
juin-22
juil-22


Trend: AMR topic
8
6
4
2
0
juil-20
août-20
sept-20
oct-20
nov-20
déc-20
janv-21
févr-21
mars-21
avr-21
mai-21
juin-21
juil-21
août-21
sept-21
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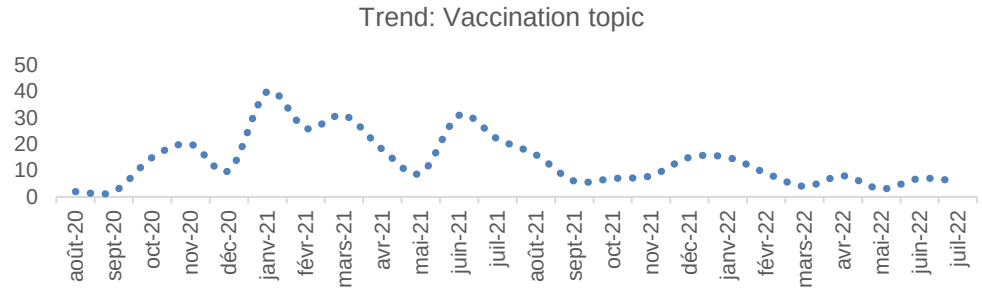

Trend: Vaccination topic
50
40
30
20
10
0
août-20
sept-20
oct-20
nov-20
déc-20
janv-21
févr-21
mars-21
avr-21
mai-21
juin-21
juil-21
août-21
sept-21
oct-21
nov-21
déc-21
janv-22
févr-22
mars-22
avr-22
mai-22
juin-22
juil-22

A5.4 Supplementary information for Q4

Baseline assessment

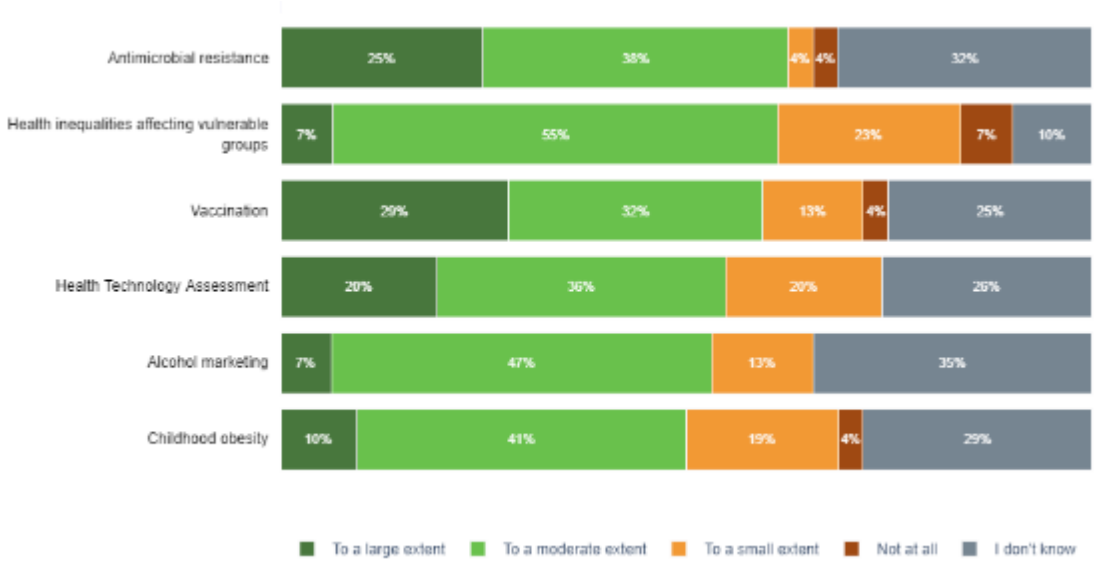
- **Baseline (2014):** 2HP addressed a variety of subjects in an effective manner, for example, through common approaches to health technology assessment (HTA), the development of common standards of care for musculoskeletal conditions and contributions to EU reports and guidelines on rare diseases. However, some funded actions did not achieve "tangible and genuinely useful results and impacts", and some joint actions (for example) did not lead to results with a practical impact due to poor design (e.g. unspecific objectives or insufficient attention to key barriers to implementation). The ex-post evaluation of 2HP urged evaluating, supporting, guiding and challenging individual actions and beneficiaries to ensure success (through factors such as feasibility of policy change, well-delineated action scope and objectives, a plausible intervention logic, involvement of relevant partners, strong project management and constructive engagement from DG SANTE and Chafea). In 2HP, some funded actions would have been more effective if they were funded through a different mechanism. Ensuring the correct mechanism is used could increase effectiveness.

- **Mid-point (2017):** 3HP contributed significantly to several areas of public health, including the establishments of ERNs, the development of a common approach on HTA policy, and supporting Member State capacity building to respond to outbreaks. The multiannual planning process allowed funding to be more strategically targeted, but the annual work planning process could be better explained to stakeholders to improve their engagement.

3HP contribution to a more comprehensive and uniform approach to health and healthcare in the EU (Q4a)

Figure 72 shows that most survey respondents believed that the 3HP contributed at least to a moderate extent to a more comprehensive and uniform approach to addressing health issues across different policy areas, ranging from 51% in the field of childhood obesity up to 63% in the field of antimicrobial resistance. In the area of health inequalities affecting vulnerable groups, respondents were more divided, as nine respondents (30%) said this was not true at all or that the 3HP only contributed to a small extent to a more comprehensive and uniform approach across the EU.

Figure 72. Survey: To what extent has the Programme contributed to a more comprehensive and uniform approach to addressing health issues across the following policy areas? (n=32)



Some interviewed stakeholders further elaborated on the effectiveness of the 3HP and its contribution to a more comprehensive and uniform approach to health issues across the EU. For instance, stakeholders from a governmental public health organisation reported that the 3HP was effective in promoting knowledge exchange, including on new

technologies applied to health, and noted that 3HP increased awareness among national and regional authorities on the EU dimension and the need for cooperation in health. Furthermore, a stakeholder from a healthcare professionals' association noted that 3HP funded actions in the area of AMR allowed Member States to follow each other's progress in tackling AMR. Lastly, a stakeholder representing patients and services users mentioned that 3HP actions contributed to greater awareness and political will on the need to comprehensively address non-communicable diseases.

Moreover, the desk research conducted under Q1 to understand the needs across the participating countries and compare them with the allocation of 3HP funding across each of the objective areas shows that 3HP funding allocations generally matched the priorities of participating countries. Furthermore, most respondents to this study's survey (20 respondents, 63%) as well as OPC respondents (37 responses, 55%) believed that measures implemented by Member States were aligned with the specific objectives and thematic priorities of the 3HP, at least to a moderate extent. For instance, a company/business organisation participating in the OPC noted that national health plans were developed according to the policies and strategies of the 3HP, and an academic/research organisation also contributing to the OPC stated that part of the Programme's measures started to be introduced into Member States' health systems.

Furthermore, most survey respondents believed that national programmes and actions reflected evidence and evidence-based approaches developed through 3HP funding (23 respondents said this was true to at least a moderate extent, 72%).

However, some stakeholders (including a few governmental public health organisations, a few NGOs, and a few healthcare professionals' organisations) indicated that the overall objectives of the 3HP were not always as aligned to key health needs as they could have been. For instance, a few interviewed governmental public health organisations reported that healthcare needs were not addressed because of factors to do with participating countries. Some stakeholders who contributed to the OPC noted limitations to the alignment of measures implemented by Member States with the specific objectives and thematic priorities of the 3HP (15 responses, 22%). In particular, a couple of public health authorities explained that Member States have engaged with the 3HP to different extents, due to cross-country differences in terms of organisation and management of healthcare systems. Furthermore, a respondent from an academic organisation and two respondents from NGOs noted that the alignment between national measures and the 3HP varied by 3HP objectives and thematic priorities across countries as in their countries less focus was put on 3HP Objective 1 "Promoting health, prevent disease and foster supportive environments for healthy lifestyles" compared to other objectives. Those stakeholders explained that, in order to properly address the thematic priorities around risk factors (such as unhealthy dietary habits, physical activity and tobacco and alcohol consumption), measures need to better capture multisectoral, integrated and structural approaches to health. While acknowledging that the 3HP stimulated some progress in this area, they added that more should be done to address health inequalities and prevent fragmented responses within health and social systems.

3HP contribution to improvements in health and healthcare in the EU and at Member State level (Q4b)

Several interviewed national policymakers reported that actions funded under the 3HP, including Joint Actions and other funded projects, influenced national strategies, helped establish national plans and create national legislation. This was especially the case in the fields of cancer, AMR, HTA, mental health and alcohol. Similarly, representatives from governmental public health organisations mentioned that the 3HP contributed to the development of national strategies and legislation, for example in the fields of digital health and cancer. A stakeholder from a governmental public health organisation stated that the main success of the 3HP has been that:

> *"Member States have shaped overarching European systems, policies, and even legislation in parliament"*

Furthermore, stakeholders from international organisations mentioned that work performed in the context of the 3HP, and the knowledge produced has benefitted EU countries, including for example to design a national action plan on AMR and reforms in national services in the field of integration of children's access to healthcare.

Additionally, a national policymaker and a stakeholder from an organisation representing patients and services users respectively reported that work undertaken in the context of the 3HP contributed to the new HTA regulation and that different Joint Actions (i.e., CHRODIS and CHRODIS+) contributed to EU-level policies, including the Europe's Beating Cancer Plan and on the initiative on non-communicable diseases.

Similarly, stakeholders who participated in this study's focus groups reflected on the 3HP contribution to the development of policy and decision-making. A stakeholder from a research organisation who participated in the focus groups on Joint Actions reported that work done in the context of the EU Healthy Gateways Joint Action[455] influenced legislation in many countries, while a representative from a governmental public health organisation noted that the work undertaken as part of the GAPP Joint Action[456] was taken into consideration for the revision of the new legislation on blood, tissues and cells. Moreover, a participant in the focus group on procurement contracts (government and policy makers group) emphasised that procurement contracts are of utmost importance to DG SANTE as they provide support in preparing legislation. Based on the 2019 Health Programme Statement, DG SANTE undertook an extensive evaluation of the Regulations on orphan medicines (141/2000) and paediatric medicines (1901/2006), including a study, a staff working document, and outreach to stakeholders. DG SANTE also launched a feasibility study for a monitoring system on reformulation initiatives for salt, sugars and fat in support of the EU framework for national initiatives on selected nutrients. A Staff Working Document to finalise the evaluation of the Directives on blood (2002/98/EC) and tissues and cells (2004/23/EC) was also adopted.

When considering the 3HP contribution in terms of implementation of best practices, coordination of efforts across Member States and changes to policy and practice at EU level, interviewed national policymakers reported that one of the successes of the 3HP was to facilitate the sharing of best practices through the best practice portal and a stakeholder from an organisation representing patients and services users highlighted the increased collaboration between the EU and Member States in the development of guidance and best practices on key health issues. Different interviewed stakeholders stressed that the 3HP contributed to promoting exchange of best practices. However, some challenges were mentioned. For example, an interviewed national policymaker believed that best practices were important, but only the Commission has been active in promoting them while best practices needed emphasising by national ministries as well.

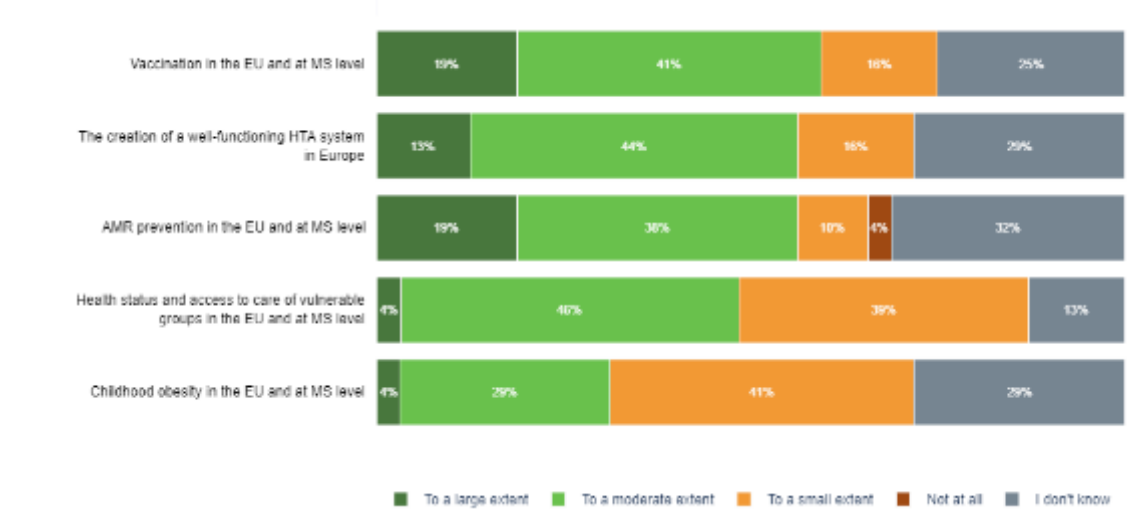
Stakeholders participating in this study's focus groups also reflected on best practices. While overall agreement on the importance of sharing best practices emerges, some stakeholders pointed out some limitations. A stakeholder representing healthcare service providers who participated in the focus group on project grants reported that this specific funding instrument (i.e., project grant) did not promote the implementation of best practices among Member States in comparison to Joint Actions, for example. During the discussion around project grants, it also emerged that there is a need for the European Commission to dedicate funding to scaling up best practices, and to allocate this funding

[455] The Joint Action Preparedness and action at points of entry (ports, airports, and ground crossings) (HEALTHY GATEWAYS) aimed to support cooperation and coordinated action of Member States to improve their preparedness and response capacities at points of entry, thus preventing and combating cross-border health threats in the transport sector.
[456] The GAPP Joint Action aimed to facilitate the development of a common approach to assess and authorise preparation processes in blood and tissues establishments.

based on the interest of Member States. Furthermore, stakeholders from academic institutions who participated in the focus group on Joint Actions also mentioned the limited dedicated budgets within the Joint Action as a limitation to the adoption of best practices.

When considering the overall 3HP contributions to improvements across the EU, most survey respondents believed that the Programme actions led to general improvements in health and healthcare in the EU and at Member State level (23 respondents said this was true to at least a moderate extent, 73%). Respondents said that the Programme contributed to improvements mainly in the following areas: vaccination in the EU and at Member State level (19 respondents said this was true to at least a moderate extent, 60%), AMR prevention in the EU and at Member State level (18, 57%), and the creation of a well-functioning HTA system in Europe (18, 57%). However, this study's survey findings show that a large proportion of respondents believed that the Programme only contributed to a small extent to improvements in two areas: childhood obesity in the EU and at Member State level (13 responses, 41%) and health status and access to care of vulnerable groups in the EU and at Member States level (12 responses, 39%). Figure 73 shows these results. The findings related to childhood obesity are in line with the evidence discussed under EQ1 as child and infant health has emerged as a topic which was not adequately addressed under the 3HP. The relatively smaller contribution perceived by stakeholders in the area of health status and access to care of vulnerable groups might be explained by changes which occurred in the European landscape in terms of health needs related to increased migration. As discussed under EQ1, despite the Programme overall remained relevant to health needs linked to migration some stakeholders reported that refugee and migrant health was not a topic adequately addressed by the 3HP.

Figure 73. Survey: To what extent has the Programme contributed to improvements in the following areas? (n=32)



These findings are corroborated by the information emerging from this study's interview programme. Stakeholders from academic institutions noted that there is a need for a stronger focus on health inequalities: the 3HP emphasis on health promotion has been positive, but healthcare access should have been more addressed (specifically for those in lower economic groups) as well as health inequalities, particularly in relation to migration.

A lower percentage of OPC respondents reported that the 3HP actions led to general improvements in health and healthcare in the EU and at Member State level at least to a moderate extent (29 responses, 43%), while 29% of respondents did not agree with this statement and 27% replied they did not know. The most commonly given examples of actions which improved health and health care in the EU and at Member State level included:

- The European Reference Networks, which reportedly have improved the visibility of rare diseases and helped patients and doctors.
- Joint Actions[457], which reportedly contributed to more cooperation between Member States, a more effective implementation of the Programme's priorities and a better integration of the Programme at the national level.

Joint Actions as a funding mechanism enabled collaboration, fostered coordination efforts amongst Member States, enabled the sharing of existing good practices and development of cross-collaboration on a number of pertinent topics. For instance, the 2019 Statement noted there was an efficient response to highly dangerous and emerging pathogens at EU level thanks to the Joint Action EMERGE, and improvement of capabilities for rapid laboratory diagnosis of new or emerging pathogens (e.g., Ebola, Zika). The 2020 Statement lauded the EU contribution (EUR 6.9 million) to the Joint Action on Antimicrobial Resistance and Healthcare-Associated Infections (EU-JAMRAI) which supported EU Member States in developing and implementing effective one health action plans against AMR and healthcare associated infections (HCAI).

This is further evidenced through scoping interviews conducted in the early stages of the study. Joint Actions were noted as being a well-designed mechanism which coexisted with national programmes and national priorities. They were also described as being accessible to Member States in comparison to other funding mechanisms, potentially as all Joint Actions qualified for the 80% grant rate under the exceptional utility criteria.

Furthermore, the establishment of 24 European Reference Networks (ERNs) is considered a flagship achievement by the Commission. The ERNs demonstrate a high level of coordination, involving healthcare providers across Europe and aim to tackle complex or rare medical diseases or conditions that require highly specialised treatment and a concentration of knowledge and resources. The 2019 and 2020 Programme Statements noted that these ERNs provide greater access to high quality healthcare and information, accurate diagnosis and appropriate treatment to patients affected by rare or low prevalence diseases. In the first phase (2017-2018), ERNs included more than 900 highly specialised healthcare providers in 300 hospitals across the EU. This number grew with time, as the 2020 Statement added that 1,185 healthcare providers and centres of expertise joined the ERNs. However, shortcomings were identified in terms of administrative burden reduction and long-term financial sustainability of the ERNs.[458]

The findings above are corroborated by information emerging from this study's interview programme. Most stakeholders overall considered the 3HP effective in contributing to improvements to health and healthcare in the EU and at member States level, including in terms of coordination of efforts across Member States. For instance, an interviewed stakeholder from a healthcare professional association believed that the 3HP improved cross-country collaboration and encouraged national governments to work more with stakeholders. A stakeholder from a governmental public health organisation reported that Joint Actions (e.g., on AMR and vaccination) helped collaboration across European agencies in a clear and practical way. Some national policymakers pointed out that the 3HP enhanced cooperation on cross-border healthcare access, improved cross-country collaborations, especially through Joint Actions, and boosted coordination to tackle rare disease through ERNs.

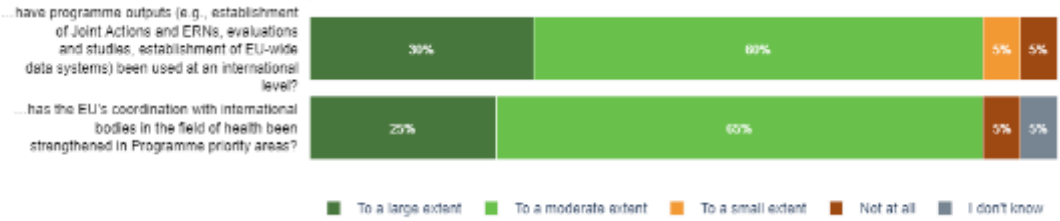
3HP contribution to EU's influence on health and healthcare standards, policies and practices at international level (Q4c)

[457] E.g., iPAAC (Innovative Partnership for Action Against Cancer Joint Action), EU-JAV (European Joint Action on Vaccination), CHRODIS (Joint Action on Chronic Diseases).

[458] European Court of Auditors., 2019. Special Report: EU actions for cross-border healthcare: significant ambitions but improved management required. Available at: https://www.eca.europa.eu/Lists/ECADocuments/SR19_07/SR_HEALTH_CARE_EN.pdf [Accessed November 2021]

Overall, public authorities surveyed as part of this study believed that the 3HP outputs (e.g., establishment of Joint Actions and ERNs, evaluations and studies, establishment of EU-wide data systems) were used at an international level, and that the EU's coordination with international bodies in the field of health had been strengthened in 3HP priority areas (18 out of 20 respondents said these two statements were true to at least a moderate extent, 90%).

Figure 74. Survey: To what extent …? (n=20, only public authorities)



Surveyed public authorities also said that the 3HP contributed to EU's influence at international level in the following areas: AMR standards, policies and practices as well as immunisation programmes (14 out of 20 respondents said this was true for both areas to at least a moderate extent, 70%). Conversely, respondents said that the 3HP contributed relatively less to the EU's influence at the international level in the area of childhood obesity standards, policies and practices (11, 59%) – this is consistent with findings discussed above showing that the 3HP was not as efficient in this area as in others.

The international dimension of the 3HP was also reflected upon by stakeholders contributing to this study's interview programme. Overall, interviewed stakeholders expressed satisfaction with the 3HP contribution to EU's influence on health issues at international level. For instance, a stakeholder from an academic institution stated that Orpha codes - the Orphanet nomenclature of rare diseases - are now implemented in other countries such as USA, Japan, Argentina, and Australia. Additionally, the 3HP has empowered the rare disease community, experts, patient organisations in promoting global networks for rare diseases, because of the EU pioneering actions in this area. A national policymaker reported that Operating Grants helped international institutions adopt 'a global health approach' while a stakeholder from DG SANTE mentioned the work supported by the 3HP undertaken by international institutions in the area of health inequalities (migration vaccination) including training programmes on vaccination were very useful and sustainable.

Lastly, in the focus group on Joint Actions, a coordinator from the EU stated that Joint Actions brought visibility to vaccination as an international issue (not just to be developed at European level), while an EU policymaker who participated in the focus group on procurement contracts reported that the projects funded under the 3HP provide useful insight and knowledge for those who are participating in high level decisions at international level.

A5.5 Supplementary information for Q5

Information about the extent to which funded actions contributed to achieving 3HP objectives (Q5a)

Baseline assessment

- **Baseline (2014):** The actions funded under the 2HP contributed to significant progress and results across its three objectives: to improve citizens' health, promote health and reduce health inequalities and generate and disseminate health information and knowledge. It did this by fostering cross-border collaboration, developing and testing common tools and approaches, and enhancing the evidence and information base.
- **Mid-point (2017):** As discussed in Q4, there were many potential benefits from funded actions, including ERNs, HTA and tackling cross border health threats. Actions examined under specific objectives 2 (cross-border health threats) and 4 (access to healthcare) may have been more likely to generate tangible benefits in the near future due to their specificity and legal basis, whereas objectives 1 (health promotion) and 3 (health systems) required plausible intervention logic and credible plans for follow-up work.

Over the 3HP implementation period, a number of health topics have been considered by the Commission as particularly important and the related funded actions have been singled out as 'highlights of the year' in the annual implementation reports of the Programme. Under Objective 1, chronic diseases, migrant's health, lifestyle risk factors, cancer prevention and health inequalities were considered priority themes. Under Objective 2, particularly important themes were migrants' health, vaccination and preparedness against cross-border health threats. In the area of health systems (Objective 3), themes that have been identified as particularly important were cross-border healthcare, HTA, rare diseases, e-Health, pharmaceutical products and medical devices. Lastly, under Objective 4, priority themes were rare diseases, medical devices and blood, tissues and cells. To address those priority themes and consequently achieve the relevant specific objectives, as described in the annual implementation reports, different actions were funded under the 3HP. The great majority of funded actions identified as 'highlights of the year' were Joint Actions, followed by Projects, and to a lower extent Direct Grants to international organisation and service contracts.

The themes (and examples of related funded actions reported in the footnotes) are presented by objective and by year in Table 27.

Table 27. 3HP Implementation Reports: priority themes per 3HP Objective and implementation year

3HP Objectives	2014[459]	2015[460]	2016[461]	2017[462]	2018[463]	2019[464]	2020[465]
Objective 1 themes	Chronic diseases[466]	Migrants' health[467]	Lifestyle risk factors (drugs, tobacco, harmful alcohol consumption) Chronic diseases Migrants' health[468]	Health inequalities and determinants of health[469] Cancer prevention[470]	Prevention of NCDs Health inequalities Alcohol-related harm Tobacco products	Tobacco legislation Harmful alcohol consumption	Tobacco legislation

[459] European Commission (2017), Implementation of the third Programme of Community action in the field of health in 2014. Available from: https://ec.europa.eu/health/sites/default/files/programme/docs/implementation2014_en.pdf [Accessed November 2021].
[460] European Commission (2018), Implementation of the third Programme of the Union's action in the field of health in 2015. Available from: https://ec.europa.eu/health/sites/default/files/funding/docs/implementation2015_en.pdf [Accessed November 2021].
[461] European Commission (2019), Implementation of the third Programme of the Union's action in the field of health in 2016. Available from: https://health.ec.europa.eu/system/files/2019-08/implementation2016_en_0.pdf [Accessed November 2021].
[462] European Commission (2020), Implementation of the third programme of EU action in the field of health in 2017. Available from: https://ec.europa.eu/health/sites/default/files/funding/docs/implementation2017_en.pdf [Accessed November 2021].
[463] European Commission (2020), Implementation of the third programme of Union action in the field of health 2018. Available from: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52021DC0680&qid=1636392822099 [Accessed November 2021].
[464] European Commission (2021), Implementation of the third Programme of Union Action in the field of health 2019. [Pending publication] [Accessed November 2021].
[465] European Commission (pending publication), Implementation of the third Programme of Community action in the field of health in 2020.
[466] Funded actions included the Joint Action on Dementia, the Joint Action on Nutrition and Physical Activity and projects in the area of active and healthy ageing, such as the PATHWAYS project.
[467] Funded actions included projects in the area of migrants' and refugees' health and a direct grant to the International Office of Migration
[468] Funded actions included a direct grant to the World Health Organisation on access to care of the migrant population in national health care systems and projects on access to care for vulnerable migrants and refugees, such as MigHealthCare, MyHealth and ORAMMA.
[469] Funded actions included the Joint Action Health Equity Europe (JAHEE)
[470] Funded actions included the Joint Action Innovative Partnership for Action Against Cancer (iPAAC).

3HP Objectives	2014[459]	2015[460]	2016[461]	2017[462]	2018[463]	2019[464]	2020[465]
Objective 2 themes	/	Migrants' health[471]	/	Vaccination challenges, including hesitancy[472] Combat health threats at EU entry and exit points	Strengthening preparedness against health threats[473]	Vaccination [474]	Vaccination [475]
Objective 3 themes	Cross-border healthcare[476]	HTA and innovation[477]	Rare diseases[478]	e-Health and health information[479] Pharmaceutical products[480]	Pricing of pharmaceutical products Medical devices	Medical devices[481]	HTA[482]

[471] Funded actions included projects in the area of migrants' and refugees' health and a direct grant to the International Office of Migration.
[472] Funded actions included the Joint Action on vaccination (EU-JAV).
[473] Funded actions included the SHARP Joint Action which aimed to build capacity to counter health threats in EU countries, support the implementation of international health regulations, and step up the implementation of EU legislation on serious cross-border health threats.
[474] Funded actions included a study to examine the feasibility of developing a common vaccination card for EU citizens.
[475] Funded actions included projects aiming to increase access to vaccination for disadvantaged, isolated, difficult-to-reach groups and newly arrived migrants, such as Projects RISE-Vac, ImmuHubs and ActToVAx4NAM.
[476] Funded actions included a study considering the effects of the Cross-border Healthcare Directive 2011/24/EU.
[477] Funded actions included a joint action on HTA, two projects and a joint action on integrated care; and preparatory work for the establishment of the ERNs.
[478] Several financing measures were used to support European Reference Networks in 2016, amounting to more than EUR 8 million. For example, requests for service were launched for the independent assessment bodies to assess candidate ERNs.
[479] Funded actions included the Joint Action supporting the eHealth Network(e-Health) and the Joint Action Information for Action (InfAct).
[480] Funded actions included a direct grant to the Council of Europe on pharmaceutical products.
[481] Funded actions included activities to run campaigns supporting the implementation of the new regulations on medical devices ((EU) 2017/745) and in vitro medical devices ((EU) 2017/746).
[482] Funded actions included a service contract for the provision of joint Health Technology Assessment (HTA) work supporting the continuation of EU cooperation on HTA.

3HP Objectives	2014[459]	2015[460]	2016[461]	2017[462]	2018[463]	2019[464]	2020[465]
Objective 4 themes	/	/	/	Medical devices[483]	Rare diseases[484]	Rare diseases[485]	Blood, tissues and cells[486]

[483] Funded actions included a three-year campaign in collaboration with DG GROW which covered the adaptation phase for the enforcement of the medical devices' regulation.
[484] Funded actions included the Orpha Codes project, the continued operation of the Orphanet Network, the administration of the 23 existing ERNs and the establishment of a new ERN (eUROGEN).
[485] Funded actions included activities to support the development of rare disease registries for the ERNs; services and technical assistance to the Commission for an integrated assessment, monitoring, evaluation and quality improvement system (AMEQUIS) for the ERNs; a programme to facilitate the exchange of visiting professionals between clinical centres in the ERNs.
[486] Funded actions included a study supporting the impact assessment of the revision of Directive 2002/98/EC on safety and quality of human blood and blood components and of Directive 2004/23/EC on safety and quality of human tissues and cells.

When considering the effectiveness of funded actions, some stakeholders who participated in the focus group on project grants mentioned some examples of successful actions that contributed to achieving the 3HP objectives. For instance, a national policy maker explained that their project developed a self-assessment tool for integrated care which is still available across Europe and useful at national and regional level. Moreover, a stakeholder from academia mentioned that the ERNs received framework grants under the 3HP which allowed the organisation and coordination of the ERNs, resulting in infrastructures for 24 ERNs. These networks deliver expert advice, conduct training and education activities, and spread knowledge about rare diseases, facilitating access to care across Europe.

Most interviewed stakeholders confirmed the effectiveness of funded actions in achieving the 3HP objectives. Academic institutions, national policy makers and healthcare services providers felt that the funded actions had enhanced cross-country collaboration and exchange of best practice. In particular, a stakeholder from academia reported that the implementation of Joint Actions was effective and that outputs were clear, while another academic institution noted that the Programme had enhanced cooperation between Member States on cross-border healthcare access and improved coordination to tackle rare diseases through the European Reference Networks. A stakeholder from the EU institutions believed that Joint Actions had produced 'considerable products' considering the limited budget.

Similarly, representatives from governmental public health institutions reported that health inequalities had been effectively addressed by the 3HP, that HTA had been effectively covered with a high number of participating countries and that the 3HP covered the main factors contributing to citizens' health. Other themes that were effectively addressed, according to the consulted stakeholders and corroborating the findings from the desk research, included safety of care, AMR, vaccination, nutrition and alcohol. A stakeholder from an organisation representing patients and service users mentioned that the 3HP had funded actions for which there was 'clear societal benefit' to patients and citizens more generally.

A5.6 Supplementary information for Q6

Baseline assessment

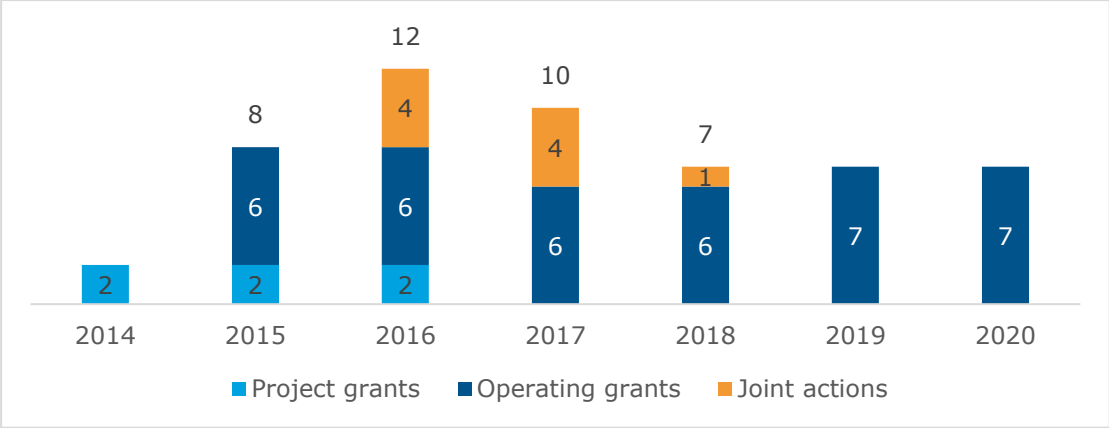
- **Baseline (2014):** 2HP was relatively successful at encouraging participation from lower income Member States, however there was room for improvement, which led to introduction of the exceptional utility criteria.
- **Mid-point (2017):** The use of the “exceptional utility” criteria helped 3HP improve the participation of lower GNI MS somewhat. The expanded scope and simplified eligibility criteria for these criteria were positive, however the mechanism was not used very much for projects and joint actions. It was used slightly more for operating grants. This may be because the criteria were poorly understood among applicants. Further, there were other barriers to participation of low GNI Member States (e.g. skills and institutional resourcing challenges) which these criteria did not address.

Use of the criteria

Note that the information reported in the annual implementation reports include funded actions under all financial instruments[487], including contracts which are not contained in the public-facing HaDEA database. The most common type of funded action which met the exceptional utility criteria was Operating Grants. There was a peak of funded actions meeting these criteria in 2016 across all relevant funding mechanisms.

[487] Grants (in the following categories: Grants under call for proposals or invitation; Project grants, including other DGA projects; ERN actions specific grant agreements (SGAs) under Framework Partnership Agreement; Operating grants for NGOs; JA grant; Conference grants to the Member States holding the EU Presidency; DGAs with international organisations); Procurement (service contracts), prizes and cross-cutting actions; and Other actions.

Figure 75. Funded actions which fulfilled the exceptional utility conditions per year



- *Source: Annual implementation reports / staff working documents*

To complement this finding, in the survey organised as part of this study, a large majority of public authorities said they did not know whether their Member State applied for funding under the exceptional utility criterion (14 out of 20 respondents, 70%). Those who did provide an answer were divided, with half saying their Member State did apply and the other half did not apply (3 each, 15%).

Participation rates of low- and high-GNI countries

Figure 76. Number of actions each country took part in as a partner (3HP)

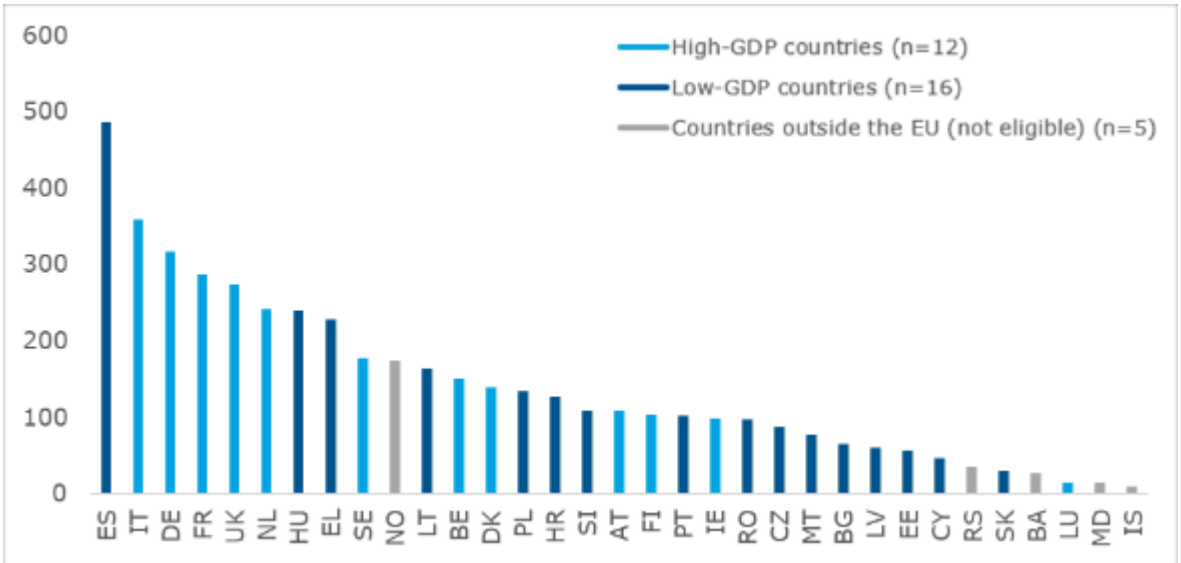


Figure 77. Number of actions each country took part in as a coordinator

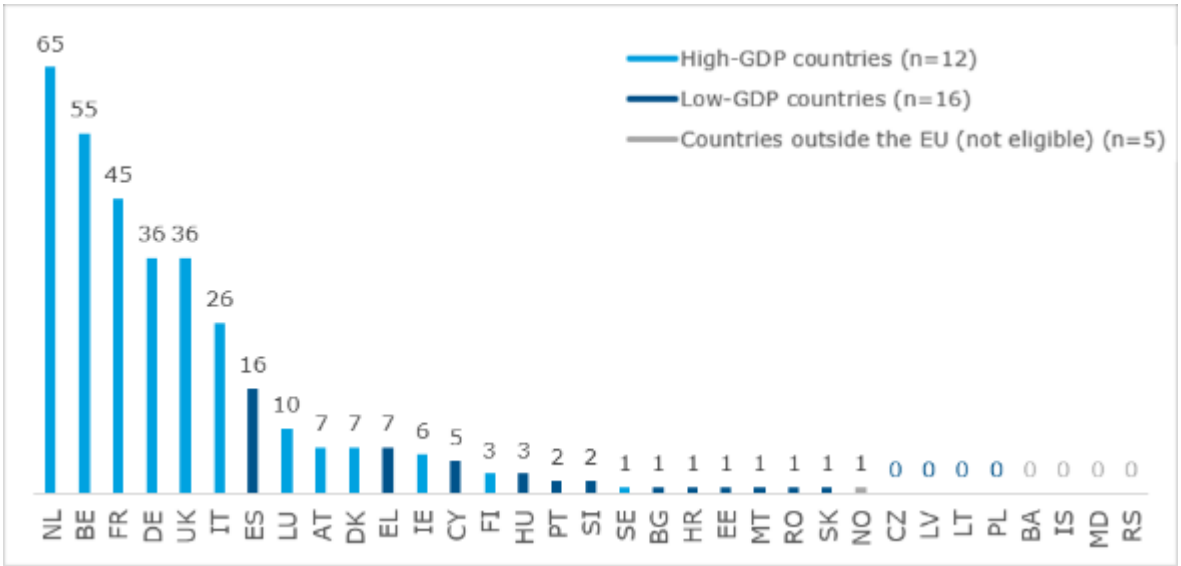
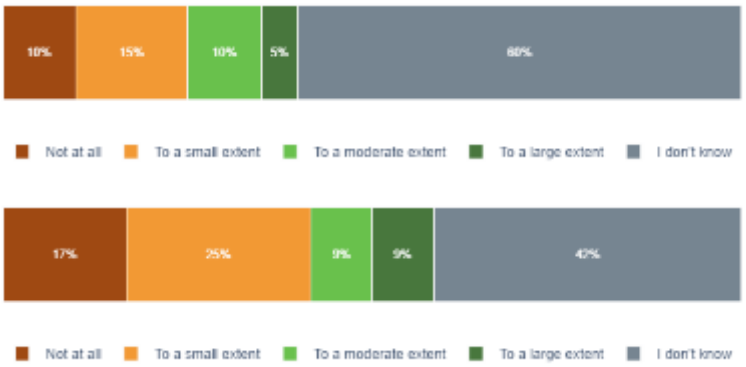


Figure 78. To what extent did the simplification measures related to the exceptional utility criteria reduce administrative costs? (first graph: n=20, only public authorities; second graph: n=12, all but public authorities)



Participation of low-GNI countries since 2HP

Table 28. Actions participated in as a partner: 2HP vs 3HP

Country	2HP	3HP	Difference
ES	182	485	+303
DE	149	317	+168
HU	71	239	+168
EL	68	227	+159
FR	131	286	+155
IT	221	359	+138
NO	45	173	+128
SE	55	177	+122
LT	45	163	+118
NL	123	241	+118
HR	35	127	+92
UK	181	273	+92
DK	53	139	+86
PL	69	134	+65
AT	53	108	+55

Country	2HP	3HP	Difference
MT	28	77	+49
FI	57	103	+46
RO	56	97	+41
PT	67	102	+35
RS	0	35	+35
CZ	57	87	+30
BA	0	26	+26
EE	31	57	+26
LV	35	60	+25
CY	25	46	+21
BG	51	65	+14
MD	0	14	+14
BE	139	151	+12
LU	7	14	+7
IS	10	10	0

Country	2HP	3HP	Difference
SI	59	109	+50
IE	49	98	+49

Country	2HP	3HP	Difference
SK	37	30	-7

- *Source: ICF analysis of public-facing HaDEA database on funded actions. Dark-blue coloured countries are those eligible for the exceptional utility criteria; light-blue coloured countries are high-GNI countries and grey coloured countries are those outside the EU.*

Table 29. Actions coordinated: 2HP vs 3HP

Country	2HP	3HP	Difference
NL	51	65	+14
FR	34	45	+11
BE	47	55	+8
DE	28	36	+8
UK	29	36	+7
CY	2	5	+3
AT	5	7	+2
EL	5	7	+2
HU	1	3	+2
LU	9	10	+1
MT	0	1	+1
RO	0	1	+1
SK	0	1	+1
BA	0	0	0
BG	1	1	0
HR	1	1	0
IS	0	0	0

Country	2HP	3HP	Difference
MD	0	0	0
NO	1	1	0
RS	0	0	0
CZ	1	0	-1
EE	2	1	-1
FI	4	3	-1
LV	1	0	-1
PT	3	2	-1
IE	8	6	-2
LT	3	0	-3
PL	4	0	-4
SE	6	1	-5
SI	7	2	-5
DK	14	7	-7
ES	27	16	-11
IT	37	26	-11

- *Source: ICF analysis of public-facing HaDEA database on funded actions.*

A5.7 Supplementary information for Q7

Baseline assessment

- **Baseline (2014)**: 2HP had some issues with ineffective dissemination strategies, and the ex-post evaluation recommended that DG SANTE and Chafea "develop a formal communication strategy to define key communication objectives, actors, messages, audiences and channels".
- **Mid-point (2017):** A communication strategy (and full-time Dissemination Officer) was in its early stages, but early indications were positive, for example the new funded actions database could enable information sharing. There was substantial investment in professional and strategic dissemination activities to consolidate and develop existing strengths. However, stakeholders felt that 3HP repeatedly addressed and supported the same beneficiaries, and more could be done to enable wider access to the Programme. Dissemination of results of actions was described as "sub-optimal" and should be improved to increase ability of stakeholders to make links to existing initiatives or national work. At the mid-term stage it was too early to adequately assess the impact of the dissemination activities.

Number of outputs by type (e.g. document, report, website, pilot etc.)

Output	Type	Total
	Document, reports…	81
	Websites, patent filing, videos etc.	19
	Other	19
	Demonstrator, pilot, prototype	1
Newsletter	***Subtotal (newsletters)***	***120***
	Document, reports…	83
	Websites, patent filing, videos etc.	4
	Other	3
	Demonstrator, pilot, prototype	1
Layman	***Subtotal (layman)***	***91***
	Document, reports	3,862
	Other	373
Others	Websites, patent filing, videos etc.	360
	Demonstrator, pilot, prototype	60
	Subtotal (others)	***4,655***
Total		**4,866**

A5.8 Supplementary information for Q8: To what extent have the recommendations from previous evaluations been implemented?

Baseline assessment

Baseline (2014): The ex-post evaluation of 2HP provided 14 "options for change" for 3HP:

- Communicate the division of roles between Chafea and DG SANTE
- Improve Programme monitoring
- Encourage greater participation from Member States that benefited less from 2HP than their public health capacity would have warranted
- Clarify whether public health capacity building is a HP objective
- Take a more strategic approach to external communication
- More insistence on, and greater scrutiny of, systematic dissemination strategy and planning
- Consider introducing 'cluster projects'
- Better reporting on action progress and results
- Enhance HP visibility in scientific publications
- Emphasise key barriers to implementation and how they can be overcome in evaluating proposals
- Review 'soft' EU added value criteria to maximise impact
- Strategically assess and define balance between funding instruments
- Maximise synergies by intensifying consultation with other DGs
- Avoid an excessive focus on health promotion to demonstrate coherence with Europe 2020

- **Mid-point (2017):** Progress had been made to implement some of the previous recommendations, including the establishment of multi-annual planning (MAP) and improving monitoring processes for the 3HP. However, there were several instances where previously identified issues remained, including the need to increase participation from poorer Member States and underrepresented organisations; improve the systems for monitoring programme implementation; implement and use programmatic and action specific monitoring indicators; and continue to step up efforts to communicate about the HP with core stakeholders and wider audiences. The Mid-term evaluation also made 10 recommendations on newly identified issues. It stated that DG SANTE should:

1) Maintain a focus on thematic areas of strong EU added value; 2) Strengthen and build links between the HP and the wider Commission and EU policy agenda to maximise impact; 3) Spell out how action targeting health promotion and health systems should generate EU added value; 4) Continue its effort to focus programme spending on identified thematic priorities; 5) Integrate multi-annual planning with existing programme processes. Further, DG SANTE and HaDEA should: 6) refine the EU added value and fully integrate criteria into the application process; 7) Develop a broader strategy to increase participation from poorer Member States and underrepresented organisations; 8) Invest in the resources necessary to improve the systems for monitoring programme implementation; 9) implement and use programmatic and action specific monitoring indicators; 10) Continue to step up efforts to communicate about the HP with core stakeholders and wider audiences.

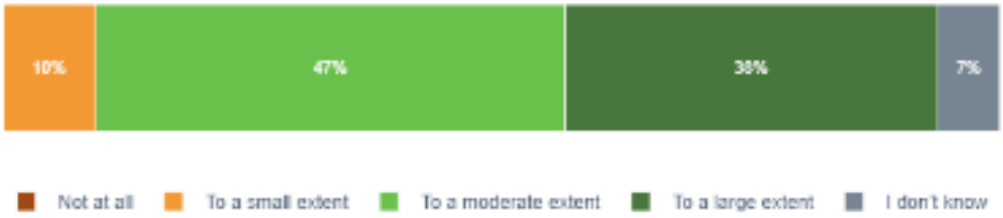
Recommendation 1: Maintaining a focus on thematic areas of strong EU added value (Q8a)

As discussed under EQ18, the analysis highlights some areas where the 3HP has a strong EU added value. Those areas include capacity building against health threats, pooling expertise and resources across the EU to reduce health inequalities, collaboration in the field of health technology assessment (HTA) and eHealth, exchange and implementation of best practice for promoting health and preventing diseases. Moreover, the analysis suggests that the 3HP also brought EU added value in the areas of rare diseases, lifestyle risk factors and determinants of health.

These findings are corroborated by evidence from the consultation activities. Overall, survey respondents reported that DG SANTE prioritised and acted upon areas of greatest added value to the EU (i.e., above what could reasonably have been expected from actions at the

national level (27 respondents said this was true to at least a moderate extent, 85%). Positive examples were provided, such as the ERN PaedCan and the Joint Action on Rare Cancers with its Work Package on Childhood Cancer. However, respondents also highlighted points of improvement, such as the need for more funding in some areas (e.g., non-communicable diseases or health equity aspects).

Figure 79. To what extent do you think DG SANTE has prioritised and acted upon areas of greatest added value to the EU (i.e., above what could reasonably have been expected from actions at the national level)? (n=32)



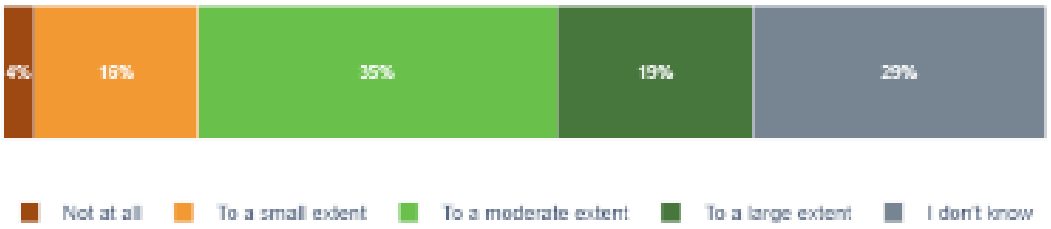
A few consulted stakeholders reflected on areas of greatest added value. Interviewed national policy makers reported that areas covered in the 3HP were still 'hot topics' for Member States and there was still a need to focus on them, especially on topics such as cancer and mental health which are considered still big challenges and that were addressed by the 3HP in previous flagship initiatives. Moreover, a representative from an academic institution who participated in the focus group on project grants highlighted rare diseases as an area of great EU added value as advances in this area could not happen solely at national level.

Recommendation 2: Strengthening and building links between the 3HP and wider Commission & EU policy agenda to maximise impact (Q8b)

Over the 3HP implementation period, links between the 3HP and wider Commission and EU policy agenda have been strengthened to maximise impacts. Efforts have been made to ensure alignment and linkages between wider Commission priorities (including the priorities of the Juncker Commission and the Von der Leyen Commission) and the ambitions of DG SANTE through the 3HP. For example, for the period 2016-2020, DG SANTE annual management plans clearly establish a structural link between the Commission's political priorities and DG SANTE action. As discussed under EQ2, DG SANTE's specific objectives related to the 3HP spending contributed to the Commission's wider priorities over the evaluation period.

The evidence collected through this study's survey confirm this finding. Overall, survey respondents believed that DG SANTE strengthened and built links between the Programme and wider Commission & EU policy agenda to maximise impact (17 respondents said this was true to at least a moderate extent, 54%). Positive examples were provided, such as the facilitation of connections between Member States, or revisions of legislations based on the output of Programme's projects (e.g., in the fields of tissues and cells, blood, organs or health information and knowledge system). However, a respondent added that initial proposals for 2021-2027 MFF only provided for a strand for health in ESF+, with a total budget of EUR413 million: they stated that it was only the Covid-19 crisis that refocussed the attention of the Commission on what contribution on health the EU could make.

Figure 80. To what extent has DG SANTE strengthened and built links between the Programme and wider Commission & EU policy agenda to maximise impact? (n=32)



Moreover, an interviewed representative from the EU institutions identified CHAFEA's (now HaDEA) involvement as being key to maximising impact, in terms of assessing the outputs and giving feedback to the projects.

Recommendation 3: Spelling out how action targeting health promotion & health systems should generate EU added value (Q8c)

Only a few interviewed stakeholders reflected on guidance explaining how actions targeting health promotion and health systems should generate EU added value. While representatives from healthcare providers and organisations representing patients and services users recalled meetings organised by the Commission and published guidance, other stakeholders, including a policy maker and a representative from governmental public health organisation reported that they were not aware of any guidance or that information received (e.g., during national focal points meetings) was limited.

Recommendation 4: Refining 3HP thematic priorities and streamlining them in EU4Health to focus spending on areas with the greatest potential impact (Q8d)

According to the Impact Assessment accompanying the proposals for the regulations on the ESF+ and EGF[488], the main challenges to be addressed by the future 4th Health Programme were determined based on the mid-term evaluation.

A5.25 maps actions identified as having high EU added value as identified in the Impact Assessment accompanying the proposals for the regulations on the ESF+ and on EGF[489] and the mid-term assessment to the priorities of the 4th Health Programme to illustrate how the 4th Health Programme has taken them into account.

After the COVID-19 outbreak in the first quarter of 2020, a standalone Health Programme (EU4Health Programme) has been established, replacing the Health Strand, initially foreseen to be part of ESF+. Objectives and priorities of EU4Health derive not only from the mid-term evaluation of 3HP and the Impact Assessment accompanying the proposals for the regulations on the ESF+ and on EGF, but also from lessons learned from the COVID-19 outbreak.

Interviewed stakeholders were divided as to whether DG SANTE has refined the 3HP thematic priorities and streamlined them in EU4Health. While a representative from a governmental public health organisation felt that EU4Health priorities were a good continuation from the 3HP and a representative from EU institutions noted that crisis preparedness was rightfully the focus of EU4Health, other stakeholders expressed concerns about the priorities of the new health programme. A stakeholder from academia was concerned that EU4Health is not sufficiently addressing rare diseases; a representative from

[488] European Commission., 2018. COMMISSION STAFF WORKING DOCUMENT: IMPACT ASSESSMENT: Accompanying the document: Proposal for a Regulation of the European Parliament and the Council on the European Social Fund Plus (ESF+); Proposal for a Regulation of the European Parliament and the Council on the European Globalisation Adjustment Fund (EGF). Available from: https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=SWD:2018:0289:FIN:EN:PDF [Accessed November 2021]

[489] European Commission., 2018. COMMISSION STAFF WORKING DOCUMENT: IMPACT ASSESSMENT: Accompanying the document: Proposal for a Regulation of the European Parliament and the Council on the European Social Fund Plus (ESF+); Proposal for a Regulation of the European Parliament and the Council on the European Globalisation Adjustment Fund (EGF). Available from: https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=SWD:2018:0289:FIN:EN:PDF [Accessed November 2021]

a healthcare professionals associations felt that EU4Health overemphasised cancer to the detriment of other disease groups. Interviewed stakeholders mentioned a few other topics which they hoped would have received much more attention as a continuation of the 3HP efforts: non-communicable diseases, the social determinants of health, migrants' health, cross-border healthcare, and the overall resilience of individuals and society.

Recommendation 5: Refining the EU-added value criteria and fully integrating these into the application process (Q8e)

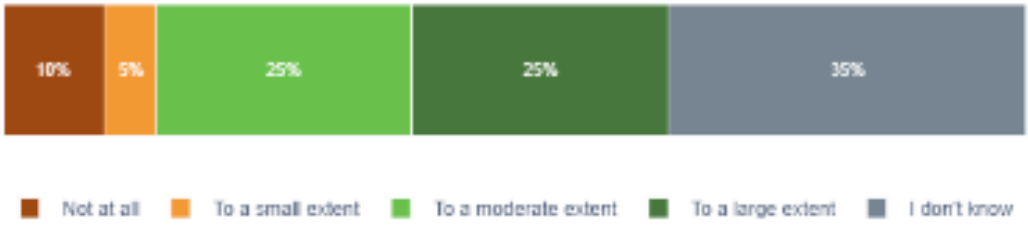
The EU added value criteria have been refined; the Annual Implementation Report from 2014[490] stated that the 3HPs improvements over 2HP included "a clear definition of 'EU added value' […] This meant, for example, that applicants and evaluators were better guided by the definition of 'EU added value'".

Overall, survey respondents who were involved in the management and administration of an action from the Programme (e.g., filled in an application form) said they understood the EU added value criteria and how to apply them (12 out of 20 respondents said this was true to at least a moderate extent, 60%).

Figure 81. To what extent did you understand the EU added value criteria and how to apply them (prior to undertaking this survey)? (n=20, only those involved in the management and administration of an action from the Programme (e.g., filled in an application form))

However, when asked about the extent to which the EU added value criteria improved the application process, a large proportion of respondents said they did not know (7 out of 20 respondents, 35%). Most of those who did provide an answer said that this was true to at least a moderate extent (10 respondents, 25%).

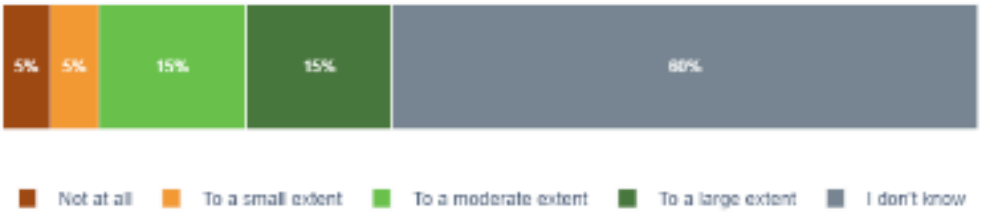
Figure 82. To what extent have the EU added value criteria improved the application process? (n=20, only those involved in the management and administration of an action from the Programme (e.g., filled in an application form))



Similarly, more than half of respondents (12 out of 20 respondents, 60%) said they did not know the extent to which the EU added value criteria were used by DG SANTE & CHAFEA (now HaDEA) in a more integrated way in the application process.

[490] European Commission., 2017. REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL: Implementation of the third Programme of Community action in the field of health in 2014. Available from: https://ec.europa.eu/health/sites/default/files/programme/docs/implementation2014_en.pdf [Accessed November 2021].

Figure 83. To what extent have the EU added value criteria been used by DG SANTE & Chafea (now HaDEA) in a more integrated way in the application process? (n=20, only those involved in the management and administration of an action from the Programme (e.g., filled in an application form))



Only a few interviewed stakeholders elaborated on the EU-added value criteria, mostly reporting some flaws in the integration of these criteria in the application process. For instance, an academic stakeholder reported that documents they normally receive include guidance on how actions can generate added value; however, the sub-national/regional element is missing. The stakeholder stressed that the biggest share of health policy is made at the sub-national level, so the regional element is always very important and regional policymakers need more guidance on what is done at EU level and how the EU can support them. Two national policy makers noted that they have received information about EU-added value criteria from CHAFEA (now HaDEA) but one of them felt this was not sufficient. Lastly, a representative from a healthcare professionals associations reported not being aware of any guidance.

Recommendation 6: Integrating multi-annual planning with existing programme processes (Q8f)

As reported in the mid-term evaluation[491], multi-annual planning was introduced in the 3HP to incorporate a more holistic, longer-term mind-set into the programming process. Multi-annual planning provides for spending across several years: the first MAP covered 2014-2016 and was updated to cover 2017-2020.

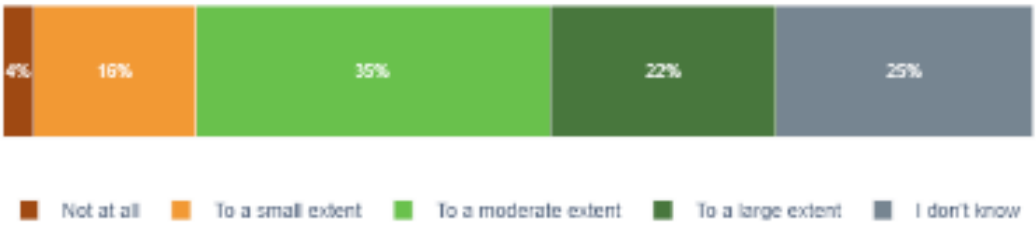
The mid-term evaluation concluded that multi-annual planning was valuable and "facilitated a quicker, less controversial, more efficient adoption of the AWP according to those involved".[492] Further, there was some evidence that multi-annual planning enabled more focused and strategic planning in the medium-term.

These findings are partly corroborated by evidence from the consultation activities. However, some limitations were identified.

Survey respondents believed that DG SANTE integrated MAP within existing programme processes (18 respondents said this was true to at least a moderate extent, 57%).

[491] Coffey International Development., 2017. Mid-term Evaluation of the third Health Programme (2014 – 2020) Final Report [online]. Available from: https://ec.europa.eu/health/sites/health/files/programme/docs/2014-2020_evaluation_study_en.pdf [Accessed November 2020].
[492] Coffey International Development., 2017. Mid-term Evaluation of the third Health Programme (2014 – 2020) Final Report [online]. Available from: https://ec.europa.eu/health/sites/health/files/programme/docs/2014-2020_evaluation_study_en.pdf [Accessed November 2020].

Figure 84. To what extent has DG SANTE integrated multi-annual planning within existing programme processes (i.e., establishing the Annual Work Programmes? (n=32)



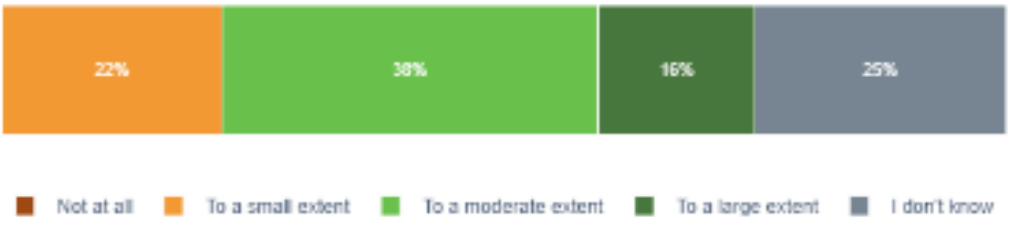
An interviewed national policy maker reported criticisms on the Commission not involving the Member States early enough in the drafting of the AWPs. Similarly, a representative from EU institutions mentioned the need for closer coordination and collaboration between DG SANTE and other EU institutions and agencies on AWPs.

Recommendation 7: Developing a broader strategy to increase participation from poorer MS & underrepresented organisations (Q8g)

As discussed under EQ6, the exceptional utility criteria were introduced in the 3HP Regulation to increase participation from poorer Member States; however, the evidence discussed under EQ6 suggests that while the criteria were used relatively often, low-GDP countries participation in the Programme has not increased as compared to the 2HP. See the analysis under EQ6 for more details.

Overall, survey respondents believed that DG SANTE & CHAFEA (now HaDEA) developed a broader strategy to increase participation from lower-income MS & underrepresented organisations, distinct from the exceptional utility criterion (17 respondents said this was true to at least a moderate extent, 54%). An academic/research organisation who benefitted from the Programme explained that based on criteria for different funding mechanisms (Joint Actions, Projects, Operating Grants) participation of low GNI-Member States and underrepresented groups was well incorporated in the Programme.

Figure 85. To what extent have DG SANTE & Chafea (now HaDEA) developed a broader strategy to increase participation from lower-income MS & underrepresented organisations (e.g., underrepresented patients' organisations, NGOs, etc.) (distinct from the exceptional utility criterion)? (n=32)



However, it is worth noting that one out of four survey respondents did not know whether a broader strategy was developed; similarly, the only interviewed stakeholder who reflected on this point was not aware of a broader strategy being deployed (representative from EU institutions).

Recommendation 8: Investing in the resources necessary to improve systems for monitoring programme implementation (Q8h)

It is unclear whether the appropriate resources have been invested to monitor the Programme's implementation.

In 2017, the Commission reportedly ensured that the implementation of the programme is monitored. Two evaluation tasks were launched in 2017: a "Data gathering study" to inform

the health policy options in the Multiannual Financing Framework 2021-2027, and the 2nd external evaluation of CHAFEA.[493]

In 2018, CHAFEA and DG SANTE contributed to the data gathering study, which involved examining documents on 70 actions (technical reports, sustainability plans, evaluations, etc.), to review and extract relevant data for the baseline analysis and modelling of impacts. This study informed the Commission's decision on future EU action on health in the MFF for 2021-2027.[494]

Most consulted stakeholders across all groups (both in the interview programme and the focus groups) raised concerns about the effectiveness of the systems for monitoring the programme implementation. Some of the limitations included a missing dedicated data collection system to perform monitoring activities per objective and per priorities; heavy reporting requirements; lack of capacity and technical expertise in smaller organisations; lack of monitoring capacity within DG SANTE; administrative burden and poor communication with EU officers managing the implementation of the programme. A representative from an NGO participating in the focus group on operating grants noted that monitoring process should be simplified.

A few stakeholders (e.g., national policy makers, representatives from governmental public health organisations, EU institutions and international organisations) reported positive feedback on the monitoring systems. For instance, an interviewed representative from EU institutions noted that monitoring platforms for project grants (such as Compass/SygMa) were useful for beneficiaries reporting back on projects. An academic stakeholder who participated in the focus group on project grants welcomed the digitalisation of the monitoring process. A few stakeholders from governmental public health organisations mentioned that monitoring had significantly improved over time, and they were satisfied with the usefulness of the process.

Recommendation 9: Implementing and using programmatic and action specific monitoring indicators (Q8i)

High-level monitoring of 3HP conducted by DG SANTE or CHAFEA (now HaDEA)[495] has comprised:

- The preparation and adoption of **AWPs** which are available online
- The annual **AIRs**, which are foreseen in the Regulation EU No 282/2014 establishing the 3rd Health Programme. The AIRs report on implementation of the Programme each year and are transmitted to the European Parliament and to the Council.
- The accompanying AIR **staff working documents**, which provide further details on the annual implementation of the Programme for the reference year concerned and also information of the Programme's actions that became available in that reference year.
- The annual **Programme Statements** which report on the performance of the 3HP during a specific year.
- **Annual activity reports**, produced by DG SANTE and CHAFEA (now HaDEA) , which list the activities carried out by these 2 services in a specific year including implementation and monitoring of the 3HP.
- CHAFEA (now HaDEA) and DG SANTE have reportedly established processes and mechanisms which enable monitoring of **budget consumption**, and also enabling appropriate remedial actions in case of deviation (e.g., underspending or overspending) from initial plans.

[493] European Commission., 2020. REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL: Implementation of the third programme of EU action in the field of health in 2017. Available from: https://ec.europa.eu/health/sites/default/files/funding/docs/implementation2017_en.pdf [Accessed November 2021].
[494] European Commission. , 2020. REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL: Implementation of the third programme of Union action in the field of health 2018. Available from: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52021DC0680&qid=1636392822099 [Accessed November 2021].
[495] DG SANTE. (2022). Ex-post evaluation of the 3rd Health Programme 2014-2020: Summary note on programme monitoring processes.

Each co-funded action (grant or procurement) is also reportedly subject to action-level monitoring, which is made up of periodic progress report and deliverables provided for in the legal act (grant agreement or service contract) underlying the action. This monitoring process is implemented by project officers responsible for the actions in CHAFEA (now HaDEA) or in DG SANTE. For grants, the monitoring process is facilitated by the Compass/SygMa systems which enable storage of all information relating to a grant over the entire cycle (from Calls for proposals until closure of the co-funded action and performance of final payment by the Commission). The Compass/SygMa repository system is complemented by the publicly available Project Database, which provides general information on the objectives and results of each co-funded project.

Only a few interviewed stakeholders from governmental public health organisations and national policy makers reflected on this point and all expressed satisfaction with key performance indicators developed by CHAFEA (now HaDEA) and outcome indicators developed in the context of individual funded actions. A stakeholder from a governmental public health organisation reported the experience of the Best-ReMaP Joint Action as the involved actors are working on a comprehensive system of indicators comprising those used by Member States.

Recommendation 10: Improving dissemination of action results (Q8j)

Following from the recommendations of the ex-post evaluation of the 2nd health programme, CHAFEA has produced a draft dissemination strategy for the 3rd Health Programme over a period of 4 years, covering the second half of the 3rd Health Programme (2017-2020).[496]

The objectives and actions of the strategy are described in Table 30 below.

Table 30. Objectives and actions of CHAFEA's (now HaDEA) dissemination strategy

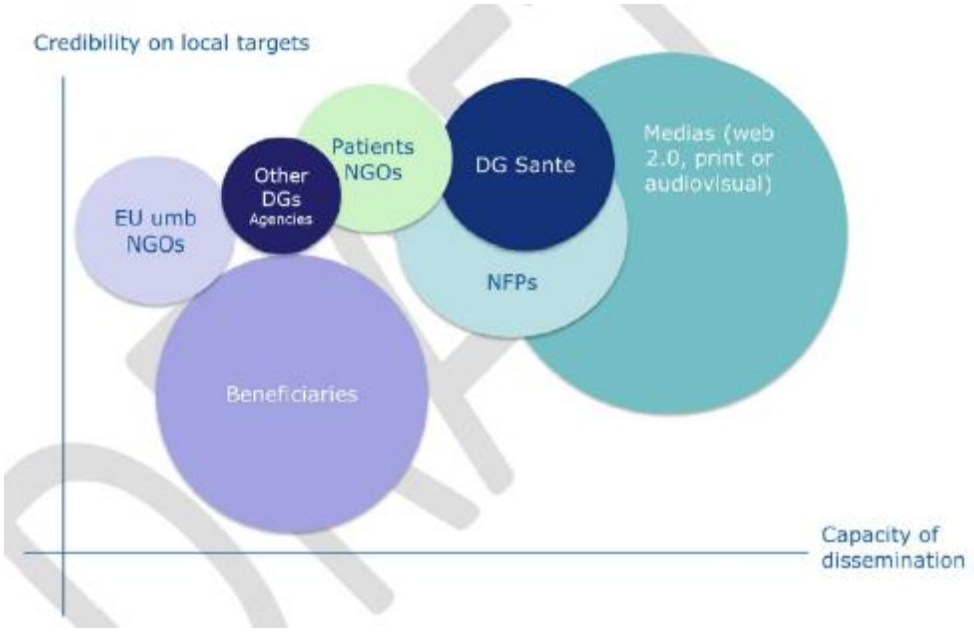
Objective	Further information or actions	Audiences targeted to fulfil this objective
Objective A: Promote actions results and benefits to amplify their impact	Support action coordinators / beneficiaries to disseminate action results and share good practice Proactively and directly promote high potential actions benefits and results	European Union institutions, European Parliament, European Council, European Commission services, DGs of the European Commission, EU MS committees and EU Agencies. Public Health Stakeholders, including NFPs, NGOs, and potential applicants People with specific conditions, such as patients or persons at risk[497]. Targeted Media (specific health magazine, bloggers). General Media, for important news or results interesting for patients / general public
Objective B: Facilitate the participation of applicants from all EU countries and encourage actions	Facilitate the participation of all countries in the Health Programme calls Promote the concept of "working together" at a pan European level to increase the EU added value of the funded actions	(Current and potential) Project coordinators and beneficiaries Public health organisations/institutions International organisations

[496] Chafea. (2022). DISSEMINATION STRATEGY FOR 3RD HEALTH PROGRAMME: Draft version 3: 29/06/2022.
[497] However, this public will not be directly targeted in the dissemination tools at EU level. They will be reached via patient organisations, professional networks or press.

with high EU added value.		Academic and research organisations – Universities and research organisations/ institutes NGOs/CSOs (e.g. patient organisations, civil society organisations, etc.).
Transversal requirement: Improve dissemination capacity and know how in Chafea to further increase its credibility in dissemination/ communication	Establish a “dissemination culture” within Chafea Feeding the pipeline of information: increasing substantially the flow information and develop high quality dissemination activities Establish Chafea dissemination workflow with define roles for each actor Prepare a dissemination agenda/planning for Chafea in line with DG SANTE priorities	

In addition to the stakeholders listed in the third column, the strategy describes some “multipliers” who can help in delivering the messages to certain target groups, but also enhance the authenticity of the messages, by adding their own “credibility”. These multipliers are listed and mapped in Figure 86 below.

Figure 86. Estimation of multipliers capacity of dissemination.



Source: Draft dissemination strategy[498]

The dissemination principles of the strategy are as follows:

- All information must be for the benefit of the EU citizen
- The information must be user-friendly and pedagogic
- The information must be useful for the targets, in order to “catch and keep the fish”
- All information must be valuable, transparent, verifiable, and reliable
- Use in priority instantaneous and modern way of exchanging information adapted to on line dissemination tools, making the best use of multipliers

[498] Chafea. (2022). DISSEMINATION STRATEGY FOR 3RD HEALTH PROGRAMME: Draft version 3: 29/06/2022.

- Better to prove than to say
- The dissemination scheduling must consider the HP priorities, the EU political agenda and notably the DG SANTE agenda, or special UN/WHO Health strategies (e.g. Sustainable Development Goals, Rare diseases day, AIDS day)

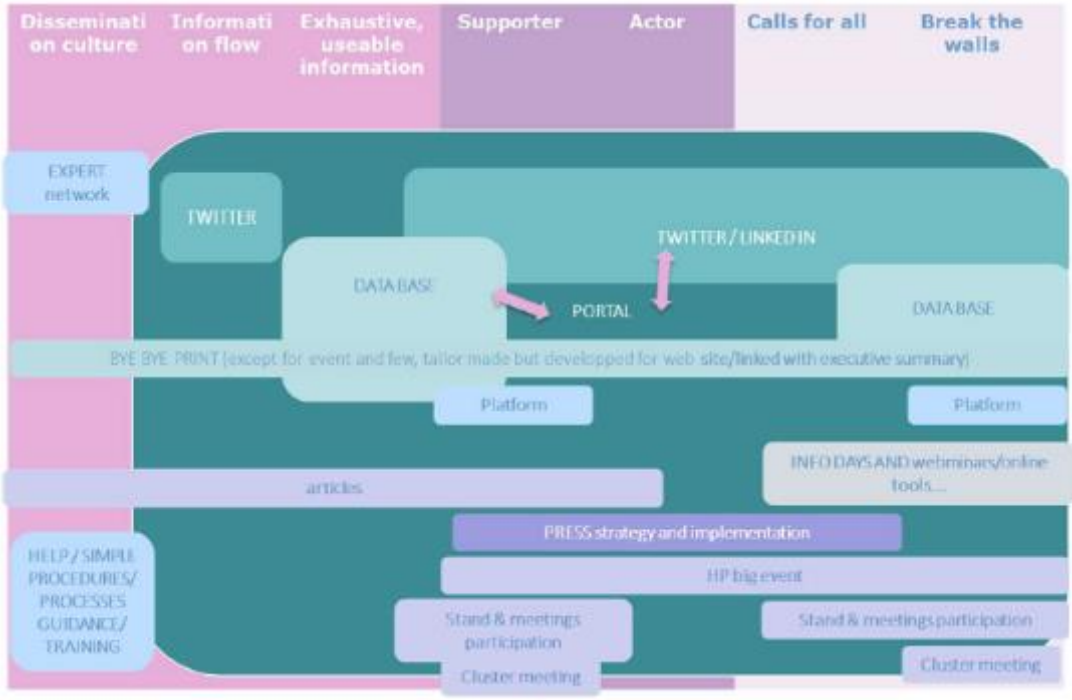
CHAFEA's (now HaDEA) draft dissemination strategy[499] stated that events are an important means for dissemination, and the strategy proposes organising an annual event on the EU Health Programme, as well as organising Cluster meetings[500] and participating in other key events. Dissemination activities organised following up on the CHAFEA's (now HaDEA) draft dissemination strategy included the following:

- **Conferences**: for example, the Conference on health inequalities and vulnerability in 2014[501], and the 2019 EU Health Programme Conference, which aimed to highlight the success stories of the 3HP and present EU health funding under the post-2020 multiannual financial framework and was attended by over 350 participants.[502]
- **Brochures and information sheets** on the 3HP's key priority areas: for example, brochures and information sheets were published in 2019 on 'e-health'[503] and 'frailty'[504], available in 24 EU languages.
- **Workshops** and **stand exhibitions**: for example, in the framework of the International Integrated care conference in Dublin, Ireland in 2017.[505]
- **Cluster meetings:** for example, "Migration and Health: paths for integration" in 2017.[506]
- **Stand-alone events** in collaboration with national authorities in Member States.

CHAFEA's (now HaDEA) draft dissemination strategy[507] lists digital tools such as Twitter, LinkedIn, the Health Policy platform, Health Programme portal, the Projects database, and e-versions of Brochures, Info sheets and policy briefs as a top operational priority. The strategy also urges intensifying media relations, and the development of a strategy for media/press. Further, the draft dissemination strategy[508] recommends implementing a European Public Health communication/dissemination officers Network, and producing dissemination toolkits for National Focal Points and beneficiaries. Overall, the main dissemination tools and objectives of dissemination are summarised in Figure 87 below.

[499] Chafea. (2022). DISSEMINATION STRATEGY FOR 3RD HEALTH PROGRAMME: Draft version 3: 29/06/2022.
[500] Meetings organised by Chafea on specific issues
[501] European Commission., 2018. COMMISSION STAFF WORKING DOCUMENT Accompanying the document: Report from the Commission to the European Parliament and the Council Implementation of the third Programme of Community action in the field of health in 2015. Available from: https://ec.europa.eu/health/sites/default/files/funding/docs/com2018_818_en.pdf [Accessed November 2021].
[502] European Commission., 2021. Report from the commission to the European Parliament and the Council. Implementation of the third Programme of Union Action in the field of health 2019. [Pending publication]. [Accessed November 2021].
[503] European Commission., 2019. Consumers, Health, Agriculture and Food Executive Agency, eHealth: digital health and care, Publications Office, 2019. Available from: https://op.europa.eu/en/publication-detail/-/publication/08e68564-67fe-11e9-9f05-01aa75ed71a1/language-en?WT.mc_id=Selectedpublications&WT.ria_c=19980&WT.ria_f=3171&WT.ria_ev=search [Accessed November 2021]
[504] European Commission., 2019. Consumers, Health, Agriculture and Food Executive Agency, Frailty: European Union support to prevent ageing decline in citizens, Publications Office, 2019. Available from: https://data.europa.eu/doi/10.2818/54185. [Accessed November 2021]
[505] European Commission., 2020. REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL: Implementation of the third programme of EU action in the field of health in 2017. Available from: https://ec.europa.eu/health/sites/default/files/funding/docs/implementation2017_en.pdf [Accessed November 2021].
[506] European Commission., 2020. REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL: Implementation of the third programme of EU action in the field of health in 2017. Available from: https://ec.europa.eu/health/sites/default/files/funding/docs/implementation2017_en.pdf [Accessed November 2021].
[507] Chafea. (2022). DISSEMINATION STRATEGY FOR 3RD HEALTH PROGRAMME: Draft version 3: 29/06/2022.
[508] Chafea. (2022). DISSEMINATION STRATEGY FOR 3RD HEALTH PROGRAMME: Draft version 3: 29/06/2022.

Figure 87. Dissemination tools linked to the main objectives of dissemination



Source: Draft dissemination strategy[509]

Following the adoption of the dissemination strategy for the 3HP (in June 2017), an annual dissemination plan was issued each year. Examples of dissemination activities undertaken in the period 2017-2020 are presented hereinafter.

In 2017, CHAFEA (now HaDEA) and DG SANTE agreed on an improved method to plan and prepare dissemination activities. The box below provides further information.

Dissemination resources produced by Chafea in 2017

- A revamped database on funded actions, allowing stakeholders to have an organised access to funded actions' deliverables.
- A set of visual depictions illustrating the different topics covered by the health programme.
- Online tutorials (videos posted on its website to assist applicants and beneficiaries).
- Regular news items for the web or social media to inform stakeholders of activities and results of funded actions.
- Chafea participated in the Europe Day in Luxembourg, organised in cooperation with SANTE.

Source: 2017 Annual Implementation Report[510]

The annual dissemination plan for 2018 focused on the Commission's key priorities for health, namely the ERNs and crisis preparedness and response.[511] Further, in 2018, participating countries were encouraged to engage in disseminating the results of co-funded actions and seek synergies with other EU funding programmes. These promotional activities

[509] Chafea. (2022). DISSEMINATION STRATEGY FOR 3RD HEALTH PROGRAMME: Draft version 3: 29/06/2022.
[510] European Commission., 2020. COMMISSION STAFF WORKING DOCUMENT Accompanying the document: Report from the Commission to the European Parliament and the Council Implementation of the third programme of EU action in the field of health in 2017. Available from: https://ec.europa.eu/health/sites/default/files/funding/docs/swd2020_52_en.pdf [Accessed November 2021].
[511] European Commission. (2020). REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL: Implementation of the third programme of Union action in the field of health (2018). Available from: https://ec.europa.eu/transparency/documents-register/detail?ref=COM(2020)691&lang=en

included holding eight information days to promote the funding opportunities offered under the 2018 AWP, in cooperation with the network of national focal points (NFPs).[512]

In 2019, over 120 cross-linked news items were published on CHAFEA's (now HaDEA) website and partly via social media, webinars on funding opportunities were published, and dissemination guidance for beneficiaries and the upgrade of the database download features were developed.[513] In 2020, the number of cross-linked news items was double that in 2019: 220 cross-linked news items appeared on CHAFEA's (now HaDEA) website with social media promo, webinars on funding opportunities, dissemination guidance for beneficiaries, and an upgrade of the database's download features.[514]

In 2020, communication and dissemination activities focused on the key communication priorities indicated by DG SANTE, including vaccination, Covid-19, promoting healthy lifestyles, health workforce, health technology assessment and digital health.[515] Also in 2020, links with DG SANTE's website and the Health-EU Newsletter was reportedly ensured to boost the communication of Commission measures taken to fight the COVID-19 pandemic.[516]

Most consulted stakeholders overall agreed that dissemination activities improved overtime. For instance, a national policy maker felt that dissemination had been improved through the introduction of the information sessions whereby the Commission committed funds towards organisation of sessions in collaboration with Member States. Similarly, stakeholders from international organisations, healthcare professional associations and organisations representing patients and service users agreed that improvements were made over time. It is worth noting that some stakeholders reported difficulties in participating to dissemination activities organised by CHAFEA. For instance, a national policymaker mentioned that despite CHAFEA organising activities to encourage dissemination, attendance was low. The same stakeholder also mentioned that despite receiving requests to participate in dissemination activities, they lacked the human resources to engage. Such limitations to the effectiveness of dissemination activities are however not attributable to the 3HP, rather related to the stakeholder level.

[512] European Commission. , 2020. REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL: Implementation of the third programme of Union action in the field of health 2018. Available from: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52021DC0680&qid=1636392822099 [Accessed November 2021].
[513] European Commission., 2021. Report from the commission to the European Parliament and the Council. Implementation of the third Programme of Union Action in the field of health 2019. [Pending publication]. [Accessed November 2021].
[514] European Commission. (pending publication). REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL: Implementation of the third Programme of Community action in the field of health in 2020. Pending publication.
[515] European Commission. (pending publication). REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL: Implementation of the third Programme of Community action in the field of health in 2020. Pending publication.
[516] European Commission. (pending publication). REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL: Implementation of the third Programme of Community action in the field of health in 2020. Pending publication.

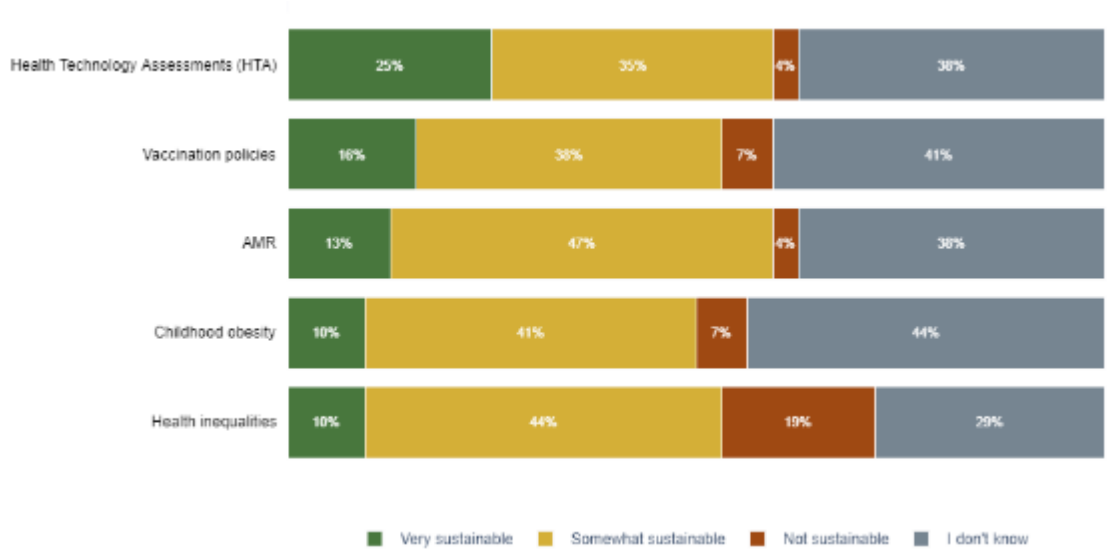
A5.9 Supplementary information for Q9

Baseline assessment

- **Baseline (2014):** In the 2HP, the timescales to impact were often long (and sometimes spanned over several actions), which impacted sustainability, as long-term EU funding (e.g. funding for a series of successive actions on a topic) was needed to create tangible impacts. In other words, "some actions would fail to take root without further funding".
- **Mid-point (2017):** There was a need to ensure that activities were anchored in local contexts, including ownership and input of the results. In one example, a challenge to this was the need to continually maintain a high level of expertise in diagnostics of rare but extremely dangerous pathogens.

Survey results about sustainability

Figure 88. How sustainable do you think the Programme results and effects are in the specific fields of…? (n=32)



Topics or actions mentioned by stakeholders as having high sustainability

According to an NGO and an EU-level government policy maker, the 3HP increased knowledge and skills in crisis preparedness for professionals in the health sector and NGOs, and evidence generated on this topic will be used beyond the 3HP (NGO; EU-level government policy maker). Further, the same NGO stated that knowledge and evidence generated through the 3HP on health prevention and promotion will be used beyond the 3HP (NGO).

There were also certain funded Joint Actions which seemed to be especially sustainable:

- The **Joint Action on alcohol** has a network which is still operational and still used by stakeholders.[517]
- The **Shipsend JA** attracted countries and buyers outside of Europe as it was a training package.[518]
- Joint actions on chronic diseases (**CHRODIS** and **CHRODIS+**) will have some lasting impacts.[519]
- The **JA Healthy Gateways** also had high sustainability.[520]

[517] Government policy maker from outside of the EU.
[518] EU-level government policy maker.
[519] Organisation representing patients and services users.
[520] Survey respondents.

- Finally, a Joint Action involving promotion of policy dialogues for **media advertising beverages and food for children**, allowed the creation of a law passing a national assembly: *"this allowed us to keep using the same intervention. In most JAs, we fulfil our goals and then everything disappears"*[521]

Barriers to sustainability related to specific funded actions

A governmental public health organisation described how the Commission has abolished the high-level group on nutrition and physical activity. This limits sustainability because there needs to be governance mechanisms to implement changes and loss of this group had reduced the high-level expertise. An indicator of Best-ReMaP[522] was to report on the implementation of the project to this high-level group, but as the group ceased to exist in the meantime, the funded actions' objectives cannot be fully achieved. As discussed above, another pertinent example used to illustrate this barrier, was an action within which registry was created for five ERNs to collect data at EU level for patients with rare diseases; however, in the focus group on Project Grants, an academic and research organisation reported that although the industry is very interested in using data collected through this mechanism and some consider this collaboration essential, the board of Member States blocked a potential collaboration with industry, thus potentially limiting the potential of the projects' outputs/outcomes. However, note that collaboration with industry can be a sensitive matter.

A stakeholder from an organisation representing patients and services users felt there were some problems in the set-up of Joint Actions which meant it was not possible to engage some stakeholders. This reportedly jeopardised the outputs of the Programme and the sustainability of the Programme.

A5.10 Supplementary information for Q10

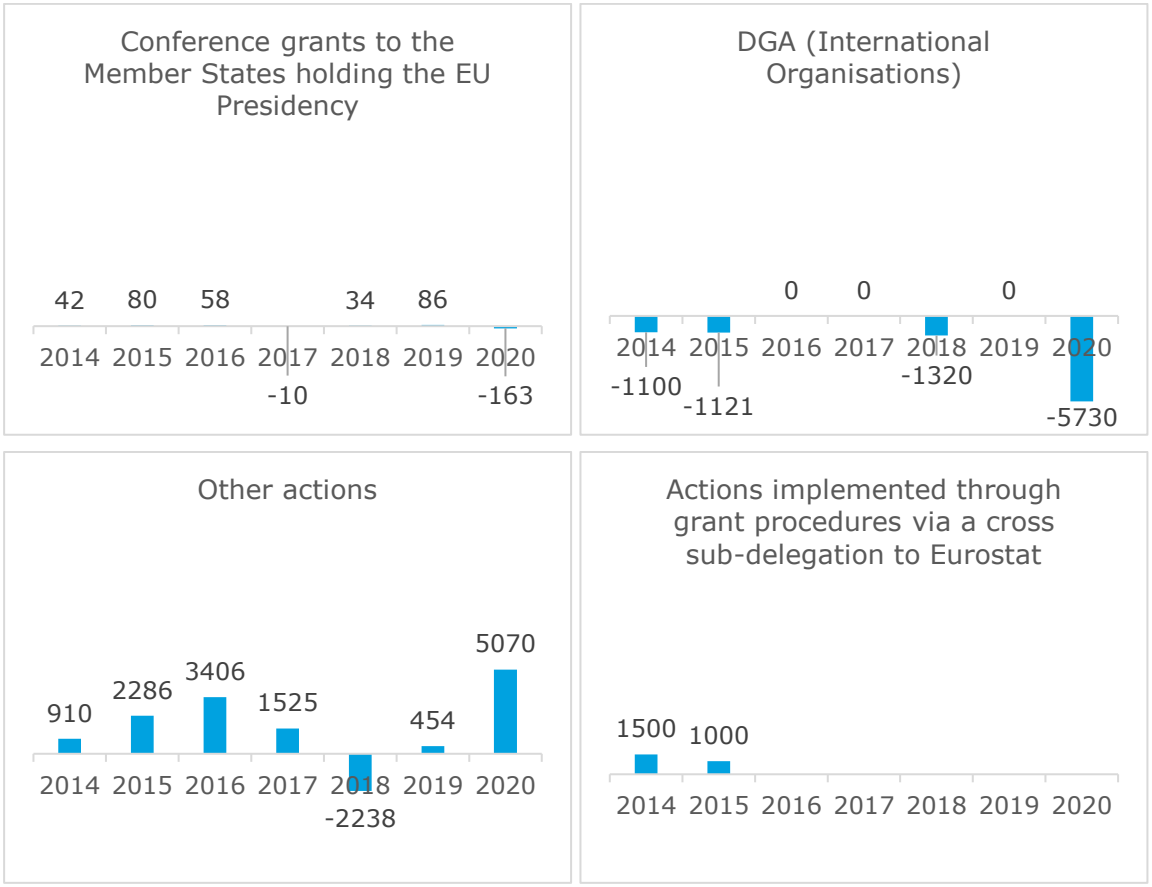
Baseline assessment

- **Baseline (2014):** the 2HP had a "small size, large scope, and lack of clear strategic focus and priorities"[523], which meant that resources could be diluted by the large number of relevant issues to be addressed. However, the ex-post evaluation of 2HP found that the second half of the programme addressed this somewhat through links in the AWPs to the Europe 2020 strategy, and an increased focus on EU added value, changes the 3HP sought to build on.

- **Mid-point (2017):** Overall, the allocation of 3HP resources was efficient. Programme management improved since 2HP, for example, through the introduction of indicators to monitor progress. Compared to other Commission programmes, 3HP was relatively inexpensive. However, "persistent inefficiencies" were observed in monitoring implementation data, which prevented 3HP from maintaining oversight of its achievements. Significant efforts were made to improve dissemination, but the mid-term evaluation identified this as a priority area for development.

[521] Government policy maker, in the focus group on joint actions.
[522] The Joint Action on Implementation of Validated Best Practices in Nutrition (Best-ReMaP) aims to deliver a harmonised EU approach to reducing unhealthy (digital) food marketing to children and adolescents and to use already developed tools for harmonised monitoring of (digital) marketing.
[523] Coffey International Development., 2015. Ex-post Evaluation of the Health Programme (2008-2013) Final report [online]. Available from: https://ec.europa.eu/health/system/files/2016-11/ex-post_ev-hp-2008-13_final-report_0.pdf [Accessed November 2020].

Table 31. Supplementary analysis for Q10: Difference between actual and planned spend per year per funding mechanism (thousand EUR)



Stakeholders' views on cost effectiveness of their work (Q10b)

Through the consultations organised as part of this study, stakeholders were asked about their views of the cost-effectiveness of the Programme. Generally, stakeholders interviewed across all groups, actions, and funding mechanisms felt that the 3HP was relatively cost-effective, with many highlighting the quantity and quality of work achieved with a small budget. Several stakeholders reported achieving more than they expected to with the funding they received:

> *'We also were creative to really to ensure, you know, cost effectiveness. And I think we really succeeded in that. So even if the funding was not necessarily how much we would have, you know ideally liked, we made the best of it'.*

> *'We did a lot of work and created a lot of synergy and added value and did a lot more than we thought we'd do'.*

Stakeholders who had worked on Joint Actions particularly stressed the cost-effectiveness of their work. Depending on the level of commitment of Member States to Joint Actions and the tailoring of Joint Actions to national contexts (as was stressed by a stakeholder from a governmental public health organisation as being crucial to achieving objectives), they were seen to provide best value for money throughout the 3HP. The level of commitment of Member States was highlighted as a key factor in determining success of an action, both in the early stages of the Joint Action and after it finishes. Stakeholders highlighted the importance of national authorities' participation for Joint Actions to be implemented nationally (according to a stakeholder utilising an Operating Grant) and the key role of Member States in deciding on the structure and development of Joint Actions (according to a stakeholder utilising Procurement Mechanisms). Joint Actions were seen to be an important opportunity for Member States to 'pilot' actions to decide if they are suitable. For example, one stakeholder from a healthcare service provider/organisations representing them reported that

during a Joint Action, they launched a pilot implementation of an integrated multi-morbidity care model which their Ministry of Health subsequently trialled in other healthcare institutions using structural funds. If this is successful, the model will be implemented throughout the entire country.

Conversely, an NGO reported that more support for NGOs was needed, and it would have been useful to include civil society organisations working on the field to ensure the involvement of stigmatised communities. A stakeholder from a healthcare professionals' organisation reported that the 3HP did enable planting the "seeds" for change to start, but there is still more work that needs to be done, and more funding should be available.

Similarly, a stakeholder representing a healthcare professionals' association reported that the funding stream provided by the 3HP was not comprehensive enough to tackle childhood cancer, nevertheless, they felt the budget had been used strategically as a result, producing valuable results. One policy maker[524] did not feel Joint Actions on HTAs were cost-effective because no sustainable cooperation was developed after three Joint Actions; however, they did produce EU legislation and helped develop a Regulation. More on the impact of insufficient funding can be found in Q11.

Stakeholders' views on the cost-efficiency of actions in the context of their organisations' internal measures (Q10b)

One stakeholder from an international organisation mentioned internal measures in their organisation which ensured 3HP funding was used efficiently. The stakeholder mentioned that value for money was a large consideration for their organisation and therefore mechanisms were already in place to ensure cost-effectiveness; for example, they conducted a top-down identification of possible areas for cooperation which helped align 3HP priorities and those of the organisation's objectives. The stakeholder reported that their organisation and European Commission had agreed new grant agreements which required the organisation to demonstrate the effectiveness of a grant, holding them accountable to achieve objectives and making them *'incredibly efficient'.* A stakeholder from a different international organisation also stressed the importance of internal measures for efficient use of funding– the FAFA mechanism was utilised in their organisation to ensure value for money.

A5.11 Supplementary information for Q11

Baseline assessment

- **Baseline (2014):** Under the 2HP funding often did not lead to concrete results or outcomes, as identifiable EU added value was sometimes comprised mainly of 'softer' rather than more tangible, outcome-based results (such as economies of scale). As discussed under EQ9, timescales to impact were often long (and sometimes spanned several actions), which impacted sustainability.
- **Mid-point (2017):** As discussed in EQ10, the 3HP was largely efficient. Specifically, a trend towards joint actions and away from projects increased its cost-effectiveness (as there were different relative administrative costs for the financial mechanisms). Simplified and digitised application and grant management procedures reduced the administrative burdens both on DG SANTE and Chafea, and on applicants and beneficiaries.

Stakeholders' views on insufficient pay (Q11b)

A few stakeholders described achieving more work than 'what was paid for' (a stakeholder from the INTEGRATE Joint Action reported this, and a stakeholder from an academic/research organisation who had worked on the Gateways Joint Action concurred).The stakeholder working on INTEGRATE noted that the budget of 2 million euros for the Joint Action meant that 'the EU actually got more than what they paid for' – not just due to the size of the budget versus what was achieved, but because of the dedication of the partners involved.

[524] In the Procurement Mechanism Focus Group

Stakeholders' views on benefits of the 3HP which are not quantifiable (Q11b)

The benefits of some actions are not quantifiable, which stakeholders highlighted made it difficult to demonstrate cost-effectiveness. One stakeholder from a governmental public health organisation mentioned that desk research within the Joint Action led to valuable networking opportunities, evidence gathering, and collaboration, which was perceived to bring sustainable benefits even after the Programme ended:

'It's the collaboration, it's the networking, it's the understanding of the situations in different countries. It's supporting each other. It's building evidence together. It's understanding what the politics and the policies in different environments in Europe are...it's also the network of people who can, for years afterwards, still work with each other, inform each other'.

Most respondents to this study's survey found that management costs for funding (10 out of 20, 50%) and 3HP operational costs (design and implementation) (8 out of 10, 40%) were deemed to be the most reasonable, at least to a moderate extent (see Figure 89). However, a large proportion of respondents said other types of costs were either not reasonable or only to a small extent: administrative costs for applicants and CHAFEA (now HaDEA) (8 out 20, 40%), and monitoring and reporting costs for Member States and the Commission (5 out of 20, 25%). This view was also shared by respondents to this study's OPC as costs that were deemed the most reasonable were programme operational costs (design and implementation) whilst least reasonable were administrative costs for applicants (see Figure 90).

Figure 89. To what extent do you consider costs associated with the Programme are reasonable and kept to the minimum necessary in order to achieve the expected results? (n=20, only those involved in the management and administration of an action from the Programme (e.g. filled in an application form)

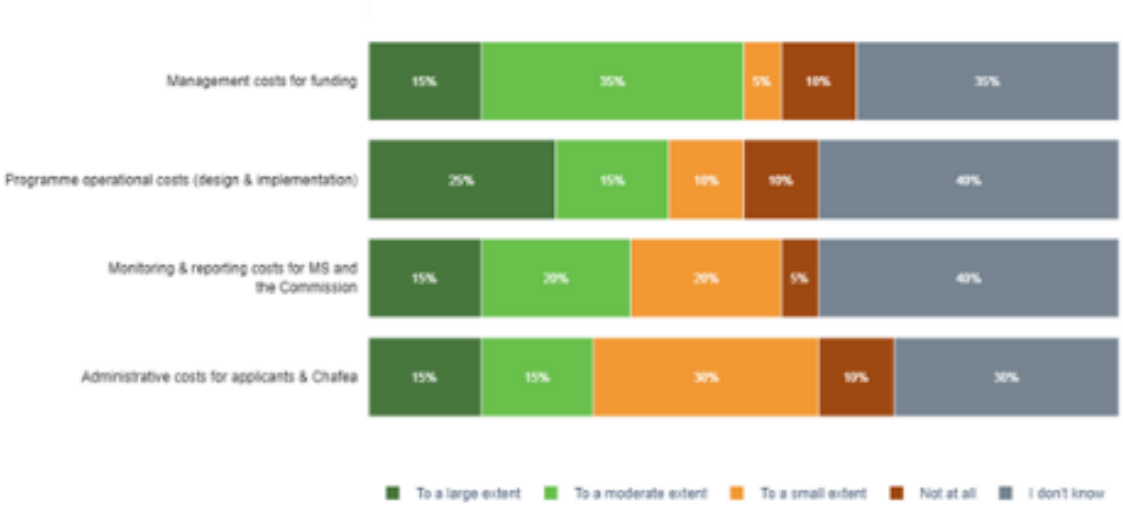
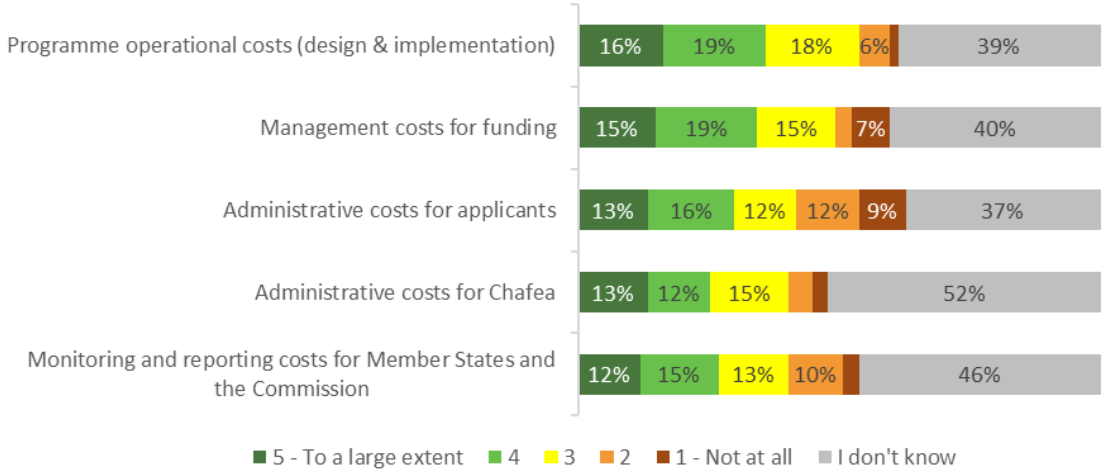


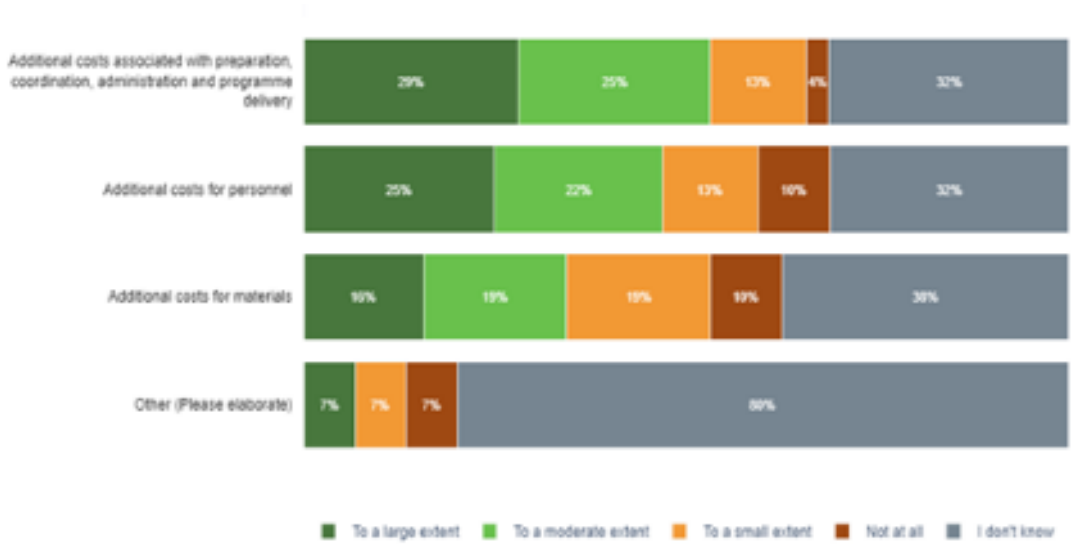
Figure 90. To what extent do you believe costs associated with the 3rd Health Programme are reasonable and kept to the minimum necessary in order to achieve the expected results? (n=67)



Stakeholders' views on factors influencing disparities between Programme costs and expected results

According to the targeted survey, factors influencing any disparities between Programme funded action costs and the expected results were to do with additional costs associated with preparation, coordination, administration and Programme delivery, followed by additional costs for personnel, and, to a lesser extent, by additional costs for materials. See Figure 91.

Figure 91. In your view, to what extent the following factors may have influenced any disparities between Programme funded actions costs and the expected results? (n=32)



Stakeholders in interviews and focus groups also stressed that, at times, the tasks they carried out were not adequately compensated for by the Programme funding. For example, a stakeholder from an academic/research organisation stated that significant amounts of work were carried out during the lengthy preparatory stages of Joint Actions which were not adequately covered by 3HP funding. Further, once actions were underway, there were incidences of partners withdrawing from Joint Actions due to the high workload and lack of funding, and some reported not being reimbursed for work undertaken or achieving *'more*

work than what was paid for'.[525] Stakeholders who had utilised Project Grants highlighted that projects focused on scaling up findings, exchange, and promotion of best practices needed to receive more financial support. Potential barriers to further funding for such projects would be limitations to EC financing: presently, Member States leading actions are encouraged to be key financial contributors and to plan financing for after an action ends as part of a sustainability strategy. These experiences of stakeholders were not able to be verified through desk research. See Q9 for more detailed description of the sustainability of actions.

Stakeholders consulted in interviews also reported additional costs in relation to applications as a factor in disparities between costs and results. Co-funding requirements particularly were seen to be too high, which impacted organisations with less access to financial and human resources. According to a government and policy maker, the smaller budget of the 3HP made it difficult to initially attract institutions to participate in actions and impacted the ability of Member States to provide co-funding. High co-funding requirements impacted a multitude of different stakeholder groups. A stakeholder from an international organisation reported that 40% co-funding within a DGA from international organisations was *'unbearable'* and may negatively impact future collaborations. A stakeholder from an NGO who utilised a Project Grant also felt that the standard co-funding requirement (40%) was too high and the application process for the 80% co-funding was difficult, particularly for smaller organisations. A stakeholder from the same focus group in an academic/research organisation also discussed the difficulty of co-funding in ERNs for healthcare providers who coordinate ERNs (but acknowledged this as a point which has been addressed in EU4HEALTH). Similarly, a stakeholder from a governmental public health organisation stressed that 20% commitment to their own funding was challenging for NGOs and may have prevented them from contributing despite the value they add to projects. A solution to co-funding issues suggested by a stakeholder from an international organisation was for DG SANTE to develop *a 'partnership agreement'* with Member States.

A5.12 Supplementary information for Q12

Baseline assessment

- **Baseline (2014):** As discussed in EQ1, the "small size, large scope, and lack of clear strategic focus and priorities"[526] in 2HP meant that resources could be diluted by the large number of relevant issues to be addressed. However, the 3HP sought to address these issues. Efficiency in 2HP was increased through greater responsibility for Chafea across all manner of administrative functions of the Programme, as this allowed certain tasks (such as changes to team costs on projects) to be streamlined. Changes in this area were implemented for 3HP, including abolishing paper-based reporting for beneficiaries and clearly defining the respective roles of Chafea and DG SANTE.
- **Mid-point (2017):** There were positive trends in the allocation of resources between the funding mechanisms, including an increase in funding for joint actions compared to projects (and the simultaneous increase in average size of projects). An increase in the size of procurement contracts managed by Chafea was also presented as a positive development by the authors of the mid-term assessment[527]. Joint actions require a high level of investment, and the mid-term evaluation noted that "irrespective of the size of an action, the biggest driver of efficiency is how effective the action is in achieving its goals and therefore the value added by EU action".

Factors outside the scope of the 3HP impacting effiency with which results were attained (Q12b)

Diverging internal rules within organisations and agencies – an external factor to the 3HP - reportedly also impacted efficiency with which achievements were attained**.** A stakeholder from

[525] These opinions were expressed by several stakeholders in the Joint Action focus group.
[526] Coffey International Development., 2015. Ex-post Evaluation of the Health Programme (2008-2013) Final report [online]. Available from: https://ec.europa.eu/health/system/files/2016-11/ex-post_ev-hp-2008-13_final-report_0.pdf [Accessed November 2020].
[527] Coffey International Development., 2017. Mid-term Evaluation of the third Health Programme (2014 – 2020) Final Report [online]. Available from: https://ec.europa.eu/health/sites/health/files/programme/docs/2014-2020_evaluation_study_en.pdf [Accessed November 2020].

the focus group on Joint Actions (GAPP) reported that her organisation's internal rules on managing a budget was a barrier to efficient use of funding. Organisations are nominated by the Ministry of Health, but they cannot spend funding to hire staff and they must verify that the amount received is spent within the financial year otherwise it goes to state budget. If the project lasts for 36 months, and payments are received at month 1 and month 18, the timeframe may overlap with financial years. On the other hand, a stakeholder from a governmental public health organisation reported that within their agency, a decision had been made - when participating in 3HP financial mechanisms - to *'put the Joint Action as close as possible to the regular organisation'.* Since this decision was made, funds have been utilised more efficiently, adding value to the department. As EU rules cannot be adapted to individual situations, such issues are out of the scope of the Programme, and flexibility is required at national level to overcome such barriers to efficiency.

A5.13 Supplementary information for Q13: Planned focus on thematic priorities which were planned to be addressed by actions in each year of the programme

Baseline assessment

- **Baseline (2014):** In 2HP, more than half of funding was devoted to the Health Promotion objective.
- **Mid-point (2017):** The structure of specific objectives plus thematic priorities allowed for efficient funding distribution, and the Regulation establishing the 3HP provided a basis on which to prioritise the limited funding. Action should be emphasised in areas where the EU added value relates to clear cross-border or internal market issues (or where there are significant advantages or efficiency gains from collaboration at Union level). The balance of funding gradually moved towards the areas addressed under specific objectives 2 (cross-border health threats) and 4 (access to health care), where the case for EU action was clearer and there were more close linkages with EU legislation and cross border issues.

Table 32. Planned focus on thematic priorities

		2014	2015	2016	2017	2018	2019	2020
Health promotion	1.1 Risk factors…							
	1.2 Drugs-related health damage, including information and prevention							
	1.3 HIV/AIDS, tuberculosis and hepatitis							
	1.4 Chronic diseases…							
	1.5 Tobacco legislation							
	1.6 Health information and knowledge system…							
Health threats	2.1 Risk assessment additional capacities for scientific expertise							
	2.2 Capacity building against health threats in Member States…							
	2.3 Implementation of Union legislation…							
	2.4 Health information and knowledge system…							
Health systems	3.1 HTA							
	3.2 Innovation and e-health							
	3.3 Health workforce forecasting and planning							
	3.4 Setting up a mechanism for pooling expertise at Union level							
	3.5 European Innovation Partnership on Active and Healthy Ageing							
	3.6 Implementation of Union legislation…							
	3.7 Health information and knowledge system…							
Better and safer healthcare	4.1 European Reference Networks							
	4.2 Rare diseases							
	4.3 Patient safety and quality of healthcare							
	4.4 Measures to prevent AMR and control healthcare-associated infections							
	4.5 Implementation of Union legislation…							

	4.6 Health information and knowledge system…							

Source: Annual Implementation Reports

A5.14 Supplementary information for Q14

Baseline assessment

- **Baseline (2014): No information found.**
- **Mid-point (2017): No information found.**

Information about stakeholders' views on factors creating differences in costs (or benefits) between 3HP participating countries

In an interview, a national governmental policy maker reported that there was not as much consultation with Member States in 3HP as there is now in the EU4Health (which has been seen as an improvement between the EU health funding programmes). A stakeholder from a governmental public health organisation mentioned that 3HP priorities were shaped partially by Member States, and sometimes the people who were responsible for certain topics did not get on board in time to intervene or have their views included, which meant that at times certain topics would appear higher on the agenda than others. Similarly, the priorities were also based on best practices submitted to the Commission, and it may have been more difficult to identify best practices in bigger countries than in smaller ones. As a result, a few national governmental policy makers felt that the 3HP was not always aligned with national priorities, and therefore Member States did not reply to all calls or chose the activities which were most interesting or most related to their national needs.

A5.15 Supplementary information for Q15

Baseline assessment

- **Baseline (2014):** No specific information available as the simplification measures had not been introduced at this time point.
- **Mid-point (2017):** Simplification measures had been recently introduced at the time of the mid-term evaluation, and they led to cost savings. The measures were largely viewed as positive, however there were some perceived complexities of the application process and reporting requirements during the implementation of funded actions, which may have increased administrative burdens.

Stakeholders' views on administrative burden (Q15b)

Stakeholders consulted also felt that further simplification of administrative processes would be beneficial. One stakeholder from a healthcare service provider/ organisation representing them praised the reduction in paperwork, but felt that locating documents was difficult, especially when trying to find out why a project was declined. Another stakeholder from a healthcare professionals' association highlighted that, prior to the pandemic, some financial officers required face-to-face meetings whereas others allowed e-meetings. The expense of travel was difficult for their small organisation.

Stakeholders' views on communication of simplification measures (EQ15b)

A stakeholder in the governmental public health organisation group reported that awareness or use of simplification measures largely depends on communication from the project officer at DG SANTE or HaDEA and felt that without this communication channel, changes were not known. Alongside information relayed by project officers, information days are run by DG SANTE, where information is provided and applicants are given the opportunity to send follow-up questions on what remains unclear.

A5.16 Supplementary information for Q16(a/b)

Baseline assessment

- **Baseline (2014):** The purpose and use of monitoring data were problematic in 2HP. There was a large burden on action leaders and partners to provide regular reports and data. There was no evidence of monitoring data being used to improve Programme performance. Action reports were technical and often confidential, and so could not be used to communicate about specific actions or the HP more generally. In other words, there were many issues with the efficiency of monitoring processes.
- **Mid-point (2017):** There were improvements in internal monitoring under 3HP, including establishing programmatic indicators and action level e-monitoring. However, there were some issues found with the indicators: programme level indicators were not comprehensive, and action-specific indicators were not used in practice. This may have been because of a lack of confidence in their usefulness.

A stakeholder belonging to the government officials/policy makers group mentioned that experts she worked alongside struggled with the budgeting table due to uncertainty and level of detail required.

A5.17 Supplementary information for Q17

Baseline assessment

- **Baseline (2014):** As with monitoring data, the purpose and use of reporting data were problematic in 2HP, and their efficiency was hindered. There was a large burden on action leaders and partners to provide regular reports, and the outputs of these requirements were not comparable due to a lack of common indicators or formats. In other words, there were many issues with the efficiency of reporting processes.
- **Mid-point (2017):** At the mid-point of the 3HP, there had been some positive improvements to reporting systems, including electronic tools for reporting. However, there were some challenges reported, including that smaller organisations struggled with the complexity and requirements of reporting, and it was difficult for programme managers to report on such a complex programme (i.e. there were many different financing mechanisms operating on different timelines). The mid-term evaluation recommended that DG SANTE and Chafea "implement and use programmatic and action specific monitoring indicators", as the indicators at the time were not comprehensive. The evaluation stressed that it was important to revisit the programmatic indicators to ensure that the key programme goals are covered.

A5.18 Supplementary information for Q18

Baseline assessment

- **Baseline (2014):** Many 2HP actions provided EU added value in some areas, however value was often found in areas with weak tangible policy benefits (e.g. identifying best practices, benchmarking and networking). Added value in terms of innovation and economies of scale was limited. A limitation of 2HP was therefore that actions needed to demonstrate credibly how they would lead to more concrete benefits over the longer term. As the 2HP evaluation report stated, "This requires a stronger focus, for example, on not only identifying good practices, but also addressing barriers to their implementation across Europe."
- **Mid-point (2017):** 3HP refined the areas in which it focused support (such as anti-microbial resistance, e-health, accreditation schemes for breast cancer screening) to ensure it can add value. The inclusion of the EU added value criteria in the regulation and proposal evaluation process also helped to ensure that funded actions considered EU added value from the earliest stage. Further streamlining to the added-value criteria would make the criteria clearer and easier for stakeholders to ensure they address them.

Information about previous evaluations on the EU added value criteria

The European Parliament conducted a mid-term review in 2019 providing an overview of the added value achieved so far through European Union action in the field of health policy. The European Parliament Research Service (EPRS) study found that 3HP was 'highly relevant' to Member States' health needs. Further, 3HP's role in facilitating coordination across Member States in the areas of free movement of persons and responses to cross-border threats and harmonisation of EU patients' rights and public health communication was highlighted as examples of effective EU added value. The 3HP also provided funding for the 'economics of prevention' action with the Commission, the OECD, and WHO to address NCDs, obesity, and harmful alcohol use, promoting EU involvement with international organisations.

Information from this study's consultation activities on 3HP added value in terms of cooperation and coordination among Member States

One stakeholder representing government and policy makers who attended the Procurement Contracts focus group mentioned that the 3HP aimed to support Member States and provide EU added value by encouraging Member States to cooperate with each other. Through the interviews, another government policy maker mentioned that the added value of 3HP comes from cooperation between multi-country institutions as different specialist come together to work on one topic. In relation to Joint Actions, this stakeholder reported that there was also involvement of ministers, and integration with EU policy processes such as uses of council conclusions. Further, this stakeholder noted that Joint Actions enabled the dissemination of results to Member States, bringing EU added value.

However, one stakeholder representing healthcare service providers and organisations who attended the Project Grants focus group mentioned that there can also be difficulties in cooperating between Member States as each of them have different health systems and models at national level.

A5.19 Supplementary information for Q19

Baseline assessment

- **Baseline (2014):** Scoring of applications for 2HP was informed by eight EU added value criteria, which meant a consideration of EU added value was included ex ante. This was done informally for the 2HP, and the Regulation which established the 3HP included the criteria in the legislation itself. As discussed under EQ18, added value was concentrated on best practices, benchmarking and networking, and not as strongly for other criteria such as innovation and economies of scale (that unambiguously require more concrete results).
- **Mid-point (2017):** Including the criteria in the funding application process was a positive development, as most relevant potential beneficiaries and assessment panels consider EU added value when preparing or assessing proposals. Some of the criteria (e.g. those related to sharing best practices, networking and benchmarking) were less outcome-focused than others which made it more difficult to use EU added value to identify potentially beneficial actions. Further, there were some difficulties experienced with the consistency of applications, and with establishing a common understanding of the criteria. Guidance on the criteria could be improved as it was difficult to determine how the scores were allocated and how this influenced funding decisions.

A5.20 Supplementary information for Q20

Baseline assessment

- **Baseline (2014):** *Internal coherence was not thoroughly assessed in the 2HP evaluation.*
- **Mid-point (2017):** There were positive improvements with internal coherence, and the new structure and funding framework was successful and "enabled more concretely defined areas of intervention". The case studies examined in the mid-term evaluation indicated that there were strong synergies between ongoing and previous actions. This was caused partially by the structure of the 3HP and partially by strong programme management and communication and actors exploiting relationships with other stakeholders. The scope of the 3HP was still too broad in some areas, which could cause individual actions to not relate or link closely to each other.

A5.21 Supplementary information for Q21

Baseline assessment

- **Baseline (2014):** 2HP was very coherent with overarching policy objectives in the EU, as it had the potential to contribute to a healthier population and workforce and/or to reducing inequalities. In the latter years of 2HP, efforts were made to address healthy ageing and health inequalities.
- **Mid-point (2017):** See EQ20 for a discussion of internal coherence broadly. In terms of coherence with wider EU policy and international obligations, 3HP strengthened and emphasised the links between economic growth and a healthy population, to bring it in line with Commission policy priorities. There were practical complementarities between the 3HP and research funding (e.g. Horizon 2020), and the 3HP made explicit reference to this funding. However, these synergies could be more systematic.

Information about actions and projects financed under Horizon 2020 and the ESI funds

Examples of projects financed under Horizon 2020 include urgent research on Ebola following the outbreak of Ebola in West Africa in 2014 and research activities in the fields related to antimicrobial resistance.[528]

Examples of actions financed in the context of the ESI funds include the promotion of digital public services through the deployment of e-health solutions (e.g., a mobile app to communicate with healthcare service practitioners and manage medical appointments was developed in a region in Spain, boosting the efficiency, availability and quality of healthcare services throughout the region) and the provision of accessible medical services to vulnerable groups (e.g., provision of access to a comprehensive range of specialised medical services not previously available locally to older residents in the Polish coastal city of Sopot).[529] Furthermore, as a result of the support dispensed by the ERDF up to 2019[530], healthcare services have been improved and made able to benefit a larger share of the population across Europe.

Evidence from this study's consultation on the 3HP coherence with other EU financial instruments

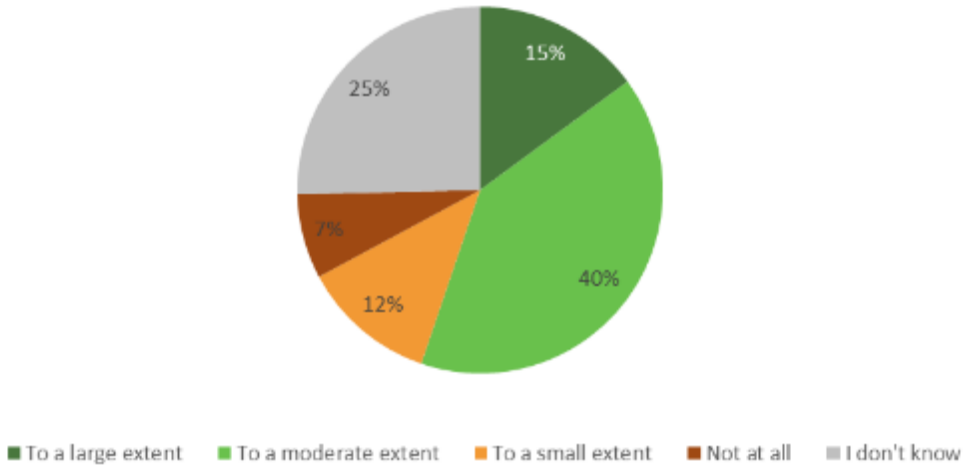
The ability of the 3HP to complement and create synergies with other EU Programmes was agreed upon by respondents to the OPC. As shown in Figure 92 below, a majority of respondents believed that the Programme complemented and/or created synergies with other EU programmes or with wider EU policies, to at least a moderate extent (37 out of 67, responses, 55%). These respondents explained that the Programme was coherent with contributions of the ESI funds and the Horizon 2020 Programme. They added that complementarities between the Programme and these other EU instruments made it possible to investigate every aspect of several topics (e.g., chronic diseases, non-communicable diseases, rare diseases) in-depth. Moreover, an interviewed stakeholder representing

[528] European Commission (2017), Interim Evaluation of Horizon 2020.
[529] European Commission, European Structural and Investment Funds 2014-2020. 2020 Summary report of the programme annual implementation reports covering implementation in 2014-2019.
[530] Activities undertaken as of 2020 are conditioned by the changed needs during the COVID-19 crisis. For this reason, the analysis is based on the ESI Funds report covering implementation in 2014-2019.

governmental public health organisations mentioned that there was a good alignment between the 3HP and Horizon 2020. Similarly, an interviewed national policy maker highlighted that the ESI funds offered a 'huge possibility' to take action in the field of health and that they have actually been used by Member States; however, this places a burden on Member States and is less easy to coordinate as compared to 3HP funded actions.

In contrast, however, some consulted stakeholders (13 out of 67OPC respondents, 19%) stated that the 3HP was not coherent with other EU programmes or with wider EU policies, with a public authority highlighting that programmes were not sufficiently interlinked, for example, with no joint, cross-funding possible. This public authority added that priorities as well as grants and tenders from other EU Programmes were often not known to national delegates of the 3HP.

Figure 92. To what extent did the 3rd Health Programme complement and/or create synergies with other EU programmes or with wider EU polices? (n=67)



Furthermore, some interviewed stakeholders representing government and policy makers, and organisations that represent patients and services users mentioned that coherence and synergies between the 3HP and Horizon 2020 could have been improved. They reported that:

- Synergies between Joint Actions and Horizon 2020 projects were difficult to unlock because the latter programme is more research oriented.
- There could have been more coherence between the 3HP funded actions and Horizon 2020 projects, by way of efforts made to connect the various projects working on similar themes and priorities, potentially limiting duplication of research and results.

Information about the WHO common policy framework Health 2020 and its alignment with the 3HP

The Health 2020 policy framework established two strategic objectives and four priority areas for policy action. These are: 1. Improving health for all and reducing health inequalities (which is reflected in the general objectives of the 3HP[531]); and 2. Improving leadership and participatory governance for health. The four priority areas suggested by the Health 2020 framework[532] and the avenues for action identified in the European Action Plan[533] are broad

[531] European Union., 2014. Regulation (EU) No 282/2014 of the European Parliament and the Council 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/EC. Available from: https://eurlex.europa.eu/legalcontent/EN/TXT/PDF/?uri=CELEX:32014R0282&from=EN. [Accessed November 2021]
[532] 1. Investing in health through a life-course approach and empowering people; 2. Tackling the Region's major health challenges of noncommunicable and communicable diseases; 3. Strengthening people-centred health systems, public health capacity and emergency preparedness, surveillance and response; 4. Creating resilient communities and supportive environments. World Health Organization.,2013. Health 2020: A European policy framework and strategy for the 21st century. Available from: https://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf [Accessed November 2021]
[533] World Health Organization., 2012. European Action Plan for Strengthening Public Health Capacities and Services. Available from: https://www.euro.who.int/__data/assets/pdf_file/0005/171770/RC62wd12rev1-Eng.pdf

topics which can be related to multiple 3HP specific objectives and, within each objective, to different thematic priorities.

Table 33 shows the alignment between the Health 2020 priority areas and activity foci[534] and the 3HP Specific Objectives. The 3HP is aligned to the Health 2020 policy framework, except for a missing clear reference in the Programme's objectives to interlinkages and collaboration between human, animal and environmental health.

Table 33. Health 2020 policy framework and the 3HP

Health 2020 priority area	Health 2020 activity focus	3HP Specific Objective
Investing in health through a life-course approach and empowering people	Health promotion throughout the life-course (e.g. improving health literacy, supporting independent living, healthy food and nutrition, healthy ageing, good mental health)	1. Promote health, prevent disease, and foster healthy lifestyles through 'health in all policies'
Tackling the Region's major health challenges of noncommunicable and communicable diseases	Tackling communicable and non-communicable diseases through health promotion, enhanced information and surveillance capacity and addressing serious viral and bacterial threats	1. Promote health, prevent disease, and foster healthy lifestyles through 'health in all policies'
		2. Protect EU citizens from serious cross-border health threats
Strengthening people-centred health systems, public health capacity and emergency preparedness, surveillance, and response	Universal coverage, primary health care and health professionals	3. Contribute to innovative, efficient, and sustainable health systems 4. Facilitate access to high quality, safe healthcare for EU citizens
	Public health emergencies	2. Protect EU citizens from serious cross-border health threats
Creating resilient communities and supportive environments	Resilient communities	1. Promote health, prevent disease, and foster healthy lifestyles through 'health in all policies'
	Collaboration between human, environmental and animal health	N/A

A5.22 Supplementary information for Q22

Baseline assessment

- **Baseline (2014):** See Q21.
- **Mid-point (2017):** 3HP emphasised coherence with wider EU policies related to economic growth, climate change and the refugee crisis. The mid-term evaluation revealed several examples of synergies between 3HP and Horizon 2020; however, awareness of potential complementarities between 3HP and EU Structural Funds, most importantly the European Social Fund (ESF) and the

[534] The Health 2020 activity foci are extrapolated from the narrative of the report; the list is not exhaustive rather represents an overview of topics addressed by the policy framework.

European Regional Development Fund (ERDF), was not as widespread as for those between 3HP and Horizon 2020.

Information about the coherence of the 3HP with other EU-level policies in the field of health

Table 34 shows a selection of EU health-related initiatives adopted over time and up to 2020 and links the actions to relevant 3HP specific objectives. While each action is associated with a specific 3HP objective, this does not imply that the actions are not relevant or do not contribute to the achievement of other 3HP objectives.

Table 34. Other EU-level health-related policies and 3HP objectives

Other EU policies and activities in the field of health	Third Health Programme Specific Objectives
Before entry into force of 3HP and covering (part of) the reference period (2014-2020)	
Action plan on Organ Donation and Transplantation (2009-2015): Strengthened Cooperation between Member States	4. Facilitate access to high quality, safe healthcare for EU citizens
Activities in the field of patients' rights in cross-border healthcare	3. Contribute to innovative, efficient, and sustainable health systems
Activities in the field of serious cross-border health threats, including the establishment of the Early Warning & Response System	2. Protect EU citizens from serious cross-border health threats
eHealth Action Plan 2012-2020 – Innovative healthcare for the 21st century	3. Contribute to innovative, efficient, and sustainable health systems
Action Plan for the EU Health Workforce	3. Contribute to innovative, efficient, and sustainable health systems
EU Framework on mental health & well-being	N/A
During the implementation of 3HP	
Commission Communication on effective, accessible and resilient health systems	3. Contribute to innovative, efficient, and sustainable health systems
EU Action Plan on Childhood Obesity 2014-2020[535]	1. Promote health, prevent disease, and foster healthy lifestyles through 'health in all policies'
Action Plan on HIV/AIDS in the EU and neighbouring countries: 2014-2016[536]	1. Promote health, prevent disease, and foster healthy lifestyles through 'health in all policies'
Activities in the field of tobacco control	1. Promote health, prevent disease, and foster healthy lifestyles through 'health in all policies'
A European One Health Action Plan against Antimicrobial Resistance (AMR)	4. Facilitate access to high quality, safe healthcare for EU citizens
Commission Communication on enabling the digital transformation of health and care in the	3. Contribute to innovative, efficient, and sustainable health systems

[535] Adopted on 24 February 2014 and further updated on 28 July 2014.
[536] Adopted on 14 March 2014, before the final approval of the Third Health Programme.

Digital Single Market; empowering citizens and building a healthier society	

In addition to the examples represented in Table 34, the 3HP is aligned with the objectives of the EU legal frameworks for medicinal products for human use and for medical devices. These two legal frameworks aim to ensure the quality, safety and efficacy of authorised medicines and medical devices, while also encouraging innovation and facilitating patient access. These objectives are reflected within the structure of the 3HP, which places attention on the implementation of Union legislation in the field of medical devices and medicinal products (thematic priority 3.6) and to patient safety and quality of healthcare (thematic priority 4.3).

Furthermore, some stakeholders representing government and policy makers and governmental public health organisations highlighted there was an alignment with other EU funded actions and policies such as:

- The EU Health Strategy "Together for Health: A Strategic Approach for the EU 2008-2013" (see Q2 for further details on the 3HP alignment with this strategic approach)
- Horizon 2020 (confirming what presented under Q21)
- The Farm to Fork Strategy

Moreover, the documentation reviewed as part of the desk research also indicates that there is alignment between different Commission services in terms of policy direction in the field of health. The analysis described under Q21 points to the external coherence of the 3HP with other EU financial instruments such as the ESI Funds and Horizon 2020. This coherence is also reflected in the policy coordination between different Commission services and between different EU policies and mechanisms involving health.

The European Semester is an example of such policy coordination. As a framework for surveillance and coordination of economic policies across the EU, the European Semester allows Member States to discuss and coordinate national fiscal, economic and social policies under a common annual timeline. Health is included in such a framework. The analysis conducted as part of this study of the Commission's Annual Sustainable Growth Surveys (ASGS)[537] over the period 2014-2020 shows that different health-related priorities have been identified in the context of the European Semester which are aligned with the 3HP objectives over the same period, indicating a strong level of coherence. Among them, a key number are of particular relevance:

- The need to strengthen the efficiency and financial sustainability of healthcare systems while enhancing their effectiveness and accessibility;
- The need to ensure timely access to affordable and high-quality care;
- Effective primary health care services, improved integration of healthcare at the primary, specialised outpatient and hospital care levels and strengthened links with social care to meet the needs of an ageing population;
- Skilled healthcare workforce;
- Better health promotion and disease prevention;
- Greater investment in health innovation and technological development.

The health-related priorities listed above present a strong level of coherence with the specific objectives of the 3HP, in particular with Objective 3 on innovative, efficient and sustainable health systems, but also with Objective 1 on health promotion and disease prevention and Objective 4 on access to high quality and safe healthcare across the EU.

Furthermore, the health-related priorities identified in the context of the European Semester are also reflected in the activity of DG REFORM. Since 2017, DG REFORM has been managing the Structural Reform Support Programme which is the main source of funding for technical support to Member States. The policy recommendations issued by the Commission

[537] The Commission's Annual Sustainable Growth Survey is the document published at the beginning of each European Semester cycle setting out general economic and social priorities for the EU and providing Member States with policy guidance for the following year.

in the context of the European Semester can be followed up on by Member States by requesting support from the Structural Reform Support Programme to implement the identified reforms. The technical support provided by DG REFORM in the area of health focuses on enhancing public health policies and the efficiency and sustainability of health systems, while guaranteeing equitable access to quality services. Examples of support areas include digital health, governance of the healthcare system, health workforce, integration of care and long-term care, access to quality care and more.[538] Those are areas which are covered by the 3HP, in particular under Objective 3 on health systems and Objective 4 on access to care.

The analysis described under Q21 also points to the coherence of the 3HP with the ERDF and Horizon 2020 which are managed respectively by DG REGIO and DG RTD. Through the ERDF, DG REGIO has financed investments in social inclusion across Member States supporting health and social infrastructures, including the modernisation of health systems.[539] This is aligned with Objective 3 of the 3HP which focuses on contributing to innovative, efficient, and sustainable health systems. Health is also an important focus of DG RTD action through the Framework Programmes for Research and Innovation. In particular, through Horizon 2020, DG RTD promotes research on improving health security against infectious diseases and on fostering personalised medicine. DG RTD also focuses on the digital transformation of health and care which is a key element of the Commission's Digital Single Market strategy and on strengthening Europe's position as a global actor in the field of health – DG RTD participated in and led several international initiatives on health such as the International Rare Diseases Research Consortium, the Global Alliance for Chronic Diseases and the Global Research Collaboration for Infectious Disease Preparedness.[540] DG RTD action thus focuses on themes and priorities which are overall aligned with the 3HP objectives, in particular with Objective 2 on serious cross-border health threats and Objective 3 on health systems.

[538] Directorate-General for Structural Reform Support, Labour market, education, health and social services. Available from: https://ec.europa.eu/info/sites/default/files/ht0120285enn.pdf. [Accessed July 2022]
[539] DG Regional and Urban Policy, 2018 Annual Activity Report. Available from: https://ec.europa.eu/info/sites/default/files/regio_aar_2018_final.pdf. [Accessed July 2022]
[540] Directorate-General for Research and Innovation, Management Plan 2019. Available from https://ec.europa.eu/info/sites/default/files/management-plan-rtd-2019_en.pdf. [Accessed July 2022]

A5.23 Supplementary information on analysis of the HaDEA public-facing database on funded actions

Methodology

To extract and compile information on the funded actions listed on the HaDEA public-facing database, we built a web scraper using the open-source programming language Python to initially iterate through the pages on the *Projects* tab. For each page the web scraper "clicked" the *Download: xls* button which downloaded the short form information for each project in Excel format. The downloaded project files were subsequently combined to form a single dataset.

From this dataset we were able to extract the 1,026 IDs that identify each unique funded action. This allowed us to then build a second web scraper that accessed each full-length project page via the url : https://webgate.ec.europa.eu/chafea_pdb/health/projects/projectID/summary (where each individual ID replaced 'projectID'). From this page, the web scraper "clicked" the *Download: XML* button and all 1,026 XML files containing the full project information were collected.

Once the XML files were downloaded, we parsed each XML file to identify the embedded *root*, *nodes* and *tags* which allowed us to extract all the information contained within the files which was then aggregated to form a single output dataset. The information extracted for each project includes:

- Project title and ID
- Project summary page including the abstract and details section
- Project partners page including coordinator and all partners details
- Project work packages page including all text as shown (publicly) on the database
- Project title and ID
- Project summary page including the abstract and details section
- Project partners page including coordinator and all partners details
- Project work packages page including all text as shown (publicly) on the database

A5.23.1 Overview of the database

As of 22/07/2021, there were 1,026 funded actions in the database of which 339 (33%) are from the 3rd Health Programme (see Table 35).

Table 35. Overview of the database

Programme	Number of funded actions in the database	%
3rd Health Programme (2014-2020)	339	33%
Second Programme of Community action in the field of Health (2008-2013)	331	32%
First Programme of Community action in the field of public health (2003-2008)	356	35%
Total	**1026**	**100%**

A5.23.2 Analysis of 3rd Health Programme funded actions

Instruments

The most common instrument across the 3rd Health Programme was Operating Grants (50%), followed by Projects (23%) (see Table 36).

Table 36. Instruments

Instrument	Number of funded actions	%
Operating Grant	170	50%
Project	78	23%
Framework Partnership Agreement	54	16%
Joint Action	27	8%
Presidential Conference	10	3%
Total	**339**	**100%**

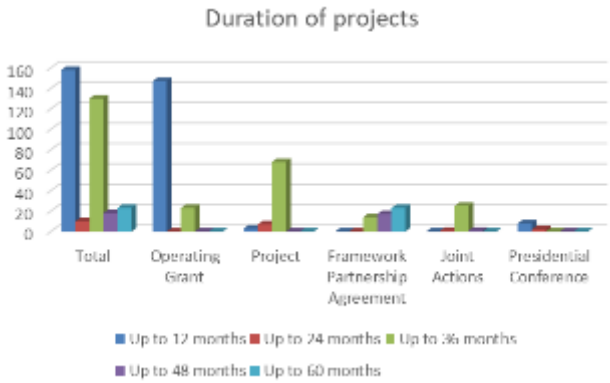
Duration

Funded actions within the 3rd Health Programme varied in length: they lasted between seven months and five years. Just under half (47%) of funded actions had a duration of 12 months or less. This was largely driven by the fact that 96% of operating grants (the most common type of funded actions as shown in Table 36) lasted 12 months.

Just under two in five funded actions (38%) had a duration of up to three years (36 months) (see Table 37). This was largely driven by the fact that 73% of Projects (the second most common type of funded actions as shown in Table 36) lasted 36 months.

Table 37. Duration of funded actions

Duration	Number of funded actions	%
Up to 12 months	158	47%
Up to 24 months	10	3%
Up to 36 months	130	38%
Up to 48 months	18	5%
Up to 60 months	23	7%
Total	**339**	**100%**

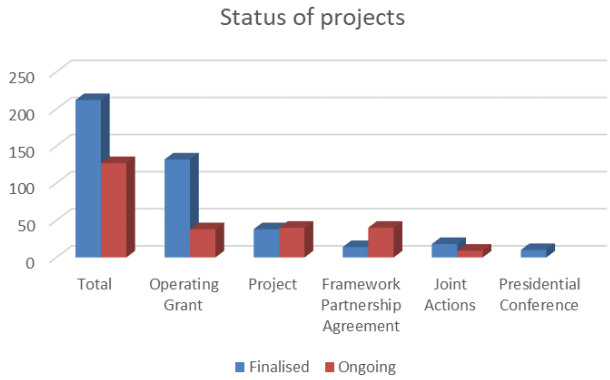


Status

Of the 339 3rd Health Programme funded actions, 63% (212) are finalised and 37% (127) are still ongoing (see Table 38). Almost three quarters (74%) of Framework Partnership Agreements are still ongoing, and so are above half (51%) of Projects. The majority of Operating Grants and Joint Actions are finalised.

Table 38. Share of ongoing vs finished funded actions

Status	Number of funded actions	%
Finalised	212	63%
Ongoing	127	37%
Total	**339**	**100%**

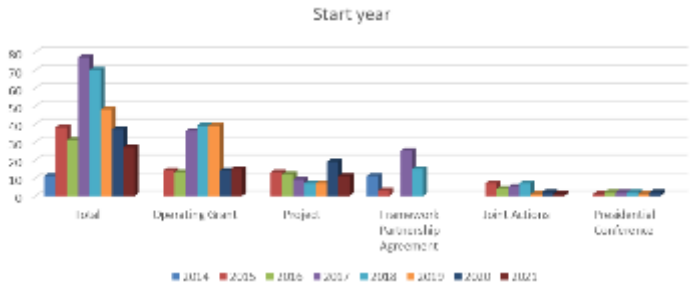


Start year

3rd Health Programme funded actions started between 2014 and 2021. Only 3% of funded actions started in 2014. In 2017, 77 funded actions were started, which was the highest number of funded actions to start in any single year; this was followed by 2018 and 2019 when respectively 70 and 48 funded actions were started (see Table 39). This was largely driven by the fact that 67% of operating grants (the most common type of funded actions as shown in Table 36) started between 2017 and 2019.

Table 39. Start year

Start year	Number of funded actions	%
2014	11	3%
2015	38	11%
2016	31	9%
2017	77	23%
2018	70	21%
2019	48	14%
2020	37	11%
2021	27	8%
Total	**339**	**100%**



Coordinating countries

Across the 3rd Health Programme, there were 25 coordinating countries. The Netherlands coordinated the highest number of funded actions (65), followed by Belgium (55)[541] and France (45). Funded actions coordinated by these three countries represented 49% of all funded actions run under the 3rd Health Programme. Overall, countries in Western Europe were much more likely to coordinate a funded actions than countries in Northern or Eastern Europe. Table 40 shows the number of funded actions coordinated by each of the 25 countries.

Table 40. Funded actions coordinated by country

Country	Number of funded actions	%
NL	65	19%
BE	55	16%
FR	45	13%
DE	36	11%
UK	36	11%
IT	26	8%
ES	16	5%
LU	10	3%
AT	7	2%
DK	7	2%
GR	7	2%
IE	6	2%
CY	5	1%
FI	3	1%
HU	3	1%
PT	2	1%
SI	2	1%
BG	1	0%
HR	1	0%
EE	1	0%
MT	1	0%

[541] 28 of the organisations marked as coordinated by Belgium are pan-European organisations headquartered in Belgium

Country	Number of funded actions	%
NO	1	0%
RO	1	0%
SK	1	0%
SE	1	0%

In 2018, 15 countries started a funded action, which is the highest across the timeframe. The most funded actions started by any one country in a single year was 15 funded actions and these were coordinated by France in 2017 (see Table 41).

Table 41. Number of funded actions by country per year

Country	2014	2015	2016	2017	2018	2019	2020	2021
Austria		2		2	2	1		
Belgium	5	8	7	8	11	5	5	6
Bulgaria				1				
Croatia							1	
Cyprus					2	1	1	1
Denmark				1	2	2	1	1
Estonia				1				
Finland		1				2		
France	1	3	1	15	8	10	6	1
Germany	1	2	1	10	9	6	4	3
Greece		1	1	3	1			1
Hungary		1				1		1
Ireland		2	3	1				
Italy		5	2	5	5	4	3	2
Luxembourg		3	1	1	2	1	1	1
Malta			1					
Netherlands	2	5	4	14	14	10	10	6
Norway								1

Country	2014	2015	2016	2017	2018	2019	2020	2021
Portugal			1		1			
Romania					1			
Slovakia			1					
Slovenia					1		1	
Spain		2	2	6	1	1	3	1
Sweden						1		
United Kingdom	2	3	6	9	10	3	1	2
Total funded actions by year	**11**	**38**	**31**	**77**	**70**	**48**	**37**	**27**
Number of countries starting a funded action in each year	**5**	**13**	**13**	**14**	**15**	**14**	**12**	**13**

The following tables and graphs show the number of funded actions coordinated by each country, broken down by type of instruments.

Table 42. Operating Grants

Country	Number of funded actions	%
BE	36	21%
NL	36	21%
FR	25	15%
UK	23	14%
DE	19	11%
IT	7	4%
LU	7	4%
CY	4	2%
DK	4	2%
AT	3	2%
IE	3	2%
ES	3	2%

Table 43. **Projects**

Country	Number of funded actions	%
NL	15	19%
IT	12	15%
DE	9	12%
ES	9	12%
FR	7	9%
BE	6	8%
UK	6	8%
GR	5	6%
HU	3	4%
IE	2	3%
DK	1	1%
LU	1	1%
PT	1	1%
SE	1	1%

Table 44. Framework Partnership Agreements

Country	Number of funded actions	%
BE	12	22%
NL	12	22%
FR	9	17%
DE	6	11%
UK	5	9%
IT	3	6%
LU	2	4%
AT	1	2%
CY	1	2%
DK	1	2%
IE	1	2%
ES	1	2%

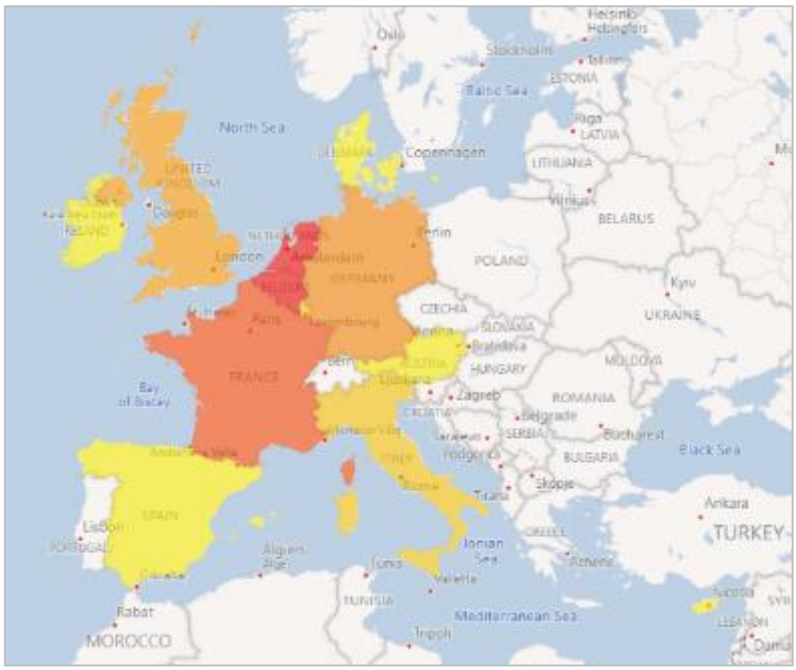


Table 45. Joint Actions

Country	Number of funded actions	%
FR	4	15%
IT	4	15%
ES	3	11%
AT	2	7%
FI	2	7%
GR	2	7%
SI	2	7%
UK	2	7%
BE	1	4%
DK	1	4%
DE	1	4%
NL	1	4%
NO	1	4%
PT	1	4%

Table 46. **Presidential Conferences**

Country	Number of funded actions	%
AU	1	10%
BG	1	10%
HR	1	10%
EE	1	10%
FI	1	10%
DE	1	10%
MT	1	10%
NL	1	10%
RO	1	10%
SK	1	10%

European Commission contribution

In total €224m was distributed through the 3rd Health Programme, an average of €661k per funded action. Funded actions received between less than €1k and €12m.

Only 2% of total EC contributions were distributed in 2014 (which can be explained by the fact only 3% of funded actions started in 2014). Total contributions peaked in 2018 with €37m dispersed (see Table 47). On average, funded actions starting in 2016 were the ones with the highest EC contribution (more than €1m on average per funded action).

Table 47. EC contribution by start year

Start year	EC contribution (EUR)	%	Average EC contribution per funded action (EUR)
2014	3,652,349	2%	332,032
2015	35,683,429	16%	939,038
2016	35,939,126	16%	1,159,327
2017	33,143,103	15%	430,430
2018	37,130,054	17%	530,429
2019	35,231,058	16%	733,980

Start year	EC contribution (EUR)	%	Average EC contribution per funded action (EUR)
2020	23,118,304	10%	624,819
2021	20,284,752	9%	751,287
Total	**224,182,175**	**100%**	**661,304**

The database categorises funded actions by the type of grant received and the contribution level. Funds were distributed through five instruments: Joint Actions received 42% of all contributions, Projects received 29% and Operating Grants received 27% (see Table 48). Joint Actions were the ones that received the highest average EC contribution (almost €3.5m on average per funded action), followed by Projects (more than €800k on average per funded action).

Table 48. EC contribution by instrument

Instrument	EC contribution (EUR)	%	Average EC contribution per funded action (EUR)
Joint Actions	93,793,221	42%	3,473,823
Project	64,266,645	29%	823,931
Operating Grant	60,411,229	27%	355,360
Framework Partnership Agreement	4,879,554	2%	90,362
Presidential Conference	831,527	<0.5%	83,153
Total	**224,182,175**	**100%**	**661,304**

As mentioned above, 25 coordinating countries received EC contributions. France, the Netherlands and Belgium[542] received the highest amount: the contributions they received accounted for 43% of the total amount dispersed (see Table 49).

Table 49. EC contribution by coordinating country

Country	EC contribution (EUR)	%	Average EC contribution per funded action (EUR)
France	32,720,931	15%	727,132
Netherlands	32,441,746	14%	499,104
Belgium	31,331,572	14%	569,665

[542] 28 of the 55 organisations marked as coordinated by Belgium are EU organisations

Country	EC contribution (EUR)	%	Average EC contribution per funded action (EUR)
Spain	22,464,662	10%	1,404,041
Italy	18,899,236	8%	726,894
Germany	16,965,587	8%	471,266
United Kingdom	13,245,873	6%	367,941
Finland	10,999,747	5%	3,666,582
Slovenia	10,500,000	5%	5,250,000
Greece	9,133,076	4%	1,304,725
Norway	4,992,836	2%	4,992,836
Denmark	4,177,351	2%	596,764
Luxembourg	3,701,288	2%	370,129
Austria	3,699,999	2%	528,571
Portugal	2,936,822	1%	1,468,411
Ireland	2,135,506	1%	355,918
Sweden	1,346,155	1%	1,346,155
Cyprus	1,068,601	<0.5%	213,720
Hungary	989,662	<0.5%	329,887
Estonia	148,620	<0.5%	148,620
Malta	100,000	<0.5%	100,000
Romania	66,000	<0.5%	66,000
Bulgaria	61,439	<0.5%	61,439
Slovakia	41,780	<0.5%	41,780
Croatia	13,687	<0.5%	13,687
Total	**224,182,175**	**100%**	**661,304**

Figure 93. Total EC contribution by coordinating country

Figure 94. Average EC contribution per funded action by coordinating country

Funded Actions: keywords

Funded actions in the database are tagged by relevant keywords[543]. In order to gauge the prevalence of keywords across funded actions, all keywords were combined for analysis[544]. There are 853 different keywords across the funded actions and Figure 95 shows the most frequently occurring terms, the top five being *ERN* (which falls under specific objective 4), *Advocacy (*which falls under specific objective 1*)*, *Capacity Building (*which falls under thematic priority 2*)*, *Rare Disease (*which falls under specific objective 4*), and Prevention (*which falls under specific objective 1*)*.

Analysis of keywords was also conducted by Instrument (see Table 50). The keyword *ERN* occurs frequently under the funded actions within Operating Grants, Projects, and Framework Partnership Agreements but not Joint Actions or Presidential Conferences. *Rare Disease* occurs predominantly under the funded actions from Operating Grants and Projects, and *Capacity Building* is frequently tagged in funded actions under Operating Grants and Framework Partnership Agreements but to a lesser extent under Projects. This suggests that there are, to an extent, keyword groupings by Instrument type.

Figure 95. Most used keywords tagged in funded actions

Top 20 keywords across funded actions	
Term	**Count**
Ern	33
Advocacy	32
Capacity Building	32
Rare Disease	27
Prevention	21
Civil Society	20
Network	18
Chronic Disease	16
E-Health	16
Dementia	13
Policy	13
Health Promotion	13
Alzheimer's Disease	13
Health Inequalities	12
Obesity	12
Health	12
Public Health	11
Education	10
Cancer	10
Dissemination	10
Tuberculosis	10
Cancer Prevention	10
Innovation	10

Table 50. Most used keywords tagged in funded actions by Instrument

Instrument	% of all funded actions	Top 3 keywords
Operating Grants	50%	Advocacy, Capacity Building, Ern
Projects	23%	Ern, Interoperability, Registry
Framework Partnership Agreements	16%	Capacity Building, Advocacy, Chronic Disease
Joint Actions	8%	Health, Antimicrobial Resistance, Implementation, Blood, Health Technology Assessment (all used in equal measure)
Presidential Conferences	3%	Alzheimer's Disease, Organ Transplantation (these were used for 2 funded actions, all other keywords were used only once)

From an analysis of keywords by funded action start year, it is possible to see focus area trends across the timeframe. Table 51 shows the most frequent eight keywords and their

[543] It appears a standard corpus was not used to assign keywords so there are varying forms of the same or similar concepts for example, Ehealth/E-health and HTA/Health Technology Assessment. Variations such as these have been standardised so that keywords are more accurately represented in the analysis.
[544] 25 funded actions were not tagged with any keywords

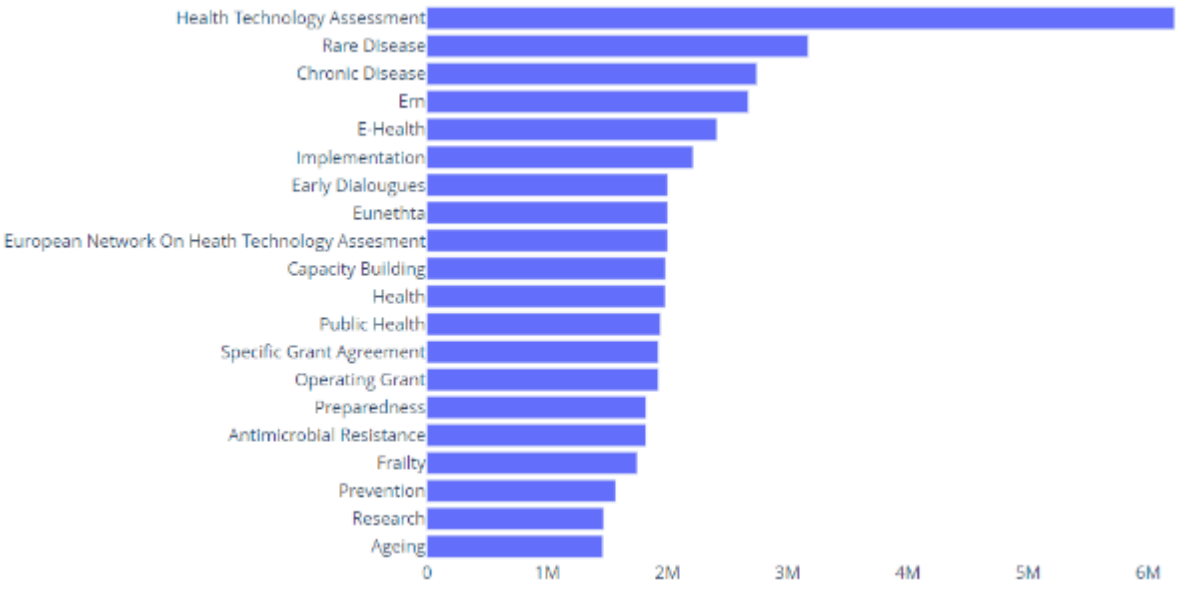
distribution. The usage of *ERN* started in 2016 with a single funded action; this increased across the timeframe to 9 in 2018 and 2019. *Advocacy* peaked in 2018 at 8 and declined to 2 in 2020, the lowest across the timeframe. The most used term in a single year was *Prevention*, which appeared 10 times in 2017.

Table 51. Keywords by start year

Keyword	2014	2015	2016	2017	2018	2019	2020
ERN	0	0	1	8	9	9	6
Advocacy	4	4	4	3	8	3	2
Capacity Building	4	6	5	1	7	3	2
Rare Disease	0	0	1	7	5	5	7
Prevention	2	2	0	10	5	1	0
Civil Society	2	2	2	2	6	3	1
Network	3	3	2	5	1	3	0
Chronic Disease	1	7	1	2	4	1	0

Making the assumption that all keywords used to tag a funded action have equal value within a funded action, it is possible to analyse which keywords, across funded actions, received the highest EC contribution. Figure 96 below shows that *Health Technology Assessment* (which falls under specific objective 3), *Rare Disease* (which falls under specific objective 4), and *Chronic Disease* (which falls under specific objective 1), have the highest value, receiving €6.21m, €3.17m, and €2.74m respectively. From a comparison of these results with the most frequently occurring terms, it is notable that none of the top 5 keywords by frequency contained terms within specific objective 3, however the keyword with the highest EC contribution falls within this specific objective. *Rare disease* is the fourth most prevalent keyword and received the second largest EC contribution. In contrast, *capacity building* is the third most prevalent keyword but only received the tenth highest EC contribution.

Figure 96. EC contribution by keyword



Funded Actions: abstracts

In addition to analysis of funded action keywords, text analysis was conducted on the funded action abstracts. Topic modelling[545] was employed to uncover the underlying topics across

[545] This is an unsupervised machine learning technique that employs computer algorithms tasked with discovering latent topics in text. Because the human eye often cannot discern topical patterns in vast amounts of textual data, the aim of topic modelling is to identify a combination of words that form a topic, which is an abstract concept that requires interpretation

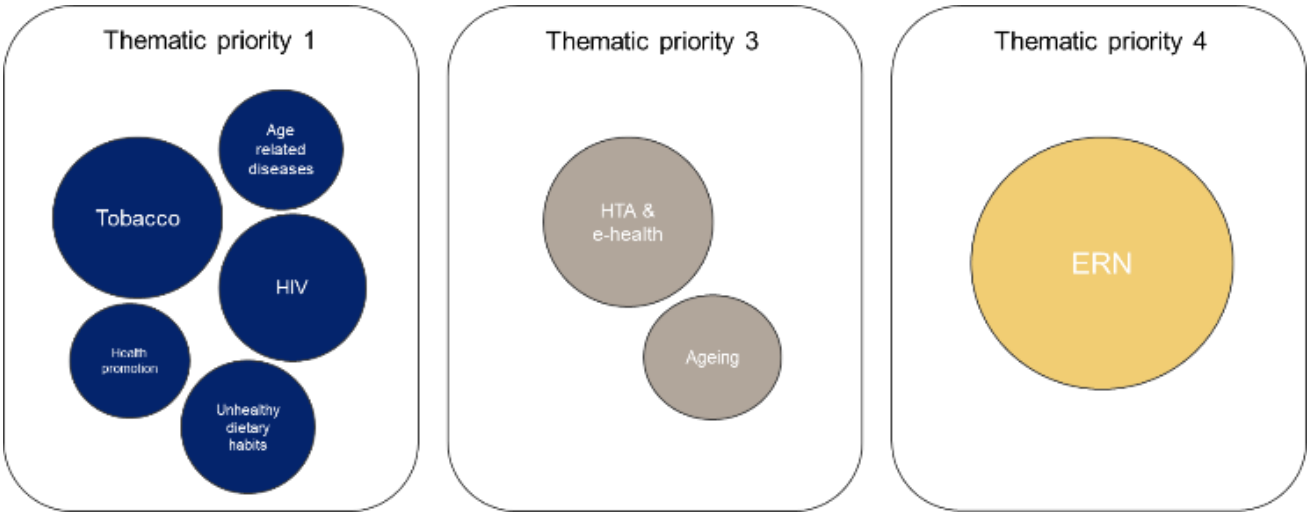
the abstracts and as shown in Table 46, 8 topics were identified. Each topic is represented by a circle, with the circle size used as a proxy for topic size, and circle colour showing thematic priority.

The 'ERN' topic was the largest identified topic with terms captured related to European Reference Networks under thematic priority 4. Five topics were uncovered under thematic priority 1 with the largest being 'Tobacco' followed by 'HIV/AIDS'. The smaller topics under this thematic priority were related to obesity and unhealthy dietary habits, age-related diseases, and health promotion. Under thematic priority 3, 'HTA and e-health' is the largest topic and it is also the second largest topic overall. The second topic under this thematic priority is 'Ageing' with terms related to frailty and care, this is distinct from the age-related diseases topic under thematic priority 1.

The results from this topic analysis suggest that funded actions under thematic priority 4 were concentrated around terms related to European Reference Networks. In contrast, they indicate that the funded actions under thematic priority 1 had a far larger spread across the specific objectives for the thematic priority. The topics covered under thematic priority 3 pertain to several of the specific objectives but the spread is not as comprehensive as those under thematic priority 1.

This text analysis did not yield topics relating to thematic priority 2. As was seen from the analysis of funded action tagged keywords, 'capacity building', a specific objective within thematic priority 2, was frequently used, as was 'cross border' but to a lesser extent. Whilst the presence of these keywords indicates that there were funded actions pertaining to thematic priority 2, topics under this priority did not present. This was either due to a low volume of abstracts containing language relating to this thematic priority or due to a divergence in the language used to discuss the thematic priority which the model did not identify.

Figure 97. Topic extracted from funded action abstracts



Coordinator Country Partner Networks

Coordinator countries worked with partners both inside their own country and internationally. Of the 25 coordinating countries, 19 had one or more partnerships. Funded actions coordinated in Bulgaria, Cyprus, Estonia, Malta, Romania, and Slovakia did not have any partners either domestically or abroad. Table 52 shows the coordinating countries, the number of international partners and the top three countries each coordinating country worked with. Eight coordinating countries had domestic partnerships appear in their top three. Figure 98 shows this network split by funding instrument.

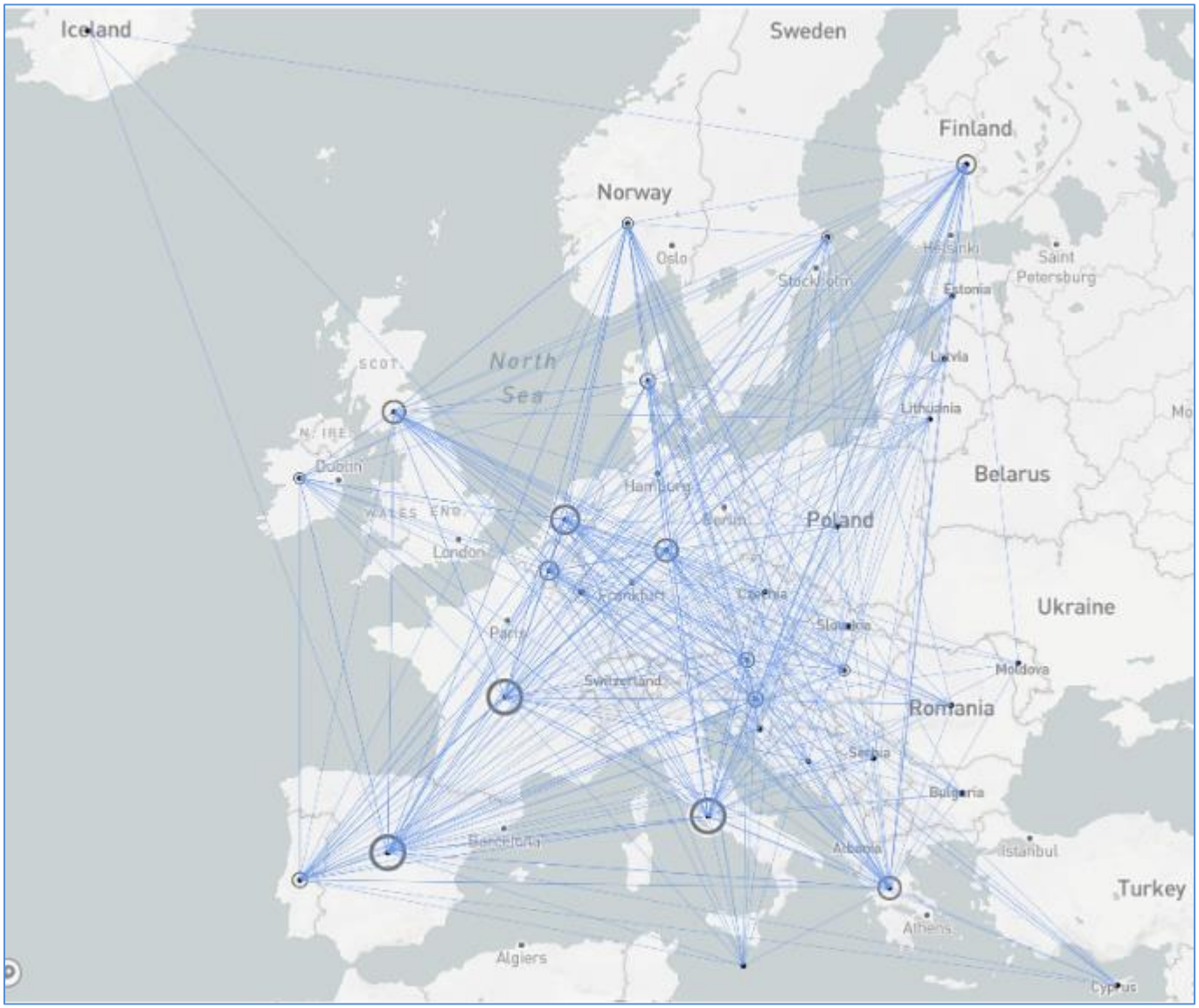
Table 52. Country networks

Coordinator country	Total partner countries	Total number of partners	Most frequent partner	Count of partnerships	Second most frequent partner	Count of partnerships	Third most frequent partner	Count of partnerships
Austria	22	113	Hungary	20	Portugal	13	Croatia	9
Belgium	30	296	Germany	28	Belgium	23	United Kingdom	21
Croatia	1	1	Croatia	1				
Denmark	17	114	Spain	19	Greece	16	Lithuania	14
Finland	27	206	Germany	23	Denmark	21	Spain	18
France	30	667	Spain	77	France	59	Netherlands	45
Germany	28	358	Italy	42	Spain	39	Germany	30
Greece	29	344	Greece	36	Netherlands	34	United Kingdom	29
Hungary	8	29	Italy	7	Czech Republic	5	Norway	5
Ireland	7	31	United Kingdom	15	Netherlands	4	Romania	4
Italy	31	627	Spain	75	Italy	62	France	58
Luxembourg	3	7	Slovenia	4	Germany	2	Estonia	1
Netherlands	30	538	Spain	72	Germany	62	United Kingdom	61
Norway	17	42	Belgium	7	Slovenia	6	France	4
Portugal	21	99	Spain	12	Hungary	9	Lithuania	8
Slovenia	28	150	France	12	Germany	11	Poland	11
Spain	31	685	Spain	78	Italy	76	Hungary	51
Sweden	9	37	Denmark	7	Lithuania	5	Portugal	5
United Kingdom	23	306	United Kingdom	40	Spain	38	Italy	32

Within country partnerships

To show the interconnectivity between coordinating countries and partner countries, a network analysis was built. The full network can be seen in the Figure 98 below. The circle size is representative of the total number of partners each coordinating country has. Spain, Italy, and France for example have the highest.

Figure 98. Interconnectivity between coordinating countries and partner countries



A5.23.3 Specific information on Joint Actions (3rd Health Programme funded actions)

The table below provides information on all 27 Joint Actions mentioned in the public-facing HaDEA database on funded actions. Details on status, EC contribution and coordinator are available.

Table 53. Background information on Joint Actions

Title	Acronym	Status	EC contribution (EUR)	Coordinator	Coordinator country
Strengthened International Health Regulations and Preparedness in the EU – Joint Action	SHARP JA	Ongoing	7,900,000	Terveyden Ja Hyvinvoinnin Laitos	Finland
European Joint Action on Vaccination	EU-JAV	Ongoing	3,530,232	Institut National De La Sante Et De La Recherche Medicale	France
Joint Action Health Equity Europe	JAHEE	Ongoing	2,499,997	Istituto Superiore Di Sanita	Italy
Joint Action supporting the eHealth Network	eHAction	Finalised	2,699,978	Bundesministerium Fuer Gesundheit (BMG)	Austria
Preparedness and action at points of entry	Healthy Gateways	Ongoing	3,000,000	Panepistimio Thessalias	Greece
Facilitating the authorisation of Preparation Process for blood and tissues and cells	GAPP	Ongoing	1,199,824	Istituto Superiore Di Sanita	Italy

Title	Acronym	Status	EC contribution (EUR)	Coordinator	Coordinator country
Innovative Partnership for Action Against Cancer	iPAAC	Ongoing	4,500,000	Nacionalni Institut Za Javno Zdravje	Slovenia
Information for Action	InfAct	Finalised	3,999,191	Sciensano	Belgium
Joint Action on Tobacco Control	JATC	Finalised	1,995,334	Hellenic Cancer Society	Greece
Joint Action on integrating prevention, testing and linkage to care strategies for HIV, viral hepatitis, TB and STIs in Europe (INTEGRATE)	INTEGRATE	Finalised	1,999,877	Region Hovedstaden	Denmark
CHRODIS-PLUS: Implementing good practices for chronic diseases	CHRODIS-PLUS	Finalised	5,000,000	Instituto De Salud Carlos III	Spain
European Joint Action on antimicrobial resistance and associated infections	EU-JAMRAI	Finalised	4,178,163	Institut National de la Sante et de la Recherche Medicale	France
Joint Action to Strengthen Health preparedness and response to Biological	JA TERROR	Ongoing	4,992,836	Helsedirektorate	Norway

Title	Acronym	Status	EC contribution (EUR)	Coordinator	Coordinator country
and Chemical terror attacks.					
Joint Action on implementation of digitally enabled integrated person-centred care	JADECARE	Ongoing	3,999,226	Kronikgune Institute for Health Services Research	Spain
Joint Action on Implementation of Validated Best Practices in Nutrition	Best-ReMaP	Ongoing	6,000,000	Nacionalni Institut Za Javno Zdravje	Slovenia
Managing Frailty. A comprehensive approach to promote a disability-free advanced age in Europe: the ADVANTAGE initiative	ADVANTAGE	Finalised	3,442,455	Servicio Madrileno De Salud	Spain
Market surveillance of medical devices	JAMS	Finalised	849,488	Medicines And Healthcare Products Regulatory Agency	United Kingdom
Joint Action on Rare Cancers	JARC	Finalised	1,499,848	Fondazione Irccs Istituto Nazionale Dei Tumori	Italy
European Network for Health Technology Assessment	EUnetHTA JA3	Finalised	#########	Zorginstituut Nederland	Netherlands

Title	Acronym	Status	EC contribution (EUR)	Coordinator	Coordinator country
(EUnetHTA) – Joint Action 3					
Joint Action on Dementia 2015-2018	DEM 2	Finalised	1,498,710	Scottish Government	United Kingdom
Joint Market Surveillance Actions on medical devices intended to be re-sterilized focusing on information in the Instruction for use and validation data necessary for the re-sterilisation by the user	COENJA2014	Finalised	199,999	Bundesamt Fuer Sicherheit Im Gesundheitswesen	Austria
Vigilance and Inspection for the Safety of Transfusion, Assisted Reproduction and Transplantation	VISTART	Finalised	2,328,664	Istituto Superiore Di Sanita	Italy
Joint Action on HIV and Co-infection Prevention and Harm Reduction	HA-REACT	Finalised	2,999,747	Terveyden Ja Hyvinvoinnin Laitos	Finland
Joint Action on Nutrition and Physical Activity	JANPA	Finalised	1,200,000	Agence Nationale de le Sécurité Sanitaire de l'Alimentation, de l'Environnement et du Travail	France

Title	Acronym	Status	EC contribution (EUR)	Coordinator	Coordinator country
Efficient response to highly dangerous and emerging pathogens at EU level	EMERGE	Finalised	3,499,873	Robert Koch Institute	Germany
Promoting Implementation of Recommendations on Policy, Information and Data for Rare Diseases	RD-ACTION	Finalised	4,379,979	Institut National de la Sante et de la Recherche Medicale	France
Joint Action to support the eHealth Network	JaseHN	Finalised	2,400,000	Bundesministerium Fuer Gesundheit (BMG)	Austria

Analysis of 2nd Health Programme funded actions not finished by 01 January 2014

There are 148 actions in the database which were funded under the 2nd Health Programme but were not finalised by 1 January 2014. Below is an analysis of these 148 actions.

Instruments – selected 2HP funded actions

The most common instrument was Projects (43%), followed by Operating Grants (26%).

Table 54. Instruments

Instrument	Number of funded actions	%
Project	64	43%
Operating Grant	39	26%
Joint Action	23	16%
Conference	22	15%
Total	**148**	**100%**

Duration – selected 2HP funded actions

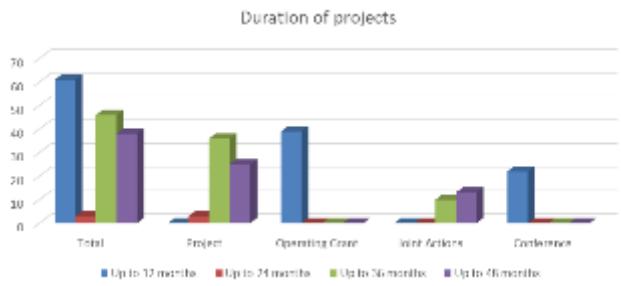
Funded actions varied in length: they lasted between less than a month and four years.

41% of funded actions had a duration of 12 months or less. This was largely driven by the fact that all of operating grants (the second most common type of funded actions) lasted 12 months.

31% had a duration of up to three years (36 months). This was largely driven by the fact that 45% of Projects (the most common type of funded actions) lasted 36 months.

Table 55. Duration of funded actions

Duration	Number of funded actions	%
Up to 12 months	61	41%
Up to 24 months	3	2%
Up to 36 months	46	31%
Up to 48 months	38	26%
Total	**148**	**100%**



Status – selected 2HP funded actions

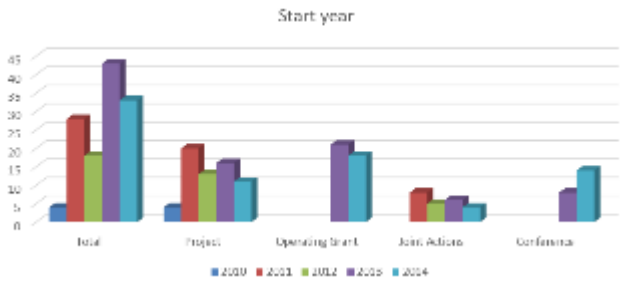
Of the 148 2d Health Programme funded actions, all are finalised.

Start year – selected 2HP funded actions

Funded actions started between 2010 and 2014.

Table 56. Start year – selected 2HP funded actions

Start year	Number of funded actions	%
2010	4	3%
2011	28	19%
2012	18	12%
2013	43	29%
2014	33	22%
Total	**148**	**100%**



Coordinating countries – selected 2HP funded actions

Across the funded, there were 19 coordinating countries. The Netherlands coordinated the highest number of funded actions (21), followed by Italy (19) and Belgium (18). Funded actions coordinated by these three countries represented 39% of all funded actions considered.

Table 57. Funded actions coordinated by country – selected 2HP funded actions

Country	Number of funded actions	%
NL	21	14%
IT	19	13%
BE	18	12%
UK	18	12%
FR	14	9%
ES	14	9%
DE	12	8%
DK	6	4%
SI	5	3%
AT	4	3%
LU	4	3%
GR	2	1%
IE	2	1%

Country	Number of funded actions	%
PL	2	1%
PT	2	1%
SE	2	1%
EE	1	1%
FI	1	1%
LT	1	1%

European Commission (EC) contribution – selected 2HP funded actions

In total €119m was distributed through the 148 funded actions considered, an average of €805k per funded action. Funded actions received between less than €1k and €6.6m.

Only 3% of total EC contributions were distributed in actions starting in 2010 (which can be explained by the fact only 3% of funded actions started in 2010). Total contributions peaked in 2011 and 2012. On average, funded actions starting in 2013 and 2014 received lower EC contribution.

Table 58. EC contribution by start year

Start year	EC contribution (EUR)	%	Average EC contribution per funded action (EUR)
2010	4,116,544	3%	1,029,136
2011	30,823,908	26%	1,100,854
2012	26,111,841	22%	1,450,658
2013	30,841,815	26%	604,741
2014	27,344,561	23%	581,799
Total	**119,238,668**	**100%**	**805,667**

The database categorises funded actions by the type of grant received and the contribution level. Funds were distributed through four instruments: Projects received 47% of all contributions and Joint Actions received 45%. Joint Actions were the ones that received the highest average EC contribution (€2.3m on average per funded action).

Table 59. EC contribution by instrument – selected 2HP funded actions

Instrument	EC contribution (EUR)	%	Average EC contribution per funded action (EUR)
Project	55,910,025	47%	873,594
Operating Grant	8,265,039	7%	211,924
Joint Action	53,499,973	45%	2,326,086
Conference	1,563,631	1%	71,074
Total	**119,238,668**	**100%**	**805,667**

As mentioned above, 19 coordinating countries received EC contributions. The United Kingdom, Spain and France received the highest amount: the contributions they received accounted for 39% of the total amount dispersed.

Table 60. EC contribution by coordinating country – selected 2HP funded actions

Country	EC contribution (EUR)	%	Average EC contribution per funded action (EUR)
United Kingdom	16,398,275	14%	911,015
Spain	16,110,922	14%	1,150,780
France	14,180,159	12%	1,012,868
Germany	11,649,012	10%	970,751
Netherlands	11,439,648	10%	544,745
Italy	10,461,938	9%	550,628
Slovenia	8,945,031	8%	1,789,006
Belgium	8,887,054	7%	493,725
Denmark	7,677,862	6%	1,279,644
Portugal	3,025,571	3%	1,512,786
Austria	2,839,152	2%	709,788
Greece	2,403,842	2%	1,201,921
Sweden	1,479,768	1%	739,884
Poland	1,473,872	1%	736,936

Country	EC contribution (EUR)	%	Average EC contribution per funded action (EUR)
Estonia	694,693	1%	694,693
Luxembourg	655,168	1%	163,792
Finland	616,063	1%	616,063
Ireland	254,650	<0.5%	127,325
Lithuania	45,989	<0.5%	45,989
Total	**119,238,668**	**100%**	**805,667**

Table 61. Updated list of sources identified by document type

Document Type	Status
3HP Implementation documentation	
Annual Work Plans	**Reviewed**
Previous Health Programme Evaluations	**Reviewed**
European Commission documentation related to Health Programme implementation	All available documents have been reviewed. **DG SANTE to provide the following additional sources if possible:** - 3HP communication strategy - European Commission documents on the EU added value criteria applied to 3HP funding proposals - Commission reports on improved results of funded actions - Programme statements for 2014, 2015, 2016, 2017, and 2018 - Other internal documents on programme implementation, including applicant packs / guidance and further administrative information on the functioning of the programme -
3HP Funded Action Reports, including project final reports	**Mostly reviewed**. Final reports to be examined for a selection of actions in the next phase, pending access to the non-publicly facing components of the HaDEA database.
Annual reports from NGOs that received an operating grant	Not reviewed. **DG SANTE to provide if applicable.**

Relevant EU Committee meeting minutes	**Partially reviewed**. The minutes of the HPC have been reviewed and relevant points have been integrated in this report. Minutes of the plenary meetings of the Expert Panel on Effective Ways of Investing in Health during the period 2013-2021[546] were originally planned for review. However, we reviewed a sample of the minutes & assessed their usefulness but didn't extract information from them due to limited details and as other sources were more relevant. DG SANTE to provide relevant minutes from other meetings if applicable.
Member State level data on funding received and costs	**Not reviewed**: DG SANTE to provide if applicable.
Strategic Documents (policies/reports) to understand relevance of the 3HP	
Relevant European Commission policy documentation[547], in particular related to DG SANTE, DG RTD, DG REGIO, DG EMPL	**Mostly reviewed**. A few types of documents outstanding from DG SANTE if applicable: - Documents on European Structural and Investment Funds - Commission documents on costs linked to other programmes - European Commission reports on other EU programmes and financial instruments - Commission level (internal) reports on policy coordination
European Commission Press Releases	**Partially reviewed**. The study team determined that press releases were not relevant to review, as they were often short summaries of reports/initiatives and did not provide substantial evidence to analyse against the evaluation questions.
SGPP reports	**Partially reviewed**. Many SGPP reports were reviewed for this report, however immediately prior to the submission of the present interim report, DG SANTE provided many other documents. These will be reviewed in the later stages of this study.
International Institution Reports (WHO, OECD)	**Reviewed**
Health strategies of all Member States and third countries[548]	**Reviewed**

[546] European Commission., 2013. Expert Panel on effective ways of investing in health-Events. Available from: https://ec.europa.eu/health/expert-panel-effective-ways-investing-health/events_en?f%5B0%5D=topic_topic%3A141. [Accessed November 2021].
[547] Note that the OECD country health profiles were originally included in this category, however as these mainly use Eurostat data, it is not necessary to review them all individually as we are reviewing Eurostat data directly.
[548] Similar to the mid-term evaluation, the priorities of the eligible countries' health strategies will be extracted in order to form a picture of the most relevant health concerns in the countries during the implementation of 3HP. For countries without a single

EU-level collected data on health indicators to help understand the relevance of the 3HP	
EU-level data (Eurobarometer, Eurostat)	**Reviewed**
Sustainable Development Goal indicators related to health	**Reviewed**
To be determined	
Documents requested from case study area experts within DG-SANTE and HaDEA	To be sent throughout consultation period
Recommendations for documents to review during interviews with National Focal Points and Programme Committee Members	To be sent throughout consultation period
Documents received from stakeholders through HPP or mentioned in the consultation activities of the study.	To be sent throughout consultation period

national health strategy, we will also consider specific health strategies such as HIV/AIDS action plans. We will map the priorities according to the year a plan was drafted, for example to track the inclusion of "cancer" in strategies year-by-year.

A5.24 Information on the allocation of funding within the 3HP

Table 62 illustrates the planned contributions to the 3HP by year. The maximum Union contribution for the implementation of the work programme increased steadily by year, with the 2020 contribution being roughly EUR 11 M higher than the 2014 contribution. The estimated additional contributions from EFTA countries for their participation in the programme decreased in the first few years to a minimum of roughly EUR 15.5 M in 2018, but then increased again in 2019 and 2020. Estimated additional contributions from other non-EU countries for their participation in the programme were reported in 2017-2020 and were mainly consistent at EUR 203820. Finally, the Maximum Union contribution to the WHO Framework Convention on Tobacco Control ranged from EUR 200 000 to EUR 230 000, without much variation year-to-year.

Table 62. Planned contributions by year (EUR)

	Maximum Union contribution for the implementation of the work programme	Estimated additional contributions from EFTA countries for their participation in the programme	Estimated additional contributions from other non-EU countries for their participation in the programme	Maximum Union contribution to the WHO Framework Convention on Tobacco Control
2014	58579000	1757370		200000
2015	59750000	1756650		210000
2016	62160000	1696968		200000
2017	64529000	1574508	148877	200000
2018	66373500	1546502	203820	230000
2019	68308000	1625730	203820	230000
2020	69674000	1679143	203820	220000

Source: Annual Work Programmes (acts/decisions)

A5.24.1 Comparison of planned to actual spend by project type and year

Table 63. Comparison of planned to actual spend by project type and year 3HP

		Project grants, including other DGA projects*	Operating grants for NGOs	Joint actions	Conference grants to Member States holding the EU Presidency	DGA (International Organisations)	Procurement (service contracts), prizes and horizontal actions	Other actions	Grant procedures via a cross sub-delegation to Eurostat	Action grants
2014	Planned	12300000	4650000	18593000	200000	2750000	12279100	2184000	1500000	
	Actual	12677193.08	4716099.8	18506972.39	157901	3849825.96	12769292.44	1273793.04		
2015	Planned	9000000	4650000	17850000	200000	2715000	16483805	3731000	1000000	
	Actual	14944000.04	5005520	17791725.6	120434.9	3835747.29	11635413.52	1445177.40		
2016	Planned	13050000	4800000	13800000	200000	4450000	14973112	6719000		
	Actual	8795212.04	5142328	14376881.83	141780.43	4450000	16089842.38	3313500.00		
2017	Planned	4850000	5000000	19700000	200000	9300000	14401585	6952500		
	Actual	0	5811912.4	20229410.14	210059	9300000	14580482.75	5427001.92		

		Project grants, including other DGA projects*	Operating grants for NGOs	Joint actions	Conference grants to Member States holding the EU Presidency	DGA (International Organisations)	Procurement (service contracts), prizes and horizontal actions	Other actions	Grant procedures via a cross sub-delegation to Eurostat	Action grants
2018	Planned	24090000	5000000	7900000	200000	2700000	14790701	7399000		
	Actual	11095795.01	5887958.53	7900000	166000	4020000	8924955.22	9636503.09		
2019	Planned	6000000	5000000	15000000	200000	5750000	24300560	7893000		
	Actual	5774147.36	5434283	14992063	113687	5750000	24359690.04	7438839.29		
2020	Planned	0	5000000	0	0	0	15965158	12241000		32155000
	Actual	7452705.51	5852209	12398329.25	162984.92	5730000	26263292.21	7171302.51		

Source: AWPs and AIRs per year

A5.25 Comparison of actions identified as having high added value to the thematic priorities of the 4th Health Programme

Actions with the highest added value		Thematic priorities of EU4Health[549]
Mid-term assessment	ESF+ and EGF Impact Assessment[550].	
Health Technology Assessments	Technical assistance to Member States aimed at enabling health systems reforms in key areas such as HTA and eHealth	**Strengthen health systems, their resilience and resource efficiency** • Improving health data and promote the uptake of digital tools and services and the digital transformation of healthcare systems • Promoting the implementation of best practices and data sharing • Improving access to quality, patient-centred, outcome-based healthcare and related care services • Supporting integrated work among national health systems
Health information and country knowledge	Work on EU cancer information system including the cancer registries (which provide information on treatments and outcomes), and more generally data and information collection, use of big data and real-world data, to inform EU and Member States' health policy actions	
Capacity building in Member States for responding to cross-border health threats	Development of common methodologies and tools for integrated work (e.g., for the new HTA framework) and the deployment of capacity building actions (e.g. development of HTA capacity in Member States lacking this at the moment).	**Protect people in the Union from serious cross-border threats to health** • Strengthening the capability of the Union for prevention, preparedness and response to cross-border health threats • Supporting actions complementing national stockpiling on essential crisis relevant products • Training a reserve of medical, healthcare and support staff
This topic was not listed as an area of highest added value in this source	AMR Action Plan promotes collaboration with national authorities to reach the objectives from a one health perspective and in support of Member States' national action plans.	**Improve and foster health in the Union** • Actions on disease prevention, health promotion and for addressing health determinants • Supporting global commitments and health initiatives
The establishment of European Reference Networks	*This topic was not listed as an area of highest added value in this source*	*Presumably these networks will continue as part of EU4Health.*
	The "State of Health in Europe" cycle	*Presumably this cycle will continue as part of EU4Health.*

[549] European Commission. (n.d.). EU4Health programme for a healthier and safer Union. Available from: https://ec.europa.eu/health/sites/default/files/funding/docs/eu4health_factsheet_en.pdf [Accessed November 2021]
[550] European Commission., 2018. COMMISSION STAFF WORKING DOCUMENT: IMPACT ASSESSMENT: Accompanying the document: Proposal for a Regulation of the European Parliament and the Council on the European Social Fund Plus (ESF+); Proposal for a Regulation of the European Parliament and the Council on the European Globalisation Adjustment Fund (EGF). Available from: https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=SWD:2018:0289:FIN:EN:PDF [Accessed November 2021]

Actions with the highest added value		Thematic priorities of EU4Health[549]
Mid-term assessment	ESF+ and EGF Impact Assessment[550].	
This topic was not listed as an area of highest added value in this source	*This topic was not listed as an area of highest added value in this source*	**Make medicines available and affordable** • Encouraging sustainable production, supply chains and innovation in the Union and supporting the prudent and efficient use of medicinal products

From this table, we found that EU4Health considered previous recommendations, for example the sub-objective “Strengthening the capability of the Union for prevention, preparedness and response to cross-border health threats” is highly aligned to a similar recommendation from the 3HP mid-term evaluation.

A5.26 OR: Spending by thematic priority and year (EUR)

Thematic priority	2014	2015	2016	2017	2018	2019	2020	Total
1.1	5161137	4734413	13895121.78	9665157.82	5797949.53	18354446.1	5058200	62666425.23
1.2	0	0	599511.79	0	0	0	0	599511.79
1.3	3347213.09	5275309.89	2818716.08	868325.6	640708	638186	664227	14252685.66
1.4	6559737.18	777731	4894530.22	7475680	7576133.13	774178	795753	28853742.53
1.5	1045724.72	815580	1614437.2	829338	1721630	985695	4079061.78	11091466.7
1.6	1099825.96	449037.24	1800000	3443976.32	0	0	500000	7292839.52
2.1	0	0	35000	0	0	0	0	35000
2.2	1802209.4	1398928.8	3912709.3	7198549.97	7900000	8058630.32	3933955.42	34204983.21
2.3	3499873	0	0	0	0	0		3499873
2.4	0	0	0	0	0	0		0
3.1	178158.42	11999798.74	383400	113035.7	0	0	2999664	15674056.86
3.2	2400000	0	283950	2699989.67	750000	804720	3462984.92	10401644.59
3.3	195350	150000	976730	0	0	0	1936269.13	3258349.13
3.4	258720	1044960	1040000	804945.25	872394	4407080.3	7593655	16021754.55
3.5	5356220.25	6837798.31	0	0	0	0	0	12194018.56
3.6	3647343.4	3775871.85	3611416.8	8642189.27	4462864.09	6322830.47	12280461.31	42742977.19
3.7	4552058.26	1298495.45	2360160	5799191.48	2337580	3938412	3206500	23492397.19
4.1	1511273.15	381372.23	6397982.11	6330343.66	18670820.3	6623097.39	5457058.21	45371947.05

4.2	5149979	2291869.04	3321162.39	1325613	4520713.53	1315547	1336935	19261818.96
4.3	903112	956054.9	741846	0	450000	0	0	3051012.9
4.4	14703	440000	4178162.75	600000	66000	5777758	0	11076623.75
4.5	3074635.2	1908627	253000	304611	1747721	328187.15	766850	8383631.35
4.6	0	150000	0	0	0	0	150000	300000
CHAFEA — communication	121811.66	0	0	0	0	0		121811.66
SANTE — IT	4071993.02	0	0	0	0	0		4071993.02
NFPs	0	0	0	0	0	0	1999905.59	1999905.59
Prizes	0	0	0	0	60000	300000	300000	660000
Dissemination	0	0	0	0	246032.85	625035.58	0	871068.43
Expert evaluators	0	0	0	0	97659	175246.37	110197.7	383103.07
Horizontal/ ICT/dissemination (In 2017, this also included evaluation call for proposals)	0	2857971.72	3578052.41	3962231.38	3404049.55	4433661.29	8399145.34	26635111.69

Annex 6 Consultation summary reports

A6.1 Overall synopsis report and annex

- **Table of Contents**

1. Introduction

This document provides a synopsis or summary of the consultation activities conducted under the *Study to support the ex-post evaluation of the European Commission's 3rd Health Programme 2014-2020*. It was prepared in accordance with the Better Regulation Guidelines Tool 55.[551]

This report is structured as follows:

623 Section 2 presents the approach to the consultations
624 Section 3 provides an overview of the results.

2. Approach to the consultation

The objective of the consultations was to collect qualitative and quantitative information from stakeholders on their views of the 3rd Health Programme (3HP).

2.1. Stakeholder selection

Eight stakeholder groups (policymakers, governmental public health organisations, international public health organisations, academic and research organisations, non-governmental organisations, healthcare service providers and organisations representing them, healthcare professionals' associations, and patients and services users and organisations representing them) were identified by the study team. The study team then aligned these categories with the groups set out in the Open Public Consultation (OPC) typology, which are already set by DG SANTE, to ensure comparability during the analysis and reporting phase of the study.

Stakeholders were identified using the public-facing database[552] for the Programme. The study team exported all stakeholder organisations from this database using a web scraper developed by the team and cleaned the dataset. This enabled us to get a longlist of stakeholder organisations who participated in the 3HP. DG SANTE also shared the contact details of the National Focal Points and of some Programme Committee members who had agreed to be contacted for the study. While the study team web scraped the organisations of all those who received funding through grants, there may have been gaps in the list for stakeholders who received other types of funding (e.g. via Procurement Contracts). This was because such information was not stored in the public facing database nor was there a list that could be shared with us for the purposes of the consultation exercise. Further, specific named contacts were not available in the public-facing database. Therefore, the team conducted desk research to collate publicly available contact names and email addresses from the websites of the identified organisations and through other desk review sources. In some cases, the study team asked for assistance from HaDEA and DG SANTE to review the list to ensure it complied with their understanding of the 3HP's stakeholders, to identify missing stakeholders and/or fill gaps in the contact details.

The lists of stakeholders contacted can be found in Annex 1. An overview of the stakeholder groups invited to participate in the consultations is show in Table 64.

Table 64. Summary of stakeholders contacted through the consultations

Cross-cutting stakeholders contacted for all consultations		
Additional stakeholders	603[553]	9

[551] https://ec.europa.eu/info/sites/default/files/file_import/better-regulation-toolbox-55_en_0.pdf

552 European Commission (2022) Health Programme Database. Available at: https://webgate.ec.europa.eu/chafea_pdb/health/

[553] The "additional stakeholders" from the survey were: companies/business organisations; consumer organisations; lead or partner organisations of funded actions; EU citizens; independent thematic experts; and public authorities.

Group-specific contact for individual consultations		
Type of organisation	**Targeted survey and OPC**	**Interviews**
Policymakers (EU institutions, national government representatives)	100[554]	43
Governmental public health organisations		83
International public health organisations	23	5
Academic and research organisations	15	6
Non-governmental organisations	53	7
Healthcare service providers and organisations representing them	14	4
Healthcare professionals' associations	22	9
Patients and services users and organisations representing them	0	7
TOTAL	**830[555]**	**173**

2.2. Consultation activities

2.2.1. Advertising the consultations

13. The study team created and used a Stakeholder Network[556] on the Health Policy Platform[557] to disseminate information on the consultation activities. The study team copied key information onto the AGORA network[558] so that all stakeholders could have the chance to participate in the consultation activities. This information was mirrored in the weekly Health Policy Platform newsletters.

14. In order to increase the number of responses, communication around the consultations was brief and informative, clearly outlining the importance of the consultations and encouraging participation, as well as clearly illustrating how to participate. The communications asked respondents to share the information amongst their own network, encouraging their peers to participate in the consultations.

15. The first email sent to stakeholders included an explanation on key details including: (a) details of the study; (b) consent procedures for taking part in the study (it was

[554] Stakeholders for the survey were identified as "public authorities"

[555] This figure does not include a generic mailing sent from our survey software tool to 143 general stakeholder contacts. These contacts were gathered as part of the general stakeholder mapping.

556 Network gathering health stakeholders on specific health policy areas

557 European Commission (2022) Health Policy Platform. Accessible : https://webgate.ec.europa.eu/hpf/#:~:text=The%20EU%20Health%20Policy%20Platform%20is%20an%20interactive%20tool%20to,actions%20among%20a%20wide%20audience.

558 Online space accessible to all users of the Health Policy Platform

clearly stated that taking part in this research was voluntary); (c) attribution of information (information and quotes were not attributed to individuals, unless explicitly approved); and (d) audio-recording of the interviews and focus groups (for accuracy and note-taking purposes, and only with specific consent). This was also accompanied by an accreditation letter from DG SANTE.

As the OPC and the survey were launched simultaneously, communications around these activities sought to clearly highlight the difference between the OPC and the targeted survey (to ensure participants were aware of the most appropriate method for them to provide their views). In addition, to make sure that participants responded to the most relevant questionnaire (either OPC or target survey), there was a filtering question at the start of both questionnaires on whether the participant (or their organisation) had been directly involved in the Programme design or implementation. If it became apparent that the respondent was using the wrong questionnaire, a prompt appeared encouraging them to switch to the other consultation activity.

Table 65 details the activities undertaken to boost the response rate to the consultations. Further information about actions taken to reach the target stakeholder groups is provided in Annex 2.

Table 65 – Activities undertaken to advertise the consultations

Consultation method	Activities undertaken to advertise the consultation
OPC	- Emails from ICF to all contacts in the database collated by ICF - Emails from DG SANTE to their stakeholders (including all members of the Programme Committee) and the contact database collated by ICF - The Health Programme webpage: https://ec.europa.eu/chafea/health/funding/index_en.htm - DG SANTE webpage: https://ec.europa.eu/info/departments/health-and-food-safety_en - The Health Policy Platform: https://webgate.ec.europa.eu/hpf/ (and the HPP newsletter)
Survey	- Emails from DG SANTE to their stakeholders and the contact database collated by ICF - Advertisements on the Health Policy Platform including the Stakeholder Network for the study and the Agora Network which were mirrored in the Health Policy Platform newsletter
Interviews	- Emails from ICF to selected contacts in the database collated by ICF - Asking interviewees to advertise the study to their network

Focus groups	- Emails from ICF to selected contacts in the database collated by ICF - Focus group participants sharing the invitation email with contacts who were involved in their funded action - Focus group participants were given the opportunity to do a follow-on interview if they had further feedback to provide - ICF worked with DG SANTE to identify the most suitable stakeholders for the focus group with EU institutions on Procurement contracts and all funding mechanisms

2.2.2. Targeted survey

The purpose of the targeted survey was to collect evidence on the views and perceptions of those with direct experience of the Programme regarding its relevance and implementation and performance. The survey was targeted at those who were directly involved in the Programme design and/ or implementation (including those who received funding from the Programme) and could therefore answer specific questions about 3HP implementation and performance.

Identification and recruitment of participants

The identification and recruitment of participants was in line with section 2.2.1 on contacting stakeholders.

Conducting the targeted survey

The targeted survey was implemented using ICF's survey platform (Qualtrics). Before participating in the survey, respondents were provided with a privacy statement to ensure they were informed of their rights under the General Data Protection Regulation (GDPR)[559] in relation to the collection and retention of their data and that they understood that their participation was on a voluntary basis. The collected personal data and all information related to the consultation were recorded in a secured and protected database hosted at ICF's secure data centre within the European Union. The database is not accessible from outside ICF. Inside ICF, the database can be accessed using a User-ID/Password. Any data transferred between ICF and DG SANTE was done using the secure file-sharing system OneDrive, which is produced and maintained by Microsoft.

The study team kept the survey open from 10 March to 13 May 2022. The survey was originally planned to be kept open from 10 March to 21 April. Despite multiple email reminders, there was a lack of response from stakeholders, and so the survey deadline was extended to 6 May. The study team sent out two email communications to stakeholders, one to all contacts notifying them of the extension and encouraging their participation, and another tailored to those who had started but not completed the survey. For this latter group, the study team offered tailored support including organising a phone call to fill in the survey with them, or to organise an interview instead. The study team also provided Word versions of the questionnaire when requested so that multiple people within an organisation could contribute to the survey submission. The survey deadline was then extended again to 13 May to encourage more participants to take part. All stakeholders were informed of this including those who had started but not completed the

559 https://gdpr-info.eu/

survey. DG SANTE also emailed all stakeholders identified in the ICF contacts file to encourage participation.

Analysis

The questions asked in the survey covered the following themes: effectiveness, efficiency, relevance, coherence, and EU added value. Analysis included: cross-tabulations of closed answer questions and qualitative analysis of additional textual feedback provided by respondents in open answer questions and through position papers uploaded to support their responses. Manual qualitative analysis was used to provide insight into the themes being discussed.

2.2.3. Open Public Consultation

An Open Public Consultation (OPC) was undertaken to provide the general public and all interested parties with the opportunity to provide information and opinions on the matters to be addressed in the study. The OPC was targeted at all those who have an interest in the 3HP but who had not necessarily been directly involved in the Programme design or implementation. Questions were therefore relatively high-level, exploring the overall perception of the Programme, and its relevance to broader health needs and objectives. The OPC asked respondents to give their view on the effectiveness, efficiency, relevance, EU added value and coherence of the Programme.

Identification and recruitment of participants

Steps taken to identify stakeholders can be found in section 2.2.1.

Conducting the OPC

The OPC was carried out using the EU Survey tool. The OPC was made accessible from the Health Policy Platform site of the European Commission: https://webgate.ec.europa.eu/hpf/.

The OPC was launched on 10 March 2022. The OPC was originally planned to close on 3 June 2022. However, during the last 2-3 days before closure of the OPC, DG SANTE's server was down and the online questionnaire was inaccessible to respondents. DG SANTE therefore extended the deadline by 1 week to 10 June.

Analysis

The analysis of the OPC included: cross-tabulations of closed answer questions and qualitative analysis of additional textual feedback provided by respondents in open answer questions and through position papers uploaded to support their responses. Manual qualitative analysis was used to provide insight into the themes being discussed.

2.2.4. Interviews

Targeted telephone interviews aimed to help the study team to understand in more depth the design and implementation of the 3HP. The interviews were also used to help us cross-check findings drawn from other data collection tasks and fill gaps in evidence collected through other tasks or where the study team identified contradictory evidence.

Identification and recruitment of participants

The study team selected potential interviewees based on their field of knowledge and expertise, their level of involvement with the Programme and on their likely ability to provide information on key issues of the evaluation. Accordingly, interviewers tailored the questions for each interview to explore specific points, rather than aiming to cover all aspects of the evaluation with each interviewee. In this way, the study team aimed to make maximum and efficient use of the time-constrained consultation period and of the resources available.

16. The study team planned to carry out up to 45 interviews and anticipated speaking with representatives from eight stakeholder groups to ensure the consultation activity was representative of different perspectives. The study team proposed to conduct the most interviews with government policymakers since these include the national focal points who were pivotal in shaping Programme priorities. The study team also proposed to conduct a large number of interviews with national public health organisations as they also played a vital role in bringing health-specific knowledge and understanding at MS level. For the remaining stakeholder groups, the study team allocated two or three interviews each. The study team also allocated a few interviews to be used as needed across the stakeholder groups based on response rate and gaps in the study.
17. Once a stakeholder responded to the invitation, the study team followed up with a short questionnaire to facilitate tailoring of the topic guides. The study team also followed up by email to schedule a telephone call or virtual meeting (as preferred by the stakeholder) and find a suitable date and time for an interview.

After being invited to interview, each stakeholder that did not respond to the invitation was contacted up to three additional times. A detailed log of all invited interviewees, contacts and consent was systematically stored on password protected computers, which helped ensure effective and efficient interview scheduling.

Conducting the interviews

The interviews followed a semi-structured topic guide, tailored to the involvement of the stakeholder in the Programme. Each interview was conducted by phone or Microsoft Teams. Each interview lasted approximately 40-60 minutes. The working language of the interviews was English.

A high-level summary of topics to be covered in the interviews (in the form of an abridged topic guide) was sent to interviewees in advance, to allow time for interviewees to prepare.

Interviews were recorded upon interviewee's consent. Recordings were stored on secure servers during the study to ensure the completeness and accuracy of qualitative and quantitative data collected.

Analysis

A summary of key points was drafted by the interviewer after each interview using the audio-recording to identify specific details and obtain direct quotes where needed. Interview write-ups were analysed thematically in order to match points discussed in each interview to the questions in the study's analytical framework. This was done per stakeholder group to allow analysis per group.

2.2.5. Focus groups

The objective of the focus groups was to gain further insight into the main funding mechanisms of the 3HP.

The study team conducted five focus groups, covering each of Project Grants, Operating Grants, Joint Actions, Procurement contracts, and a final focus group on all funding mechanisms. Due to a lack of participation and availability of DG SANTE and HaDEA staff, the fifth focus group was concluded early, and follow-up interviews were scheduled instead.

Identification and recruitment of participants

There is no fixed ideal number of participants for a focus group, as this depends on the level of experience of the participants, how sensitive the topic is, how complex the questions are, and how long the team has for the discussion. For each focus group, the study team aimed to recruit between 5 and 12 participants. Recruiting a

minimum of five participants meant that the study team had enough participants to engage in a meaningful discussion and gather sufficient feedback from a variety of stakeholders. Limiting the focus groups to a maximum of 12 participants meant that participants would be more comfortable and willing to speak, that each participant could have an opportunity to share insights and observation, and facilitators could more efficiently moderate the discussion so that it stayed on topic.

When a stakeholder responded to the invitation, the study team followed up with an email with further information including an agenda for the focus group and asking for the name and contact email of any colleagues who may want to attend with them. The link to join the focus group and a guidance note was then shared in advance with all attendees. For each focus group, the study team kept a detailed log of all invited participants responses. After being invited to the focus group, each stakeholder that did not respond to the invitation was contacted up to three additional times.

Conducting the focus groups

The focus groups took place virtually, online. The benefit of this was that more individuals were able to participate and from different locations. The study team conducted the focus groups via Microsoft Teams and used tools such as Sli.do which allowed for instant polls, word-clouds and quantification of stakeholder feedback.

In advance of the focus groups, the study team provided a guidance note to participants so they could consider the topics of the focus group in advance.

The focus groups started with a presentation on the 3HP with emerging findings from the study to date, a plenary session to discuss overall views of the Programme and the specific funding mechanism in question, followed by sub-groups to discuss specific evaluation criteria, and finally a plenary session to share views as a group. Each focus group lasted for up to 4 hours depending on the topics to be covered and the participation of attendees.

Analysis

Notes about the discussions in the plenary sessions and breakout rooms were summarised in a report for each focus group. These reports were organised by evaluation question to enable findings to be easily integrated into the main report.

Limitations

The **online survey** and **OPC** yielded fewer replies than anticipated, despite a dissemination campaign and reminder emails. This may be due to a lack of engagement by stakeholders and other contextual factors (including delays to the overall study timeline, the study being run after the launch of the new health programme, and thus a risk of de-prioritisation of the previous programme). A larger number of survey responses would have provided greater depth to the qualitative analysis, but the coverage of stakeholder interests was good, with no obvious gaps (see section 3 for further details).

Similarly, for the **stakeholder interviews**, multiple invitations were sent to stakeholders from 30 March 2021 to 27 June2021, however targets per stakeholder group were not met for two groups: government policymakers, and healthcare service providers and organisations representing them. The target for government policymakers was 20 and 10 interviews were conducted; the target for healthcare service providers and organisations representing them was 2-3, and 1 interview was conducted. While the target was to have 45 participants in the interviews, despite substantial attempts to engage with stakeholders, 34 stakeholders participated in total. This figure includes follow-up interviews which were scheduled to compensate for a focus group with DG SANTE staff on 'Procurement contracts' and 'All funding mechanisms'. This is because the participation from DG SANTE was limited due to lack of staff availability.

3. Overview of contributions

18. The sample of organisations consulted with covered a range of sectors, engagement with the Programme and geographic areas. All the key stakeholder groups were covered by at least one activity.

Targeted Survey

While no specific quota was set, the study team aimed to receive at least 70 responses (the number received in the mid-term evaluation). Due to a lack of engagement by stakeholders and other contextual factors, a total of 32 fully completed responses was received. Most of these came from public authorities (20 responses, 62%), half of which were from central government or a ministry of health (10 responses, 50%) and the other half were public health authorities or agencies (10 responses, 50%). Seven responses were also received from non-governmental organisations (22%), and five from academic/research organisations (16%). No responses were received from consumer organisations, or from company/business associations.

Almost three quarters of survey respondents (23 responses, 72%) worked for an organisation focused on only one country, while the rest (9 responses, 29%) worked for an organisation with a pan-European or international focus.

Almost all survey respondents were either directly involved in the implementation of the Programme (16 responses, 50%), or stakeholders who benefitted from the Programme (14 responses, 44%). Only one stakeholder directly involved in the design of the Programme responded to the survey (3%), and only one respondent said they were not directly involved in the Programme but only had an interest in it (3%). No responses were received from stakeholders directly involved in the evaluation of the Programme.

Respondents who said they were directly involved in the Programme or benefited from it were asked about their awareness of the different types of funding instruments. Almost all said they were aware of Joint Actions (30 responses, 97%). Most respondents were also aware of Project Grants (20, 65%) and Operating Grants (13, 42%). However, less than a third of respondents were aware of the Health Policy Platform and Health Award/Health Prizes (11, 35%), and even fewer knew about Direct Grants to international organisations (8, 26%) and Procurements Contracts (7, 23%).

Out of the 32 respondents, a majority (20 responses, 63%) had been involved in the management and administration of an action from the Programme (e.g. filled in an application form).

Open Public Consultation

Whereas no specific quota was set, the study team aimed to receive at least 133 responses (the number received in the mid-term evaluation).

Due to a lack of engagement by stakeholders and other contextual factors, a total of 69 responses were received to the OPC. Three responses were identical (including responses to open-ended questions), and so they were considered as one response. Analysis therefore focused on 67 responses. More than a quarter of these came from public authorities (18 responses, 27%). These public authorities were mostly national (14 responses), but a few answers were also received from local public authorities (2 responses), as well as regional or international authorities (1 response each). Eleven of these were public health authorities or agencies, and seven were central governments or ministries of health. Responses were also received from EU citizens and academic/research institutions (16 responses each, 24%), and from NGOs (15 responses, 22%). In addition, a few responses were received from companies/business organisations (2 responses, 3%).

Respondents came from 22 different countries (AT, BE, BG, CH, CY, CZ, DE, DK, EL, ES, FI, FR, HR, IE, IT, LT, PL, PT, SE, SI, SK, UK). The most commonly represented countries were Spain (11 responses, 16%), Belgium and Italy (7 responses each, 10%) and Poland (6 responses, 9%).

Just over half of respondents said that they had applied for funding from the Programme (34 responses, 51%). Just over a third said that they had not applied for funding through the Programme (23 responses, 34%) and the rest either said they were not aware, or that the question was not applicable to them (10 responses, 14%). More than four in ten respondents said that they had received funding from the Programme (28 responses, 42%). Almost half of respondents said they had never received funding (30 responses, 45%) and the rest said they did not know (9 responses, 13%).

The type of funding instruments that were most familiar to respondents was Joint Actions (26 responses, 39%), followed by Project Grants (20 responses, 30%) and Operating Grants (8 responses, 12%). Only five or fewer respondents said they wre familiar with the Health Policy Platform and Health Award/Health Prize (5 responses, 7%), Direct Grants to international organisations (3 responses, 4%) or Procurement Contracts (1 response, 1%). More than half of respondents did not provide an answer to this question. Unsurprisingly, when asked about what types of funding instruments they benefitted from, respondents cited the same instruments: Joint Actions (20 responses, 30%), Project Grants (13 responses, 19%), and Operating Grants (3 responses, 4%).

Interviews

An overview of the type of stakeholders who participated in the interviews is shown in 0.

Table 66 Stakeholder interview participants

Types of stakeholders	Number of participants
Policymakers (EU institutions, national government representatives)	10
Governmental public health organisations	7
International public health organisations	2
Academic and research organisations	4
Non-governmental organisations	4
Healthcare professionals' associations	4
Healthcare service providers and organisations representing them	1
Patients and service users and organisations representing them	2
Totals	**34**

Focus Groups

There were between 3-10 participants at each focus group (Table 67). Overall, the groups tended to be somewhat homogenous, however this was intentional as only certain groups have used certain mechanisms under the 3HP. For example, Operating Grants were given to NGOs, so NGO representatives comprised most of the focus group participants on this topic.

Table 67 Focus group participants

	1: Project Grants	2: Operating Grants	3: Procurement contracts	4: Joint Actions	5: Procurement mechanisms	Total
Government policymakers	1		8	2	3	**11***
Governmental public health organisations	1			4		**5**
International public health organisations						**0**
Academic and research organisations	1			4		**5**
Non-governmental organisations	2	8		0		**10**
Healthcare service providers and organisations representing them	2	1				**3**
Healthcare professionals' associations						**0**
Patients and services users and organisations representing them						**0**
Total	**7**	**9**	**8**	**10**	**3**	**37**

**Note the three participants in focus group 5 were also present at focus group 3, therefore the totals do not sum*

There were no stakeholders at any focus groups from the following stakeholder groups: international public health organisations, healthcare professionals' associations, and patients and services users and organisations representing them. Further information about the distribution of participants by focus group is given below:

- 1 (Project Grants): Attendees worked for seven different organisations and had taken part in seven projects.
- 2 (Operating Grants): Three of the participants were from the same NGO.
- 3 (Procurement Contracts): All but one participant were from DG SANTE. The remaining participant was from HaDEA.

- 4 (Joint Actions): Attendees were from seven organisations (three organisations had two representatives each). Attendees represented seven Joint Actions.
- 5 (All funding mechanisms): All attendees were from DG SANTE.

4. Analysis of the replies

The following subsections summarise the evidence collected and analysed across the consultation activities.

Relevance

During the implementation of the 3HP, the main health needs in the EU related to health promotion and better and safer healthcare. An interviewed academic / research stakeholder, as well as a few NGOs, reported that the promotion of healthy behaviours (objective 1) was a key health need in the EU.[560] There were also some reported key health needs which related to objective 4 (better and safer healthcare), for example an academic / research stakeholder reported that visibility of rare diseases was a key healthcare need. Some interviewed stakeholders[561] also reported that health and social inequalities represent a key health need in the EU as there are health differences across regions and socio-economic groups. There were also a few identified needs under objective 3 (health systems).[562]

The 3HP has largely been relevant to these key health needs in the EU. More than three quarters of OPC respondents said that the 3HP correctly identified the health and healthcare needs and problems at the time of its development, to at least a moderate extent (52 responses, 77%). Similarly, a large majority of survey respondents said that all four of the Programme's specific objectives were relevant in relation to EU health needs at the time of the Programme's development. OPC respondents and interviewees[563] believed that all four of the Programme's specific objectives were very relevant in relation to EU health needs. In the OPC, objective 1 was rated as the most relevant to EU health needs (46 responses, 69%). Objective 1 was also deemed relevant by most survey respondents (29 out of 32 or 91%). In the survey, objective 3 was seen as the most relevant out of the four priorities, with almost all respondents considering it was relevant to at least a moderate extent (31 out of 32, 97%).

There were some factors about the 3HP which enabled the Programme to address the most important health needs. In interviews, some government policy makers (at the regional, national, and EU level) reported that the 3HP was aligned with national-level priorities potentially due to the involvement of participating countries in designing parts of 3HP. In the focus group on procurement mechanisms, a government and policy maker reported that each unit in their organisation contributed to defining the Health Programmes, ensuring that health needs are covered throughout the Programme because all policy units are involved.

The 3HP has for the most part remained relevant to changes in health needs over time. In the survey, respondents were asked about the extent to which the Programme's specific objectives had remained relevant over time. More than two thirds (20 responses,

[560] For example a stakeholder from an organisation representing patients and services users reported the main healthcare needs included a lack of accessibility of PrEP (a preventative drug for HIV), and a need to reduce stigma and discrimination related to HIV and AIDS.
[561] Including an academic / research stakeholder, a governmental public health organisation, and an organisation representing patients and services users
[562] Including a lack of training in certain procedures or conditions or about health inequalities (academic / research stakeholder; healthcare professionals' organisation) and a lack of capacity to monitor and/or respond to serious cross-border health threats (academic / research stakeholder; governmental public health organisation).
[563] Including some governmental policy makers and governmental public health organisations, a few stakeholders from organisations representing patients and services users, an academic / research stakeholder, a stakeholder from an healthcare professionals' organisation, and a stakeholder from an organisation representing healthcare service providers

67%) said that objective 2 had become more relevant over time, mainly due to new and emerging cross-border health threats during the time of the Programme[564] and the severity of communicable diseases. This was a higher proportion than for the other three specific objectives (between 12 and 13 responses, or between 39% and 42%). One specific change in health needs was that in 2015, the EU was impacted by increased migration; some governmental public health organisations felt this need was addressed, however some stakeholders[565] reported that refugee and migrant health was not a topic adequately addressed by the 3HP. Another major health challenge during the period of the 3HP was the Covid-19 pandemic, and for the most part stakeholders[566] felt this need was well-addressed. However, in the focus groups on Project Grants, a governmental public health organisation reported it would have been beneficial if the 3HP had more leeway to act on unanticipated priorities through contingency funding.

***There were some limiting factors to the relevance of the 3HP overall*.** Overall, a few stakeholders[567] indicated that the objectives of the 3HP were not always as aligned to key health needs as they could have been. A few governmental public health organisations reported that healthcare needs were not addressed because of factors to do with participating countries, for example the countries were not involved enough, or experienced financial difficulties which hindered their ability to participate in activities. Another somewhat commonly reported limitation to the relevance of the 3HP was insufficient funding.[568] Most stakeholders consulted in the focus group on Project Grants considered that the thematic priorities of the 3HP were too broad.

***There were a few notable topics or needs which the 3HP did not adequately address*.** In the OPC, a large proportion of respondents said that some relevant problems or needs were not identified by the Programme at the time of its development (30 responses, 45%). Some consulted stakeholders[569] did not feel the 3HP adequately addressed needs related to health inequalities. For example, a few stakeholders from an organisation representing patients and service users also reported the work on access to healthcare and health inequalities has not been done comprehensively, particularly around patient empowerment. A few stakeholders[570] also reported the 3HP did not adequately address mental health or wellbeing. OPC respondents said that although the Programme acknowledged the high prevalence of mental health problems, they felt that the issue was not extensively included as a key thematic priority in and of itself. They added that the Programme could have been a key tool in integrating a psychosocial approach to mental wellbeing, taking into account and linking to the social and environmental factors that undeniably play a role in community positive mental health. Some stakeholders also reported the 3HP did not adequately address environmental issues[571], including interplays between the climate and health, as key health needs in the EU.

***There was clear alignment between funded actions and the specific thematic priorities set out by the Programme*.** In the survey and interviews[572], a large majority of respondents said that the Programme's funded actions were aligned with the Programme's four specific objectives. In particular, 85% of respondents to the survey said actions were aligned to a large or moderate extent with objective 1. However, a national

[564] A note in the survey indicated to respondents that Covid-19 was not in the scope of this study. However, respondents did mention Covid-19 as a factor explaining why this specific objective became more relevant over time. Other factors mentioned by respondents included cross-border movement/migrations, globalisation and environmental threats.
[565] An interviewed academic stakeholder and participants in the focus group on Project Grants.
[566] Academic / research stakeholders; stakeholder from an organisation representing patients and services users; NGO
[567] including a few governmental public health organisations, a few NGOs, and a few healthcare professionals' organisations
[568] Reported by an NGO and a stakeholder from a healthcare professionals' organisation
[569] OPC respondents; interviewed governmental public health organisation; A few stakeholders from an organisation representing patients and services users; academic / research stakeholders
[570] an interviewed academic / research stakeholder and participants in the focus group on Project Grants
[571] academic / research stakeholder and a governmental public health organisation
[572] an academic / research stakeholder, a few governmental policy makers and governmental public health organisations, a stakeholder from an organisation representing patients and services users

governmental policy maker reported that some objectives of 3HP were implemented or used more than others. For example, actions related to health security (objective 2) were not used often. Two EU-level policy makers reported that the objectives and thematic priorities were very broad and wide-reaching, therefore it was not possible to address them all with the same level of intensity or funding.

***The funded actions were also aligned with the Commission's wider priorities*.** In the survey, a large majority of respondents said that the 3HP's thematic priorities were relevant to the Commission's wider priorities to a large (36%) or moderate extent(30%). More than 30% of respondents said the Programme's thematic priorities were relevant to a large extent to the following two Commission's wider priorities: "Promoting our European Way of Life" and "Europe 2020 strategy for smart, sustainable and inclusive growth". Notably, there were large rates of "I don't know" responses to this question (between 10-33% of respondents varying by Commission priority), illustrating how those involved with 3HP may not have been aware of the Commission's wider priorities.

***The 3HP has largely been relevant to citizens' needs*.** In the survey, almost 90% of respondents believed that the Programme's thematic priorities were relevant in light of citizens' perceptions of key health issues in the EU, to at least a moderate extent (28 responses, 89%). Similarly, almost 90% of respondents believed that the Programme responded to citizens' health needs, to at least a moderate extent (27 responses, 86%). However, a national public authority involved in the Programme implementation said that these were not relevant at all due to a mismatch of health priorities between the Programme and the national context, citing that, in their country, the waiting list to receive medical services was a greater problem and that this was not resolved by the Programme thematic priorities. Two EU-level NGOs who benefitted from the Programme noted that the funding opportunities for childhood cancer were valuable but insufficient to address the magnitude of the issues in this disease area.

***There has been some variation in the engagement of citizens with the 3HP*.** Some interviewees reported there were differences in the engagement of citizens in the 3HP. A few stakeholders reported that there were differences across the Member States in the participation and effectiveness of work relating to migrants (academic / research stakeholder). An NGO reported that Balkan countries are facing severe funding problems and are struggling with more basic services, and different countries have different needs and interests. Further, a stakeholder from an organisation representing patients and services users reported there has not been much investment in disseminating the Programme, which has limited citizen engagement. Interestingly, a stakeholder from an organisation representing patients and services users reported that in many cases citizens may be engaged in actions of the Programme but not know there is a Programme behind it.

Effectiveness

Consulted stakeholders reported that overall, the 3HP contributed to a more comprehensive and uniform approach to health issues across the EU. A majority of targeted survey respondents (20 respondents, 63%) and OPC respondents (37 responses, 55%) believed that measures implemented by Member States were aligned with the specific objectives and thematic priorities of the 3HP, at least to a moderate extent. Similarly, most survey respondents believed that national programmes and actions reflected evidence and evidence-based approaches developed through 3HP funding (23 respondents said this was true to at least a moderate extent, 72%).

However, some limitations exist mostly due to national differences in terms of organisation of health systems and national priorities. Some stakeholders who contributed to the OPC noted limitations to the alignment of measures implemented by Member States with the specific objectives and thematic priorities of the 3HP, mostly due

to the fact that national health systems are complex and sometimes fragmented infrastructures and national priorities do not always reflect 3HP priorities.

Overall, consulted stakeholders reported that the knowledge produced by the 3HP was used in policymaking and the 3HP contributed to improvements in health and healthcare in the EU and at Member State level. For instance, several interviewed national policymakers reported that actions funded under the 3HP, including Joint Actions and other funded projects, influenced national strategies, helped establish national plans and create national legislation. Moreover, 79% of survey respondents believed that the 3HP actions led to new knowledge and evidence which were used in the development of policy and decision-making at least to a moderate extent.

Overall, most survey respondents believed that **the Programme actions led to general improvements in health and healthcare in the EU and at Member State level** (23 respondents said this was true to at least a moderate extent, 73%). Respondents said that the Programme contributed to improvements mainly in the following areas: vaccination in the EU and at Member State level (19 respondents said this was true to at least a moderate extent, 60%), AMR prevention in the EU and at Member State level (18, 57%), and the creation of a well-functioning HTA system in Europe (18, 57%).

Most consulted stakeholders believed that **the 3HP contributed to some extent to the EU's influence on health and healthcare standards, policies and practices at international level**. Overall, public authorities surveyed as part of this study believed that the results of 3HP (e.g., establishment of Joint Actions and European Reference Networks, evaluations and studies, establishment of EU-wide data systems) were used at an international level, and that the EU's coordination with international bodies in the field of health had been strengthened in 3HP priority areas (18 respondents said these two statements were true to at least a moderate extent, 90%).

Not many consulted stakeholders were familiar with the exceptional utility criteria, but those who were felt it increased participation from some countries. In the survey, a majority of public authorities said they did not know whether their Member State applied for funding under the exceptional utility criteria (14 respondents, 70%). In the focus group on Joint Actions, an academic / research organisation stakeholder reported that in two Joint Actions they worked on, they used the exceptional utility criteria as they had several low Gross National Income (GNI) countries involved, so more budget could go to low GNI countries. Nevertheless, some stakeholders felt the criteria increased participation from low-GNI countries[573]. Some public authorities reported factors which contributed to their country's participation, including securing co-financing, followed by the administrative capacity to manage actions in the Member State and language skills.[574]

However, there may have been some limitations to the benefits of the exceptional utility criteria. In the survey, only six academic/research organisations and NGOs (50% of survey respondents) said that the scope of the exceptional utility criteria reduced the differences in costs and benefits between countries. Similarly, more than half of surveyed respondents said they did not know whether simplification measures related to the exceptional utility criteria had reduced administrative costs (17 responses, 53%). Those who did provide an answer tended to say that these measures did not reduce administrative costs, or only to a small extent. A number of factors determined stakeholders' decision not to apply for funding under the

[573] "low-GDP" and "high-GDP" are used here to refer to countries which did and did not meet the exceptional utility criteria, respectively.

[574] Further, in interviews, some EU-level government policy makers felt that there were more partners participating low-GDP countries due to added benefits from the exceptional utility criteria. A stakeholder from HADEA mentioned information sessions run by the Agency as particularly useful for alerting potential beneficiaries to actions. Further, in the focus group on joint actions, a governmental public health organisation reported that the criteria were sensible and effective for partners who worked heavily on the action. In the same focus group, a stakeholder from a Governmental public health organisation reported that the criteria made it much easier for partners to participate as a 40% contribution is prohibitive to some partners, so the 20% level makes it more accessible.

exceptional utility criteria including: that the criteria is not always easy to use[575]; the lack of administrative capacity to manage actions in the Member State; administrative burden (once a project is up and running); complexity of the application process.[576]

Some consulted stakeholders believed that 3HP results have been published to a good extent. Some interviewed stakeholders and participants in the focus group on Joint Actions confirmed that 3HP results and outputs were published on the HaDEA dedicated database. Moreover, different stakeholders from academic institutions and national policymakers reported that scientific publications linked to 3HP actions were published in scientific journals. Stakeholders noted that barriers to accessing results of funded actions include that many deliverables were delayed due to the Covid-19 crisis, as well as a lack of clarity regarding where publications can be found.

Publications resulting from the 3HP are available to wider stakeholders and the public to a moderate extent. Most survey respondents said they had access to publications resulting from the Programme's actions/outcomes/results at least to a moderate extent (23 respondents, 73%). Some interviewed stakeholders and participants in the focus group on Joint Actions indicated that dissemination activities were effective in reaching the scientific community and the wider public.

However, improvements to the dissemination of results are needed. Several consulted stakeholders reported limitations to access to publications and dissemination activities, including a lack of contact between researchers and the private sector; weak engagement with health services and healthcare professional; and lack of a systematic way to monitor the extent to which 3HP beneficiaries disseminate findings after a project.

Data emerging from the consultation activities shows that stakeholders have used outputs and results from 3HP activities. Some results used by stakeholders included outputs from the EUnetHTA which supported legislation; results of CHRODIS and CHRODIS + which generated screening guidelines; outputs of the RARHA Joint Action and the Oramma projects; the Health at a Glance publications, chronic disease reports and reports on pharmaceuticals.

Moreover, ***3HP results have been reported as impactful by different stakeholders***, for instance by raising awareness among patients and healthcare providers in the field of digital health, tackling scepticism and helping realise a European digital health space; proving to ministries of health the effectiveness of undertaken interventions and creating an impact on citizens at the local and regional level.

Evidence reported by stakeholders suggests that ***some of the previous recommendations of the Programme have been addressed***. This includes strengthening and building links between the 3HP and wider Commission & EU policy agenda to maximise impact. There is evidence that there is room to improve systems for monitoring programme implementation, and thus other recommendations are likely yet to be implemented.

Some consulted stakeholders felt the effects of the 3HP were sustainable*.* In the survey, six respondents (19%) thought that the results of the Programme were very sustainable. Similarly, some interviewees and focus group participants felt the actions were sustainable. Some elements or aspects of the 3HP itself seemed to help ensure projects would be sustainable following their conclusion. For example, according to a governmental public health organisation, adding the compulsory work package 4 on

575 Reported by an academic / research organisation stakeholder in the focus group on Joint Actions

576 Three public authorities responding to survey and a stakeholder from an NGO in the focus group on project grants

sustainability[577] was a key success factor of 3HP. Stakeholders from an international organisation felt that when funds were more structured, sustainability was more assured[578]. Another key to ensuring sustainability seemed to be the relationships and connections built through an action.[579] Some results have been sustainable because of the actions of participating countries.[580]

Some consulted stakeholders mentioned specific topics which were seen as having particularly high sustainability. Survey respondents highlighted the following specific fields as having achieved most sustainability: Health Technology Assessments (8 responses, 25%), vaccination policies (5, 16%) and antimicrobial resistance (4, 13%). According to an NGO and an EU-level government policymaker, the 3HP increased knowledge and skills in crisis preparedness for professionals in the health sector and NGOs, and evidence generated on this topic will be used beyond the 3HP. There were also certain funded actions which seemed to be especially sustainable, including many Joint Actions.[581] A few stakeholders also highlighted sustainability within the European Reference Networks, and finally, the SCIROCCO[582] project has created sustainable outputs.

However, there were some reported challenges to sustainability.

For purposes of this study, we consider sustainability to mean the extent to which the results of funded actions are likely to last once funding from the 3HP has ceased. A majority of respondents thought the results of the Programme were somewhat sustainable (21 responses, 66%). Further, two stakeholders[583] reported that results from 3HP were not always integrated into policy. It seems that some threats to sustainability were regarding issues with sustained funding including due to a lack of permanent funding in the EU budget.[584] There may also be barriers related to political will or interest to continue with work; some survey respondents stated that results might not be used nor capitalised on fully by Member States due to a lack of interest and involvement from national authorities which leads to results of funded actions remaining at a local level. Some stakeholders[585] also mentioned that the design of the programme or actions did not lend themselves to increasing sustainability: in the survey, an EU public authority involved in the Programme design explained that results were mostly too limited in scale and/or ambition to be

577 work package introduced as part of all funded actions to ensure demonstration of sustainability after funding period ends

[578] Further, a stakeholder from DG SANTE highlighted that implementation of best practices are a positive way of ensuring sustainability as it is moving from an older to a newer system. Related to best practices, in the focus group on joint actions, an academic/research organisation stakeholder discussed how the transfer of good practices to other regions across Europe needs to be supported by guidelines which in turn support knowledge from expert beneficiaries. Overall, a stakeholder from a governmental public health organisation reported that there was increased planning around sustainability from Member States and the Commission regarding the 3HP.

[579] Reported by academic/research stakeholders and a governmental public health organisation

[580] An EU-level government policy maker felt that the 3HP allowed Member States to see whether actions are suitable and if they are, they can apply for other funding, and indeed an interviewed academic/research stakeholder stated that many projects received more funding to continue beyond the 3HP. In the focus group on joint actions, an academic/research organisation stakeholder highlighted policy dialogues as a useful approach to make actions more sustainable, commenting on good buy-in from policymakers in member states. As a specific example of Member States creating sustainability, an EU-level government policy maker mentioned that Member States drafted and introduced their national cancer strategies following 3HP.

[581] EUnetHTA, AMR Joint Actions, Joint Action on alcohol, Shipsend JA, CHRODIS and CHRODIS+, JA Healthy Gateways, and a joint action involving promotion of policy dialogues for media advertising beverages and food for children.

582 Scaling Integrated Care in Context

583 A stakeholder from an organisation representing patients and services users in interview and a governmental public health organisation in the focus group on project grants

584 a stakeholder from DG SANTE

[585] EU public authority involved in the Programme design, EU-level government policymaker, NGO, government Public health organisation, Healthcare Professionals' Association

sustainable, and that sustainability was not "*in the DNA of the Programme or the participants*".

Efficiency

***The 3HP was largely viewed as cost-effective, with high quantities of work achieved with a low budget*.** Generally, stakeholders interviewed across all groups, actions, and funding mechanisms felt that the 3HP was relatively cost-effective, with many highlighting the quantity and quality of work achieved with a small budget. Respondents to the stakeholder survey considered some costs associated with the 3HP to be reasonable and kept to a minimum necessary to achieve expected results. Deemed to be most reasonable (to a moderate extent) by those who provided an answer were management costs for funding (10 respondents, 50%) and 3HP operational costs (design and implementation) (8 respondents, 40%). Several stakeholders reported achieving more than they expected to with the funding they received, and those who had worked on Joint Actions particularly stressed the cost-effectiveness of their work.[586] In the survey, internal factors which positively influenced the Programme's results were identified as collaboration between Member States and development of guidance to assist funding applicants (22 responses each, 69%), followed by facilitation/coordination of the Programme by DG SANTE/CHAFEA (20 responses, 63%). External factors that positively influenced the Programme's results were identified as science and technological progress in the area of health and healthcare (25 responses, 79%), followed by solutions developed at national level, or by private or non-for-profit actors (19 responses, 60%) and changes in citizens' opinions or perspectives on health systems (13 responses, 41%).

While there were some deviations from the originally planned resources, this was expected and not seen as an issue. Some stakeholders reported deviating from planned resource budgets due to personal costs, partners leaving the project, the Covid-19 pandemic, lack of Member State capacity, or changing priorities over the course of the action. However, due to the high number of partners involved in some actions and the duration of projects, it was generally expected that changes would be made to budgets. Several stakeholders (particularly those involved in Project Grants and Joint Actions) were grateful that the budget could be changed without having to request an amendment from HaDEA; budgets were permitted to be transferred between allowed institutions at a certain percentage because of Covid-19. The flexibility of the management of the budget in the 3HP was thus identified as a key success in cost efficiency.

***There were some factors of the 3HP which meant that costs may not have been proportional to all benefits*.** A large proportion of respondents said some types of costs were either not reasonable or only to a small extent: administrative costs for applicants and Chafea (now HaDEA) (8 responses, 40%), and monitoring and reporting costs for Member States and the Commission (5 responses, 25%). Factors influencing any disparities between Programme funded action costs and the expected results were to do with additional costs associated with Programme preparation, coordination, administration, and delivery, followed by additional costs for personnel, and, to a lesser extent, by additional costs for materials.

According to survey respondents, external factors which had a negative influence on the results of the Programme included changes in prevalence and severity of communicable diseases, and the demographic context affecting health and sustainability of health systems (9 responses each, 29%), followed by new and emerging cross-border health threats during the time of the Programme (6 responses, 19%).[2] Stakeholders in interviews and focus groups stressed the need for tasks to be commensurate with the budget if costs are to be outweighed by benefits. Stakeholders who had utilised Project Grants highlighted that projects focused on scaling up findings, exchange, and promotion of best practices needed to receive more support that is proportional to the expected benefits.

[586] Including a stakeholder from a governmental public health organisation and a government official/policy-maker

Stakeholders in the focus group on Operating Grants also underlined that appropriate budgets attract good candidates.

***Evolving and established procedures of the programme impacted its efficiency*.** The number of partners involved in an action was identified by stakeholders as a factor which sometimes negatively influenced the efficiency with which achievements were attained.[587] Another factor in observed disparities between costs and benefits was co-funding, for example a stakeholder from an international organisation reported that 40% co-funding within a Direct Grant Agreement from international organisations is 'unbearable' and may negatively impact future collaborations.[588] Several stakeholders also mentioned that timing of projects and funding caps could negatively impact the efficiency with which achievements are attained, for example the projects had short durations and insufficient accountability mechanisms.[589] More emphasis on planning for sustainability before an action begins and sustainability mechanisms when an action ends was perceived as a way to marry costs with benefits. Available financial and human resources was identified as a defining factor in efficiency of achievements.

***There were few stakeholders who reported that programme objectives were unmet or partially unmet. Further, programme credits were distributed efficiently between the four thematic priorities*.** A majority of stakeholders consulted in interviews and focus groups felt that there was an efficient distribution of Programme credits among the four thematic priorities and several stakeholders mentioned priorities being in line more widely with EU objectives. For example, those who had received Operating Grants largely agreed that they were in line with 3HP objectives, and stakeholders in the Procurement Contracts focus group also felt that the funding was aligned with EU objectives.

Most stakeholders considered funding allocation to be critical to achieve expected results. Stakeholders from the Operating Grants focus group felt that funding allowed them to plan and deliver on projects with (financial) security. Those in governmental public health organisations also emphasised how invaluable funding was to achieving results: one stakeholder reported that funds would not have been directed to the identified priorities without 3HP, and another stakeholder from the same group highlighted that funding was critical for enabling low-GNI countries to achieve results with other Member States. A stakeholder from a healthcare professionals' association also highlighted how external stakeholders would not have been engaged in innovations in healthcare systems in the same way without the funding.

***There were some differences in costs between countries, caused by several factors*.** Some academic/research organisations and NGOs believed there were differences in costs between countries. Some respondents believed these differences were caused by differing staff expenses, which impacted achievable goals and work performance. Some stakeholders also identified cost differences which could be linked to the Programme.[590] Survey results suggested a larger perceived difference in benefits gained through the Programme; stakeholders believed that tasks and the level of

[587] A government official/policy maker in the focus group for Procurement Mechanisms mentioned that there were too many partners in the HTA Joint Action and suggested that the maximum number of partners should be indicated by the European Commission in the eligibility criteria. This sentiment was echoed by a stakeholder from the government officials and policymakers' group, who reported difficulty in coordinating a number of entities working on a Joint Action. If one partner does not submit cost, then it cannot be funded by the Commission.

[588] Further, a stakeholder from an NGO who utilised a Project Grant also felt that the standard co-funding requirement (40%) is too high and the application process for the 80% co-funding is difficult, particularly for smaller organisations. A stakeholder from the same focus group in an academic/research organisation also discussed the difficulty of co-funding in ERNs (but acknowledged this as a point which has been addressed in EU4HEALTH). Similarly, a stakeholder from a governmental public health organisation stressed that 20% commitment to their own funding was challenging for NGOs and may prevent them from contributing despite the value they add to projects.

589 reported by a stakeholder from a government public health organisation

[590] A stakeholder from a governmental public health organisation felt that the divergence in daily payment amounts from participating countries in Joint Actions should be reconsidered. One stakeholder from a healthcare service provider/ organisation representing them highlighted that payments to those working on projects were adjusted to countries' levels, meaning different people were paid different amounts.

involvement of Member States in projects/actions dictated to what degree countries benefitted from the Programme. The exceptional utility criteria were perceived by half of respondents as a factor which reduced differences in costs and benefits. Other factors affecting differences were identified in the survey as: organisational capacity to deliver funded actions (8 responses, 67%), administrative burden of applying for and receiving funding (7 responses, 59%), and countries' public health capacity to apply for and manage funding (6 responses, 50%). Stakeholders interviewed identified geographical location as another factor which caused differences in benefits between participating countries.[591]

***While some respondents did not know much about the simplification measures, those who did generally felt they contributed to the efficiency of the Programme*.** 32% of respondents in the survey did not know whether the simplification measures contributed to the efficiency of the Programme, and those who did answer were divided. Ways in which simplification measures *were* deemed to be efficient were in the introduction of electronic tools for the submission of proposals, management of grants and e-reporting and monitoring (subject to the system functioning efficiently), the introduction of a negotiation process for Joint Actions, and the ability for beneficiaries to transfer resources between different cost categories without the need for an amendment. Stakeholders consulted[592] generally felt that simplification measures had reduced administrative costs and improved efficiency of the Programme, for example by reducing paperwork and improving operational running of Joint Actions.[593]

Many stakeholders felt that there was further scope to reduce costs. Most proposed changes were related to application processes.[594] Further simplification of administrative processes was a common improvement suggested by stakeholders. One stakeholder from a healthcare service provider/ organisation representing them praised the reduction in paperwork, but felt that locating documents was difficult, especially when trying to find out why a project was declined. Another stakeholder from a healthcare professionals' association highlighted that, prior to the pandemic, some financial officers required face-to-face meetings whereas others allowed e-meetings; this affected the financing as travel expenses were difficult to cover.

***Monitoring costs were largely seen as reasonable and cost-effective*.** A majority of respondents who were involved in the management and administration of an action from the Programme said that the monitoring costs were reasonable and kept to the minimum necessary in order to achieve the expected results, at least to a moderate extent (11 responses, 55%). According to some respondents, the key factors enabling efficiency were the relevance of indicators (10 responses, 50%) and the level of clarity of the indicators (9 responses, 45%).

However, there were a few challenges with the monitoring processes. Whilst some stakeholders noticed improvements in the monitoring process, many still felt it could be simplified (particularly stakeholders from healthcare professionals' associations and NGOs). A stakeholder belonging to the governmental policymakers group mentioned that experts they worked alongside struggled with the budgeting table due to uncertainty and

[591] Stakeholders in focus groups on Joint Actions and Operating Grants particularly felt that Western European countries were still overrepresented in the Programme, and a stakeholder in the focus group on Project Grants felt that this was due to the difficulty faced by low GNI countries in meeting co-funding rates. A stakeholder from a governmental public health organisation highlighted that countries with low GDP struggled to see the same benefits of Joint Actions due to not having the resources and capacity to participate. However, one stakeholder from the government officials/policy makers group highlighted that even with more funding, some countries still would not have had the resources or capacity to participate effectively in the Programme.

[592] Including in the Project Grants focus group and the Operating Grants focus group.

593 Reported by a stakeholder from research/academic organisation

[594] One government/policy maker stated that more flexibility was still needed in Project Grant funding for Joint Actions. The stakeholder worked on a Joint Action on vaccination where the Ministry of Health were nominated as the competent authority to work with a university, but they were not able to justify the affiliated entity aspect of the university. Another stakeholder from a healthcare professionals' association felt that applications for ERNs should not be annual, but every 5-10 years to reduce administrative burden.

level of detail required. Increased dissemination of project information was seen to make the Programme more efficient as a whole. Communication within project teams was also highlighted as key to having an efficient monitoring process.[595] Some stakeholders suggested different, more efficient methods of monitoring the Programme.[596]

Reporting systems were seen as reasonably-priced and beneficial. In the survey, respondents involved in the management and administration of an action reported benefits of the reporting system, including allowing the tracking of progress on actions against their original plan (11 responses, 55%), increasing visibility of the Programme and its actions (6 responses, 30%) and allowing Programme participants to manage budgets effectively (5 responses, 25%). Eight respondents (40%) said that the costs of the reporting system were reasonable and kept to the minimum necessary to achieve expected results, at least to a moderate extent. Interviews with stakeholders revealed perceived benefits of the reporting system.[597]

However, there were some limitations of the reporting system identified. 65% of respondents felt that the reporting system could be improved by 'simplifying the reporting procedure' (through reducing administrative burden, time and effort required). In line with survey findings, a few stakeholders consulted in focus groups and interviews indicated that reporting systems could be more effectively implemented in the 3HP. Suggested improvements were related to reducing administrative burden on applicants; stakeholders in the Project Grants focus group highlighted the need to reduce the level of detail required for financial reports, and two stakeholders from NGO and organisations representing patients and service users groups mentioned the administrative burden of submitting Operating Grant reports specifically. For smaller organisations without technical capacity and knowledge, the administration involved in Operating Grant reports was discouraging according to a stakeholder from organisations representing patients and services users. The stakeholder from an NGO also felt that submitting a few smaller Operating Grant reports throughout the year as opposed to one big report annually may be more efficient.

EU added value

***The 3HP achieved more added value than what Member States could have achieved acting individually*.** Most respondents to the OPC[598] considered that 3HP provided added value beyond what could have been achieved by Member States acting alone. The additional value of having an EU health programme was also validated by stakeholders who attended the focus group on Joint Actions. Stakeholders representing governmental public health organisations mentioned that the 3HP enabled partners to contact other EU organisations and use that support to have a greater impact at national level. Furthermore, these stakeholders considered that it was beneficial to have actions at regional, national and EU level depending on the level of devolution within a country.

595 reported by stakeholder from an academic/research organisation

[596] Several government and policy makers in the Procurement Mechanism focus group highlighted the difficulty of measuring/monitoring impact of funding as there is no specific framework for measuring results of activities and quantifying progress is challenging. One stakeholder from the group suggested that operational units should put emphasis on what is the best that can be achieved with the available budget at the beginning as a better way of monitoring. Another stakeholder (from an NGO) suggested monitoring progress through 'looking at how actions affect communities – assessing to what extent is everyone at the table'. One government official/policy maker stakeholder reported that there is a need for a dedicated data collection system to perform monitoring activities per objective and per priorities, as there is currently a missing link between individual projects and specific objectives and thematic priorities.

[597] Such as: the portal, which made reporting more efficient (according to a government official/policy maker); Compass and SYGMA reporting systems, which enabled beneficiaries to report back to the Commission with less administrative burden and to track projects from start to end (according to a government/policy maker); and the role of FPA and SGA in reducing administrative burden for applicants and the European Commission (according to a government/policy maker).

598 Almost four in ten respondents to the OPC said the Programme provided high added-value (26 responses, 39%) and an additional third said that it provided moderate added-value (23 responses, 34%).

Coherence

***The activities carried out under 3HP were aligned with the thematic priorities of the Programme*.** The majority of survey respondents mentioned that there were consistent and coherent funding decisions across specific objectives during the Programme period. Very few respondents to the survey said that funding decisions were not at all coherent with the specific objectives. For example, just 2 respondents to the survey (7%) said this was the case for objective 2,[599] and another 2 respondents for objective 3.[600] There were very few stakeholders reporting inconsistencies between actions, or gaps, duplications or contradictions, which lead to inefficiencies) (2 respondents to the survey, 4%).

Reasons given by stakeholders for a inconsistencies, gaps, duplications or contradictions within the Programme detailed that these were mainly due to: issues linked with the relationships between different actors/beneficiaries; programme management and communication with core stakeholders; and the lack of national political uptake or capitalisation of findings arising from the Programme funding actions.

The 3HP complemented and created synergies with other EU Programmes. A majority of OPC respondents believed that the Programme complemented and/or created synergies with other EU programmes or with wider EU policies, to at least a moderate extent (37 out of 67, responses, 55%). These respondents explained that the Programme was coherent with contributions of the European structural and investment funds (ESIF), the Horizon 2020 Programme and the European Social Fund. They added that complementarities between the Programme and these other EU policies made it possible to investigate some topics (e.g. chronic diseases, non-communicable diseases, rare diseases) in-depth.

The Programme was coherent with other EU policies in the field of health. Several stakeholders representing government and policymakers, academic and research organisations and governmental public health organisations agreed that the 3HP was aligned and coherent with other EU policies in the field of health. Furthermore, some stakeholders representing government and policymakers and governmental public health organisations highlighted the alignment with other EU funded actions and policies such as Horizon 2020, and the Farm to Fork Strategy.

However, some respondents felt the Programme was not as coherent with other EU programmes. Some OPC respondents (13 out of 67, 19%) said the Programme was not coherent with other EU programmes or with wider EU policies, with one NGO noting very few synergies for instance between the Programme and the Horizon 2020 programme for R&D and a public authority explaining that programmes were not interlinked with no joint funding possible. This public authority added that priorities as well as grants and tenders from other EU Programmes were often not known to delegates of the Programme. Furthermore, some stakeholders representing government and policymakers, and organisations that represent patients and service users mentioned that coherence and synergies between the 3HP and Horizon 2020 could have been improved.[601] Furthermore, looking at the relation between the 3HP and EU financial instruments, some stakeholders representing government and policy makers and organisations representing patient and service users were asked if the health programme encouraged cooperation with the European Structural and Investment Funds (ESIF) and other EU financial instruments.

599 Objective 2: Protect Union citizens from serious cross border health threats" (2 respondents

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

[601] They reported that synergies between Joint Actions and Horizon were difficult to unlock because the latter programme is more research-oriented. Further, there could have been more coherence between the funded actions and the research programme (Horizon 2020). The stakeholder did not see any methods to motivate/promote synergies with the actions funded under the programme to feed into others. She pointed that some recipients of these programme acknowledge these synergies and made the best use of them. But in her view, there was not a consistent effort to connect projects and/or programmes.

Stakeholders agreed there was a room for further cooperation between the 3HP and the ERDF, the European Social Fund Plus (ESF) and ESIF.

***Funded actions within the 3HP contributed to, and were aligned with, wider EU policies*.** This was confirmed by some stakeholders representing NGOs, international organisations and organisations representing patients and service users. For example, one stakeholder representing NGOs highlighted that there was alignment between the 3HP and other EU funding mechanisms in relation to migrant health. Furthermore, a government policy maker that attended the focus group on Procurement Contracts mentioned that the work of the 3HP in the migration crisis was linked to the wider EU policy on the migration crisis. This work therefore contributed to achieving a specific objective of the 3HP as well as a wider EU priority.

***The 3HP was aligned with national priorities*.** In the OPC, a majority of public authorities said that the Programme was aligned with and addressed national health priorities during the Programme period to at least a moderate extent (14 out of 20 responses, 70%). Additionally, half of respondents to the OPC believed that the Programme complemented and/or created synergies with national initiatives and/or programmes, to at least a moderate extent (33 out of 67 responses, 49%). Several stakeholders[602] agreed that the 3HP priorities and objectives were aligned with Member State initiatives in the field of health. Among the national initiatives that were aligned with the 3HP, stakeholders mentioned actions on tobacco use and alcohol abuse by young people, obesity, and the prevention of frailty. Similarly, three out of five stakeholders that attended the focus group on Joint Actions indicated that the Programme's interventions were complementary to other EU or Member State initiatives in the field of health. However, a few other respondents to the OPC (13 responses, 19%) said the Programme was not coherent with national initiatives and/or programmes.

5. Feedback on the consultation process

During the consultation period, a few stakeholders noted that they were unable to participate in the interviews and focus groups due to competing priorities including responding to the effects of the Covid-19 pandemic and the conflict in Ukraine. Lastly, due to technical issues on the last day of the OPC, one stakeholder was initially unable to submit their response to the survey and OPC, however this was addressed by extending the deadline for these consultation activities.

6. Use of the information gathered

All of the information gathered as part of the stakeholder consultations was firstly converted into useable units of analysis. For example, interview audio recordings were used to write notes for each interview to summarise key points and quotes. A summary of key findings per evaluation question was written for each focus group. Summary tables and graphs were created per question for the OPC, and stakeholder survey and open-text responses were collated into a file.

- Then, these data sources were analysed to identify patterns and trends across stakeholder groups. These data sources were used to examine each evaluation question alongside the desk research conducted for this study, and to reach the conclusions and recommendations contained in the final study.

602 Stakeholders from the following groups mentioned this: stakeholders representing government policy makers, governmental public health organisations, NGOs, academic and research organisations and organisations representing patients and service users

Annex 6.1.A List of stakeholders contacted

This annex contains the lists of stakeholders invited to participate in the consultation activities.

Table 65. Stakeholders contacted – Stakeholder survey and OPC

Institution name	Country
Academic and research organisations	
Immunity and Infections (CHIP) Denmark	Denmark
University of Thessaly	Greece
University of Leuven	Belgium
International Centre of Excellence in Chronicity Research (Cyprus)	Cyprus
Institute Curie France	France
Mario-Negri Institute for Pharmacological Research	Italy
Université Libre de Bruxelles	Belgium
University of Central London	UK
Maastricht University	Netherlands
University of Valencia	Spain
Karolinska Institute Sweden	Sweden
The University of Edinburgh	UK
Medical University of Graz	Austria
University of Crete	Greece
The University of West Attica in Athens	Greece
Company/business organisation	
MedTech Europe	EU
Pharmeca	Czech Republic
Medtronic PLC	UK
Comité Européen des Entreprises Vins	EU
Federation française des vins d'apéritifs (FFVA)	France
Plasma Protein Therapeutic Association (PPTA)	EU
Consumer organisation	
European Patients Forum (EPF)	EU
European Cancer Patient Coalition	EU
AGE Platform Europe	EU
Pain Alliance Europe	EU
The European Consumer Organisation (BEUC)	EU
European Renal Association/European Dialysis and Transplantation Association (ERA-EDTA)	EU
EURORDIS (The Voice of Rare Disease Patients in Europe)	EU
ECCO - the European CanCer Organisation	EU
European Federation of Neurological Associations [EFNA]	EU
European Federation of Allergy and Airways Diseases Patients' Associations (EFA)	EU
Global Alliance of Mental Illness Advocacy Networks (GAMIAN-Europe)	EU

European Liver Patients' Association	EU
European Multiple Sclerosis Platform (EMSP)	EU
Youth Cancer Europe	EU
Thalassaemia International Federation	Cyprus
Healthcare professionals' associations	
Standing Committee of European Doctors (CPME)	EU
European Federation of Nurses Associations (EFN)	EU
European Midwives Association	EU
Royal College of Physicians of Edinburgh (RCPE)	UK
European Society of Cataract and Refractive Surgeons Limited (ESCRS)	EU
European Association of Hospital Managers (EAHM)	EU
The European Hospital and Healthcare Employers' Association (HOSPEEM)	EU
Consociazione Nazionale Ass. Infermieri	Italy
Spanish General Council of Nursing	Spain
SIOPE - the European Society for Paediatric Oncology	EU
EUROCAM (European platform for organisations representing patients, medical doctors, veterinarians, and practitioners in the sector of Traditional, Complementary, and Integrative Medicine (TCIM)	EU
European Committee for Homeopathy (ECH)	EU
European Federation of osteopaths	EU
European Health Chamber	EU
IAVH	
Council of Occupational Therapists for the European Countries (COTEC)	EU
IVAA -International Federation of Anthroposophical Medical Associations	EU
Pharmaceutical Group of the European Union (PGEU)	EU
European Association of Hospital Pharmacists	EU
European Federation of Psychologists Associations	EU
European Federation of Internal Medicine (EFIM)	EU
European Respiratory Society (ERS)	EU
Healthcare service provider and organisations representing them	
European Hospital and Healthcare Federation (HOPE)	EU
Erasmus MC	Netherlands
European University Hospital Alliance	EU
European Union of Private Hospitals (UEPH)	EU
EUREGHA European Regional and Local Health Authorities	EU
Academic Medical Center University of Amsterdam (AMC)	Netherlands
Assistance Publique - Hôpitaux De Paris	France
Hopitaux Universitaires De Strasbourg	France
Vilnius university hospital Santaros Klinikos	Greece
Istituto Giannina Gaslini	Italy
University Medical Center Groningen	Netherlands
Great Ormond Street Hospital for Children NHS Trust	UK

Newcastle upon Tyne Hospitals NHS Foundation Trust	UK
AGENAS (National Agency for Regional Health Services, Italy)	Italy
International organisations	
Global Alliance for TB Drug Development	International
European Parliament	EU
The Council of Europe	EU
European Commission - DG SANTE	EU
DG RTD	EU
DG DEVCO	EU
DG CONNECT	EU
DG GROW	EU
CHAFEA	EU
HaDEA	EU
European Medicines Agency (EMA)	EU
ECHA	EU
EFSA	EU
European Centre for Disease prevention and Control (ECDC)	EU
EMCDDA European Monitoring Centre for Drugs and Drug Addiction	EU
DG REGIO	EU
DG EMPL	EU
DG REFORM	EU
WHO Europe Regional Office	EU
European Observatory on Health Systems and Policies (EOHSP)	EU
OECD	International
NACIONALNI INSTITUT ZA JAVNO ZDRAVJE (National insittute of public health Slovenia)	International
NACIONALNI INSTITUT ZA JAVNO ZDRAVJE	International
UNAIDS	International
Lead or partner organisation of funded action	
STICHTING DE REGENBOOG GROEP	Netherlands
SMOKEFREE PARTNERSHIP FONDATION	EU
EUROPEAN PUBLIC HEALTH ALLIANCE	EU
Danish Veterinary and Food Administration	Denmark
KRAEFTENS BEKAEMPELSE	Denmark
GOSPODARSKA ZBORNICA SLOVENIJE	Slovenia
SOSIAALI- JA TERVEYSMINISTERIÖ (Ministry of Social Affairs and Health of Finland)	Finland
Azienda ULSS 6 Euganea	Italy
VIESTOJI ISTAIGA CENTRO POLIKLINIKA	Italy
ASOCIATA AER PUR ROMANIA	Romania
ASOCIACION CENTRO DE EXCELENCIA INTERNACIONAL EN INVESTIGACION SOBRE CRONICIDAD	Basque Country

TERVEYDEN JA HYVINVOINNIN LAITOS	Finland
ROBERT KOCH-INSTITUT	Germany
ISTITUTO NAZIONALE PER LE MALATTIEINFETTIVE LAZZARO SPALLANZANI-ISTITUTO DI RICOVERO E CURA A CARATTERESCIENTIFICO	Italy
BUNDESMINISTERIUM FUER GESUNDHEIT	Germany
HRVATSKI ZAVOD ZA JAVNO ZDRAVSTVO	Croatia
STATNI USTAV JADERNE, CHEMICKE A BIOLOGICKE OCHRANY vvi	Czech Republic
STATENS SERUM INSTITUT	Denmark
SOTSIAALMINISTEERIUM	Republic of Estonia
KENTRO ELENCHOU & PROLIPSIS NOSIMATON	Greece
ETHNIKOS ORGANISMOS DIMOSIAS YGEIAS (THE NATIONAL PUBLIC HEALTH ORGANIZATION(NPHO)	Greece
LIETUVOS RESPUBLIKOS SVEIKATOS APSAUGOS MINISTERIJA	Republic of Lithuania
Ministry for Health - Government of Malta	Malta
RIJKSINSTITUUT VOOR VOLKSGEZONDHEID EN MILIEU	Netherlands
HELSEDIREKTORATE	Norway
NARODOWY INSTYTUT ZDROWIA PUBLICZNEGO-PANSTWOWY ZAKLAD HIGIENY	Poland
MINISTERIO DA SAUDE - REPUBLICA PORTUGUESA	Portugal
INSTITUT ZA JAVNO ZDRAVLJE SRBIJE 'MILAN JOVANOVIC - BATUT'	Serbia
INSTITUTO DE SALUD CARLOS III	Spain
FOLKHALSOMYNDIGHETEN	Sweden
AGENTIA NATIONALA PENTRU SANATATE PUBLICA	Moldova
UNIVERSITAIR MEDISCH CENTRUM UTRECHT	Netherlands
UNIVERSITAETSKLINIKUM HAMBURG-EPPENDORF	Germany
ERASMUS UNIVERSITAIR MEDISCH CENTRUM ROTTERDAM	Netherlands
INSTITUT NACIONAL D'EDUCACIO FISICA DE CATALUNYA	Spain
JOHANN WOLFGANG GOETHE-UNIVERSITATFRANKFURT AM MAIN	Germany
REGION MIDTJYLLAND	Denmark
VLAAMS INSTITUUT VOOR GEZONDHEIDSPROMOTIE EN ZIEKTEPREVENTIE VZW	Germany
AZIENDA UNITA LOCALE SOCIO SANITARIA N 9 DI TREVISO	Belgium
AZIENDA OSPEDALIERO UNIVERSITARIA PISANA	Italy
SERVICIO MADRILENO DE SALUD	Spain
AZIENDA SANITARIA UNIVERSITARIA INTEGRATA DI UDINE	Italy
ISTITUTO ORTOPEDICO RIZZOLI	Italy
ST. ANNA KINDERKREBSFORSCHUNG	Austria
UNIVERSITAETSKLINIKUM HEIDELBERG	Germany
STICHTING KATHOLIEKE UNIVERSITEIT (Radbount Universiteit)	Netherlands
Universitaetsklinikum Tuebingen	Germany
Academisch Medisch Centrum bij de Universiteit van Amsterdam	Netherlands
KLINIKUM DER JOHANN WOLFGANG VON GOETHE UNIVERSITAET	Germany
NEMZETI EGESZSEGBIZTOSITASI ALAPKEZELO	Hungary

GESUNDHEIT ÖSTERREICH GMBH	Austria
STATNI USTAV PRO KONTROLU LECIV	Czech Republic
TANDVARDS-OCH LAKEMEDELSFORMANSVERKET	Sweden
STATENS LEGEMIDDELVERK	Norway
SCOTTISH GOVERNMENT	UK
OPTIMEDIS AG	Germany
AGENZIA REGIONALE SANITARIA PUGLIESE	Italy
UNIVERZITA PAVLA JOZEFA SAFARIKA V KOSICIACH	Slovakia
UNIVERSITAT DE VALENCIA	Spain
VIESOJI ISTAIGA VILNIAUS UNIVERSITETO LIGONINE SANTAROS KLINIKOS	Lithuania
ASSEMBLEE DES REGIONS D'EUROPE ASSOCIATION	International
NARODOWY FUNDUSZ ZDROWIA	Poland
VLAAMS GEWEST	Belgium
Servicio Vasco de Salud Osakidetza	Spain
INSTITUT REPUBLIKE SLOVENIJE ZA SOCIALNO VARSTVO	Slovenia
EMPIRICA GESELLSCHAFT FUER KOMMUNIKATIONS- UND TECHNOLOGIE FORSCHUNG MBH	Germany
STICHTING INTERNATIONAL FOUNDATION FOR INTEGRATED CARE	UK
AZIENDA OSPEDALIERA UNIVERSITARIA FEDERICO II	Italy
UNIVERSYTET MEDYCZNY W LODZI.	Poland
MEDIZINISCHE UNIVERSITAT GRAZ	Austria
FUNDACIO INSTITUT GUTTMANN	Spain
CONSEJERIA DE SALUD DE LA JUNTA DE ANDALUCIA	Spain
UNIVERSITEIT TWENTE	Netherlands
REGIONAL HEALTH AND SOCIAL CARE BOARD	UK
PANEPISTIMIO KRITIS	Greece
UNIVERSITA DEGLI STUDI DI ROMA TOR VERGATA	Italy
UNIVERSITA DEGLI STUDI DI PARMA	Italy
AZIENDA SANITARIA UNIVERSITARIA GIULIANO ISONTINA	Italy
INSTITUT NATIONAL DE LA SANTE ET DE LA RECHERCHE MEDICALE	France
USTAV ZDRAVOTNICKYCH INFORMACI A STATISTIKY CESKE REPUBLIKY	Czech Republic
BUNDESINSTITUT FUR ARZNEIMITTEL UND MEDIZINPRODUKTE	Germany
DEUTSCHES INSTITUT FUR MEDIZINISCHE DOKUMENTATION UND INFORMATION (DIMDI)	Germany
CENTRO DE INVESTIGACION BIOMEDICA EN RED	Spain
FUNDACION PARA EL FOMENTO DE LA INVESTIGACION SANITARIA Y BIOMEDICA DELA COMUNITAT VALENCIANA	Spain
REGIONE DEL VENETO	Italy
Directia de Sanatate Publica a judetului Iasi	Romania
MINISTERUL SANATATII	Romania
MINISTERSTVO NA ZDRAVEOPAZVANETO	Bulgaria
ISTITUTO SUPERIORE DI SANITA	Italy

SLIMIBU PROFILAKSES UN KONTROLES CENTRS	Latvia
FOLKEHELSEINSTITUTTET	Norway
MINISTERSTVO ZDRAVOTNICTVA SLOVENSKEJ REPUBLIKY	Slovakia
FUNDACION PUBLICA MIGUEL SERVET	Spain
SERVICE PUBLIC FEDERAL SANTE PUBLIQUE, SECURITE DE LA CHAINE ALIMENTAIRE ET ENVIRONNEMENT	Belgium
NATSIONALEN CENTAR PO OBSHTESTVENO ZDRAVE I ANALIZI	Bulgaria
Ministry of Health of the Republic of Cyprus	Cyprus
STATNI ZDRAVOTNI USTAV	Czech Republic
REGION SJAELLAND	Belgium
TERVISE ARENGU INSTITUUT	Estonia
BUNDESZENTRALE FUR GESUNDHEITLICHE AUFKLARUNG	Germany
MINISTERIE VAN VOLKSGEZONDHEID, WELZIJN EN SPORT	Netherlands
THE MINISTRY OF HEALTH OF THE REPUBLIC OF POLAND	Poland
ESCUELA ANDALUZA DE SALUD PUBLICA SA	Spain
WELSH ASSEMBLY GOVERNMENT	UK
SPMS - SERVICOS PARTILHADOS DO MINISTERIO DA SAUDE EPE	Portugal
GEMATIK GESELLSCHAFT FUR TELEMATIKANWENDUNGEN DER GESUNDHEITSKARTE MBH	Germany
DIOIKISI 3IS YGEIONOMIKIS PERIFEREIAS MAKEDONIAS	Greece
Ministerio de Sanidad, Servicios Sociales e Igualdad	Spain
HRVATSKI ZAVOD ZA ZDRAVSTVENO OSIGURANJE	Croatia
ORSZAGOS KORHAZI FOIGAZGATOSAG	Hungary
MINISTERO DELLA SALUTE	Italy
AGENCE ESANTE	Luxembourg
NACIONALAIS VESELIBAS DIENESTS	Latvia
STICHTING NATIONAAL ICT INSTITUUT IN DE ZORG	Netherlands
Directorate for e-Health	Norway
PANEPISTIMIO THESSALIAS	Greece
NACIONALINIS VISUOMENES SVEIKATOS CENTRAS PRIE SVEIKATOS APSAUGOS MINISTERIJOS	Lithuania
GENIKO PERIFERIAKO NOSOKOMEIO PAPAGEORGIOU	Greece
DIOIKHSH YGEIONOMIKHS PERIFEREIAS KRHTHS	Greece
REGISTRUL NATIONAL AL DONATORILOR VOLUNTARI DE CELULE STEM HEMATOPOIETICE	Romania
MINISTARSTVO ZDRAVLJA REPUBLIKE HRVATSKE	Croatia
Health and Social Care Inspectorate (IVO)	Sweden
HEALTH PRODUCTS REGULATORY AUTHORITY	Ireland
SERVEI CATALA DE LA SALUT	Spain
VIESOJI ISTIAGA NACIONALINIS KRAUJO CENTRAS	Lithuania
Agence de la biomédecine	France
LAAKEALAN TURVALLISUUS-JA KEHITTAMISKESKUS	Finland
BUNDESINSTITUT FUR IMPFSTOFFE UND BIOMEDIZINISCHE ARZNEIMITTEL	Germany

BANC DE SANG I TEIXITS	Spain
KRAJOWE CENTRUM BANKOWANIA TKANEK I KOMOREK	Poland
HUMAN TISSUE AUTHORITY	UK
AGENTIA DE TRANSPLANT	Moldova
EXECUTIVE AGENCY FOR TRANSPLANTATION	Bulgaria
EXECUTIVE AGENCY 'MEDICAL SUPERVISION'	
Medical Products Agency	Sweden
ASOCIACION ESPAÑOLA DE BANCOS DE TEJIDOS	Spain
SERVICIO ANDALUZ DE SALUD	Spain
LIETUVOS SVEIKATOS MOKSLU UNIVERSITETO LIGONINE KAUNO KLINIKOS	Lithuania
FONDAZIONE IRCCS CA' GRANDA - OSPEDALE MAGGIORE POLICLINICO	Italy
MINISTRY OF HUMAN CAPACITIES	Hungary
INSTITUT NATIONAL DU CANCER GIP	France
Orszagos Onkologiai Intezet	Hungary
INSTITUTIA MEDICO-SANITARA PUBLICA INSTITUTUL ONCOLOGIC	Moldova
OSLO UNIVERSITETSSYKEHUS HF	Norway
INSTITUT CATALA D'ONCOLOGIA	Spain
BIOMEDICINSKE CENTRUM SLOVENSKEJ AKADEMIE VIED	Slovakia
UNIVERSITY OF DUNDEE	UK
WESTFAELISCHE WILHELMS-UNIVERSITAET MUENSTER	Germany
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	UK
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	UK
AGENCE NATIONALE DE SANTE PUBLIQUE	France
ETHNIKOS ORGANISMOS PAROCHIS YPIRESION YGIAS	Greece
UNIVERSITATEA DE STAT DE MEDICINA SI FARMACIE NICOLAE TESTEMITANU DIN REPUBLICA MOLDOVA	Moldova
EUROHEALTHNET ASBL	Belgium
HOSPITAL SANT JOAN DE DÉU	Spain
OSPEDALE PEDIATRICO BAMBINO GESU	Italy
VSEOBECNA FAKULTNI NEMOCNICE V PRAZE	Czech Republic
UNIVERSITY OF GLASGOW	UK
UNIVERSITAT ZU LUBECK	Germany
UNIVERSITEIT GENT	Belgium
ISTITUTO AUXOLOGICO ITALIANO	Italy
SEMMELWEIS EGYETEM	Hungary
LUDWIG-MAXIMILIANS-UNIVERSITAET MUENCHEN	Germany
STOCKHOLMS LANS LANDSTING	Sweden
FAKULTNI NEMOCNICE V MOTOLE	Czech Republic
HANNOVERSCHE KINDERHEILANSTALT	Germany
AZIENDA OSPEDALIERA DI PADOVA	Italy
EBERHARD KARLS UNIVERSITAET TUEBINGEN	Germany

GDANSKI UNIWERSYTET MEDYCZNY	Poland
INSTITUT CATALA DE LA SALUT	Spain
OSTERREICHISCHE AGENTUR FUR GESUNDHEIT UND ERNAHRUNGSSICHERHEIT GMBH	Austria
SIKKERHEDSSTYRELSEN	Denmark
TERVISEAMET	Estonia
AGENCE NATIONALE DE LA SECURITE SANITAIRE DE L ALIMENTATION DE L ENVIRONNEMENT ET DU TRAVAIL	France
BUNDESINSTITUT FUER RISIKOBEWERTUNG	Germany
ETHNIKO KENTRO EREVNAS KAI TECHNOLOGIKIS ANAPTYXIS	Greece
ISTITUTO DI RICERCHE FARMACOLOGICHE MARIO NEGRI	Italy
VESELIBAS INSPEKCIJA	Latvia
Drug, tobacco and alcohol control department	Lithuania
NACIONALINE VISUOMENES SVEIKATOS PRIEZIUROS LABORATORIJA	Lithuania
NACIONALNI LABORATORIJ ZA ZDRAVJE, OKOLJE IN HRANO	Slovenia
ELLINIKI PNEYMONOLOGIKI ETAIREIA	Greece
REGION HOVEDSTADEN	Denmark
UNIVERSITY COLLEGE DUBLIN, NATIONAL UNIVERSITY OF IRELAND, DUBLIN	Ireland
FONDAZIONE LEGA ITALIANA PER LA LOTTA CONTRO L'AIDS - LILA MILANO ONLUS	Italy
FONDAZIONE VILLA MARAINI ONLUS	Italy
KRAJOWE CENTRUM D/S AIDS	Poland
UDRUGA ZA UNAPREDENJE KVALITETE ZIVLJENJA "LET"	Croatia
CONSORCI INSTITUT D'INVESTIGACIONS BIOMEDIQUES AUGUST PI I SUNYER	Spain
ARCIGAY	Italy
VILNIAUS PRIKLAUSOMYBES LIGU CENTRAS	Lithuania
UZKRECIAMUJU LIGU IR AIDS CENTRAS	Lithuania
SPITALUL CLINIC DE BOLI INFECTIOASE SI PNEUMOFTIZIOLOGIE VICTOR BABES CRAIOVA	Romania
ORGANISMO AUTONOMO INSTITUTO DE SALUD PUBLICA Y LABORAL DE NAVARRA	Spain
INSTITUTUL DE PNEUMOFTIZIOLOGIE MARIUS NASTA	Romania
HRVATSKA UDRUGA ZA BORBU PROTIV HIV-A I VIRUSNOG HEPATITISA	Croatia
ISKORAK	Serbia
TECHNISCHE UNIVERSITAET DRESDEN	Germany
UNIVERSITAET ULM	Germany
KLINIKUM DER UNIVERSITAET REGENSBURG	Germany
ARISTOTELIO PANEPISTIMIO THESSALONIKIS	Greece
OTTO-VON-GUERICKE-UNIVERSITAET MAGDEBURG	Germany
INSTITUTE OF PUBLIC HEALTH IN IRELAND LIMITED	Ireland
AZIENDA SANITARIA LOCALE TO3	Italy
FONDAZIONE IRCCS ISTITUTO NEUROLOGICO CARLO BESTA	Italy

FACULTY OF MEDICINE, UNIVERSITY OF BELGRADE	Serbia
AGENCIA DE QUALITAT I AVALUACIO SANITARIES DE CATALUNYA	Spain
CONSEJERIA DE SANIDAD DE CANTABRIA	Spain
INSTITUTO ARAGONES DE CIENCIAS DE LA SALUD	Spain
VILNIAUS UNIVERSITETAS	Lithuania
UNIVERSITA CATTOLICA DEL SACRO CUORE	Italy
NARODOWY INSTYTUT GERIATRII REUMATOLOGII I REHABILITACJI IM.PROF.DR HAB. MED. ELEONORY REICHER	Poland
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PAULA STRADINA KLINISKA UNIVERSITATES SLIMNICA	Latvia
VETERINAERINSTITUTTET - NORWEGIAN VETERINARY INSTITUTE	Norway
NARODOWY INSTYTUT LEKOW	Poland
UNIVERSITATEA DE MEDICINA SI FARMACIE IULIU HATIEGANU CLUJ-NAPOCA	Romania
AGENCIA ESPANOLA DE MEDICAMENTOS Y PRODUCTOS SANITARIOS	Spain
DEPARTAMENT DE SALUT - GENERALITAT DE CATALUNYA	Spain
FUNDACION PARA LA FORMACION E INVESTIGACION SANITARIAS DE LA REGION DE MURCIA	Spain
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UPPSALA LANS LANDSTING	Sweden
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EHKAISEVA PAIHDETYO EHYT RY FOREBYGGANDE RUSMEDELSARBETE EHYT RF	Finland
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ETABLISSEMENT FRANCAIS DU SANG	France
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BLUTSPENDEDIENST DES BAYERISCHEN ROTEN KREUZES GGMBH	Germany
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NHS NATIONAL SERVICES SCOTLAND	UK
OSTERREICHISCHES ROTES KREUZ	Austria

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DRK-BLUTSPENDEDIENST NORD - OST GGMBH	Germany
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ISTITUTO PER SERVIZI DI RICOVERO E ASSISTENZA AGLI ANZIANI	Italy
Anonimi Etairia Erevnas, Kainotomias kai Anaptiksis Tilematikis Texnologias - VIDAVO A.E.	Greece
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ELISAN RESEAU EUROPEEN POUR L'INCLUSION ET L'ACTION SOCIALE LOCALE ASSOCIATION	France
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PERIFEREIA STEREAS ELLADAS	Greece
KOPERAZZJONI INTERNAZZJONALI - MALTA (KOPIN) ASSOCIATION	Malta
UPPSALA UNIVERSITET	Sweden
KENTRIKI ENOSI DIMON KAI KOINOTITON ELLADOS	Greece
VEREIN MULTIKULTURELL	Austria
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MIGRANTAS EV	Germany
EUROPEAN INSTITUTE OF WOMEN'S HEALTH LIMITED	Ireland
UNIVERSITY OF GREENWICH	UK
ASSERTA GLOBAL HEALTHCARE SOLUTIONS	Spain
FAKULTNI NEMOCNICE U SV. ANNY V BRNE	Czech Republic
REGIONE EMILIA ROMAGNA	Italy
CHARITE - UNIVERSITAETSMEDIZIN BERLIN	Germany
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PRO MENTE OBEROSTERREICH-GESELLSCHAFT FUR PSYCHISCHE UND SOZIALE GESUNDHEIT VEREIN	Austria
CENTRA VOOR ALCOHOL EN ANDERE DRUGPROBLEMEN LIMBURG VZW	Netherlands
NARODNI USTAV DUSEVNIHO ZDRAVI	Czech Republic
FORUM PREVENZIONE ONLUS	Italy
CEPT CENTRE DE PREVENTION DES TOXICOMANIES	Luxembourg
STICHTING TACTUS VERSLAVINGSZORG	Netherlands

KOBENHAVNS UNIVERSITET	Denmark
SYDDANSK UNIVERSITET	Denmark
NORCE NORWEGIAN RESEARCH CENTRE AS	Norway
RIJKSUNIVERSITEIT GRONINGEN	Netherlands
UNIVERSIDAD DE LAS PALMAS DE GRAN CANARIA	Spain
CENTRE HOSPITALIER UNIVERSITAIRE DE NICE	France
MANO SEIMOS GYDYTOJAS	Lithuania
SOCIEDAD ESPANOLA DE MEDICINA DE FAMILIA Y COMUNITARIA	Spain
European Association for Clinical Pharmacology and Therapeutics	UK
CENTRE HOSPITALIER UNIVERSITAIRE DE RENNES	France
UNIVERSITAT INTERNACIONAL DE CATALUNYA	Spain
EUROMETROPOLE DE STRASBOURG	France
4I DIOIKISI YGEIONOMIKIS PERIFEREIAS MAKEDONIAS KAI THRAKIS	Greece
AGENZIA NAZIONALE PER I SERVIZI SANITARI REGIONALI	Italy
ADMINISTRACAO CENTRAL DO SISTEMA DESAUDE IP	Portugal
MINISTARSTVO ZDRAVLJE	Serbia
MAX RUBNER INSTITUT BUNDESFORSCHUNGSINSTITUT FUR ERNAHRUNG UND LEBENSMITTEL	Germany
INSTITOUTON YGEIAS TOU PAIDIOU	Greece
SLASKI UNIWERSYTET MEDYCZNY W KATOWICACH	Poland
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	UK
SO EUROPE EURASIA FOUNDATION	Ireland
ASSOCIATION MEDECINS DU MONDE	Belgium
INSTYTUT POMNIK CENTRUM ZDROWIA DZIECKA	Poland
UNIVERSITE LIBRE DE BRUXELLES	Belgium
THE CYPRUS FOUNDATION FOR MUSCULAR DYSTROPHY RESEARCH	Cyprus
STICHTING EAU FOUNDATION FOR UROLOGICAL RESEARCH	Netherlands
ACADEMISCH ZIEKENHUIS GRONINGEN	Netherlands
KATHOLIEKE UNIVERSITEIT LEUVEN	Belgium
MIDDLESEX UNIVERSITY HIGHER EDUCATION CORPORATION	UK
AARHUS UNIVERSITET	Denmark
ECLECTICA SAS DI BECCARIA FRANCA, ERMACORA ANTONELLA E C.	Italy
INSTYTUT PSYCHIATRII I NEUROLOGII	Poland
EUROPAISCHES ZENTRUM FUR WOHLFAHRTSPOLITIK UND SOZIALFORSCHUNG	Austria
FRANKFURT UNIVERSITY OF APPLIED SCIENCES	Germany
CHANGE, GROW, LIVE	UK
TECHNOLOGIKO EKPAIDEFTIKO IDRYMA ATHINAS	Greece
CMT PROOPTIKI CONSULTING MANAGEMENT TRAINING	Greece
SHEFFIELD HALLAM UNIVERSITY	UK
KONINKLIJKE NEDERLANDSE ORGANISATIE VAN VERLOSKUNDIGEN	Netherlands
ELLINIKO MESOGEIAKO PANEPISTIMIO	Netherlands

FODELSEHUSET	Sweden
MEDIZINISCHE HOCHSCHULE HANNOVER	Germany
COMPANY OF PSYCHOSOCIAL RESEARCH AND INTERVENTION (EPSEP)	Greece
PANEPISTIMIO PATRON	Greece
ISTITUTO NAZIONALE DI RIPOSO E CURA PER ANZIANI INRCA	Italy
REGIONE MARCHE	Italy
LIETUVOS SVEIKATOS MOKSLU UNIVERSITETAS	Lithuania
MINISTRY FOR THE FAMILY AND SOCIAL SOLIDARITY	Malta
CENTRUL NATIONAL DE SANATATE MINTALA SI LUPTA ANTIDROG	Romania
UNIVERSITATEA BABES BOLYAI	Romania
FUNDACION PARA LA INVESTIGACION DEL HOSPITAL CLINICO DE LA COMUNITAT VALENCIANA, FUNDACION INCLIVA	Spain
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NATIONAL UNIVERSITY OF IRELAND GALWAY	Ireland
AGENCE NATIONALE DE SECURITE DU MEDICAMENT ET DES PRODUITS DE SANTE	France
INFARMED - AUTORIDADE NACIONAL DO MEDICAMENTO E PRODUTOS DA SAUDE IP	Portugal
FONDAZIONE IRCCS ISTITUTO NAZIONALE DEI TUMORI	Italy
ORGANISATION OF EUROPEAN CANCER INSTITUTES	Belgium
PECSI TUDOMANYEGYETEM - UNIVERSITY OF PECS	Hungary
SIOP EUROPE ASBL	Belgium
SUOMEN SYOPAYHDISTYS -CANCERFORENINGEN I FINLAND RY - CANCER SOCIETY OF FINLAND CSF	Finland
NATIONAL CANCER REGISTRY BOARD	Ireland
GPOH GEMEINNUTZIGE GMBH	Germany
PANCARE	Netherlands
DEUTSCHE KREBSGESELLSCHAFT EV	Germany
ZORGINSTITUUT NEDERLAND	Netherlands
HAUPTVERBAND DER OSTERREICHISCHEN SOZIALVERSICHERUNGSTRAGER	Austria
LUDWIG BOLTZMANN GESELLSCHAFT GMBH	Austria
UMIT- PRIVATE UNIVERSITAT FUER GESUNDHEITSWISSENSCHAFTEN, MEDIZINISCHEINFORMATIK UND TECHNIK GMBH	Austria
FEDERAAL KENNISCENTRUM VOOR DE GEZONDHEIDSZORG	Belgium
AGENCIJA ZA KVALITETU I AKREDITACIJU U ZDRAVSTVU I SOCIJALNOJ SKRBI	Croatia
TARTU ULIKOOL	Estonia
HAUTE AUTORITE DE SANTE	France
GEMEINSAMER BUNDESAUSSCHUSS	Germany
STIFTUNG FUR QUALITAT UND WIRTSCHAFTLICHKEIT IM GESUNDHEITSWESEN	Germany
ETHNIKOS ORGANISMOS FARMAKON	Greece
ONASEIO KARDIOCHEIROURGIKO KENTRO	Greece

ORSZAGOS GYOGYSZERESZETI ES ELELMEZES-EGESZSEGUGYI INTEZET	Hungary
HEALTH INFORMATION AND QUALITY AUTHORITY	Ireland
THE HAUGHTON INSTITUTE FOR GRADUATE EDUCATION AND TRAINING IN THE HEALTH SCIENCES LIMITED	Ireland
AGENZIA ITALIANA DEL FARMACO	Italy
VALSTYBINE AKREDITAVIMO SVEIKATOS PRIEZIUROS VEIKLAI TARNYBA PRIE SVEIKATOS APSAUGOS MINISTERIJOS	Lithuania
AGENCJA OCENY TECHNOLOGII MEDYCZNYCH I TARYFIKACJI	Poland
UNIVERZITA KOMENSKEHO V BRATISLAVE	Slovakia
Ministrstvo za zdravje	Slovenia
AXENCIA GALEGA PARA A XESTION DO CONECEMENTO EN SAUDE	Spain
CONSEJERIA DE DESARROLLO ECONOMICO Y COMPETITIVIDAD-EUSKO JAURLARITZA-GOBIERNO VASCO	Spain
STATENS BEREDNING FOR MEDICINSK OCH SOCIAL UTVARDERING	Sweden
NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE	UK
STICHTING TRIMBOS- INSTITUUT, NETHERLANDS INSTITUTE OF MENTAL HEALTH AND ADDICTION	Netherlands
INSTITUT ZA RAZISKAVE IN RAZVOJ UTRIP ZAVOD	Slovenia
INSTITUTO EUROPEO DE ESTUDIOS EN PREVENCION	Spain
LIVERPOOL JOHN MOORES UNIVERSITY	UK
IFT NORD INSTITUT FUR THERAPIE UND GESUNDHEITSFORSCHUNG GEMEINNUTZIGE GESELLSCHAFT MIT BESCHRANKTER HAFTUNG	Germany
KAROLINSKA INSTITUTET	Sweden
UNIVERSITY COLLEGE LONDON	UK
KONINKLIJKE NEDERLANDSE CENTRALE VERENIGING TOT BESTRIJDING DER TUBERCULOSE (KNCV)	Netherlands
OSPEDALE SAN RAFFAELE SRL	Italy
UNIVERSITA DEGLI STUDI DI BRESCIA	Italy
DELFT IMAGING SYSTEMS BV	Netherlands
AGENCIA PIAGET PARA O DESENVOLVIMENTO	Portugal
SPORA SINERGIES SCCL	Spain
AZIENDA UNITA' SANITARIA LOCALE DI BOLOGNA	Italy
SPITALUL CLINIC DR VICTOR BABES BUCURESTI - SVB	Romania
UNIVERSITY OF BRISTOL	UK
UNIVERSITY COLLEGE LONDON HOSPITALSNHS FOUNDATION TRUST	UK
EUROPEAN SOCIETY OF CORNEA AND OCULAR SURFACE DISEASE SPECIALISTS	Ireland
FONDAZIONE BANCA DEGLI OCCHI DEL VENETO ONLUS	Italy
BLEKINGE LANS LANDSTING	Sweden
UNIVERSITEIT MAASTRICHT	Netherlands
NEDERLANDSE TRANSPLANTATIE STICHTING	Netherlands
ISTITUTO NAZIONALE PER LA PROMOZIONE DELLA SALUTE DELLE POPOLAZIONI MIGRANTI ED IL CONTRASTO DELLE MALATTIE DELLA POVERTA	Italy

ENTE STRUMENTALE ALLA CROCE ROSSA ITALIANA	Italy
AZIENDA OSPEDALIERO-UNIVERSITARIA ANNA MEYER	Italy
NHS 24 (SCOTLAND)	UK
VRIJE UNIVERSITEIT BRUSSEL	Belgium
FAKULTNI NEMOCNICE OLOMOUC	Czech Republic
NORRBOTTENS LANS LANDSTING	Sweden
ORGANIZACION NACIONAL DE TRASPLANTES	Spain
Universitair Ziekenhuis Gent	Belgium
DEUTSCHE GESELLSCHAFT FUR GEWEBETRANSPLANTATION GEMEINNUTZIGE GESELLSCHAFT MBH	Germany
TAMPEREEN YLIOPISTO	Finland
ECOLE ROYALE MILITAIRE - KONINKLIJKE MILITAIRE SCHOOL	Belgium
PHILIPS MEDIZIN SYSTEME BOBLINGEN GMBH	Netherlands
REGION SYDDANMARK	Denmark
PHILIPS ELECTRONICS NEDERLAND B.V.	Netherlands
CITY UNIVERSITY OF LONDON	UK
UNIVERSITAETSKLINIKUM WUERZBURG - KLINIKUM DER BAYERISCHEN JULIUS-MAXIMILIANS-UNIVERSITAT	Germany
UNIVERSITY OF HULL	UK
GESUNDES KINZIGTAL GMBH	Germany
UNIVERSITE LYON 1 CLAUDE BERNARD	France
UNIWERSYTET MEDYCZNY W LUBLINIE	Poland
BYLGARSKO DRUZHESTVO PO DEMENZII	Bulgaria
SYKEHUSET I VESTFOLD HF	Norway
THE UNIVERSITY OF LIVERPOOL	UK
STICHTING NEDERLANDS INSTITUUT VOOR ONDERZOEK VAN DE GEZONDHEIDSZORG	Netherlands
SVEUCILISTE U ZAGREBU FILOZOFSKI FAKULTET	Croatia
MEDIZINISCHE UNIVERSITAET WIEN	Austria
UNIVERZA V LJUBLJANI	Slovenia
STICHTING ARQ	Netherlands
AZIENDA UNITA SANITARIA LOCALE 11 EMPOLI	Italy
DEBRECENI EGYETEM	Hungary
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ASSOCIATION DOCTORS OF THE WORLD-GREEK DEPARTMENT	Greece
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STIFTELSEN KIRKENS BYMISJON OSLO	Norway
AZIENDA UNITA SANITARIA LOCALE DI REGGIO EMILIA	Italy
TRNAVSKA UNIVERZITA V TRNAVE	Slovakia
UNIWERSYTET JAGIELLONSKI	Poland

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FEDERAL AGENCY FOR MEDICINES AND HEALTH PRODUCTS	Belgium
AGENCIJA ZA LIJEKOVE I MEDICINSKE PROIZVODE	Croatia
STATNY USTAV PRE KONTROLU LIECIV	Slovakia
ORSZAGOS VERELLATO SZOLGALAT - OVSZ	Hungary
HELLENIC NATIONAL BLOOD EY A	Greece
INSTYTUT HEMATOLOGII I TRANSFUZJOLOGII	Poland
NARODOWE CENTRUM KRWI	Poland
AGENTIA NATIONALA DE TRANSPLANT	Romania
URAD VLADY CESKE REPUBLIKY	Czech Republic
ORSZAGOS TISZTIFOORVOSI HIVATAL	Hungary
LANDSPITALI UNIVERSITY HOSPITAL	Iceland
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DEUTSCHE GESELLSCHAFT FUR ERNAHRUNG E.V.	Netherlands
AID INFODIENST ERNAHRUNG, LANDWIRTSCHAFT, VERBRAUCHERSCHUTZ EV	Germany
Alexander Technological Educational Institute of Thessaloniki (TECHNOLOGIKO EKPAIDEFTIKO IDRYMA THESSALONIKIS)	Greece
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PANSTWOWY INSTYTUT WETERYNARYJNY - PANSTWOWY INSTYTUT BADAWCZY	Poland
INSTITUTO NACIONAL DE SAUDE DR. RICARDO JORGE	Portugal

INSTITUTUL NATIONAL DE CERCETARE DEZVOLTARE PENTRU MICROBIOLOGIE SI IMUNOLOGIE	Romania
HRVATSKI SAVEZ ZA RIJETKE BOLESTI	Croatia
RINNEKOTI SAATIO	Finland
UNIVERSITATEA DE MEDICINA SI FARMACIE GRIGORE T.POPA IASI	Romania
UNIVERZITETNI KLINICNI CENTER LJUBLJANA	Slovenia
UNIVERSITY OF NEWCASTLE UPON TYNE	UK
TobaccoFree Research Institute Ireland LBG	Ireland
FUNDACIO PRIVADA CLINIC PER A LA RECERCA BIOMEDICA	Spain
NORTHERN HEALTH AND SOCIAL SERVICESTRUST	UK
UNIVERSIDADE DE COIMBRA	Portugal
UNIVERSITY OF PELOPONNESE	Greece
THE ROBERT GORDON UNIVERSITY	UK
VALSTYBINE LIGONIU KASA PRIE SVEIKATOS APSAUGOS MINISTERIJOS	Lithuania
E-HALSOMYNDIGHETEN	Sweden
NHS HEALTH AND SOCIAL CARE INFORMATION CENTRE	UK
BIPRO GMBH	Germany
UMWELTBUNDESAMT	Germany
FUNDACION PRIVADA INSTITUTO DE SALUD GLOBAL BARCELONA	Spain
FUNDACIO CENTRE DE RECERCA EN EPIDEMIOLOGIA AMBIENTAL - CREAL	Spain
VLAAMSE INSTELLING VOOR TECHNOLOGISCH ONDERZOEK N.V.	Belgium
DUBLIN CITY UNIVERSITY	Ireland
SWANSEA UNIVERSITY	UK
EUROSAFE - THE EUROPEAN ASSOCIATIONFOR INJURY PREVENTION AND SAFETY PROMOTION	UK
FACULDADE DE ECONOMIA DA UNIVERSIDADE NOVA DE LISBOA	Portugal
UNIVERSIDADE NOVA DE LISBOA	Portugal
UNIVERSITA COMMERCIALE LUIGI BOCCONI	Italy
HOFMARCHER-HOLZHACKER MARIA	Austria
TECHNISCHE UNIVERSITAET BERLIN	Germany
INSTITUT DE RECHERCHE ET DOCUMENTATION EN ECONOMIE DE LA SANTE	France
ECOLE PRATIQUE DES HAUTES ETUDES	France
UNIVERSITY OF SURREY	UK
European Society of Oncology pharmacy	Luxembourg
DEUTSCHE GESELLSCHAFT FUR ONKOLOGISCHE PHARMAZIE	Netherlands
EESTI HAIGLAAPTEEKRITE SELTS	Estonia
LEKARNISKA ZBORNICA SLOVENIJE	Slovenia
UNIVERSITAETSKLINIKUM FREIBURG	Germany
STICHTING UNITED PARENT PROJECTS MUSCULAR DYSTROPHY	Netherlands
STICHTING DUCHENNE DATA FOUNDATION	Netherlands
ASSOCIATION INSTITUT DE MYOLOGIE	France

ASS FRANCAISE CONTRE LES MYOPATHIES	France
LATVIJAS UNIVERSITATE	Latvia
ROESSINGH RESEARCH AND DEVELOPMENT BV	Netherlands
UNIWERSYTET MEDYCZNY IM PIASTOW SLASKICH WE WROCLAWIU	Poland
ASTON UNIVERSITY	UK
ESCOLA SUPERIOR DE ENFERMAGEM DE COIMBRA	Portugal
UNIVERSIDADE DE AVEIRO	Portugal
ESTUDIOS DE SOFTWARE AVANZADO Y MANTENIMIENTO DE TECNOLOGIA SOCIEDAD LIMITADA	Spain
LANCASTER UNIVERSITY	UK
REGIONE PIEMONTE	Italy
REGIONE LIGURIA	Italy
UNIVERSIDAD DE LA IGLESIA DE DEUSTO	Spain
EUROPEAN REGIONAL AND LOCAL HEALTH AUTHORITIES ASBL	Belgium
CENTRE HOSPITALIER UNIVERSITAIRE DE TOULOUSE	France
CAISSE D ASSURANCE RETRAITE ET DE LA SANTE AU TRAVAIL DU LANGUEDOC ROUSSILLON	France
AZIENDA SANITARIA LOCALE BI	Italy
UNIVERSITA DEGLI STUDI DEL PIEMONTE ORIENTALE AMEDEO AVOGADRO	Italy
FUNDACION PARA LA INVESTIGACION DEL HOSPITAL UNIVERSITARIO LA FE DE LA COMUNIDAD VALENCIANA	Spain
LIETUVOS ISSETINES SKLEROZES SAJUNGA	Lithuania
UNIVERSIDAD AUTONOMA DE MADRID	Spain
PARC SANITARI SANT JOAN DE DEU	Spain
LANDESKRANKENANSTALTEN-BETRIEBSGESELLSCHAFT	Austria
UNIVERZITETNI REHABILITACIJSKI INSTITUT REPUBLIKE SLOVENIJE-SOCA	Slovenia
EUROPEAN ASSOCIATION OF SERVICE PROVIDERS FOR PERSONS WITH DISABILITIES	Belgium
Fachhochschule Kärnten - gemeinnützige Privatstiftung	Austria
UNIVERZITA KARLOVA	Czech Republic
FUNDACION PARA LA INVESTIGACION BIOMEDICA DEL HOSPITAL UNIVERSITARIO DE GETAFE	Spain
DIABETES FRAIL LIMITED	UK
CBO BV	Netherlands
Stichting Dutch Institute for Clinical Auditing	Netherlands
KEPLER UNIVERSITATSKLINIKUM GMBH	Austria
RUHR-UNIVERSITAET BOCHUM	Germany
SCUOLA SUPERIORE DI STUDI UNIVERSITARI E DI PERFEZIONAMENTO S ANNA	Italy
Ministarstvo vanjskih i europskih poslova	Croatia
UNIVERSITA DI PISA	Italy
AZIENDA SOCIO-SANITARIA TERRITORIALE (ASST) SANTI PAOLO E CARLO	Italy
National Administration of Penitentiaries	Moldova

Health Without Barriers - European Federation for Prison Health (HWBs)	France
CYPRUS NATIONAL ADDICTIONS AUTHORITY	Cyprus
MINISTRY OF JUSTICE AND PUBLIC ORDER	Cyprus
UNIVERSITA DEGLI STUDI DI ROMA LA SAPIENZA	Italy
CSI CENTER FOR SOCIAL INNOVATION LTD	Cyprus
VIENNA VACCINE SAFETY INITIATIVE EV	Germany
EUROPEAN ACADEMY OF PAEDIATRICS AISBL	Italy
EUROPEAN PARENTS ASSOCIATION	Austria
Associação para Investigação e Desenvolvimento da Faculdade de Medicina	Portugal
EUROPEAN UNIVERSITY CYPRUS	Cyprus
UNIWERSYTET RZESZOWSKI	Poland
UNIVERZITET U BEOGRADU - Filozofski fakultet	Serbia
EUROPEAN ALLIANCE AGAINST DEPRESSION EV	Germany
NATIONAL SUICIDE RESEARCH FOUNDATION	Ireland
Végeken Egészséglélektani Alapítvány	Hungary
AKADEMIA PEDAGOGIKI SPECJALNEJ IM.MARII GRZEGORZEWSKIEJ	Poland
ASSOCIATION FOR REGIONAL DEVELOPMENT AND MENTAL HEALTH	Greece
EESTI-ROOTSI VAIMSE TERVISE JA SUITSIDOLOOGIA INSTITUUT	Estonia
Stichting Wemos	Netherlands
FUNDATIA CENTRUL PENTRU POLITICI SISERVICII DE SANATATE	Romania
Medijski edukativni centar	Serbia
STICHTING VU	Netherlands
ASSOCIAZIONE CITTADINANZATTIVA ONLUS	Italy
UNIVERSITETET I SOROST-NORGE	Norway
PoliS-Lombardia	Italy
UNIVERSITA DEGLI STUDI DI PALERMO	Italy
Centro per la formazione permanente e l'aggiornamento del personale del servizio sanitario	Italy
Spaarne Gasthuis	Netherlands
COMITE PERMANENT DES MEDECINS EUROPEENS AISBL	Belgium
GROUPEMENT PHARMACEUTIQUE DE L'UNION EUROPEENNE AISBL*GPUE PHARMACEUTICAL GROUP OF THE EU	France
UNIVERSITEIT ANTWERPEN	Belgium
EUROPA MEDIA SZOLGALTATO NON PROFITKOZHASZNU KFT	Hungary
VAASAN YLIOPISTO	Finland
FUNDACION AVEDIS DONABEDIAN PARA LA MEJORA DE LA CALIDAD ASISTENCIAL	Spain
SVEUCILISTE U ZAGREBU MEDICINSKI FAKULTET	Croatia
INHWE LTD	Spain
Non-governmental organisations	
Smokefree Partnership	EU
Alzheimer Europe	EU

AIDS Action Europe, Deutsche Aidshilfe	Germany
European Forum for Primary Care	EU
European Public health Association (EUPHA)	EU
World Marrow Donor Association	International
Red Cross	International
World Obesity Federation	International
Results Education, Hellenic cancer society	Greece
Oxfam Italia Onlus (OXFAM Italy)	Italy
European Public Health Alliance (EPHA)	EU
European Network for Health Technology Assessments	EU
European Health Telematics Association	EU
Association of European Cancer Leagues (ECL)	EU
Health Action International (HAI)	EU
European Heart Network	EU
Red Cross EU Office (represents National Red Cross Societies in the EU	EU
European Network for Smoking & Tobacco Prevention (ENSP)	EU
the Norwegian Red Cross	Norway
the Icelandic Red Cross	Iceland
the International Federation of Red Cross and Red Crescent Societies)	International
Italian Red Cross	Italy
Médecins sans Frontières	International
ARCIGAY Italy	Italy
European Alcohol Policy Alliance	EU
EuroHealthNet	EU
Lila Milano (Italian League for Fighting AIDS)	Italy
Fondazione LILA Milano ONLUS	Italy
Eastern Partnership Civil Society Forum	Belgium
ANGEV-Pro.Civ. - Associazione Nazionale Guardie Ecologiche Volontarie e Protezione Civile	Italy
Health Literacy Coalition, Belgium	Belgium
REGenableMED Consortium	UK
Slovak League against Cancer	Slovakia
Apoyo Positivo	Spain
Correlation Network	Netherlands
Ehkäisevä päihdetyö EHYT ry	Finland
European AIDS Treatment Group	EU
European Critical Care Foundation	Neatherlands
European Federation of Allergy and Airways Diseases Patients' Association	Belgium
ILGA-Europe	EU
Mental Health Europe	EU
SKUC	Slovenia

TB Europe Coalition	EU
Results UK (RUK)	UK
Global Health Advocates (GHA)	International
Schools for Health in Europe Network Foundation	EU
IDF Europe - International Diabetes Federation	EU
European Health Management Association	EU
Health First Europe	EU
IHE-EUROPE	EU
Health Care Without Harm Europe	EU
European Brain Council	EU
European Kidney Health Alliance (EKHA)	EU
Public authority	
Ministry (Min) of Health of Bulgaria	Bulgaria
Ministry of Health of the Czech republic	Czechia
Ministry of Rep of Cyprus (Ministry of Health)	Cyprus
Bosnia & Herzegovina Ministry of Civil Affairs	Bosnia and Herzegovina
German Federal Min of Health	Germany
Min of Social Affairs Estonia	Estonia
Italia Min of Health	Italy
Min of Health, Social Services & Equality for Spain	Spain
Min of Health for Malta	Malta
Minister of Human Capacities of Hungary	Hungary
Min of Health Wellbeing & Sports of the Netherlands	Netherlands
Min of Health of the Slovak Republic	Slovakia
Diretorate-General of Health of Portugal (Ministry of Health)	Portugal
Min of Health of the Balearic Islands	Spain
Health Council of Andalusia	Spain
National Focal Points Austria	Austria
National Focal Points Belgium	Belgium
National Focal Points Bulgaria	Bulgaria
National Focal Points Croatia	Croatia
National Focal Points Cyprus	Cyprus
National Focal Points Czechia	Czechia
National Focal Points Denmark	Denmark
National Focal Points Estonia	Estonia
National Focal Points Finland	Finland
National Focal Points France	France
National Focal Points Germany	Germany
National Focal Points Greece	Greece
National Focal Points Hungary	Hungary

National Focal Points Ireland	Ireland
National Focal Points Italy	Italy
National Focal Points Latvia	Latvia
National Focal Points Lithuania	Lithuania
National Focal Points Luxemburgo	Luxembourg
National Focal Points Malta	Malta
National Focal Points Neatherlands	Netherlands
National Focal Points Poland	Poland
National Focal Points Portugal	Portugal
National Focal Points Romania	Romania
National Focal Points Slovakia	Slovakia
National Focal Points Slovenia	Slovenia
National Focal Points Spain	Spain
National Focal Points Sweden	Sweden
National Focal Points United Kingdom	UK
Programme Committee member Austria	Austria
National Institute of Public Health of Slovenia,	Slovenia
Austrian Agency for Health and Food Safety	Austria
Bulgarian National Centre of Public Health	Bulgaria
National Institute for Health Development of Estonia	Estonia
Carlos III Health Institute Spain	Spain
Hellenic National Public Health Organization	Greece
Croatian Institute for Public Health	Croatia
The Institute of Public Health in Ireland	Ireland
Norwegian Institute of Public Health	Norway
Moldova National Agency for Public Health (Ministry of Health)	Moldova
National Institute of Public Health of Romania	Romania
European Association for Palliative Care Belgium	Belgium
The Migrant Resource Centre (MRC)	UK
The National Institute for Health and Care Excellence (NICE) UK	UK
The National Institute of Public Health – National Institute of Hygiene Institute of Hygiene (NIPH-NIH) Poland,	Poland
Italian National Institute of Health (ISS) [Also known as Isituto Superiore di Sanita - ISS),	Italy
The National Agency for the Safety of Medicines and Health Products France (ANSM)	France
Iceland Health Security Committee	Iceland
UK Medicines and Healthcare Products Regulatory Agency (MHRA)	UK
Swedish Medical Products Agency	Sweden
National Authority of Medicines and Medical Devices of Romania	Romania
National Authority of Medicines and Healthcare products (Infarmed) Portugal	Portugal
Italian Medicine Agency (AIFA)	Italy

Danish Medicines Agency	Denmark
Finnish Medicine Agency (FIMEA)	Finland
Spanish Agency of Medicines and Sanitary Products (AEMPS)	Spain
Health Products Regulatory Authority of Ireland	Ireland
Bulgarian Drug Agency	Bulgaria
Cyprus Anti-Drugs Council	Cyprus
Servicio Canario de la Salud	Spain
National Institute of Public Health (NIPH) (Státní zdravotní ústav , SZÚ)	Czechia
The Institute of Public Health in Germany - Robert Koch Institute (RKI)	Germany
RSU Institute of Public Health	Latvia
Higienos Institutas	Lithuania
Sciensano Belgium	Belgium
Luxembourg Institute of Health	Luxembourg
Institute for Public Health FB&H	Bosnia and Herzegovina
spiez laboratory	Switzerland
INSERM France	France
Paul Ehrlich Institute	Germany
Federal Ministry of Social Affairs, Health, Care and Consumer Protection	Austria
Federal Public service Health, Food Chain Safety and Environment	Belgium
The Danish Ministry of Health	Denmark
Ministry of Social Affairs and Health	Finland
Ministry of Health of France	France
Ministry of Health Greece	Greece
Ministry of Health of Iceland	Iceland
Ministry of Health Ireland	Ireland
Ministry of Health Latvia	Latvia
Ministry of Health Lithuania	Lithuania
Ministry of Health Luxembourg	Luxembourg
Ministry of Health and Care Services of Norway	Norway
Ministry of Health of Slovenia	Slovenia
Ministry of Health and Social Affairs	Sweden
Federal Office of Public Health FOPH	Switzerland
Department of Health and Social Care	UK
Other - EU Citizen	
One EU citizen	
Other - Independent thematic experts	
Semmelweiss University Budapest	Hungary

Table 66. Stakeholders contacted – focus groups

Institution name/country	Involvement in the programme

Focus Group 1: Project Grants	
Lead or partner organisation of funded action	
Academisch Medisch Centrum bij de Universiteit van Amsterdam, Netherlands	Project Grant coordinator
ACADEMISCH ZIEKENHUIS LEIDEN, Netherlands	Project Grant coordinator
AZIENDA OSPEDALIERO UNIVERSITARIA PISANA, Italy	Project Grant coordinator
AZIENDA OSPEDALIERO-UNIVERSITARIA ANNA MEYER, Italy	Project Grant partner
AZIENDA SANITARIA LOCALE BI, Italy	Project Grant coordinator
Azienda ULSS 6 Euganea, Italy	Project Grant coordinator
CENTRE FOR ADVANCEMENT OF RESEARCH AND DEVELOPMENT IN EDUCATIONAL TECHNOLOGY LTD-CARDET, Cyprus	Project Grant partner
CMT PROOPTIKI CONSULTING MANAGEMENT TRAINING, Greece	Project Grant partner
ENTE STRUMENTALE ALLA CROCE ROSSA ITALIANA, Italy	Project Grant partner
ERASMUS UNIVERSITAIR MEDISCH CENTRUM ROTTERDAM, Netherlands	Project Grant coordinator
ESCUELA ANDALUZA DE SALUD PUBLICA SA, Spain	Project Grant coordinator
FOLKHALSOMYNDIGHETEN, Sweden	Project Grant coordinator
FONDAZIONE IRCCS ISTITUTO NAZIONALE DEI TUMORI, Italy	Project Grant coordinator
FONDAZIONE IRCCS ISTITUTO NEUROLOGICO CARLO BESTA, Italy	Project Grant coordinator
FUNDACION PARA LA INVESTIGACION BIOMEDICA DEL HOSPITAL UNIVERSITARIO DE GETAFE, Spain	Project Grant coordinator
INSTITUT NATIONAL DE LA SANTE ET DE LA RECHERCHE MEDICALE, France	Project Grant coordinator
ISTITUTO NAZIONALE PER LA PROMOZIONE DELLA SALUTE DELLE POPOLAZIONI MIGRANTI ED IL CONTRASTO DELLE MALATTIE DELLA POVERTA, Italy	Project Grant coordinator
KATHOLIEKE UNIVERSITEIT LEUVEN, Belgium	Project Grant coordinator
KLINIKUM DER JOHANN WOLFGANG VON GOETHE UNIVERSITAET, Germany	Project Grant coordinator
LANDSCHAFTSVERBAND WESTFALEN-LIPPE, Germany	Project Grant coordinator
REGIONE EMILIA ROMAGNA, Italy	Project Grant partner
SCOTTISH GOVERNMENT, UK	Project Grant coordinator
STICHTING KATHOLIEKE UNIVERSITEIT, Netherlands	Project Grant coordinator

STICHTING NEDERLANDS INSTITUUT VOOR ONDERZOEK VAN DE GEZONDHEIDSZORG, Netherlands	Project Grant coordinator
Stichting Sanquin Bloedvoorziening, Netherlands	Project Grant coordinator
STICHTING TRIMBOS- INSTITUUT, NETHERLANDS INSTITUTE OF MENTAL HEALTH AND ADDICTION, Netherlands	Project Grant coordinator
Stichting Wemos, Netherlands	Project Grant coordinator
SYN EIRMOS NGO OF SOCIAL SOLIDARITY ASTIKI ETAIRIA, Greece	Project Grant partner
UNIVERSITAETSKLINIKUM HEIDELBERG, Germany	Project Grant coordinator
Universitaetsklinikum Tuebingen, Germany	Project Grant coordinator
UNIVERSITY OF GLASGOW, UK	Project Grant coordinator
Healthcare service provider and organisations representing them	
ASSISTANCE PUBLIQUE - HOPITAUX DE PARIS, France	Project Grant coordinator
HOPITAUX UNIVERSITAIRES DE STRASBOURG, France	Project Grant coordinator
ISTITUTO GIANNINA GASLINI, Italy	Project Grant coordinator
Other	
ASTIKI MIKERDOSKOPIKI ETAIREIA PROLIPSIS, Greece	Project Grant coordinator
ETHNIKO KAI KAPODISTRIAKO PANEPISTIMIO ATHINON, Greece	Project Grant partner
EUROCARE - EUROPEAN ALCOHOL POLICY ALLIANCE AISBL, Belgium	Project Grant coordinator
FUNDACIO HOSPITAL UNIVERSITARI VALL D'HEBRON - INSTITUT DE RECERCA, Spain	Project Grant coordinator
INSTITUT NATIONAL DE LA SANTE ET DE LA RECHERCHE MEDICALE, France	Project Grant coordinator
MIGRANTAS EV Germany, Germany	Project Grant partner
NATIONAL CENTER OF INFECTIOUS AND PARASITIC DISEASES, Bulgaria	Project Grant partner
PRAKSIS, GREECE, Greece	Project Grant partner
ProMIS network, None listed	Project Grant partner
ROLE ERASMUC MC, Netherlands	Project Grant partner
Focus Group 2: Operating Grants	
Lead or partner organisation of funded action	
Academisch Medisch Centrum bij de Universiteit van Amsterdam (Netherlands)	Received Operating Grant(s): Gateway to Uncommon And Rare Diseases of the Heart; European Reference Network on HEART (GUARD-HEART)
AZIENDA OSPEDALIERO UNIVERSITARIA PISANA (Italy)	Received Operating Grant(s)

AZIENDA SANITARIA UNIVERSITARIA INTEGRATA DI UDINE (Italy)	Received Operating Grant(s)
CBO BV (Netherlands)	Received Operating Grant(s):
Non-governmental organisation	
ALZHEIMER EUROPE (UK)	Received Operating Grant(s): ALZHEIMER EUROPE; Alzheimer Europe (2015-2017); Alzheimer Europe 2016; Alzheimer Europe 2017; Alzheimer Europe 2018; Alzheimer Europe 2019; Alzheimer Europe 2020; Alzheimer Europe 2021
DEUTSCHE AIDS-HILFE EV (Germany)	Received Operating Grant(s): DEUTSCHE AIDS-HILFE EV; AIDS Action Europe - Stronger Together; Stronger Together; AIDS Action Europe - Continuity and Innovation 2017; AIDS Action Europe - Continuity and Innovation 2016; AIDS Action Europe - Continuity and Innovation
EU-patient (Europe-wide)	Received Operating Grant(s)
EUROPEAN HEART NETWORK AISBL (Europe-wide)	Received Operating Grant(s): Addressing the Burden of Cardiovascular Disease in a Year of Transition; European Heart Network - Cardiovascular Health at the Heart of EU Policies
EUROPEAN NETWORK FOR SMOKING PREVENTION (Europe-wide)	Received Operating Grant(s): EUROPEAN NETWORK FOR SMOKING PREVENTION; ENSP - The Network - United for a Tobacco Free Europe; Saving lives by ending tobacco in Europe - from grassroots networking at EU countries level to the partnership with the Presidency of the Council of the EU; Supporting the European Commission Green Deal and Europe's Beating Cancer Plan to address tobacco use - a global concern in a global public health crisis environment.; ENSP - The Network - Paving the way for a tobacco free Europe.; Bridging the gaps for a united Europe to denormalise tobacco use; ENSP year 2016: Building Europe's capacity to fight against the tobacco epidemic; ENSP action for year 2015
EUROPEAN PATIENTS FORUM FPE EPF (Europe-wide)	Received Operating Grant(s):
EUROPEAN PUBLIC HEALTH ALLIANCE (Europe-wide)	Received Operating Grant(s): Proposal for a Specific Grant Agreement 2020; Proposal for a Specific Grant Agreement 2019; EUROPEAN PUBLIC HEALTH ALLIANCE; 2021 Specific Grant Agreement - European Public Health Alliance (EPHA); EPHA SGA 2018; EPHA SGA-2017; EPHA Operating Grant Proposal 2016 SGA; EPHA 2015: Protecting and improving public health and well-being in all policies.
EUROPEAN PUBLIC HEALTH ASSOCIATION (Europe-wide)	Received Operating Grant(s): Operating Grant proposal by European Public Health Association (EUPHA) for operating costs of 2019; EUROPEAN PUBLIC HEALTH ASSOCIATION; Operating Grant proposal by European Public Health Association (EUPHA) for operating costs of 2020.; European Public Health Association (EUPHA) - proposal for operating activities in 2021; EUPHA Operating Grant
EURORDIS - EUROPEAN ORGANISATION FOR RARE DISEASES ASSOCIATION (Europe-wide)	Received Operating Grant(s): EURORDIS - EUROPEAN ORGANISATION FOR RARE DISEASES ASSOCIATION; EURORDIS SGA2021; EURORDIS RARE DISEASES EUROPE SGA 2020; EURORDIS RARE DISEASES EUROPE SGA 2019; EURORDIS RARE DISEASES EUROPE SGA 2018; EURORDIS RARE DISEASES EUROPE SGA 2017; EURORDIS SGA 2016; Proposal for Operating Grant Framework Partnership Agreement 2015-2017 for the European Organisation for Rare Diseases (EURORDIS)

FORUM DES PATIENTS EUROPEENS ASBL EUROPEAN PATIENTS FORUM FPE EPF (Europe-wide)	Received Operating Grant(s): EPF Annual Work Programme 2017; European Patients' Forum - Specific Grant Agreement 2016; EUROPEAN PATIENTS' FORUM - OPERATING GRANT 2015-2017
RESULTS EDUCATION (UK)	Received Operating Grant(s): Strengthening the capacity and capability of civil society to drive the TB response in Europe; TBEC: strengthening TB response in the WHO Europe region; Strengthening the role of civil society within the TB response in Europe
SCHOOLS FOR HEALTH IN EUROPE NETWORK FOUNDATION (Europe-wide)	Received Operating Grant(s): SCHOOLS FOR HEALTH IN EUROPE NETWORK FOUNDATION; Schools for Health in Europe network foundation 2021; Schools for Health in Europe Network Foundation (SHE); Schools for Health in Europe Network Foundation
SMOKEFREE PARTNERSHIP FONDATION (Europe-wide)	Received Operating Grant(s): SMOKEFREE PARTNERSHIP FONDATION; Preventing cancer and chronic diseases through smoking prevention: Proposal for a Specific Grant Agreement for the Smoke Free Partnership Coalition annual work programme 2019; Preventing cancer and chronic diseases through smoking prevention: SFP Coalition workplan in 2021; Preventing cancer and chronic diseases through smoking prevention - 2018 annual work plan for the Smoke Free Partnership; Preventing cancer and chronic diseases through smoking prevention; Smoking Prevention in Action: Smoke Free Partnership Coalition Operating Grant 2017; Smoking prevention in action: the Smoke Free Partnership Coalition
STICHTING DE REGENBOOG GROEP (the Netherlands)	Received Operating Grant(s):
STICHTING HEALTH ACTION INTERNATIONAL (the Netherlands)	Received Operating Grant(s): STICHTING HEALTH ACTION INTERNATIONAL; A Plan for Action: Ensuring Equitable, Affordable and Responsibly Used Medicines in the European Union; HAI_FY2017; HAI_FY2016; Health Action International (HAI) Europe Multi-annual Programme 2015-2017: Equitable access to medicines, their rational use and good governance in the European Union; Health Action International proposal for a Specific Grant Agreement on operating costs for 2020
STICHTING KATHOLIEKE UNIVERSITEIT (Belgium)	Received Operating Grant(s):
Thalassaemia International Federation (Cyprus)	Received Operating Grant(s):
World Marrow Donor Association (Europe-wide)	Received Operating Grant(s): Equal access for all patients to high quality cells for transplantation; High-quality blood stem cell products for all patients in need, while protecting the rights and welfare of the volunteer donors; Optimise the journey from donor recruitment to stem cell transplant; Equal access to high quality cells for transplants for donors whose rights and safety are protected.
WORLD OBESITY FEDERATION (Europe-wide)	Received Operating Grant(s): WORLD OBESITY FEDERATION; OBesity Training And Information Services in Europe - phase 2; Obesity Training And Information Services for Europe
ASSOCIATION MEDECINS DU MONDE (France)	Received Operating Grant(s)
ASSOCIATION EUROPEENNE DES LIGUES CONTRE LE CANCER ASBL (Belgium)	Received Operating Grant(s): ASSOCIATION EUROPEENNE DES LIGUES CONTRE LE CANCER ASBL; Correlation-European Harm Reduction Network; European Cancer Leagues Collaborating for Impact in Cancer Control (2019); Cancer Leagues Collaborating in Cancer Prevention and

	Control at the EU and National Level; European Cancer Leagues Collaborating for Impact in Cancer Control (2018); Cancer Leagues Collaborating in Cancer Prevention and Control at the National and European Level; European Cancer Leagues Collaborating for Impact in Cancer Control (2020)
Healthcare service providers and organisations representing them	
ERASMUS UNIVERSITAIR MEDISCH CENTRUM ROTTERDAM (the Netherlands)	Received Operating Grant(s): ERASMUS UNIVERSITAIR MEDISCH CENTRUM ROTTERDAM; European Reference Network for Craniofacial Anomalies and ENT Disorders 2019-2021; ERNICA work programme for 2019-2021; Rare craniofacial anomalies and ENT disorders; ERNICA SGA 2017; SGA ERNICA; ERN Rare Craniofacial Anomalies and ENT Disorders
Great Ormond Street Hospital for Children NHS Trust (UK)	Received Operating Grant(s): EpiCARE – a European Reference Network for rare and complex epilepsies; A European Network for Rare and Complex Epilepsies
HOPITAUX UNIVERSITAIRES DE STRASBOURG (France)	Received Operating Grant(s): Specific grant Agreement 2019-2021 with THE HOPITAUX UNIVERSITAIRES DE STRASBOURG; ERN-EYE
HOSPICES CIVILS DE LYON (France)	Received Operating Grant(s):
ISTITUTO ORTOPEDICO RIZZOLI (Italy)	Received Operating Grant(s):
KLINIKUM DER JOHANN WOLFGANG VON GOETHE UNIVERSITAET (Germany)	Received Operating Grant(s): European Reference Network for rare respiratory diseases (ERN-LUNG); ERN-LUNG Year 2 SGA
SERVICIO MADRILENO DE SALUD (Spain)	Received Operating Grant(s): 3rd to 5th annual work program ERN TransplantChild; SGA 2nd Yr ERN TransplantChild; ERN in Transplantation in Children (SOT HSCT)
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST (UK)	Received Operating Grant(s): THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST; ERN-RARE-LIVER: The European Reference Network in Rare Liver Disease; ERN RITA: European Reference Network on Rare Immunodeficiency, Autoinflammatory and Autoimmune Diseases: Year 2 Workplan; Rare Neuromuscular Disease European Reference Network; EUROPEAN REFERENCE NETWORK ON RARE IMMUNODEFICIENCY, AUTOINFLAMMATORY AND AUTOIMMUNE DISEASE NETWORK (ERN-RITA); ERN-RARE-LIVER: The European Reference Network in Rare Liver Disease; European Reference Network for Rare Neuromuscular Diseases
UNIVERSITAETSKLINIKUM HAMBURG-EPPENDORF (Germany)	Received Operating Grant(s)
UNIVERSITAETSKLINIKUM HEIDELBERG (Germany)	Received Operating Grant(s)
Universitaetsklinikum Tuebingen (Germany)	Received Operating Grant(s)
UNIVERSITAIR MEDISCH CENTRUM UTRECHT (the Netherlands)	Received Operating Grant(s)
ASSISTANCE PUBLIQUE - HOPITAUX DE PARIS (France)	Received Operating Grant(s): ASSISTANCE PUBLIQUE - HOPITAUX DE PARIS; EURO-NMD, an ERN for Rare Neuromuscular Diseases; EUROPEAN REFERENCE NETWORK FOR INTELLECTUAL DISABILITY TELEHEALTH AND CONGENITAL ANOMALIES; EUROPEAN REFERENCE NETWORK ON RARE HEMATOLOGICAL DISEASES; VASCERN 3-year Detailed Work programme for third to fifth year of the FPA implementation (March 2019-February 2022); European Reference Network for Rare, Low Prevalence, Diagnosed and Undiagnosed Skin Disorders - Year 3 to 5; EUROPEAN REFERENCE NETWORK ON RARE HEMATOLOGICAL DISEASES; VASCERN Specific Grant

	Agreement Proposal (Action Plan Year 2: March 2018-February 2019); European Reference Network for Rare, Low Prevalence, Diagnosed and Undiagnosed Skin Disorders - Year 2; European Reference Network (ERN) on Rare Multisystemic Vascular Diseases (VASCERN), SGA Proposal 2017; European Reference Network for Rare, Low Prevalence, Diagnosed and Undiagnosed Skin Disorders
CENTRE ANTICANCEREUX LEON BERARD (France)	Received Operating Grant(s): European Reference Network EURACAN - Specific Grant Agreement 2019-2022 - Detailed Work programme for third to fifth year of the FPA implementation; European Reference Network on Rare Adult Cancers - Specific Grant Agreement for year 2; EUROPEAN REFERENCE NETWORK ON RARE ADULT CANCERS
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (UK)	Received Operating Grant(s)
Academic and research organisation	
ST. ANNA KINDERKREBSFORSCHUNG (Austria)	Received Operating Grant(s): Paediatric Cancer European Reference Network Y3-5; Paediatric Cancer European Reference Network Y2; European Reference Network in Paediatric Cancer
ACADEMISCH ZIEKENHUIS LEIDEN (Netherlands)	Received Operating Grant(s)
Focus Group 3: Procurement contracts	
Governmental policy makers	
HaDEA	European Commission
SANTE-A1	Unit of DG SANTE (European Commission)
SANTE-A3	Unit of DG SANTE (European Commission)
SANTE-B1	Unit of DG SANTE (European Commission)
SANTE-C1	Unit of DG SANTE (European Commission)
SANTE-C3	Unit of DG SANTE (European Commission)
Focus Group 4: Joint Actions	
Coordinator of funded action	
ADVANTAGE	Contact point for the Joint Action: Managing Frailty. A comprehensive approach to promote a disability-free advanced age in Europe: the ADVANTAGE initiative
Best-ReMaP	Contact point for the Joint Action: Joint Action on Implementation of Validated Best Practices in Nutrition
EU-JAV	Contact point for the Joint Action: European Joint Action on Vaccination
InfAct	Contact point for the Joint Action: Information for Action
INTEGRATE	Contact point for the Joint Action: Joint Action on integrating prevention, testing and linkage to care strategies acros HIV, viral hepatitis, TB and STIs in Europe (INTEGRATE)
JADECARE	Contact point for the Joint Action: Joint Action on implementation of digitally enabled integrated person-centred care
JATC	Contact point for the Joint Action: Joint Action on Tobacco Control
Governmental Public Health Institutions	
Finnish institute for health	Involved in Joint Action: Strengthened International Health Regulations and Preparedness in the EU - Joint Action

French National Institute of Health and Medical Research (INSERM)	Involved in Joint Action: European Joint Action on antimicrobial resistance and associated infections
Insitituto superioire di sanita, Rome	Involved in Joint Actions: Joint Action Health Equity Europe; facilitating the Authorisation of Preparation Process for blood and tissues and cells
National Institute of Public Health of the Republic of Slovenia	Involved in Joint Action: Innovative Partnership for Action Against Cancer
Governmental policy makers	
Portuguese Ministry of Health representation	Involved in several Joint Actions
The Norwegian Directorate of Health; Norway (coordinator)	Involved in Joint Action: Joint Action to Strengthen Health preparedness and response to Biological and Chemical terror attacks.
Academic or research organisation	
National Institute of Public Health of the Republic of Slovenia	Involved in Joint Action: Innovative Partnership for Action Against Cancer
University of Thessaly	Involved in Joint Action: Preparedness and action at points of entry (coordinator)
Focus Group 5: all funding mechanisms	
Governmental Policy makers	
SANTE-C1	Unit of DG SANTE (European Commission)
SANTE-C3	Unit of DG SANTE (European Commission)
SANTE-C3	Unit of DG SANTE (European Commission)
SANTE-A1	Unit of DG SANTE (European Commission)
SANTE-B1	Unit of DG SANTE (European Commission)

Table 67. Stakeholders contacted - interviews

Institution name	Country
Academic and research organisations	
Aletta Jacobs School of Public Health	Netherlands
Karolinska Institute Sweden	Sweden
Mario-Negri Institute for Pharmacological Research Italy	Italy
Phned	Netherlands
Stakeholder involved in the Joint Action Promoting Implementation of Recommendations on Policy, Information and Data for Rare Diseases (RD-ACTION)	Europe-wide
University of Greenwich	UK
Government policymakers	
European and International Affairs DPT – Covid Crisis Center (Directorate General for Health) (France)	France
Austrian Ministry of Health	Austria
Bulgarian government	Bulgaria
Central Government Ministry for Health - Ireland	Ireland
Danish Health Authority	Denmark
Department for Health Ministry of Civil Affairs of Bosnia and Herzegovina	Bosnia and Herzegovina
Department of European Affairs Ministry of Health (Cyprus)	Cyprus

Department of International Cooperation - Ministry of Health (Poland)	Poland
Department of International Relations - Directorate-General of Health (Portugal)	Portugal
DG SANTE	European Commission
Directorate of Health (Embaetti landlaeknis) (Iceland)	Iceland
Division of Financial Analysis - Budget and Investment Department; Ministry of Health of the Republic of Latvia	Latvia
European and International Affairs Mission - Directorate General of Health - Ministry of Solidarity and Health (France)	France
Federal Ministry of Social Affairs, Health, care and consumer protection Section (Belgium)	Belgium
Federal Ministry of Social Affairs, Health, care and consumer protection Section V (Austria)	Austria
Health Promotion Department - Ministry of Health (Lithuania)	Lithuania
Implementation of International Projects and International Policies - Section of European Programmes and Projects	Slovakia
International Research Programmes - Instituto de Salud Carlos III (Spain)	Spain
Ministry of Health	Croatia
Ministère de la Santé (Luxembourg)	Luxembourg
Ministry for Health (Malta)	Malta
Ministry of Health - Directorate General for Public Health and Healthcare Services (Greece)	Greece
Ministry of Health - Implementation and Coordination Unit Programme (Romania)	Romania
Ministry of Health Department of Prevention and Communication (Italy)	Italy
Ministry of Health Lithuania	Lithuania
Ministry of Health of the Republic of Slovenia	Slovenia
Ministry of Health of the Slovak Republic	Slovakia
Ministry of Human Resources - Department of HR Strategy in the Health Sector (Hungary)	Hungary
Ministry of Social Affairs and Health (Finland)	Finland
Monitoring and Evaluation Department la Ministry of Health Republic of Moldova	Moldova
NHS European Office (UK)	UK
Norwegian Directorate for Health	Norway
Office of the Permanent Secretary (Malta)	Malta
Permanent Representation of Hungary to the EU	Hungary
Policy Evaluation and External Relations Unit (Ireland)	Ireland
Prevention Department - National Institute for Health Development (Estonia)	Estonia
Programme Implementation and Coordination Unit, Ministry of Health (Romania)	Romania
Public Health Authority Belgium	Belgium
Referat Grundsatzfragen, Gesundheitsberichterstattung, Europäische und internationale Angelegenheiten - Bundesministerium für Gesundheit (Germany)	Germany
Regional Ministry of Health and Families of Andalusia (Spain)	Spain
Rijksdienst voor Ondernemend Nederland - Ministerie van Economische Zaken	The Netherlands
Sector for European integration and international cooperation - Ministry of Health of Serbia	Serbia
University Medical Center Hamburg-Eppendorf	Germany

Governmental public health organisations	
Agency for medicinal products and medical devices of Croatia	Croatia
Agency for Medicinal Products and Medical Devices of the Republic of Slovenia	Slovenia
ANSM	France
Association of Schools of Public Health in the European Region (ASPHER)	Europe-wide
Association of specialists in public health disciplines in the Federation of Bosnia and Herzegovina	Bosnia and Herzegovina
Austrian Agency for Health and Food Safety	Austria
Austrian Public Health Association	Austria
Bulgarian Drug Agency	Bulgaria
Bulgarian Public Health Association	Bulgaria
Croatian Public Health Association	Croatia
Czech Society of Social Medicine and Health Care Management	Czechia / Czech Republic
Danish Medicines Agency	Denmark
Danish Society of Public Health	Denmark
Department of Public Health of the Babeș-Bolyai University	Romania
ESCUELA ANDALUZA DE SALUD PUBLICA SA (Spain)	Spain
European Centre for Disease Prevention and Control	Europe-wide
European Medicines Agency	Europe-wide
European Society for Prevention Research (EUSPR)	Europe-wide
European Society for Quality in Healthcare (ESQH)	Europe-wide
European Union of Medical Specialists (UEMS) - Section for Public Health	Europe-wide
Federal Agency for Medicines and Health Products (FAMHP)	Belgium
Federal Institute for Drugs and Medical Devices	Germany
Finnish Medicines Agency	Finland
German Public Health Association - DGPH	Germany
German Society of Medical Sociology	Germany
GGD GHOR Nederland	Netherlands
Health Products Regulatory Authority (HPRA)	Ireland
Health Promotion Union of Estonia	Estonia
Healthcare and Youth Care Inspectorate, Ministry of Health, Welfare and Sport	Netherlands
Hungarian Association of Public Health Training and Research Institutions - NKE	Hungary
Institut National de la Sante et de la Recherche Médicale (INSERM)	France
INSTITUT SCIENTIFIQUE DE SANTE PUBLIQUE (Belgium)	Belgium
INSTITUTE OF HEALTH INFORMATION AND STATISTICS OF THE CZECH REPUBLIC	Czechia / Czech Republic
ISTITUTO NAZIONALE DI RIPOSO E CURA PER ANZIANI INRCA (Italy)	Italy
Italian Medicines Agency	Italy
Italian Society of Hygiene, Preventive Medicine and Public Health	Italy
Karolinska Institute, Department of Global Public Health	Sweden
Kooperationsverbund 'Hochschulen für Gesundheit' (Germany)	Germany
Latvian Centre for Disease Prevention and Control	Latvia
Law & Non-Communicable Diseases Unit (UK)	UK

Lithuanian Public Health Association	Lithuania
Maastricht University, Department of International Health	Netherlands
Malta Association of Public Health Medicine	Malta
Medicines Evaluation Board	Netherlands
Ministry of Health	Luxembourg
Ministry of Health - Pharmaceutical Services	Cyprus
NACIONALNI INSTITUT ZA JAVNO ZDRAVJE (NIJZ, National Institute of Public Health) (Slovenia)	Slovenia
National Authority of Medicines and Medical Devices of Romania	Romania
National Health Agency of Sweden	Sweden
National Institute of Pharmacy and Nutrition	Hungary
National Institute of Public Health of the Czech Republic	Czechia
National Organization for Medicines	Greece
National School of Public Health, Management and Professional Development	Romania
NIVEL	Netherlands
Norwegian Medicines Agency	Norway
Norwegian Public Health Association	Norway
NOVA National School of Public Health (NOVA NSPH)	Portugal
Office for Registration of Medicinal Products, Medical Devices and Biocidal Products	Poland
ORSZAGOS TISZTIFOORVOSI HIVATAL (Hungary)	Hungary
Panhellenic Union of Public Health Physicians of National Health System (PEIDY E.S.Y.) (Greece)	Greece
Polish Society of Public Health	Poland
Portuguese Association for the Public Health Promotion	Portugal
Portuguese Association of Public Health Doctors	Portugal
Public Health Agency of Sweden (Folkhälsomyndigheten)	Sweden
Public health Association of Latvia	Latvia
REGISTRUL NATIONAL AL DONATORILOR VOLUNTARI DE CELULE STEM HEMATOPOIETICE (Romania)	Romania
RIVM	Netherlands
Romanian Public Health and Health Management Association	Romania
SAVEZ - Slovak Public Health Association	Slovakia
Sciensano (Belgium)	Belgium
Serbian Public Health Association	Serbia
Slovenian Institute of Public Health	Slovenia
Slovenian Medical Society - Slovenian Preventive Medicine Society	Slovenia
Société Française de Santé Publique	France
Society for Social Medicine in Finland	Finland
Society of Social Medicine - Public Health of Bosnia and Herzegovina	Bosnia and Herzegovina
Spanish Agency for Medicines and Health Products	Spain
State Agency of Medicines	Estonia
State Agency of Medicines	Latvia
State Institute for Drug Control	Czechia / Czech Republic
Swedish Medical Products Agency	Sweden

The Bridge Foundation	Italy
International Association for Communication in Healthcare (EACH)	Europe-wide
Healthcare professionals' associations	
Council of occupation Therapists for the European Countries (COTEC)	Europe-wide
eHealth Network	Europe-wide
European Association of Dental Public Health (EADPH)	Europe-wide
European Federation of Nurses Associations	Europe-wide
European Forum for Primary Care (EFPC)	Europe-wide
European Health Management Association (EHMA)	Europe-wide
European Midwives Association	Europe-wide
Standing Committee of European Doctors (CPME)	Europe-wide
The European Society for Paediatric Oncology (SIOP Europe)	Europe-wide
Healthcare service provider and organisations representing them	
European Hospital and Healthcare Federation (HOPE)	Europe-wide
European Union of Private Hospitals (UEPH)	Europe-wide
European University Hospital Alliance (EUHA)	Europe-wide
VšĮ: Vilnius University Hospital Santaras Klinikos	Europe-wide
International public health organisations	
Council of Europe	Europe-wide
European Observatory on Health Systems and Policies	Europe-wide
International Migration Organisation	International
OECD	International
WHO	International
Non-governmental organisations	
Correlation-European Harm Reduction Network	Europe-wide
European Network for Smoking & Tobacco Prevention (ENSP)	Europe-wide
European Public Health Association (EUPHA)	Europe-wide
Federation for Health	Netherlands
Health Action International (HAI)	International
Mental Health Europe	Europe-wide
Migrants e.V.	International
Other	
Agency for medicinal products and medical devices (Croatia)	Croatia
Other: stakeholder contacted because of role in specific joint action	
ANSES (France)	France
Department of Public Health of the Babeș-Bolyai University	Romania
Federal Institute for Pharmaceuticals and Medical Products (Germany)	Germany
Ministry of Health Lithuania	Lithuania
NHS Education for Scotland Digital Service	UK
Stakeholder involved in the Joint Action Efficient response to highly dangerous and emerging pathogens at EU level (EMERGE)	Europe-wide
UPV Universitat Politècnica de València	Spain
Zorginstituut Nederland	Netherlands
Patients and services users and organisations representing them	

AIDS Action Europe	Europe-wide
Alzheimer Europe	Luxembourg
European Cancer Patient Coalition	Europe-wide
European Patients Forum (EPF)	Europe-wide
European Renal Association/European Dialysis and Transplantation Association (ERA-EDTA)	Europe-wide
EURORDIS (The Voice of Rare Disease Patients in Europe)	Europe-wide
The European Consumer Organisation (BEUC)	Europe-wide

Annex 6.1.B Actions taken to disseminate the consultations

Consultation method	Engagement activity carried out	Dates (all in 2022)
All consultation methods	Overview of the 3rd Health Programme, the purpose and scope of the study and the upcoming consultations – Stakeholder Network	10 February
Open Public Consultation and targeted stakeholder survey	Information posted on Health Policy Platform (HPP) inviting stakeholders to join the stakeholder network. Information included about the purpose of the study and the consultation strands.	17 February
	Reminder post about both consultations and deadlines – Agora Network and HPP newsletter	14 March
	Reminder post about both consultations and deadlines – Stakeholder Network	18 March
	Reminder post about both consultations and deadlines – Agora Network and HPP newsletter	28 March
	Reminder post about both consultations and deadlines - Agora Network and HPP newsletter	12 April
	DG SANTE sent invitation to members of the Programme Committee inviting them to take part in the OPC or targeted stakeholder survey	03 May
	On 6th May, ICF requested DG SANTE and HaDEA to send a mailing list of beneficiaries /participants in the 3rd health programme so the study team could invite them to take part in the survey. HaDEA did not have this list available. DG SANTE agreed to send out a reminder email on the OPC and targeted stakeholder survey from the DG SANTE Functional Mailbox using ICF's stakeholder contacts database.	6 May
OPC	Email reminder sent from DG SANTE Functional Mailbox to contacts collated by ICF	18 May
	Email reminder sent from DG SANTE Functional Mailbox to contacts collated by ICF	23 May
	Email reminder sent from DG SANTE Functional Mailbox to contacts collated by ICF	30 May
	Deadline for OPC extended from 03 to 10 June due to online questionnaire being inaccessible to attendees due to technical issues with DG SANTE's server. ICF informed of this on 07 June.	3 June
	Additional response to OPC sent by SANTE to ICF	13 June
Targeted stakeholder survey	First email sent to all stakeholder contacts (702 invitations sent)	11 March
	DG SANTE emailed NFPs	March
	DG SANTE emailed NFPs and Programme Committee members that did not consent to have their details sent to ICF	March
	First reminder sent	7 April
	Second reminder sent to all participants who had not completed any of the survey (639 reminders sent)	13 April
	Targeted email sent to stakeholders who partially completed the survey, encouraging them to complete and submit their responses and to offering assistance in supporting them to complete the survey (73 emails sent)	13 April
	Targeted email sent to stakeholders who partially completed the survey, encouraging them to complete and submit their responses	26 April

Consultation method	Engagement activity carried out	Dates (all in 2022)
	and to offering assistance in supporting them to complete the survey including the option to carry out a short phone call	
Focus Groups	Invitation for Project Grants and Joint Actions Focus group sent	6 April
	Reminder email sent for Project Grants focus group to specific stakeholders	11 April
	Reminder email sent for Project Grants focus group to specific stakeholders	12 April
	Reminder email sent for Project Grants focus group to specific stakeholders	13 April
	Additional desk research caried out to find more targeted stakeholder contacts for specific Project Grants. Invitations to Project Grants focus group sent to these stakeholders.	14 April
	Additional desk research caried out to find more targeted stakeholder contacts for specific Project Grants. Invitations to Project Grants focus group sent to these stakeholders.	19 April
	Additional desk research caried out to find more targeted stakeholder contacts for specific Project Grants. Invitations to Project Grants focus group sent to these stakeholders.	20 April
	Agenda and guidance note sent to final participants for focus group on Project Grants	25 April
	Additional desk research carried out to find specific named contacts for Joint Actions and Operating Grants issued under 3rd Health Programme	End of April and early May
	Email invitations sent for focus group on Joint Actions	03 May
	Email invitations sent for focus group on Operating Grants	04 May
	Email invitations sent for focus group on Operating Grants	06 May
	Participants of Joint Actions Focus group notified that there had been a change of date to allow more stakeholders to attend.	09 May
	Email invitations sent for focus group on Operating Grants	10 May
	Agenda and guidance note sent to final participants for focus group on Operating Grants	11 May
	Agenda and instructions sent to final participants for focus group on Procurement contracts	13 May
	Targeted emails and follow-up emails sent to potential participants for Joint Actions focus group. Agenda and instructions sent to those who confirmed their participation.	16 May
	Email invitations sent to additional participants for Procurement Contracts focus group	16 May
	Agenda and instructions sent to those who confirmed their participation in the focus group on all funding mechanisms	18 May
	Agenda and instructions sent to those who confirmed their participation in the focus group on Joint Actions	19 May
	Thank you email sent to all attendees including PowerPoint slides and invitation to take part in a follow-up interview	08 June
Interviews	Initial invitation email sent to selected stakeholder groups as per the sampling strategy	30 and 31 March
	Reminder email sent to selected stakeholder groups as per the sampling strategy	20 April

Consultation method	Engagement activity carried out	Dates (all in 2022)
	Individual email exchanges with stakeholders to arrange a suitable date and time for interview	Throughout April, May and June
	Invitation email sent to further stakeholder groups	5 May
	Invitation email sent to further stakeholder groups	12 May
	Invitation email sent to further stakeholder groups	16 May
	Invitation email sent to additional contacts for Governmental authorities, National Focal Points and Programme Committee Members who agreed to share their contacts with us.	17 and 18 May
	ICF sent email arranging follow-up interviews with potential participants of the last focus group on all funding mechanisms.	24 May
	Additional desk research carried out to find more named contacts. Invitation email sent to these stakeholder contacts	26 May
	Additional desk research carried out to find more named contacts. Invitation email sent to these stakeholder contacts	31 May
	Additional desk research carried out to find more named contacts for government authorities and public health institutions. Invitation email sent to these stakeholder contacts	06- 14 June

A6.2 Interview summary report

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1. Introduction

In accordance with the Better Regulation Guidelines, this document provides a factual summary of the Stakeholder Interviews carried out in support of the *Study to support the ex-post evaluation of the European Commission's Third Health Programme*. 34 interviews were carried out between 21/04/2022 and 29/07/2022.

This report is structured as follows:

- Section 2 presents the approach to the stakeholder interviews.
- Section 3 provides an overview of the results.

2. Approach to the consultation

The objective of the interviews was to collect qualitative information from stakeholders on their views of the 3rd Health Programme (3HP). The findings of the interviews were analysed and compared with the findings from the desk phase and other consultation activities (targeted stakeholder survey, Open Public Consultation, and focus groups) for use in the final report for the study.

2.1. Stakeholder selection

Seven key stakeholder groups (governmental organisations and policy makers, public health organisations, international organisations, academic and research organisations, NGOs, companies/business organisations) were identified by the study team.

A list of specific organisations within each group were defined based on the public facing database of the 3HP which listed 'coordinator' and 'partner' organisations. Additional desk research was conducted by the study team to find specific named contacts and organisations who may have interacted with the Programme. The study team did not have access to a stakeholder contacts list and so had to build its own database, using publicly available email addresses. Occasionally, interviewees recommended relevant stakeholders who were approached to fill gaps in the study.

The contacted stakeholder list can be found in Annex 1.

All identified stakeholders received an invitation email, encouraging them to agree to participate in an interview. As soon as stakeholders responded to the invitation, a follow-up email was sent, asking them to provide a list of availabilities during a given timeframe. A detailed log of all invited participants' availabilities was kept, and this was updated once an interview was arranged and completed. After being invited to an interview, each stakeholder that had not responded to the invitation was contacted up to two additional times.

An overview of the type of stakeholders who participated in the Stakeholder Interviews is shown in Table 64 below.

Table 68. Summary of type of stakeholder who participated in the Stakeholder Interviews

Types of stakeholders	Number of participants
Government policymakers (EU Institutions, National Government Representatives)	10
Governmental public health organisations	7
International public health organisations	2
Academic and research organisations	4
Non-g539 overnmental organisations	4

Healthcare professionals' associations	4
Healthcare service providers and organisations representing them	1
Patients and service users and Organisations representing them	2

2.2. Limitations

Multiple invites were sent to stakeholders from 30/03/2021 to 27/06/2021, however targets per stakeholder group were not met for two groups: government policymakers and healthcare service providers and organisations representing them. The target for government policymakers was 20 and 10 interviews were conducted; the target for healthcare service providers and organisations representing them was 2-3, and 1 interview was conducted. While the target was to have 45 participants in the interviews, despite substantial attempts to engage with stakeholders, 34 stakeholders participated in total. This figure includes follow-up interviews which were scheduled to compensate for a focus group with DG SANTE staff on 'Procurement contracts' and 'All funding mechanisms'. This is because the participation from DG SANTE was limited due to lack of staff availability.

3. Summary of key issues

Each interview was tailored to the stakeholder being interviewed, taking into account their relation to and involvement with the 3HP. As the interviews ran concurrently with the other consultation activities (focus groups, open public consultation and stakeholders survey), the interviews were also used to plug gaps which emerged from the other consultation activities and the desk phase of the study. Generally, the interviews focussed on stakeholders' views of the relevance, effectiveness, efficiency, coherence, and EU-added value of the 3HP.

3.1 Relevance

A number of health needs during the time of the Programme were identified by participants, including in relation to health inequalities, mental health needs, health systems improvements, non- communicable diseases, rare diseases and monitoring and responding to cross-border health threats. Overall, stakeholders across all groups reported that 3HP has been relevant in addressing these needs across the programme period, but that the depth of focus may have been limited for some health issues due to the broad focus of the Programme. For example, some government policy makers reported that 3HP was aligned with national level policies, whilst others noted that some health needs such as in the area of mental health were not sufficiently addressed in 3HP but rather in preceding programme (2HP), but also featuring in the current EU4Health programme (2021-2027).

19. The link between the objectives, thematic priorities and funded actions of the Programme was discussed. Stakeholders largely agreed that the funded actions implemented under the Programme were aligned with the objectives and thematic priories of 3HP. However, some noted that a lack of quantifiable objectives (such as quantifiable improvements in healthy life expectancy) limited the relevance (and potential) of the Programme.

20. At the national level, stakeholders reported that positively, Member States were given the opportunity to integrate their national health priorities into the Annual Work Programmes. However, one governmental public health stakeholder noted that this

was dependent on the availability of national staff and that some topics were prioritised due to the engagement of staff with thematic expertise in these areas.

21. With regard to citizen's needs, stakeholders reported that citizens' engagement was limited due to a lack of dissemination of the results of the Programme.

3.2. Effectiveness

Overall, stakeholders across all groups interviewed felt that the 3HP produced valuable qualitative and quantitative results at national, EU, and to a lesser degree, international level. Stakeholders highlighted the effectiveness of the Best Practice Portal, the Joint Actions and Project Grants' funding mechanisms, and ERNs in contributing to a more comprehensive and uniform approach to health and healthcare in the EU and Member States (depending on national capacity). Most stakeholders also felt that the Programme contributed to improvements in health and healthcare in the EU and at Member State level. Joint Actions had reportedly helped Member States establish national action plans and implement legislation, regulations, and policies in several key areas (AMR, alcohol, mental health, HTAs), and some stakeholders reported that findings impacted decision-making at EU level. A few stakeholders also reported that the Programme contributed to the EU's influence on health and healthcare standards, policies and practices at international level. Some tools and products generated through the 3HP were used in non-EU countries and Operating Grants were seen to be particularly effective in developing a 'global health approach', creating stakeholder networks which could respond to urgent health needs. Barriers to the effectiveness of the 3HP in influencing health solutions at an international level were seen as factors which distanced projects from policy.

Many stakeholders felt that the Programme's objectives had been met, and that 3HP funding mechanisms and the Programme's design had strongly influenced observed achievements. Stakeholders highlighted that work in the areas of AMR, vaccination, alcohol, nutrition, and tobacco, funded through the 3HP, were particularly effective in generating healthcare solutions and tackling health challenges. The scope of the Programme was widely perceived to be well-defined and 'strong joint alignment' of objectives improved project delivery. The main factors which influenced objectives being partially met or unmet was reported as being a lack of Member State capacity and co-funding requirements.

The extent to which recommendations from previous evaluations had been implemented divided stakeholders. With a few exceptions, there was a general lack of awareness as to whether DG SANTE spelt out how actions targeting health promotion and health systems should generate EU added value and whether the EU-added value criteria had been fully integrated into the application process. Generally, stakeholders felt clearer guidance was needed. In terms of monitoring, several stakeholders praised the shift to an electronic monitoring system and felt that Project Grant monitoring platforms were useful. Many stakeholders, however, reported that monitoring procedures remained burdensome for those without technical expertise and for smaller organisations, and a few stakeholders mentioned the need for more 'harmonised' monitoring systems to assess health indicators across the EU and between and within countries, and to monitor activities per programme objective and per priority. Similarly, many stakeholders felt that although improved, dissemination could be further pushed by the Commission. Although research collaboration was perceived to be strong, some stakeholders felt that crucial groups were not reached through dissemination (including the private sector, health services, national focal points, health specialists, the wider population, and healthcare professionals). Several stakeholders noted that the findings of funded actions needed to be grounded in policy implementation instead of document dissemination.

A few stakeholders reported there was a more concerted effort by Member States and the Commission throughout the 3HP to embed sustainability in planning, including through the

addition of theobligatory WP4 about sustainability. Those who felt that the Programme results, and effects, were likely to be sustainable mentioned the longevity of actions with follow-up activities (e.g., EUnetHTA) and actions which clearly supported policy and legislative development. Main concerns were that the results from the Programme were not always integrated into policies due to there being no overarching policy framework in which to feed results. A lack of permanent funding and opportunities for further funding was also raised as a barrier to sustainability of results. To improve sustainability of actions, stakeholders felt a more comprehensive and coordinated approach was needed, for example, one stakeholder from an academic and research organisation suggested a mechanism through which the Commission could identify and fund sustainability measures for projects with added value.

3.3. Efficiency

Across all interviewed groups, when explicitly asked to what extent 3HP was cost-effective, stakeholders qualitatively reported that 3HP and the funded actions they worked on were cost-effective in that the results delivered were proportionate to the budget spent. In particular, Joint Actions were mentioned as being a particularly cost-effective funding mechanism due in part to the high participation of Member States.

Sustainability of funded actions was mentioned as a barrier to cost-effectiveness. One academic research stakeholder reported that outputs were not planned with sustainability in mind, and that when the project and the 3HP funding ends, Member States have to continue through their own funding means, or the action would cease. This stakeholder noted that there should be a mechanism within the 3HP to continue funding the major EU successes including those actions that have a translational and wider EU impact, so cost is not only shouldered by Member States. Other stakeholders mentioned the importance of having accountability mechanisms for Member States to continue the work of Joint Actions. Also related to sustainability, stakeholders reported barriers in disseminating the results of funded actions as a limiting factor.

Other barriers to cost-effectiveness mentioned by stakeholders interviewed include: challenges in getting other institutions on board with 3HP funded actions due to relatively small budgets available; difficulties for Member States in providing co-funding which impacted the achievement of objectives; that coordination could have been more efficient with the use of structural funds; that funding was insufficient to meaningfully impact some health needs including childhood cancer; and that there is a need for a dedicated data collection system for monitoring activities per objective and per priorities, as there is a missing link between funded actions and specific objectives and thematic priorities.

Positively, stakeholders reported several aspects which contributed to cost-effectiveness. This included: clear aims and deliverables which strengthened the efficiency of funded actions; Joint Actions were much more cost-effective and efficient when they had been thought about in relation to Member States' specific national contexts; detailed grant agreements pushed organisations to demonstrate cost effectiveness throughout the funding period; and simplification of paperwork and the ability to reallocate funding without creating contract amendments was welcomed. However, stakeholders reported that further streamlining of administrative processes including monitoring and reporting are needed to improve the efficiency of 3HP.

It appears that participating countries with low GDP and smaller organisations may have faced additional barriers to fully participating in funded actions due to financial and human resource barriers. Several stakeholders also questioned the equity of having divergences

in daily payment amounts for participating countries in Joint Actions and that this should be reconsidered.

3.4 Coherence

Governmental policy makers and organisations representing patients and service users reported good coherence and synergies between the funded actions and other funding instruments such as Horizon 2020 and Horizon Europe. However, stakeholders also recognised the potential to collaborate with the European Regional Funds and structural funds. Another stakeholder representing patient and service users mentioned that more effort could be made through the 3HP to motivate synergies between the programme and other programmes or funding mechanism.

Stakeholders commenting on coherence, considered there to be good external coherence of the 3HP, reporting a good level of alignment between the programme and EU (e.g., migration) and international objectives (e.g. UN SDGs, WHO priorities).

Similarly, stakeholders reported that the 3HP was well coordinated with other EU health policies. Regarding international health objectives, a international organisation mentioned there was a complete alignment between objectives of OECD activities and 3HP activities, the interviewee noted coherence was especially high during the period of 2016-2019, as the actions during this period focussed on supporting Member States to build their knowledge of their own health systems and its performance, in addition to sharing best practices.

Overall, stakeholders from across all groups felt that there was a good level of alignment between the 3HP and national priorities and that main health needs were addressed through the programme. However, one stakeholder mentioned that priority alignment differed across countries. One priority area that a few stakeholders mentioned to have good coherence with national priorities was prevention of non-communicable diseases and health promotion.

3.5. EU-added value

Several stakeholders reported that the 3HP enabled coordination and cooperation across Member States that would most likely not have happened in the absence of the Programme. This was noted to be particularly important for knowledge exchange in the area of HTAs, communicable diseases and cross-border health threats.

One government policy maker mentioned that the added value of 3HP comes from cooperation between multi-country institutions as different specialist come together to work on one topic. In relation to Joint Actions, this stakeholder reported that there was also involvement of ministers, and integration with EU policy processes such as uses of council conclusions. Further, this stakeholder noted that Joint Actions enabled the dissemination of results to Member States states, bringing EU added value.

A government public health policy maker stated that without 3HP some countries would have been able to achieve the same results, but that others who lacked access to alternative funding sources would not. Another stakeholder from the same group noted that 3HP was a bridge to enable science, research and policies to impact Member States daily activities in the field of health. Others were sceptical of how useful and practical new knowledge generated through 3HP would be in impacting citizens' health.

Recommendations to improve the EU-added value of the Programme were suggested by stakeholders, including that cooperation across Directorate-Generals of the European

Commission (DGs) in some areas should be streamlined for some diseases, and that involvement of technical institutions and agencies would be beneficial in addition to DGs.

Annex 6.2.A. Contacted stakeholders list

Table 69. Contacted list of stakeholders for interviews

Institution name	Country
Academic and research organisations	
Aletta Jacobs School of Public Health	Netherlands
Karolinska Institute Sweden	Sweden
Mario-Negri Institute for Pharmacological Research Italy	Italy
Phned	Netherlands
Stakeholder involved in the Joint Action Promoting Implementation of Recommendations on Policy, Information and Data for Rare Diseases (RD-ACTION)	Europe-wide
University of Greenwich	UK
Government policymakers	
European and International Affairs DPT – Covid Crisis Center (Directorate General for Health) (France)	France
Austrian Ministry of Health	Austria
Bulgarian government	Bulgaria
Central Government Ministry for Health - Ireland	Ireland
Danish Health Authority	Denmark
Department for Health Ministry of Civil Affairs of Bosnia and Herzegovina	Bosnia and Herzegovina
Department of European Affairs Ministry of Health (Cyprus)	Cyprus
Department of International Cooperation - Ministry of Health (Poland)	Poland
Department of International Relations - Directorate-General of Health (Portugal)	Portugal
DG SANTE	European Commission
Directorate of Health (Embaetti landlaeknis) (Iceland)	Iceland
Division of Financial Analysis - Budget and Investment Department; Ministry of Health of the Republic of Latvia	Latvia
European and International Affairs Mission - Directorate General of Health - Ministry of Solidarity and Health (France)	France
Federal Ministry of Social Affairs, Health, care and consumer protection Section (Belgium)	Belgium
Federal Ministry of Social Affairs, Health, care and consumer protection Section V (Austria)	Austria
Health Promotion Department - Ministry of Health (Lithuania)	Lithuania
Implementation of International Projects and International Policies - Section of European Programmes and Projects	Slovakia
International Research Programmes - Instituto de Salud Carlos III (Spain)	Spain
Ministry of Health	Croatia
Ministère de la Santé (Luxembourg)	Luxembourg
Ministry for Health (Malta)	Malta
Ministry of Health - Directorate General for Public Health and Healthcare Services (Greece)	Greece
Ministry of Health - Implementation and Coordination Unit Programme (Romania)	Romania
Ministry of Health Department of Prevention and Communication (Italy)	Italy

Ministry of Health Lithuania	Lithuania
Ministry of Health of the Republic of Slovenia	Slovenia
Ministry of Health of the Slovak Republic	Slovakia
Ministry of Human Resources - Department of HR Strategy in the Health Sector (Hungary)	Hungary
Ministry of Social Affairs and Health (Finland)	Finland
Monitoring and Evaluation Department la Ministry of Health Republic of Moldova	Moldova
NHS European Office (UK)	UK
Norwegian Directorate for Health	Norway
Office of the Permanent Secretary (Malta)	Malta
Permanent Representation of Hungary to the EU	Hungary
Policy Evaluation and External Relations Unit (Ireland)	Ireland
Prevention Department - National Institute for Health Development (Estonia)	Estonia
Programme Implementation and Coordination Unit, Ministry of Health (Romania)	Romania
Public Health Authority Belgium	Belgium
Referat Grundsatzfragen, Gesundheitsberichterstattung, Europäische und internationale Angelegenheiten - Bundesministerium für Gesundheit (Germany)	Germany
Regional Ministry of Health and Families of Andalusia (Spain)	Spain
Rijksdienst voor Ondernemend Nederland - Ministerie van Economische Zaken	The Netherlands
Sector for European integration and international cooperation - Ministry of Health of Serbia	Serbia
University Medical Center Hamburg-Eppendorf	Germany
Governmental public health organisations	
Agency for medicinal products and medical devices of Croatia	Croatia
Agency for Medicinal Products and Medical Devices of the Republic of Slovenia	Slovenia
ANSM	France
Association of Schools of Public Health in the European Region (ASPHER)	Europe-wide
Association of specialists in public health disciplines in the Federation of Bosnia and Herzegovina	Bosnia and Herzegovina
Austrian Agency for Health and Food Safety	Austria
Austrian Public Health Association	Austria
Bulgarian Drug Agency	Bulgaria
Bulgarian Public Health Association	Bulgaria
Croatian Public Health Association	Croatia
Czech Society of Social Medicine and Health Care Management	Czechia / Czech Republic
Danish Medicines Agency	Denmark
Danish Society of Public Health	Denmark
Department of Public Health of the Babeş-Bolyai University	Romania
ESCUELA ANDALUZA DE SALUD PUBLICA SA (Spain)	Spain
European Centre for Disease Prevention and Control	Europe-wide
European Medicines Agency	Europe-wide
European Society for Prevention Research (EUSPR)	Europe-wide
European Society for Quality in Healthcare (ESQH)	Europe-wide

European Union of Medical Specialists (UEMS) - Section for Public Health	Europe-wide
Federal Agency for Medicines and Health Products (FAMHP)	Belgium
Federal Institute for Drugs and Medical Devices	Germany
Finnish Medicines Agency	Finland
German Public Health Association - DGPH	Germany
German Society of Medical Sociology	Germany
GGD GHOR Nederland	Netherlands
Health Products Regulatory Authority (HPRA)	Ireland
Health Promotion Union of Estonia	Estonia
Healthcare and Youth Care Inspectorate, Ministry of Health, Welfare and Sport	Netherlands
Hungarian Association of Public Health Training and Research Institutions - NKE	Hungary
Institut National de la Sante et de la Recherche Médicale (INSERM)	France
INSTITUT SCIENTIFIQUE DE SANTE PUBLIQUE (Belgium)	Belgium
INSTITUTE OF HEALTH INFORMATION AND STATISTICS OF THE CZECH REPUBLIC	Czechia / Czech Republic
ISTITUTO NAZIONALE DI RIPOSO E CURA PER ANZIANI INRCA (Italy)	Italy
Italian Medicines Agency	Italy
Italian Society of Hygiene, Preventive Medicine and Public Health	Italy
Karolinska Institute, Department of Global Public Health	Sweden
Kooperationsverbund 'Hochschulen für Gesundheit' (Germany)	Germany
Latvian Centre for Disease Prevention and Control	Latvia
Law & Non-Communicable Diseases Unit (UK)	UK
Lithuanian Public Health Association	Lithuania
Maastricht University, Department of International Health	Netherlands
Malta Association of Public Health Medicine	Malta
Medicines Evaluation Board	Netherlands
Ministry of Health	Luxembourg
Ministry of Health - Pharmaceutical Services	Cyprus
NACIONALNI INSTITUT ZA JAVNO ZDRAVJE (NIJZ, National Institute of Public Health) (Slovenia)	Slovenia
National Authority of Medicines and Medical Devices of Romania	Romania
National Health Agency of Sweden	Sweden
National Institute of Pharmacy and Nutrition	Hungary
National Institute of Public Health of the Czech Republic	Czechia
National Organization for Medicines	Greece
National School of Public Health, Management and Professional Development	Romania
NIVEL	Netherlands
Norwegian Medicines Agency	Norway
Norwegian Public Health Association	Norway
NOVA National School of Public Health (NOVA NSPH)	Portugal
Office for Registration of Medicinal Products, Medical Devices and Biocidal Products	Poland
ORSZAGOS TISZTIFOORVOSI HIVATAL (Hungary)	Hungary
Panhellenic Union of Public Health Physicians of National Health System (PEIDY E.S.Y.) (Greece)	Greece

Polish Society of Public Health	Poland
Portuguese Association for the Public Health Promotion	Portugal
Portuguese Association of Public Health Doctors	Portugal
Public Health Agency of Sweden (Folkhälsomyndigheten)	Sweden
Public health Association of Latvia	Latvia
REGISTRUL NATIONAL AL DONATORILOR VOLUNTARI DE CELULE STEM HEMATOPOIETICE (Romania)	Romania
RIVM	Netherlands
Romanian Public Health and Health Management Association	Romania
SAVEZ - Slovak Public Health Association	Slovakia
Sciensano (Belgium)	Belgium
Serbian Public Health Association	Serbia
Slovenian Institute of Public Health	Slovenia
Slovenian Medical Society - Slovenian Preventive Medicine Society	Slovenia
Société Française de Santé Publique	France
Society for Social Medicine in Finland	Finland
Society of Social Medicine - Public Health of Bosnia and Herzegovina	Bosnia and Herzegovina
Spanish Agency for Medicines and Health Products	Spain
State Agency of Medicines	Estonia
State Agency of Medicines	Latvia
State Institute for Drug Control	Czechia / Czech Republic
Swedish Medical Products Agency	Sweden
The Bridge Foundation	Italy
International Association for Communication in Healthcare (EACH)	Europe-wide
Healthcare professionals' associations	
Council of occupation Therapists for the European Countries (COTEC)	Europe-wide
eHealth Network	Europe-wide
European Association of Dental Public Health (EADPH)	Europe-wide
European Federation of Nurses Associations	Europe-wide
European Forum for Primary Care (EFPC)	Europe-wide
European Health Management Association (EHMA)	Europe-wide
European Midwives Association	Europe-wide
Standing Committee of European Doctors (CPME)	Europe-wide
The European Society for Paediatric Oncology (SIOP Europe)	Europe-wide
Healthcare service provider and organisations representing them	
European Hospital and Healthcare Federation (HOPE)	Europe-wide
European Union of Private Hospitals (UEPH)	Europe-wide
European University Hospital Alliance (EUHA)	Europe-wide
VšĮ: Vilnius University Hospital Santaras Klinikos	Europe-wide
International public health organisations	
Council of Europe	Europe-wide
European Observatory on Health Systems and Policies	Europe-wide
International Migration Organisation	International
OECD	International

WHO	International
Non-governmental organisations	
Correlation-European Harm Reduction Network	Europe-wide
European Network for Smoking & Tobacco Prevention (ENSP)	Europe-wide
European Public Health Association (EUPHA)	Europe-wide
Federation for Health	Netherlands
Health Action International (HAI)	International
Mental Health Europe	Europe-wide
Migrants e.V.	International
Other	
Agency for medicinal products and medical devices (Croatia)	Croatia
Other: stakeholder contacted because of role in specific joint action	
ANSES (France)	France
Department of Public Health of the Babeş-Bolyai University	Romania
Federal Institute for Pharmaceuticals and Medical Products (Germany)	Germany
Ministry of Health Lithuania	Lithuania
NHS Education for Scotland Digital Service	UK
Stakeholder involved in the Joint Action Efficient response to highly dangerous and emerging pathogens at EU level (EMERGE)	Europe-wide
UPV Universitat Politècnica de València	Spain
Zorginstituut Nederland	Netherlands
Patients and services users and organisations representing them	
AIDS Action Europe	Europe-wide
Alzheimer Europe	Luxembourg
European Cancer Patient Coalition	Europe-wide
European Patients Forum (EPF)	Europe-wide
European Renal Association/European Dialysis and Transplantation Association (ERA-EDTA)	Europe-wide
EURORDIS (The Voice of Rare Disease Patients in Europe)	Europe-wide
The European Consumer Organisation (BEUC)	Europe-wide

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A6.3 Open public consultation report

1. Introduction

The 3rd Health Programme (hereafter, the Programme) was a sectorial financial instrument under the Multiannual Financial Framework (MFF) 2014-2020 in the field of health. It aimed to underpin 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 their responsibilities in health and healthcare policy.

ICF conducted a study to support the evaluation (running from July 2021- Summer 2022) of the Programme, in order to monitor, evaluate and report on the implementation of the actions of the Programme in relation to its objectives and indicators (time period: 2014-2020). As part of this study, a series of stakeholder consultations were carried out, including an open public consultation (OPC). The purpose of this exercise was to provide the general public and all interested parties with the opportunity to provide information and opinions on the matters to be addressed in this study. The OPC was targeted at all those who have an interest in the 3rd Health Programme but who had not necessarily been directly involved in the Programme design or implementation. Questions were therefore relatively high-level, exploring the overall perception of the Programme, and its relevance to broader health needs and objectives.

The OPC asked respondents to give their view on the effectiveness, efficiency, relevance, EU added value and coherence of the Programme.

This summary report presents an overview of the results of responses to this survey.

2. Factual summary report

2.1. Overview of respondents

A total of 69 responses were received. Three responses were identical (including responses to open-ended questions), and so they have been considered as one response. The information presented in this report therefore focuses on 67 responses. One civil society organisation submitted an offline response in PDF. Their submission was reviewed and relevant qualitative information was incorporated in this summary report.

More than a quarter of these came from public authorities (18 responses, 27%). These public authorities were mostly national (14 responses), but a few answers were also received from local public authorities (2 responses), as well as regional or international authorities (1 response each). Eleven of these public authorities were public health authorities or agencies, and seven were central governments or ministries of health.

Responses were also received from EU citizens and academic/research institutions (16 responses each, 24%), and from NGOs (15 responses, 22%). In addition, a couple of responses came from companies/business organisations (2 responses, 3%).

Respondents came from 22 different countries, mostly Spain (11 responses, 16%), Belgium and Italy (7 responses each, 10%) and Poland (6 responses, 9%). The remaining countries represented 6% or less of respondents, and no responses were received from Estonia, Hungary, Latvia, Luxembourg, Malta, Netherlands, or Romania.

Almost three quarters of respondents had at least some knowledge of the Programme (49 responses, 73%). Ten respondents had only very basic knowledge of the Programme (15%), and eight said they had no knowledge of it at all (12%).

When asked about their background in relation to the Programme, just under half of respondents said they had "an interest" in it (33 responses, 49%). More than a quarter said they benefited from the Programme (19 responses, 28%), and several respondents said they were directly involved in the

Programme implementation (12 responses, 18%). Only three respondents (4%) said they were directly involved in the Programme evaluation.

Just over half of respondents said that they had applied for funding from the Programme (34 responses, 51%). Just over a third said the opposite (23 responses, 34%) and the rest either said they were not aware, or that the question was not applicable to them (10 responses, 15%).

Among the 24 respondents who said they had not applied for funding from the Programme, almost half said it was because they were not aware or informed of the existence of the Programme (11 responses, 48%). Another reason to not apply for funding was the fact that respondents did not have enough staff or resource capacity to apply (5 responses, 22%). A few respondents also explained they did not apply because they did not feel prepared to apply for funding or because the topic of the calls did not correspond to their profile (3 responses each, 13%).

More than four in 10 respondents said that they had received funding from the Programme (28 responses, 42%). Almost half of respondents said they had never received funding (30 responses, 45%) and the rest said they did not know (9 responses, 13%).

The type of funding instruments indicated by respondents was joint actions (26 responses, 39%), followed by project grants (20 responses, 30%) and operating grants (8 responses, 12%). Only five or fewer respondents said they came across Health Policy Platform & Health Award/Health Prize (5 responses, 7%), direct grants to international organisations (3 responses, 4%) or procurement contracts (1 response, 1%). More than half of respondents did not provide an answer to this question.

When asked about what types of funding instruments they benefitted from, respondents cited the same instruments: joint actions (20 responses, 30%), project grants (13 responses, 19%), followed by operating grants (3 responses, 4%).

2.2. RELEVANCE

This section invited respondents to assess whether the priorities and objectives of the Programme addressed needs and problems in society.

More than three quarters of respondents said that the Programme correctly identified the health and healthcare needs and problems at the time of its development, to at least a moderate extent (52 responses, 77%). Among the few respondents who said otherwise (7 responses, 10%), some mentioned that the Programme did not make sufficient distinction between 'treating patients' (illness care) and 'making people healthy' (noting that making people healthy needs a different, more 'individual-patient-based approach). A few respondents also stated that too much focus was put on the Covid-19 crisis and vaccination, to the detriment of other health and healthcare needs and problems during this time period, such as the need for other types of prevention initiatives (e.g. related to diets or physical activity).

A large proportion of respondents said that some relevant problems or needs were not identified by the Programme at the time of its development (30 responses, 45%). One public authority noted that the Programme was too small in size and could therefore not address all issues. When asked to elaborate about problems which were not identified by the programme, respondents mentioned health inequalities (beyond systematic differences between the Member States, but also within the Member States). More specifically:

- An NGO respondent noted that although health inequalities were included as a general objective for the Programme, they were not sufficiently addressed throughout the Programme's thematic priorities. The respondent added that the Programme could have shed more light on the systems and processes that widen the health inequalities gap across the social gradient and along the life course and use this knowledge to move towards more sustainable and innovative health systems. They also stated that the Programme could have made a much stronger impact on progressing social rights and the right to health by providing for actions on poverty (especially in childhood), income and living conditions, by prioritising investments in building capacities, applying equity impacts assessments, and building

partnerships across the sectors and disciplines to address inequalities in health in a more holistic and integrated manner.

- Another NGO respondent also mentioned gender equity in health as an issue that was not properly identified by the Programme.
- Several NGO respondents noted that the rapid development of health technologies could have been addressed more explicitly with respect to issues related to digital inclusion, health and digital literacy and skills, and their unequal distribution across the social gradients.

An EU citizen added that the Programme should have put a stronger focus on issues related to unhealthy lifestyles. Other respondents also made similar comments:

- Respondents (an NGO, an EU citizen, and a Public authority) explained that the Programme could have better tackled the role of food in health (e.g. reducing junk food and shifting towards more plant-based food), and could have done more in terms of encouraging physical activity.
- NGO respondents also noted that the Programme should have better recognised addictions as a health problem. They added that insufficient resources were invested to comprehensively and holistically address the spread of illicit drug use as well as the non-medical use of controlled substances for medical use and alcohol. An NGO respondent reported that there is no provision for an approach to prevent the harm that these substances cause to the health — both physical and mental — of individuals and to the development of society as a whole, including the social and economic aspects that have a major negative impact.

An NGO respondent said that although the Programme acknowledged the high prevalence of mental health problems, they felt that the issue was not extensively included as a key thematic priority in and of itself. They added that the Programme could have been a key tool in integrating a psychosocial approach to mental wellbeing, taking into account and linking to the social and environmental factors that undeniably play a role in community positive mental health. An academic/Research Institution respondent also noted the importance of sexual and child abuse, which they said may lead to poorer health in the long run than other issues supported by the Programme's projects.

Respondents provided other examples of problems or needs that were not identified by the Programme, such as antimicrobial resistance as a global health threat (NGO respondent), and other health threats linked to the development of the internal market and EU trade policies (noting and addressing the role of commercial determinants in the development and prevalence of (preventable) chronic diseases in the EU; NGO respondent), and emerging diseases due to climate change (including Lyme disease) (Academic/Research Institution respondent).

Out of 67 respondents, 46 (69%) reported that the objective "Promote health, prevent disease and foster supportive environments for healthy lifestyles" was very relevant in relation to EU health needs. 37 respondents (55%) reported that each of the three other objectives ("Protect Union citizens from serious cross border health threats"; "Contribute to innovative, efficient and sustainable health systems"; "Facilitate access to better and safer healthcare for Union citizens") were very relevant. An academic/research organisation remarked that all four objectives are very general (even though they are presented as specific), and are therefore very relevant to a set of health needs in the EU. Two NGOs said that although the four objectives were very relevant, they did not include all the relevant identified needs and problems, such as health inequalities (which was identified as one of the six needs and problems but was not included explicitly in any of the four specific objectives or any of the 23 thematic priorities).

Respondents were asked to rate the relevance of the Programme's priorities in terms of promoting health, prevent disease and foster supportive environments for healthy lifestyles. According to them, the most relevant priorities were: "Chronic diseases including cancer, age-related diseases and neurodegenerative diseases" and "Risk factors such as use of tobacco and passive smoking, harmful use of alcohol, unhealthy dietary habits and physical inactivity" (respectively 44 and 42 respondents said '5 – very relevant', 66% and 63%).

Respondents were asked to rate the relevance of the Programme's priorities in terms of protecting Union citizens from serious cross border health threats. According to them, the most relevant priorities were: "Health information and knowledge system to contribute to evidence-

based decision making" and "Implementation of Union legislation on communicable diseases and other health threats, including those caused by biological, and chemical incidents, environment and climate change" (respectively 41 and 37 respondents said '5 – very relevant', 61% and 55%).

Respondents were asked to rate the relevance of the Programme's priorities in terms of contributing to innovative, efficient, and sustainable health systems. According to them, the most relevant priorities were: "Innovation and e-health" and "Health workforce forecasting and planning" (31 respondents said '5 – very relevant' for each, 46%).

Respondents were asked to rate the relevance of the Programme's priorities in terms of protecting Union citizens from serious cross border health threats. According to them, the most relevant priorities were: "Patient safety and quality of healthcare" and "Measures to prevent Antimicrobial resistance and control healthcare-associated infections" (respectively 43 and 36 respondents said '5 – very relevant', 64% and 54%).

2.3. EFFECTIVENESS

This section invited respondents to assess how successful the Programme was in achieving or progressing towards its stated objectives:

- Promote health, prevent disease and foster supportive environments for healthy lifestyles;
- Protect Union citizens from serious cross-border health threats;
- Contribute to innovative, efficient and sustainable health systems; and
- Facilitate access to better and safer healthcare for Union citizens.

A majority of respondents believed that measures implemented by Member States were, overall, aligned with the specific objectives and thematic priorities of the Programme, at least to a moderate extent (37 responses, 55%). For instance, a company/business organisation noted that national health plans were developed according to the policies and strategies of the Programme, and an academic/ research organisation stated that part of the Programme's measures started to be introduced into Member States' health systems. As part of the open-ended questions, a couple of respondents mentioned the usefulness of joint actions, which supported the Programme's objectives by allowing Member States to exchange best practice and take on board guidance developed.

However, several respondents noted limitations to the alignment of measures implemented by Member States with the specific objectives and thematic priorities of the Programme (15 responses, 22%). When prompted about this further through an open text box, respondents mentioned the following examples:

- A couple of public health authorities/agencies explained that not all Member States responded in the same way to the inputs of the Programme, due to the internal fragmentations in terms of healthcare management.
- Several respondents (an academic/research organisation and two NGOs) noted that the alignment depended on the thematic priorities. The NGOs explained that in their country, less focus was put on "Promoting health, prevent disease and foster supportive environments for healthy lifestyles" compared to other objectives, and that more effort and funding at EU and national level are needed to effectively boost health promotion and disease prevention, encouraging system reforms and cross-sectoral collaboration. An NGO explained that, in order to properly address the thematic priorities around risk factors (such as unhealthy dietary habits, physical activity and tobacco and alcohol consumption), measures need to better capture multisectoral, integrated and structural approaches to health. The same respondent acknowledged that the Programme stimulated some progress in this area, but added that more can be done to ensure that measures do not increase health inequalities and promote/encourage fragmented responses within health and social systems.

As part of the open-ended questions, several EU citizens suggested that too much emphasis was put by Member States in the past few years on the Covid-19 crisis and on vaccination, to the detriment

of other measures which could have aligned with other specific objectives and thematic priorities of the Programme (4 responses, 6%).

When asked whether Programme actions led to general improvements in health and healthcare in the EU and at Member State level, more than a quarter of respondents said they did not know (18 responses, 27%). Those who did provide an answer tended to believe that Programme actions did lead to such improvements, at least to a moderate extent (29 responses, 43%). The most commonly given examples of actions which improved health and health care in the EU and at Member State level included:

- The European Reference Networks, which reportedly have improved the visibility of rare diseases and helped patients and doctors.
- Joint Actions[603], which reportedly contributed to more cooperation between Member States, a more effective implementation of the Programme's priorities and a better integration of the Programme at the national level.
- Cross-border health threat prevention actions. However, respondents noted that while these have been useful, a lot of additional work is still required in this area.

Other examples were provided, such as:

- the guidance on cancer treatment across the EU, which reportedly helped to bring state-of-the-art care to patients (although the respondent noted that this guidance may not necessarily be taken up by health systems in all Member States);
- the work carried out in the area of tobacco cessation; and
- a more agile approach in setting concrete measures through legal documents (e.g. Regulations). The respondent provided digital health-related measures as an example.

However, 30% of respondents also said that Programme actions did not lead to improvements in health and healthcare in the EU and at Member State level, or only to a small extent (20 responses, 30%).

Respondents were asked about the extent to which the 3HP is able to strengthen the impact of EU health policy in several areas. Out of 67 respondents, 44 (66%) reported the 3HP was able to do this 42 (63%) reported this was the case for coordinating cross-border health threats. There were two areas for which more than one in five respondents said the Programme was not able to strengthen the impact of EU health policy, or only to a small extent: preventing and responding to diseases (15 responses, 22%) and complementing national policies (17 responses, 25%).

2.4. EFFICIENCY

This section invited respondents to assess the relationship between the resources used by the Programme and the changes it generated.

When asked whether costs associated with the Programme were reasonable and kept to the minimum necessary in order to achieve the expected results, a large proportion of respondents said they did not know (between 25 and 35 responses, 37% and 52%). Those who thought that costs were reasonable answered that costs that were deemed the most reasonable were programme operational costs (design and implementation) (11 respondents said they were reasonable to a large extent, 16%), while the ones that were deemed the least reasonable were administrative costs for applicants (6 respondents said they were not at all reasonable, 9%).

2.5. EU ADDED VALUE

This section invited respondents to indicate changes which could reasonably be argued to be due to the Programme, over and above what could reasonably have been expected from national actions alone.

[603] E.g. iPAAC (Innovative Partnership for Action Against Cancer Joint Action), EU-JAV (European Joint Action on Vaccination), CHRODIS (Joint Action on Chronic Diseases)

Overall, respondents believed that the Programme had significant EU-added value: almost four in ten respondents said it provided high added-value (26 responses, 39%) and an additional third said that it provided moderate added-value (23 responses, 34%).

Respondents were asked which of the seven EU value-added criteria was the most important according to them. More than a third said the most important criteria was "Exchanging good practices between Member States" (23 responses, 34%). The criteria "Supporting networks for knowledge sharing or mutual learning" and "Improving efficiency by avoiding waste of resources due to duplication and optimising use of financial resources" were also frequently cited as the most important criteria (respectively 14 and 10 responses, 21% and 15%). No respondent said the following criteria was the most important one: "Addressing issues relating to the internal market where the Union has substantial legitimacy to ensure high-quality solutions across Member States".

2.6. COHERENCE

This section invited respondents to indicate the extent to which the Programme complemented and created synergies with other EU Programmes and with national initiatives.

A majority of respondents believed that the Programme complemented and/or created synergies with other EU programmes or with wider EU policies, to at least a moderate extent (37 responses, 55%)[604]. These respondents explained that the Programme was coherent with contributions of the European structural and investment funds (ESIF), the Horizon 2020 Programme and the European Social Fund. They added that complementarities between the Programme and these other EU policies made it possible to investigate every aspect of several topics (e.g. chronic diseases, non-communicable diseases, rare diseases) in-depth.

However, other respondents (13 responses, 19%) said the Programme was not coherent with other EU programmes or with wider EU policies, with one NGO noting very few synergies for instance between the Programme and the Horizon 2020 programme for R&D and a public authority explaining that programmes were not interlinked with no joint funding possible. This public authority added that priorities as well as grants and tenders from other EU Programmes were often not known to delegates of the Programme.

A quarter respondents said they did not know (17 responses, 25%).

Almost half of respondents believed that the Programme complemented and/or created synergies with national initiatives and/or programmes, to at least a moderate extent (33 responses, 49%). When probed through an open text box, respondents added that:

- National initiatives were often stimulated by the opportunities launched in the framework of the Programme and aligned to its priorities (reported by a public authority).
- One Joint Action developed a toolset to assist European countries implement the Orphanet nomenclature of rare diseases (ORPHA codes, standardised coding system) (reported by a Public authority).
- Another Joint Action transferred and implemented good practice examples from national initiatives on physical activity in primary schools (Active Schools Flag) to other Member States (reported by a Public authority).
- The iPAAC (Innovative Partnership for Action Against Cancer) Joint Action was very effective in terms of providing ready-made solutions that could be implemented in the Polish National Oncology Strategy (reported by an Academic/Research Institution).

However, other respondents (13 responses, 19%) said the Programme was not coherent with national initiatives and/or programmes.

Almost a third of respondents said they did not know (21 responses, 31%). For instance, a public authority explained that the Joint Action/VISTART 2014 programme on "Strengthening the Member States' capacity of monitoring and control in the field of blood transfusion and tissue and cell

[604] The survey provided the following examples to guide the respondents: the Horizon 2020 Programme for Research and Innovation, EU Structural Funds, the European Social Fund, the European Fund for Strategic Investments (EFSI), Asylum, Migration and Integration Fund, Citizens, Equality, Rights and Value Programme, COSME

transplantation" under the Programme has not been directly translated into national programmes, as the process of amending the Directives in this area has not yet been completed and therefore, for example, it is not possible, for example, to carry out inspections in the area of substances of human origin of one country in another country.

2.7. Closing questions

Respondents were given the opportunity to share any other thoughts or comments they might have on the Programme.

Themes that emerged from responses to this question included:

- The importance of giving priority to health promotion and disease prevention as a thematic objective, considering the importance of investment in these areas to create healthy living environments.
- The need to make the reduction of health inequalities across the life course and social gradients an explicit standalone objective.
- The need to adopt a psychosocial approach to health - integrating health, social, digital, commercial and environmental, and structural determinants within the specific objectives and thematic priorities, to enable a wider pool of stakeholders to take on a more active role.
- A concern about the limited to no possibility for civil society organisations and public health stakeholders other than the national public bodies to participate in the Joint Actions activities funded by the Programme. Respondents advised to open Joint Actions to other types of stakeholders, to further foster integrated and multi-sectoral approaches to health.
- The importance of multi-annual operating grants, and the need to support their reinstatement in the long-term.
- The need to allocate enough funding in the next few years to support a smooth application of the Health Technology Assessment (HTA) Regulation (specific funding should be allocated to enhance the capacity of those Member States with less experience in conducting HTA - this is essential to ensure they can contribute fully to the work that will be undertaken under the future framework and shape their outputs).
- The need to focus on mitigating and responding to the emergence of zoonotic disease spill overs. Respondents explained that a highly precautionary approach to wildlife trade and trafficking is urgently needed to prevent future pandemics. They added that the EU must adopt a precautionary approach to risk, and ensure that activities occurring within its territory or carried out by its residents do not present any regional or international threats: this could be achieved through the adoption and implementation of a more ambitious and effective EU Action Plan against Wildlife Trafficking, the mainstreaming of a comprehensive One Health approach across all relevant EU laws and policies, and a change of perspective regarding wildlife trade, which should only be permitted when strict criteria designed to ensure human and animal health and welfare are met.
- Some concerns that this study excluded the management of the Covid-19 crisis and vaccination programme from the scope of the evaluation.
- In addition, respondents were given the opportunity to share any other document they deemed useful for the study, as PDF attachments. A total of five PDFs were received and reviewed, and their results were incorporated in this summary report in the relevant sections above

A6.4 Focus groups summary report

- **Table of Contents**

1. Introduction

In accordance with the Better Regulation Guidelines, this document provides a factual summary of the Focus Groups carried out in support of the *Study to support the ex-post evaluation of the European Commission's Third Health Programme*. Five Focus Groups were organised in over Aprils and May 2022.

This report is structured as follows:

- Section 2 presents the approach to the Focus Groups
- Section 3 provides an overview of the results.

2. Approach to the consultation

The objective of the consultations was to collect qualitative and quantitative information from stakeholders on their views of the 3rd Health Programme (3HP). For each Focus Group the aim was to focus on a specific type of funding mechanism and on the gaps emerging from the previous research carried out within the study[605]. As for the last Focus Group, the aim was to discuss all funding mechanisms.

2.1. Stakeholder selection

Seven key stakeholder groups (governmental organisations and policy makers, public health organisations, international organisations, academic and research organisations, NGOs, companies/business organisations) were identified by the study team.

A list of specific organisations within each group were defined based on the public facing database of the 3HP which listed 'coordinator' and 'partner' organisations. Additional desk research was conducted by the study team to find specific named contacts and organisations who may have interacted with the Programme. The Study Team did not have access to a stakeholder contacts list and so had to build its own database, using publicly available email addresses. With regard to the Focus Groups focusing on 'Procurement contracts' and 'All funding mechanisms' DG SANTE suggested the list of colleagues to be consulted and ensured their participation.

The contacted stakeholder list can be found in Annex 1.

All identified stakeholders received an invitation email, encouraging them to agree to participate in a focus group. As soon as stakeholders responded to the invitation, a follow-up email was sent, asking them to provide a list of availabilities during a given timeframe. For each focus group, a detailed log of all invited participants' availabilities was kept. Once a slot that worked for a minimum of five participants was identified, the study team sent an email to all invitees, confirming the date/time.

After being invited to the focus group, each stakeholder that had not responded to the invitation was contacted up to three additional times.

An overview of the type of stakeholders who attended the Focus Groups is shown in Table 64 below.

Table 69 Summary of type of stakeholder who participated in the Focus Groups

Focus Group	Types of stakeholders	Number of participants

[605] Desk research Phase.

1.	Project grants (28 April)	Public authorities, public health organisations, academic and research organisations[606]	7
2.	Operating Grants (18 May)	NGOs, public health organisations, academic and research organisations[607]	7
3.	Procurement contracts (19 May)	Governmental organisations (DG SANTE and HaDEA representatives)	8
4.	Joint Actions (23 May)	Governmental organisations and policy makers, public health organisations	14
5.	All funding mechanisms (24 May)	Governmental organisations (DG SANTE and HaDEA representatives)	3

2.2. Limitations

Multiple invites were sent to stakeholders well in advance, however only a limited of organisations were able to participate in the Focus Groups. While the target was to have 12 participants per Focus Group, the maximum was eight attendees.

As for the Focus Groups focusing on 'Procurement contracts' and 'All funding mechanisms' the participation from DG SANTE was also limited, due to lack of staff availability, in particular for the last Focus Group, where only three representatives attended. Additional follow-up interviews were scheduled to compensate for this.

3. Summary of key issues

As mentioned above, each Focus Group discussion focused on a specific type of funding mechanism under the 3HP (Project grants, Operating Grants, Procurement Contracts, Joint Actions), except for the last Focus Group, where all funding mechanisms were discussed. The Focus Group discussions also covered the gaps emerging from the previous phases of the study, so a diverse range of topics were touched upon.

3.1. Project grants (28 April)

Participants highlighted the need for more flexibility in project grants, in particular in reallocating resources for unforeseeable challenges/priorities, through contingency funding.

While they reported that project grants enable innovative and collaborative actions, they also stated that this funding mechanism didn't sufficiently promote the implementation of best practices among Member States, in comparison with Joint Actions. More generally, the dissemination of results was considered as weak.

With regard to the duration and sustainability of the funded actions, participants reported that the maximum duration of three years is not sufficient to achieve lasting results.

[606] Organisations that have implemented projects as a collaborative effort.
[607] Organisations that have implemented projects.

As for the application process, stakeholders pointed out that the standard co-funding requirement of 40% is high, and the application process for the 80% co-funding is difficult, especially for small organisations.

Nevertheless, participants found the application process smooth, and praised the funding portal. They also felt that this funding mechanism was used strategically within the programme. All participants agreed that the simplifications methods helped reducing the costs for applicants and welcomed the digitalisation of the monitoring process, but called for a simpler digital tool, easily understandable by all stakeholders.

22. The EU added value of the Programme was also recognised, as MSs and stakeholders were given a space to come together and learn from each other.

23. Participants believed the programme was complementary with other MS and EU level initiatives and funding programmes (e.g., Horizon Europe). Some participants acknowledged a good alignment between the 3HP priorities and DG SANTE's most recent flagship initiative, the Beating Cancer Plan. As for the internal coherence of the Programme, participants noted a good alignment between objectives 1, 3 and 4.

3.2. Operating Grants (18 May)

All participants agreed that the Operating Grants received were in line with the 3rd Health Programme objectives and the vast majority considered that the funding provided to Operating Grants (OG) was split among the thematic areas in an effective way. The results from the Operating Grants they were involved in were considered to be in line with the objectives of the 3HP.

Receiving Operating Grants under a framework agreement was perceived as a way of obtaining security and stability for their organisations; participants declared that this allowed them to plan and deliver on the projects. However, participants highlighted the difficulties in measuring to what extent the outputs and activities contributed to the desired changes in health.

In relation to the exceptional utility criteria, some of the participants explained that changes were made between the 3HP and EU4Health programmes; under the EU4Health programme, 30% of the operating grants have to be spent in low GNI countries, which is difficult if the organisations are not based in these countries.

With regard to the factors that hindered the achievement of progress towards each general and specific objective of the 3HP, all stakeholders agreed that the COVID-19 pandemic was an important obstacle to achieve the objectives of the 3HP.

As for the simplification measures, all participants agreed that they led to a reduction in the administrative costs for applicants, however, they considered that more changes should be made to simplify measures and reduce costs.

Participants highlighted that synergies were present between Operating Grants and Project Grants; however these could be improved if better networking and dissemination activities were carried out.

3.3. Procurement contracts (19 May)

With regard to the design of procurement contracts, European Commission representatives explained that the appropriate funding mechanism is chosen based on the problems that need to be tackled. The type of funding is defined in the financing decision. Following the preparation phase of the Annual Work Programmes, a consultation phase takes place either with the Commission, the Executive Agency (HaDEA), and the Member States on the actions that will be implemented the following year. The decision on the funding mechanism therefore depends on the political objectives and the results to be achieved.

As for the effectiveness of the application processes, participants highlighted that changes in the tenders' application process were made by the European Commission, aiming at improving the process. These were however not specific to the 3HP (e.g. the time allowed to respond to tenders was extended to 37 days).

With regard to the monitoring process, one participant highlighted internal issues in the changing and reduction of staff, which affected in some instances the monitoring capacity of European Commission staff.

In terms of success factors of the 3HP, participants stated that all actions funded by DG SANTE were successful because they were of interest for the stakeholders. Also, DG SANTE's priorities and MSs priorities were deemed coherent, as the former were agreed with the national authorities.

With regard to the results and impact of procurement contracts, participants highlighted that procurement contracts are of the utmost importance to DG SANTE as they provide support in preparing legislation. Moreover, the funded service contracts provided useful insights and knowledge for high level decision makers at international level.

As for the main challenges with regards the implementation of the 3HP, one of the issues highlighted was the changing number of contracts to be managed by HaDEA, which sometimes puts a strain on the implementation of the contracts. A second issue was the quality of the deliverables and uptake of results; participants highlighted that the uptake of results is sometimes challenging because results are achieved (and information obtained) when the political priorities have changed.

Procurement contracts implemented were generally considered as relevant to the 3HP objectives and to the wider EC policy priorities.

As for the EU added value of this funding mechanism, stakeholders reported that procurement contracts produced EU wide studies that provided valuable information on the public health situation and issues across EU. This was perceived to go beyond the capacity of single Member States.

In terms of costs incurred by DG SANTE and HaDEA in relation to procurement contracts, simplification measures were put in place, such as an automatised management tool, which helped reduce the administrative burden for EC personnel. More improvements should however be made in the future, in particular within DG SANTE.

3.4. Joint Actions (23 May)

In terms of relevance of the 3HP, participants stated that Joint Actions (JA's) covered almost all 3HP objectives, but there was a lack of synergies between different Joint Actions. Also, they highlighted that more information should be shared by the European Commission with regards to how the Joint Actions fit into the broader EU health priorities.

With regard to the successes of the Programme, participants highlighted that collaboration between stakeholders, opportunities to learn, funding provided and support from DG SANTE/HaDEA were the main achievements.

As for the dissemination of results, the JAs' results were shared online, but also through forums, conferences, and scientific publications. However, participants recommended that professional communication tools should be used to disseminate the results of JAs more widely.

Similarly, according to the participants, more support would be needed to share good practice with other regions and to increase sustainability. Some participants expressed the concern that sustainability wasn't achieved, and results would disappear after completion;

this should be tackled through additional funding in their view and through improved dissemination, as mentioned above.

Mixed views were expressed in terms of effectiveness of the funding. Many participants stated that the funding wasn't sufficient to achieve all the objectives, or for coordinator organisations to manage large partnerships.

Participants pointed out that the JAs allowed their organisations to access broad EU communication networks, having harmonised reference documents, and having access to EU databases.

3.5. All funding mechanisms (24 May)

The last Focus Group was only attended by three EC representatives, and one had to leave during the morning session. The study team therefore decided to cover only part of the questions and follow up with individual interviews.

With regard to the different funding mechanisms, EC representatives restated the differences between the different funding mechanisms and explained that they are chosen on the basis of the objectives to be achieved and the funding beneficiaries.

Participants highlighted that measuring the impact of the funding was a challenge; a framework to measure the results of the activities implemented was indeed lacking. Assessing the overall cost-effectiveness of the 3HP was also considered an issue.

As for the effectiveness in achieving the Commission's intended results, Procurement contracts were considered more effective, as DG SANTE and HaDEA are more in control of the process - i.e., drafting specific terms of reference and contractors being bound to them - as compared to Project Grants.

As for the JAs, participants considered that they were successful in achieving convergence in important specific areas, such as Health Technology Assessment, but were less successful in terms of sustainability of results.

Finally, participants considered that the objectives and priorities in the 3HP were relevant to health needs across the EU. Each unit contributes to the definition of the objectives and priorities, according to what has emerged from their work.

Annexes

Annex 6.4.A. Contacted stakeholders list

Table 70. Contacted list of stakeholders

Stakeholder organisations
INSTITUT SCIENTIFIQUE DE SANTE PUBLIQUE (SCIENSANO)
INSTITUT NATIONAL DE LA SANTE ET DE LA RECHERCHE MEDICALE (INSERM)
ASSOCIATION MEDECINS DU MONDE
SCOTTISH GOVERNMENT
INSTITUT CATALA DE LA SALUT
EUROHEALTHNET
ASTIKI MIKERDOSKOPIKI ETAIREIA PROLIPSIS
UNIVERSITY COLLEGE LONDON
EMPIRICA GESELLSCHAFT FUER KOMMUNIKATIONS- UND TECHNOLOGIE FORSCHUNG MBH
ISTITUTO NAZIONALE PER LA PROMOZIONE DELLA SALUTE DELLE POPOLAZIONI MIGRANTI ED IL CONTRASTO DELLE MALATTIE DELLA POVERTA
EUROPEAN ALLIANCE AGAINST DEPRESSION
UNIVERSITAT DE VALENCIA
STICHTING KATHOLIEKE UNIVERSITEIT
FOLKHALSOMYNDIGHETEN
NATIONAL CENTER OF INFECTIOUS AND PARASITIC DISEASES
ETHNIKO KAI KAPODISTRIAKO PANEPISTIMIO ATHINON
CENTRE FOR ADVANCEMENT OF RESEARCH AND DEVELOPMENT IN EDUCATIONAL TECHNOLOGY LTD-CARDET
FUNDACIO HOSPITAL UNIVERSITARI VALL D'HEBRON - INSTITUT DE RECERCA
MIGRANTAS EV GERMANY
ASSERTA GLOBAL HEALTHCARE SOLUTIONS
REGIONE EMILIA ROMAGNA
PRAKSIS
CMT PROOPTIKI CONSULTING MANAGEMENT TRAINING
AZIENDA OSPEDALIERO-UNIVERSITARIA ANNA MEYER
FOLKHALSOMYNDIGHETEN
EMPIRICA GESELLSCHAFT FUER KOMMUNIKATIONS- UND TECHNOLOGIE FORSCHUNG
KLINIKUM DER JOHANN WOLFGANG VON GOETHE UNIVERSITAET
UNIVERSITAETSKLINIKUM HEIDELBERG
UNIVERSITY OF GLASGOW

AZIENDA OSPEDALIERA DI PADOVA
EUROPEAN ALCOHOL POLICY ALLIANCE
STICHTING SANQUIN BLOEDVOORZIENING
ERASMUS UNIVERSITAIR MEDISCH CENTRUM ROTTERDAM
LANDSCHAFTSVERBAND WESTFALEN-LIPPE
STICHTING TRIMBOS- INSTITUUT
ROLE ERASMUC MC
ASSISTANCE PUBLIQUE - HOPITAUX DE PARIS
ISTITUTO GIANNINA GASLINI
AZIENDA SANITARIA LOCALE BI
FONDAZIONE IRCCS ISTITUTO NEUROLOGICO CARLO BESTA
STICHTING NEDERLANDS INSTITUUT VOOR ONDERZOEK VAN DE GEZONDHEIDSZORG
FUNDACION PARA LA INVESTIGACION BIOMEDICA DEL HOSPITAL UNIVERSITARIO DE GETAFE
ERASMUS UNIVERSITAIR MEDISCH CENTRUM ROTTERDAM
FONDAZIONE IRCCS ISTITUTO NAZIONALE DEI TUMORI
UNIVERSITAETSKLINIKUM TUEBINGEN
HOPITAUX UNIVERSITAIRES DE STRASBOURG
ACADEMISCH ZIEKENHUIS LEIDEN
AZIENDA OSPEDALIERO UNIVERSITARIA PISANA
ACADEMISCH MEDISCH CENTRUM BIJ DE UNIVERSITEIT VAN AMSTERDAM
EUROPEAN PUBLIC HEALTH ASSOCIATION
THALASSAEMIA INTERNATIONAL FEDERATION
EUROPEAN NETWORK FOR SMOKING PREVENTION
DEUTSCHE AIDS-HILFE
EUROPEAN PATIENTS' FORUM
UNIVERSITY MEDICAL CENTRE HAMBURG-EPPENDORF
WOLRD MARROW DONOR ASSOCIATION
FINNISH INSTITUTE
INSTITUTO SUPERIOIRE DI SANITA

A6.5 Targeted survey summary report

1. Factual summary report

1.1. Introduction

The 3rd Health Programme (hereafter, the Programme) was a sectorial financial instrument under the Multiannual Financial Framework (MFF) 2014-2020 in the field of health. It aimed to underpin 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.

ICF conducted a study to support the evaluation (running from July 2021- Summer 2022) of the Programme, in order to monitor, evaluate and report on the implementation of the actions of the Programme in relation to its objectives and indicators (time period: 2014-2020). As part of this study, a series of stakeholder consultations were carried out, including a targeted stakeholder survey. The purpose of this exercise was to collect further evidence on the views and perceptions of those with direct experience of the Programme regarding its relevance and implementation and performance. The survey was targeted at all those who have been directly involved in the Programme design and/ or implementation (including those having received funding from the Programme) and who were therefore able to answer relatively specific questions on the implementation and performance of the Programme.

This summary report presents an overview of the results of responses to this survey.

1.2. Overview of respondents

A total of 32 responses were received. Most of these came from public authorities (62%), half of which were from a central government or ministry of health and the other half were public health authorities or agencies. Responses were also received from non-governmental organisations (22%), and from academic/research organisations (16%).

Almost three quarters of survey respondents (72%) worked for an organisation focused on only one country, while the rest (29%) worked for an organisation with a Pan-European or international focus.

Almost all survey respondents were either: directly involved in the implementation of the Programme (50%), or stakeholders who benefitted from the Programme (44%). Only one stakeholder directly involved in the design of the Programme responded to the survey (3%), and only one respondent said they were not directly involved in the Programme but only had an interest in it (3%).

Respondents who said they were directly involved in the Programme, or benefited from it were asked what type of funding instruments they were aware of. Almost all said they were aware of Joint Actions (97%). Most respondents were also aware of Project Grants (65%) and Operating Grants (42%). However, less than a third of respondents were aware of the Health Policy Platform & Health Award/Health Prizes (35%), and even fewer knew about Direct Grants to international organisations (26%) and Procurements Contracts (23%).

1.3. Topics addressed

The survey asked respondents to give their view on the effectiveness, efficiency, relevance, EU added value and coherence of the Programme. A summary of the main findings is provided below.

Effectiveness:

- Respondents said the Programme contributed to a more comprehensive and uniform approach to addressing health issues across different policy areas, such as antimicrobial resistance and vaccination. However, there were two other areas for which a relatively large proportion of respondents said the Programme did not

contribute to a more comprehensive and uniform approach to health: childhood obesity and health technology assessment.

- Overall, respondents believed that the Programme actions led to: new knowledge and evidence which was used in the development of policy and decision-making; and general improvements in health and healthcare in the EU and at Member State level.
- Respondents said that the Programme contributed to improvements mainly in the following areas: vaccination in the EU and at Member State level, AMR prevention in the EU and at Member State level, and the creation of a well-functioning HTA system in Europe.
- Overall, public authorities believed that the Programme outputs were used at an international level, and that the EU's coordination with international bodies in the field of health had been strengthened in Programme priority areas.
- Public authorities said that the Programme contributed to EU's influence at international level in the following areas: AMR standards, policies and practices as well as immunisation programmes. Respondents said that the Programme contributed relatively less to the EU's influence at the international level in the area of childhood obesity standards, policies and practices.
- When asked whether their Member State applied for funding under the exceptional utility criterion (which provides for a higher level of co-funding for actions that include a certain proportion of members from low-GNI countries) a large majority of public authorities said they did not know. Those who did provide an answer were divided, with half saying their Member State did apply and the other half did not apply. When asked about the extent to which simplification measures related to the exceptional utility criteria had reduced administrative costs, more than half of respondents said they did not know. Those who did provide an answer tended to say that these measures did not reduce administrative costs, or only to a small extent.
- Just under 20% of respondents thought that the results of the Programme were very sustainable. A majority of respondents thought the results of the Programme were somewhat sustainable, citing a number of concerns around the following themes, including the risk that results might not be used nor capitalised on fully by Member States, due to a lack of interest and involvement from national authorities which leads to results of funded actions remaining at a local, and therefore limited, level.

Efficiency:

- Respondents considered that some costs associated with the Programme were reasonable and kept to the minimum necessary in order to achieve the expected results, such as management costs for funding and the Programme operational costs (design and implementation). However, a large proportion of respondents said other types of costs were not as reasonable, including: administrative costs for applicants and Chafea (now HaDEA), and monitoring and reporting costs for Member States and the Commission.
- According to respondents, a number of internal factors positively influenced the Programme's results, such as collaboration between Member States and development of guidance to assist funding applicants. Respondents also mentioned a number of external factors that positively influenced the Programme's results: science and technological progress in the area of health and healthcare, followed by solutions developed at national level, or by private or non-for-profit actors and changes in citizens' opinions or perspectives on health systems. Other positive factors influencing the efficiency with which achievements were attained included : the thematic priority structure of the Programme, the multi-annual planning process, the definition of the specific and operational objectives and the extent to which actions were well-designed.
- However, respondents also mentioned some external factors which had a negative influence on the results of the Programme, such as changes in prevalence and

severity of communicable diseases, and the demographic context affecting health and sustainability of health systems. In addition, a quarter of respondents highlighted that the lack of available financial and human resources for the Programme hindered the efficiency with which achievements were attained.

- Respondents were divided on the extent to which the simplification measures reduce administrative costs for applicants and Chafea, with some saying they did and others disagreeing.
- Respondents were also divided on the extent to which there was scope to further reduce costs. Some said there was no scope to further reduce costs, while others said that this was possible.
- A majority of respondents who were involved in the management and administration of an action from the Programme said that the monitoring costs were reasonable and kept to the minimum necessary in order to achieve the expected results.
- Respondents were also divided when asked about whether the costs of the reporting system were reasonable and kept to the minimum necessary in order to achieve the expected results, with some agreeing and others disagreeing.

Relevance:

- A large majority of respondents said that all four of the Programme's specific objectives in relation to EU health needs were relevant at the time of the Programme's development.
- A large majority of respondents said that the Programme's funded actions were aligned with the Programme's four specific objectives.
- A large majority of respondents said that the Programme's thematic priorities were relevant to the Commission's wider priorities over the implementation of the Programme.
- Almost 90% of respondents believed that the Programme's thematic priorities were relevant in light of citizens' perceptions of key health issues in the EU, and that the Programme responded to citizens' health needs.

EU added value:

- Almost 90% of respondents believed that the Programme provided added-value, beyond what Member States could have achieved acting alone.
- Almost all public authorities said that Member State actions were helped or incentivised by the Programme.
- A large proportion of survey respondents were not able to answer questions on the seven added value criteria. Among those who answered, feedback was generally positive. All respondents said that the seven added value criteria should be retained in future health programmes (albeit with some improvement).

Coherence:

- Most respondents said that all four of the Programme's specific objectives enabled consistent and coherent funding decisions across actions during the Programme period.
- A majority of public authorities said that the Programme was aligned with and addressed national health priorities during the Programme period.

2. Factual report

2.1. Introduction

The 3rd Health Programme (hereafter, the Programme) was a sectorial financial instrument under the Multiannual Financial Framework (MFF) 2014-2020 in the field of health. It aimed to underpin 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.

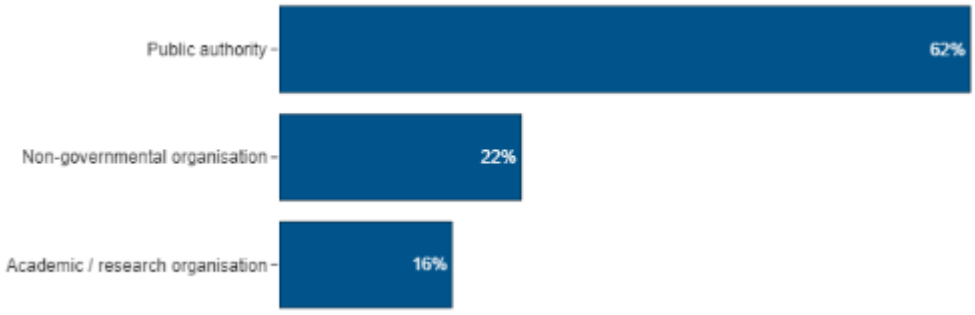
ICF conducted a study to support the evaluation (running from July 2021- Summer 2022) of the Programme, in order to monitor, evaluate and report on the implementation of the actions of the Programme in relation to its objectives and indicators (time period: 2014-2020). As part of this study, a series of stakeholder consultations were carried out, including a targeted stakeholder survey. The purpose of this exercise was to collect further evidence on the views and perceptions of those with direct experience of the Programme regarding its relevance and implementation and performance. The survey was targeted at all those who have been directly involved in the Programme design and/ or implementation (including those having received funding from the Programme) and who were therefore able to answer relatively specific questions on the implementation and performance of the Programme.

This report presents the detailed results of responses to this survey.

2.2. Overview of respondents

A total of 32 responses were received. Most of these came from public authorities (20 responses, 62%), half of which were from a central government or ministry of health (10, 50%) and the other half were public health authorities or agencies (10, 50%). Seven responses were also received from non-governmental organisations (22%), and five from academic/research organisations (16%). No responses were received from consumer organisations, or from company/business associations.

Figure 99. I am giving my contribution as a representative of a[n]: (n=32)

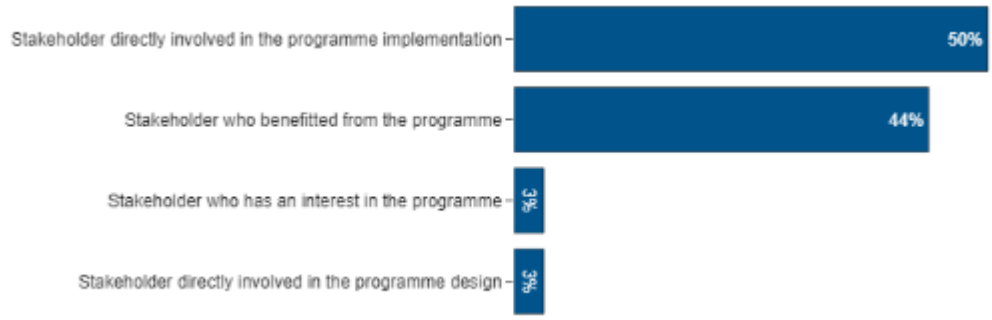


Almost three quarters of survey respondents (23 responses, 72%) worked for an organisation focused on only one country, while the rest (9, 29%) worked for an organisation with a Pan-European or international focus.

Figure 100. Does your organisation work mainly in one country, or is it Pan-European or international organisation? (n=32)

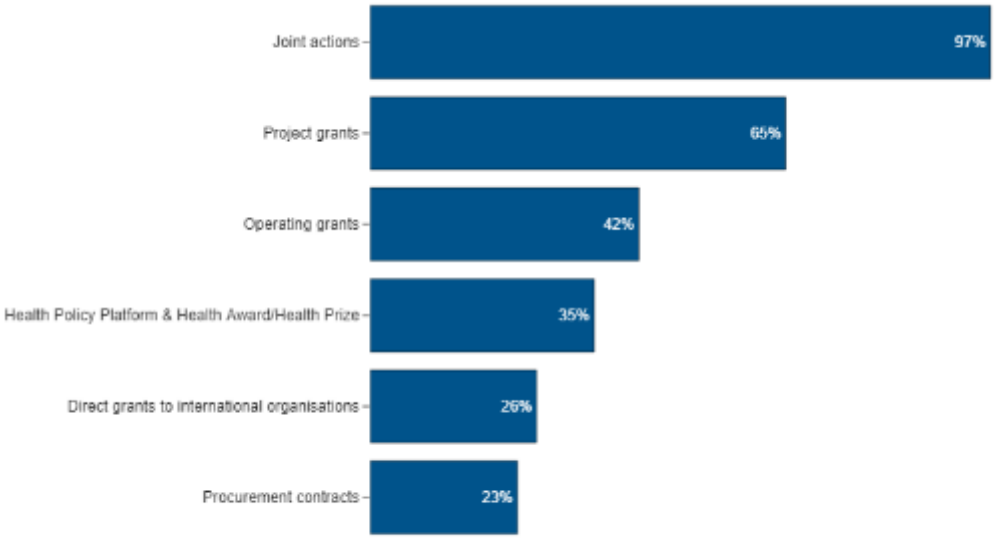
Almost all survey respondents were either directly involved in the implementation of the Programme (16 responses, 50%), or stakeholders who benefitted from the Programme (14, 44%). Only one stakeholder directly involved in the design of the Programme responded to the survey (3%), and only one respondent said they were not directly involved in the Programme but only had an interest in it (3%). No responses were received from stakeholders directly involved in the evaluation of the Programme.

Figure 101. What is your background in relation to the Programme? (n=32)



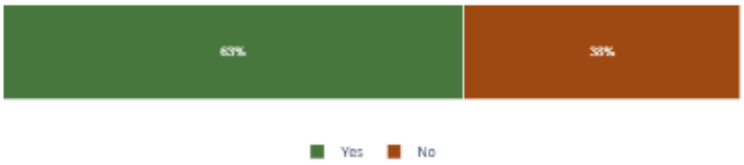
Respondents who said they were directly involved in the Programme, or benefited from it were asked what type of funding instruments they were aware of. Almost all said they were aware of Joint Actions (30 responses, 97%). Most respondents were also aware of Project Grants (20, 65%) and Operating Grants (13, 42%). However, less than a third of respondents were aware of the Health Policy Platform & Health Award/Health Prizes (11, 35%), and even fewer knew about Direct Grants to international organisations (8, 26%) and Procurements Contracts (7, 23%).

Figure 102. As part of your involvement in the Programme, what type of funding instruments are you aware of? (Select all that apply) (n=31, only those who were directly involved in the Programme, or benefited from it)



Out of the 32 respondents, a majority (20 responses, 63%) had been involved in the management and administration of an action from the Programme (e.g. filled in an application form).

Figure 103. Have you been involved in the management and administration of an action from the Programme (e.g. filled in an application form)? (n=32)



2.3. Effectiveness

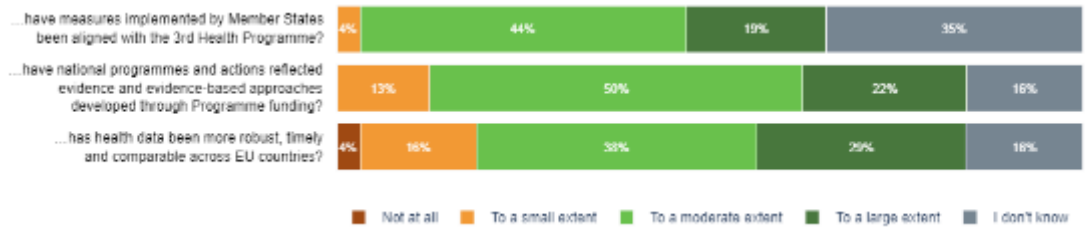
This section invited respondents to assess how successful the Programme was in achieving or progressing towards its stated objectives (i.e. looking at the effects of the Programme, and the extent to which the observed effects can be linked to it).

Overall, respondents believed that measures implemented by Member States as a result of the Programme were aligned with the aims and objectives of the Programme (20 respondents said this was true to at least a moderate extent, 63%).

Overall, respondents believed that national programmes and actions reflected evidence and evidence-based approaches developed through Programme funding (23 respondents said this was true to at least a moderate extent, 72%).

Overall, respondents believed that health data was more robust, timely and comparable across EU countries as a result of the Programme (21 respondents said this was true to at least a moderate extent, 67%). However, one in five respondents said this was true at all, or only to a small extent (6, 20%).

Figure 104. To what extent …? (n=32)

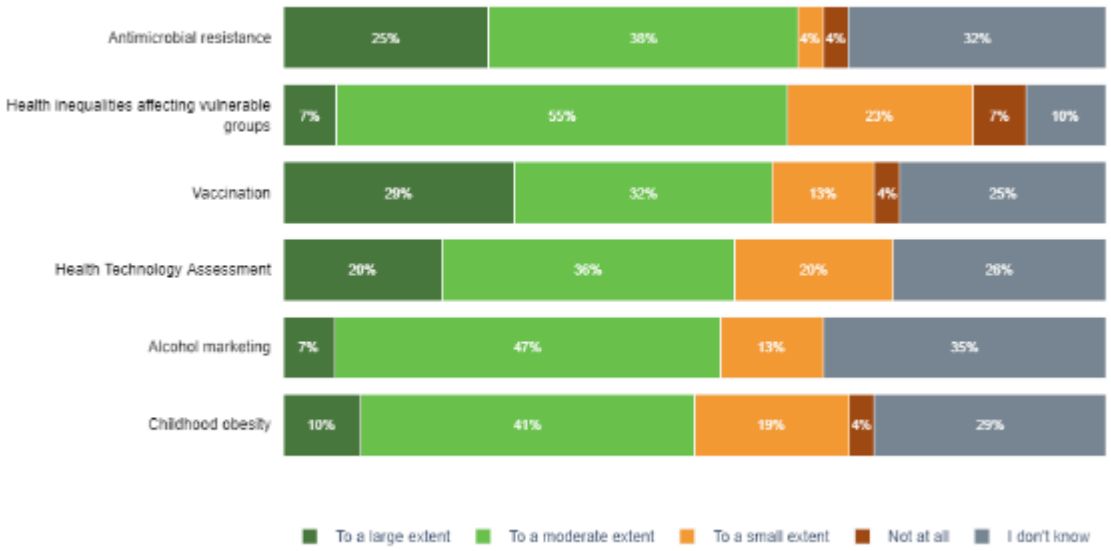


Respondents said the Programme contributed to a more comprehensive and uniform approach to addressing health issues across different policy areas, such as antimicrobial resistance (20 respondents said this was true to at least a moderate extent, 63%) and vaccination (19, 61%).

Respondents were divided when asked about the extent to which the Programme contributed to a more comprehensive and uniform approach to health in the area of health inequalities affecting vulnerable groups. A large proportion said this was true at least to a moderate extent (19, 62%), but nine others said this was not true at all or only to a small extent (30%).

There were two other areas for which a relatively large proportion of respondents said the Programme did not contribute to a more comprehensive and uniform approach to health, or only to a small extent: childhood obesity (6, 23%) and health technology assessment (7, 20%).

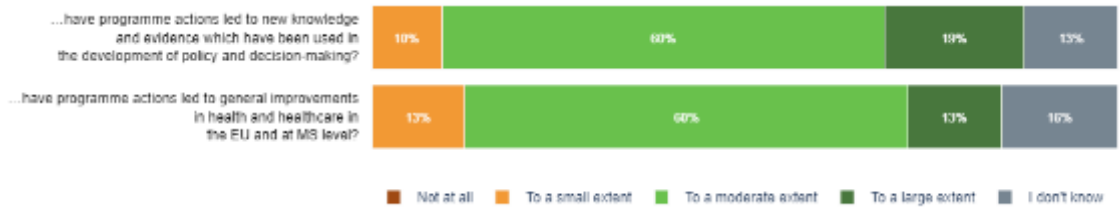
Figure 105. To what extent has the Programme contributed to a more comprehensive and uniform approach to addressing health issues across the following policy areas? (n=32)



Overall, respondents believed that the Programme actions led to new knowledge and evidence which was used in the development of policy and decision-making (25 respondents said this was true to at least a moderate extent, 79%).

Overall, respondents believed that the Programme actions led to general improvements in health and healthcare in the EU and at Member State level (23 respondents said this was true to at least a moderate extent, 73%).

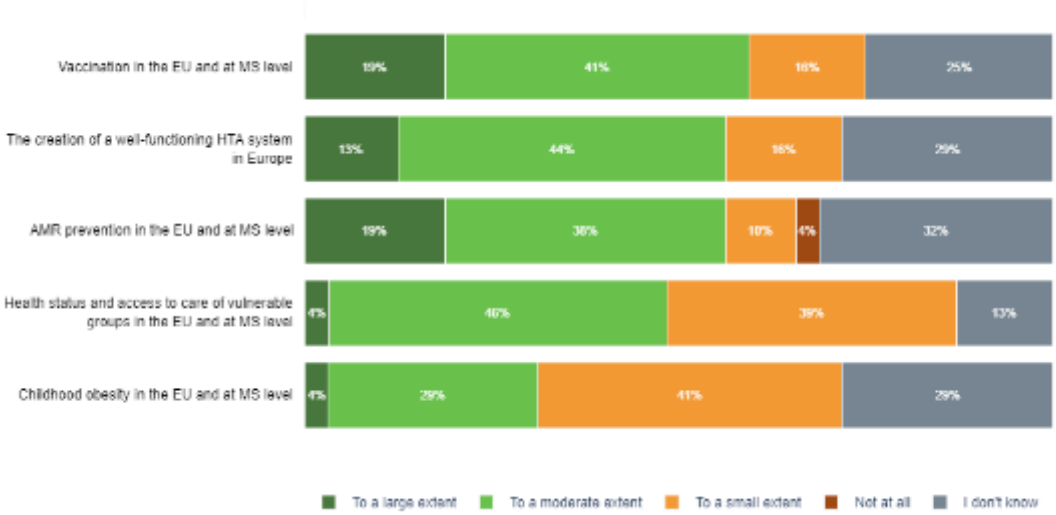
Figure 106. To what extent …? (n=32)



Respondents said that the Programme contributed to improvements mainly in the following areas: vaccination in the EU and at Member State level (19 respondents said this was true to at least a moderate extent, 60%), AMR prevention in the EU and at Member State level (18, 57%), and the creation of a well-functioning HTA system in Europe (18, 57%) (despite a relatively large proportion of respondents saying the Programme did not contribute to a more comprehensive and uniform approach in terms of health technology assessment).

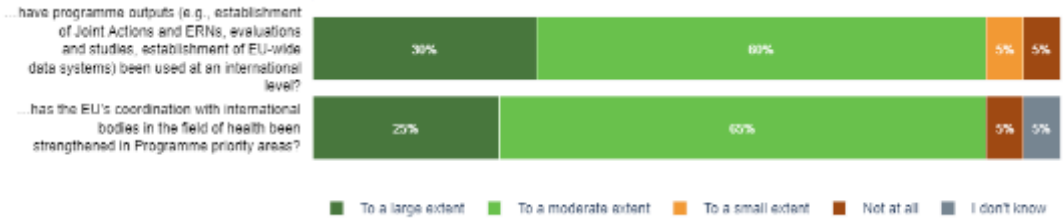
There were two other areas for which a large proportion of respondents said the Programme did not contribute to improvements, or only to a small extent: childhood obesity in the EU and at Member State level (13, 41%) and health technology assessment (12, 39%). These were the same two areas for which a relatively large proportion of respondents said the Programme did not contribute to a more comprehensive and uniform approach to health, or only to a small extent. An EU public authority involved in the Programme design said that actions were generally too limited in scale and ambition to generate real change. In addition, a national public authority involved in the Programme implementation explained that for real improvement in the mentioned areas, KPI and benchmarking indicators should be elaborated as support for decisions based on evidence and equity in resources allocation.

Figure 107. To what extent has the Programme contributed to improvements in the following areas? (n=32)



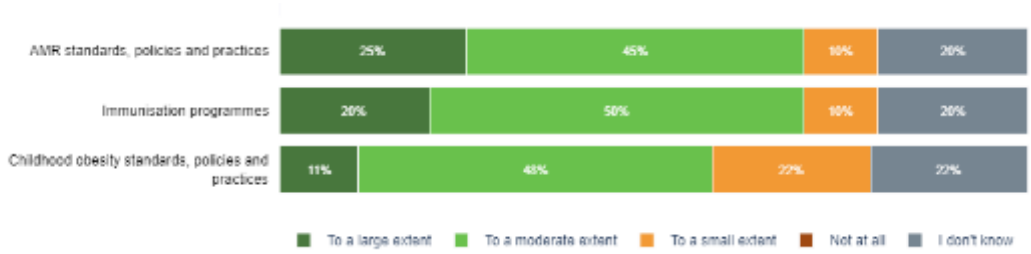
Overall, public authorities believed that the Programme outputs (e.g., establishment of Joint Actions and ERNs, evaluations and studies, establishment of EU-wide data systems) were used at an international level, and that the EU's coordination with international bodies in the field of health had been strengthened in Programme priority areas (18 out of 20 respondents said these two statements were true to at least a moderate extent, 90%).

Figure 108. To what extent …? (n=20, only public authorities)



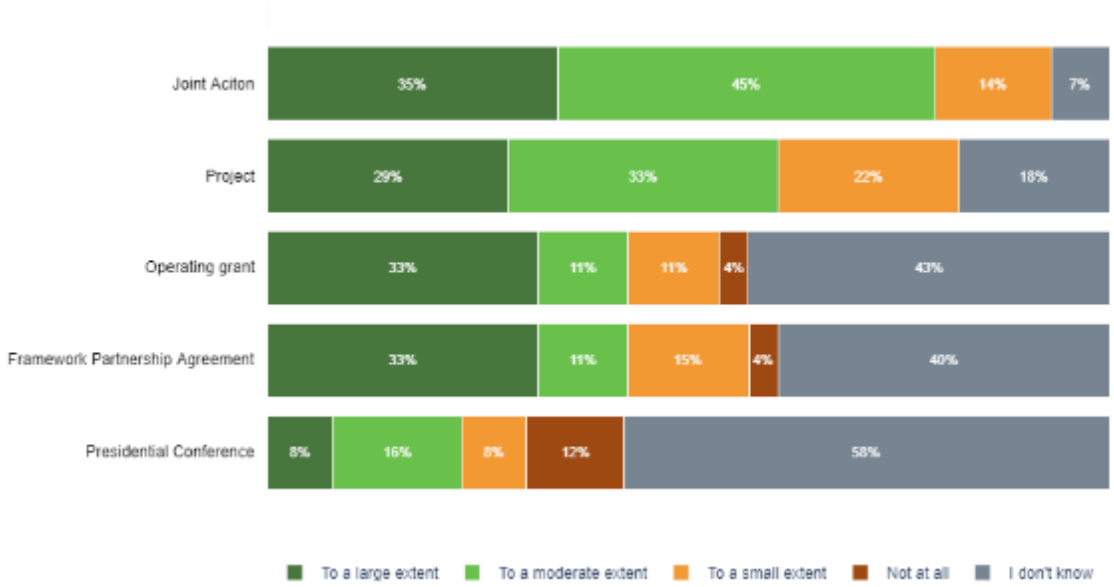
Public authorities said that the Programme contributed to EU's influence at international level in the following areas: AMR standards, policies and practices as well as immunisation programmes (14 out of 20 respondents said this was true for both areas to at least a moderate extent, 70%). Respondents said that the Programme contributed relatively less to the EU's influence at the international level in the area of childhood obesity standards, policies and practices (11, 59%) – this is consistent with answers to previous questions of this survey showing that the Programme was not as efficient in this area as in others. An EU public authority involved in the Programme design said that formally, the EU remains a limited player on the international health scene (except in specific circumstances such as the World Health Organisation's Framework Convention on Tobacco Control (FCTC). This limited the Programme's scope for influence. In addition, a national public authority involved in the Programme implementation explained that elaborated standards and policies were not fully implemented. They added that the EU Health Programme should have allocated resources for following up and monitoring the actions in all the Member States, as well as publishing reports and articles in scientific journals.

Figure 109. To what extent has the Programme contributed to EU's influence at international level in the following areas? (n=20, only public authorities)



Respondents were asked about which funded actions contributed to achieving the objectives of the Programme. The actions that were most frequently mentioned were: Joint Actions (23 responses, 80%) and Projects (17, 62%). In contrast, Presidential Conferences were not frequently mentioned, with some respondents citing they did not contribute to achieving the objectives of the Programme at all.

Figure 110. To what extent have the funded actions you have been involved in contributed to achieving the objectives of the Programme? (n=32)



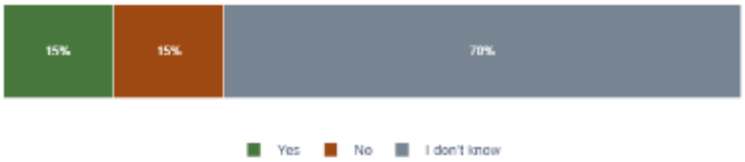
When asked whether their Member State applied for funding under the exceptional utility criterion (which provides for a higher level of co-funding for actions that include a certain proportion of members from low-GNI countries) a large majority of public authorities said they did not know (14 out of 20 respondents, 70%). Those who did provide an answer were divided, with half saying their Member State did apply and the other half did not apply (3 each, 15%).

Two of the three public authorities who said their Member State applied for funding using the exceptional utility criterion (in Italy and Poland) added that their country's participation had been incentivized by the criterion to a small extent, and the third one (in Lithuania) said the criterion had incentivised their participation to a moderate extent. These three countries also explained that the following factors contributed to their country's participation: securing co-financing, followed by the administrative capacity to manage actions in the Member State and then by language skills.

The three public authorities who said their Member State did not apply for funding using the exceptional utility criterion (in Croatia, Ireland and Sweden) said that a number of factors determined the decision to not apply for funding under the exceptional utility criterion, including: the lack of administrative capacity to manage actions in the Member State, the

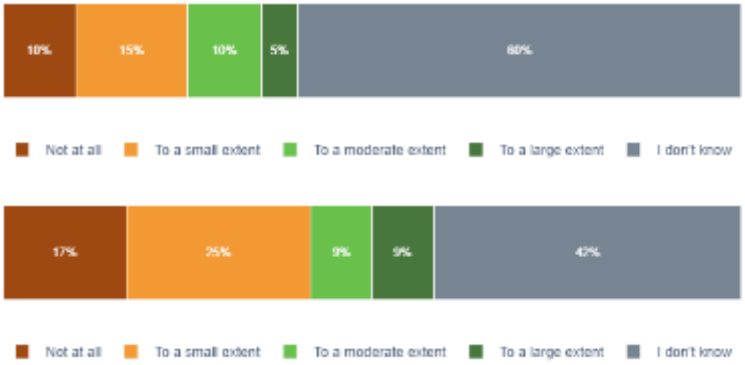
administrative burden (once project is up and running), and the complexity of application process.

Figure 111. Has your Member State applied for funding under the exceptional utility criterion? (n=20, only public authorities)



When asked about the extent to which simplification measures related to the exceptional utility criteria had reduced administrative costs, more than half of respondents said they did not know (17 responses, 53%). Those who did provide an answer tended to say that these measures did not reduce administrative costs, or only to a small extent.

Figure 112. To what extent did the simplification measures related to the exceptional utility criteria reduce administrative costs? (first graph: n=20, only public authorities; second graph: n=12, all but public authorities)

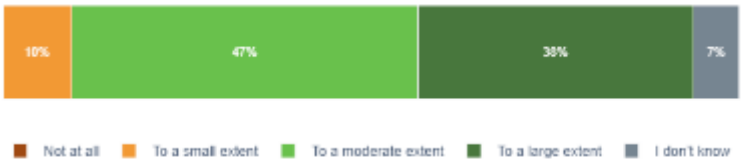


Overall, respondents said they had access to publications resulting from the Programme's actions/outcomes/results (23 respondents said this was true to at least a moderate extent, 73%). Among those who said this was not true or only to a small extent, reasons provided included the fact that many deliverables were delayed due to the Covid-19 crisis and a lack of clarity regarding where these publications can be found.

Figure 113. To what extent do you have access to publications resulting from the Programme's actions/outcomes/results? (n=32)

Overall, respondents reported that DG SANTE prioritised and acted upon areas of greatest added value to the EU (i.e., above what could reasonably have been expected from actions at the national level (27 respondents said this was true to at least a moderate extent, 85%). Positive examples were provided, such as the ERN PaedCan and the Joint Action on Rare Cancers with its Work Package on Childhood Cancer. However, respondents also highlighted points of improvement, such as the need for more funding in some areas (e.g. non communicable diseases or health equity aspects).

Figure 114. To what extent do you think DG SANTE has prioritised and acted upon areas of greatest added value to the EU (i.e., above what could reasonably have been expected from actions at the national level)? (n=32)



Overall, respondents believed that DG SANTE strengthened and built links between the Programme and wider Commission & EU policy agenda to maximise impact (17 respondents said this was true to at least a moderate extent, 54%). Positive examples were provided, such as the facilitation of connections between Member States, or revisions of legislations based on the output of Programme's projects (e.g. in the fields of tissues and cells, blood, organs or health information and knowledge system). Another respondent suggested that DG SANTE made the maximum use of the Programme internally with other EU actors, notably research, being ready to compromise as needed to get acceptability and recognition. However, this same respondent added that proposals for 2021-2027 MFF only provided for a strand for health in ESF+, with a total budget of EUR413 million: they stated that it was only the Covid-19 crisis that refocussed the attention of the Commission on what contribution on health the EU could make.

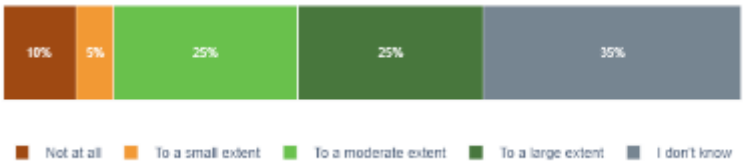
Figure 115. To what extent has DG SANTE strengthened and built links between the Programme and wider Commission & EU policy agenda to maximise impact? (n=32)

Overall, respondents who were involved in the management and administration of an action from the Programme said they understood the EU added value criteria and how to apply them prior to undertaking this survey (12 out of 20 respondents said this was true to at least a moderate extent, 60%).

Figure 116. To what extent did you understand the EU added value criteria and how to apply them (prior to undertaking this survey)? (n=20, only those involved in the management and administration of an action from the Programme (e.g. filled in an application form))

When asked about the extent to which the EU added value criteria improved the application process, a large proportion of respondents who were involved in the management and administration of an action from the Programme said they did not know (7 out of 20 respondents, 35%). Most of those who did provide an answer said that this was true to at least a moderate extent (10, 25%)).

Figure 117. To what extent have the EU added value criteria improved the application process? (n=20, only those involved in the management and administration of an action from the Programme (e.g. filled in an application form))

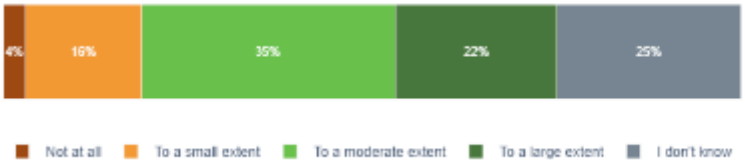


When asked about the extent to which the EU added value criteria were used by DG SANTE & Chafea (now HaDEA) in a more integrated way in the application process, more than half of respondents who were involved in the management and administration of an action from the Programme said they did not know (12 out of 20 respondents, 60%). Most of those who did provide an answer said that this was true to at least a moderate extent (6, 35%)).

Figure 118. To what extent have the EU added value criteria been used by DG SANTE & Chafea (now HaDEA) in a more integrated way in the application process? (n=20, only those involved in the management and administration of an action from the Programme (e.g. filled in an application form))

Multi-annual planning (MAP), which provides for spending across several years, was introduced in the Programme to incorporate a more holistic, longer-term mindset into the programming process. Overall, respondents believed that DG SANTE integrated MAP within existing programme processes (18 respondents said this was true to at least a moderate extent, 57%).

Figure 119. To what extent has DG SANTE integrated multi-annual planning within existing programme processes (i.e. establishing the Annual Work Programmes? (n=32)



Overall, respondents believed that DG SANTE & Chafea (now HaDEA) developed a broader strategy to increase participation from lower-income MS & underrepresented organisations, distinct from the exceptional utility criterion[608] (17 respondents said this was true to at least a moderate extent, 54%). An academic/research organisation who benefitted from the Programme explained that based on criteria for different funding mechanisms (Joint Actions, Projects, Operating Grants) participation of low GNI-Member States and underrepresented groups was well incorporated in the Programme.

[608] The exceptional utility criterion provides for a higher level of co-funding for actions that include a certain proportion of members from low-GNI countries.

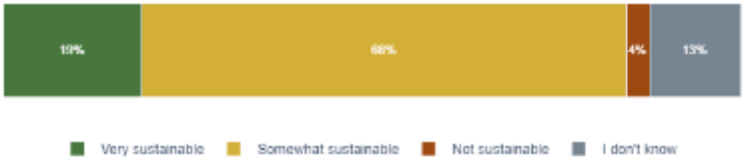
Figure 120. To what extent have DG SANTE & Chafea (now HaDEA) developed a broader strategy to increase participation from lower-income MS & underrepresented organisations (e.g., underrepresented patients' organisations, NGOs, etc.) (distinct from the exceptional utility criterion)? (n=32)

Six respondents (19%) thought that the results of the Programme were very sustainable. Examples provided included: the stem cell registry, achievements through JA Healthy Gateways, and the launch of the ERN PaedCan which set the basis for the further development of this important model to address healthcare delivery for paediatric cancers as a collection of rare diseases.

A majority of respondents thought the results of the Programme were somewhat sustainable (21 responses, 66%), citing a number of concerns around the following themes, including the risk that results might not be used nor capitalised on fully by Member States, due to a lack of interest and involvement from national authorities which leads to results of funded actions remaining at a local, and therefore limited, level.

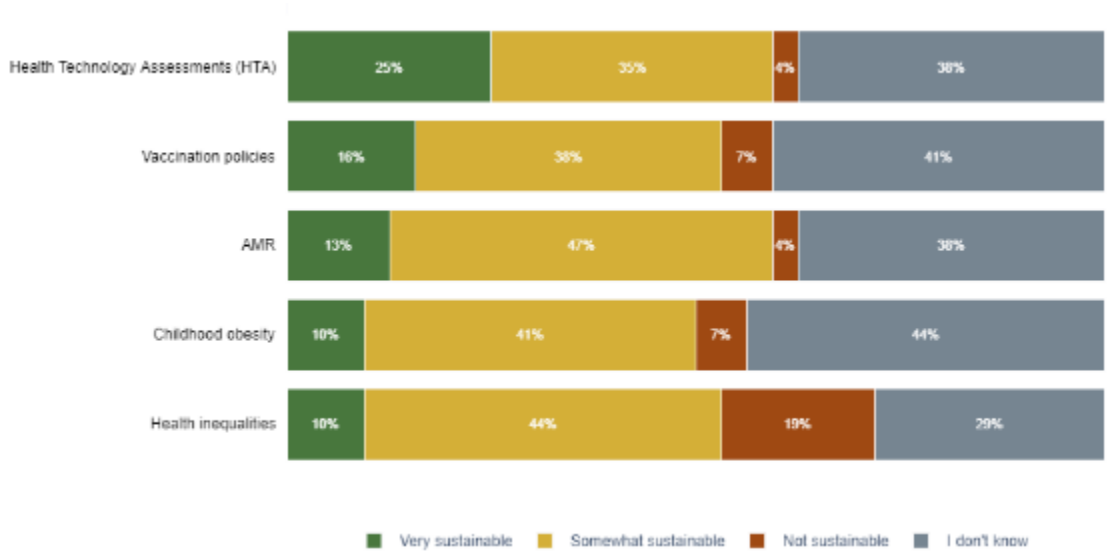
One EU public authority involved in the Programme design said that results were not sustainable (4%). They explained that results were mostly too limited in scale and or ambition to be sustainable, and that sustainability was not "in the DNA of the Programme or the participants".

Figure 121. How sustainable do you think the results of the Programme (and its funded actions) are? (n=32)



Regarding sustainability of results and effects (of the Programme), respondents highlighted the following specific fields as having achieved most sustainability: health technology assessments (8 responses, 25%), vaccination policies (5, 16%) and AMR (4, 13%).

Figure 122. How sustainable do you think the Programme results and effects are in the specific fields of…? (n=32)

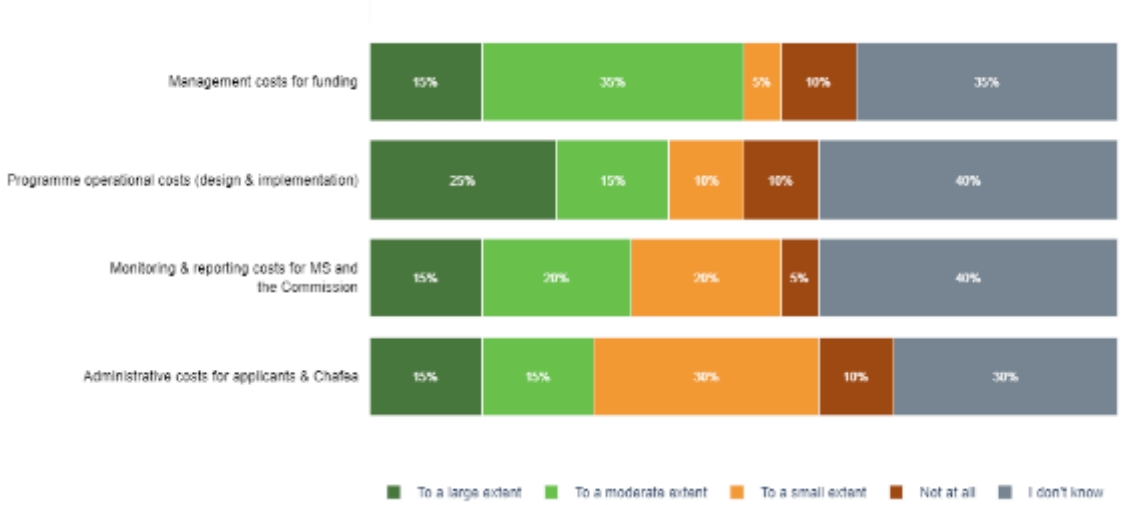


2.4. Efficiency

This section of the targeted survey invited respondents to assess the relationship between the resources used by the Programme and the changes it generated.

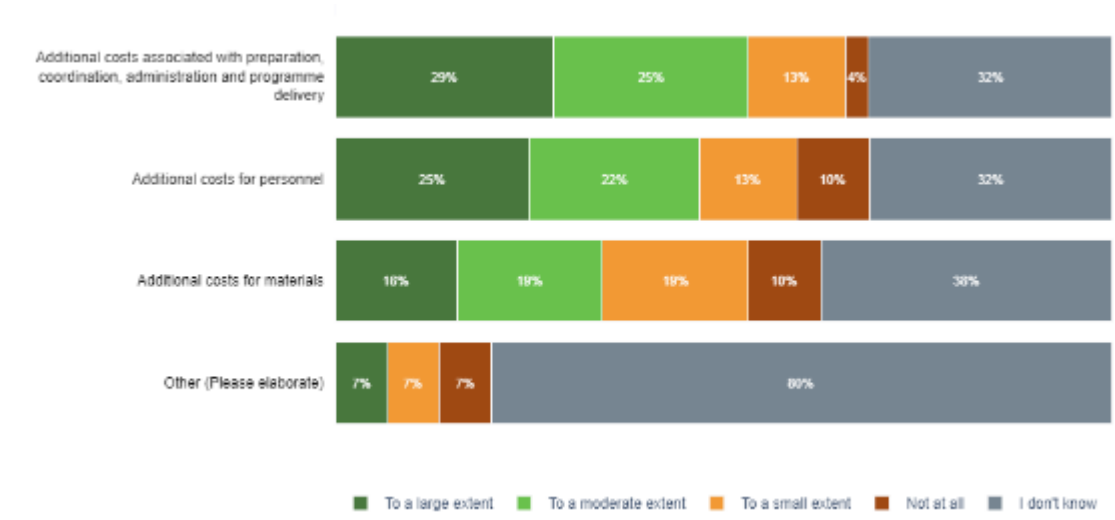
When asked about the extent to which costs associated with the Programme were reasonable and kept to the minimum necessary in order to achieve the expected results, a large proportion of respondents who were involved in the management and administration of an action from the Programme said they did not know (between 6 and 8 respondents, or between 30% and 40%). Costs that were deemed the most reasonable (at least to a moderate extent) by those who did provide an answer were: management costs for funding (10, 50%) and the Programme operational costs (design and implementation) (8, 40%). However, a large proportion of respondents said other types of costs were either not reasonable or only to a small extent: administrative costs for applicants and Chafea (now HaDEA) (8, 40%), and monitoring and reporting costs for Member States and the Commission (5, 25%).

Figure 123. To what extent do you consider costs associated with the Programme are reasonable and kept to the minimum necessary in order to achieve the expected results? (n=20, only those involved in the management and administration of an action from the Programme (e.g. filled in an application form))



According to respondents, factors that may have influenced any disparities between Programme funded actions costs and the expected results were mainly additional costs associated with preparation, coordination, administration and Programme delivery, followed by additional costs for personnel, and, to a lesser extent, by additional costs for materials.

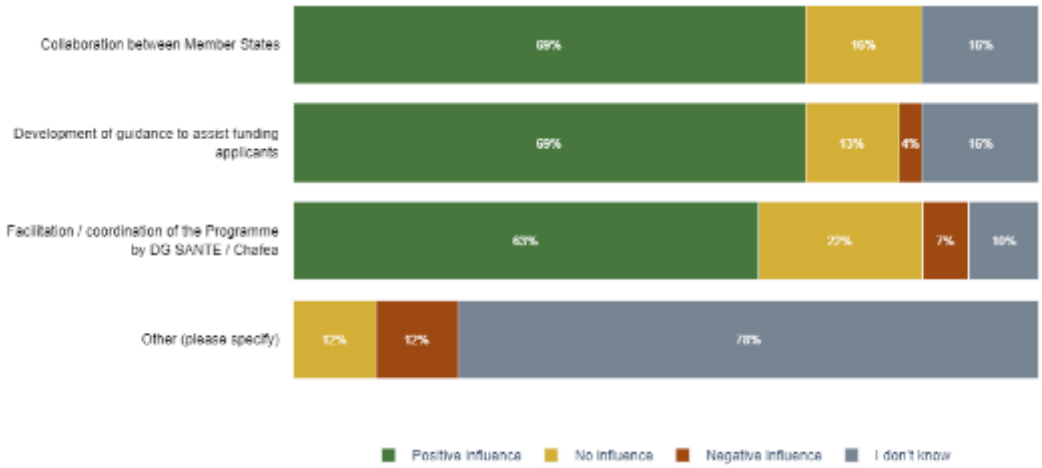
Figure 124. In your view, to what extent the following factors may have influenced any disparities between Programme funded actions costs and the expected results? (n=32)



In addition, according to respondents, a number of internal factors positively influenced the Programme's results: collaboration between Member States and development of guidance to assist funding applicants (22 responses each, 69%), followed by facilitation/coordination of the Programme by DG SANTE/CHAFEA (20, 63%).

A national public authority involved in the Programme implementation mentioned the fact that the guidance to assist with funding was very complicated and onerous can be deemed an internal factor that negatively influenced the Programme's results.

Figure 125. In your view, what internal factors might have influenced the Programme's results, in addition to costs? (n=32)

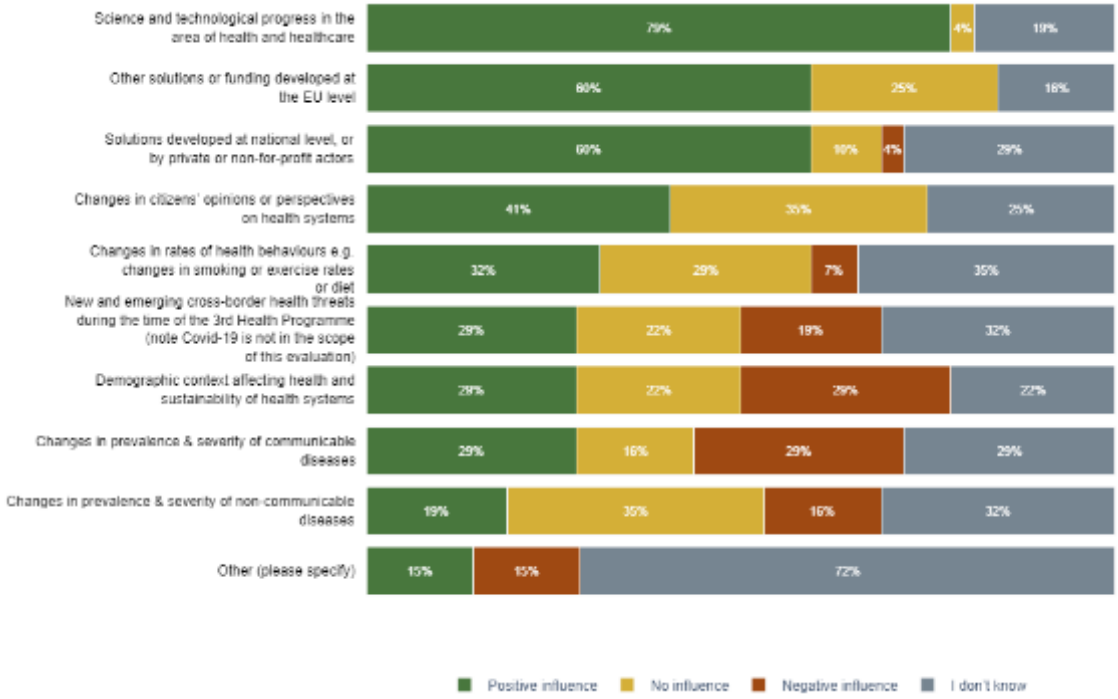


In addition to internal factors, respondents also mentioned a number of external factors that positively influenced the Programme's results: science and technological progress in the area of health and healthcare (25, 79%), followed by solutions developed at national level, or by private or non-for-profit actors (19, 60%) and changes in citizens' opinions or perspectives on health systems (13, 41%).

Respondents also said that some external factors had a negative influence on the results of the Programme, such as changes in prevalence and severity of communicable diseases, and the demographic context affecting health and sustainability of health systems (9 responses each, 29%), followed by new and emerging cross-border health threats during the time of the Programme (6, 19%)[609].

[609] A note in the survey indicated to respondents that Covid-19 was not in the scope of this study.

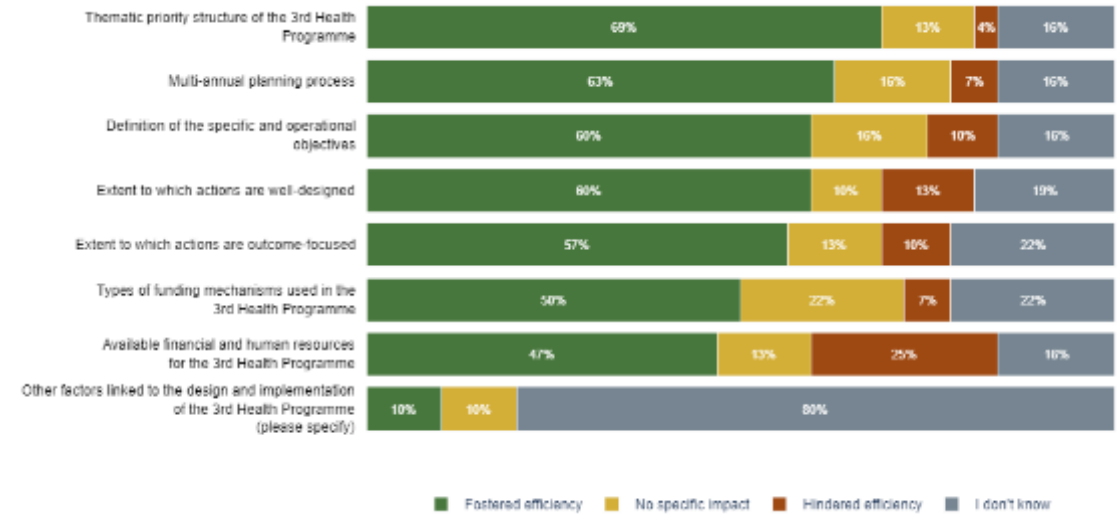
Figure 126. In your view, what external factors might also have influenced the Programme's results, beyond what the Programme funding could have achieved? (n=32)



Respondents were also asked about other factors influencing the efficiency with which achievements were attained. According to survey results, the most positive factors were: the thematic priority structure of the Programme (22 responses, 69%), the multi-annual planning process (20, 63%), the definition of the specific and operational objectives and the extent to which actions were well-designed (19 each, 60%), followed by the extent to which actions were outcome-focused (18, 57%).

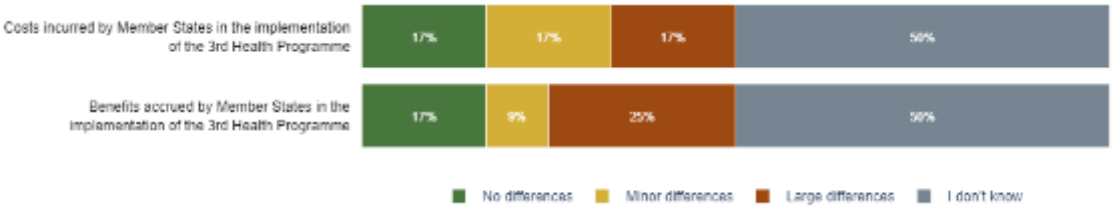
A quarter of respondents highlighted that the lack of available financial and human resources for the Programme hindered the efficiency with which achievements were attained (8, 25%). This was a much larger proportion than any other factor.

Figure 127. In your view, how have the following factors influenced the efficiency with which achievements were attained? (n=32)



Academic/research organisations and NGOs were asked whether there had been any differences between participating countries in terms of costs incurred or benefits accrued by Member States in the implementation of the Programme. Half of the respondents did not know. Those who answered suggested that there had been some differences in costs incurred, for instance as there were large differences between countries in staff costs and thereby achievable goals/work performance per Member States (this issue was raised by an academic/research organisation who benefitted from the Programme). Survey responses suggest that differences in benefits accrued between Member States were even larger. The same academic/research organisation who benefitted from the Programme noted that depending on the tasks and level of involvement of Member States in projects/actions, countries may benefit from the Programme to a different extent.

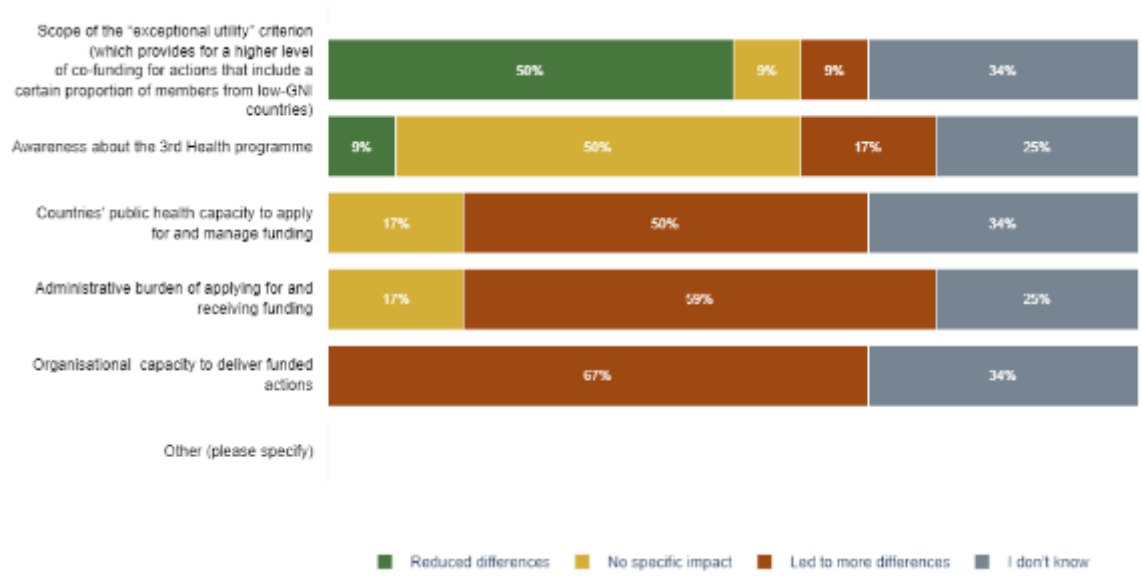
Figure 128. Have there been any differences between participating countries in the following…? (n=12, only academic/research organisations or NGOs)



Academic/research organisations and NGOs were also asked about factors impacting the differences in costs and benefits between countries. Six respondents (50%) said that the scope of the "exceptional utility" criterion (which provides for a higher level of co-funding for actions that include a certain proportion of members from low-GNI countries) reduced differences.

Respondents also mentioned factors that led to more differences, including: organisational capacity to deliver funded actions (8 responses, 67%), administrative burden of applying for and receiving funding (7, 59%) and countries' public health capacity to apply for and manage funding (6, 50%).

Figure 129. In your view, how have the following factors impacted the differences in costs and benefits between countries? (n=12, only academic/research organisations or NGOs)



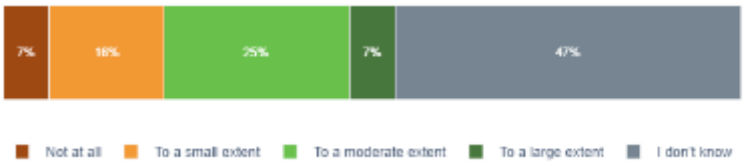
When asked about the extent to which the simplification measures reduce administrative costs for applicants and Chafea, a large proportion of respondents said they did not know

(10 respondents, 32%). Those who did provide an answer were divided. Some said that they did not reduce administrative costs or only to a small extent. Others said that they did reduce costs, to a moderate or large extent. Reasons given to explain why these measures helped reduce costs included: the introduction of electronic tools for the submission of proposals, management of grants and e-reporting and monitoring (subject to the system functioning efficiently), the introduction of a negotiation process for Joint Actions and the ability for beneficiaries to transfer resources between different cost categories without the need for an amendment.

Figure 130. To what extent did the simplification measures reduce administrative costs for applicants and Chafea? (n=32)

When asked about the extent to which there was scope to further reduce costs, almost half of respondents said they did not know (15 respondents, 47%). Those who did provide an answer were divided. Seven respondents (23%) said there was no scope at all to further reduce costs, or only to a small extent. However, 10 others (32%) said that this was possible, to at least a moderate extent. Suggestions on how to further reduce costs included further simplifying and rationalising (e.g., by using unit costs or lump sums), improving the reporting system, or simplifying specific information requested in the application form (budget breakdown).

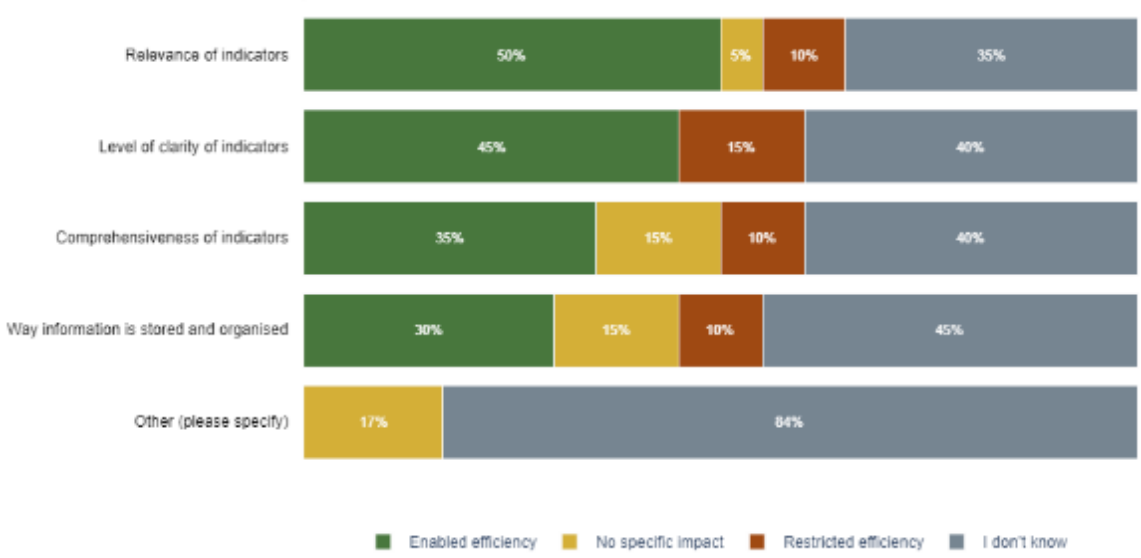
Figure 131. To what extent is there scope to further reduce costs? (n=32)



Monitoring occurred during the Programme at several points[610]. When asked about the factors which influenced the efficiency of the monitoring processes, a large proportion of respondents who were involved in the management and administration of an action from the Programme said they did not know (between 7 and 9 respondents, between 35% and 45%). Two noteworthy factors that were said to enable efficiency were the relevance of indicators (10, 50%) and the level of clarity of indicators (9, 45%).

[610] At lower levels, direct monitoring of implementation occurred (for example, funded actions were monitored to determine how many actions had been launched under each of the finding instruments, and how much budget had been consumed for co-funding the actions). At an intermediary or medium level, outputs and outcomes of actions were monitored in terms of results achieved by the actions and actions to disseminate these results to encourage their wider uptake. Finally, there was higher level of monitoring which consisted in assessing the impact of the actions, of a group of actions or a feature of an entire programme. The high-level monitoring system included a set of indicators which contributed to assessing overall performance of the Programme

Figure 132. In your view, how have the following factors influenced the efficiency of the monitoring processes? (n=20, only those involved in the management and administration of an action from the Programme (e.g. filled in an application form))



A majority of respondents who were involved in the management and administration of an action from the Programme said that the monitoring costs were reasonable and kept to the minimum necessary in order to achieve the expected results, at least to a moderate extent (11 responses, 55%). Only two respondents (15%) said they were not at all reasonable, or only to a small extent.

Figure 133. To what extent do you consider the monitoring costs are reasonable and kept to the minimum necessary in order to achieve the expected results? (n=20, only those involved in the management and administration of an action from the Programme (e.g. filled in an application form))

As part of the Programme, there were regular reporting requirements for each funded action e.g. documenting and reporting on project activities, outputs, outcomes and impacts. Respondents who were involved in the management and administration of an action from the Programme mentioned a few benefits that resulted from this reporting system, such as: allowing Programme participants to track actions' progress against their original plan (11 out of 20 respondents, 55%), increasing the visibility of the Programme and its actions (6, 30%), followed by allowing Programme participants to manage actions' budget more effectively (5, 25%).

When asked about whether the costs of the reporting system were reasonable and kept to the minimum necessary in order to achieve the expected results, respondents were divided. Eight respondents (40%) said this was true, at least to a moderate extent. However, seven others (35%) said they were not at all reasonable, or only to a small extent.

Figure 134. To what extent do you believe the costs of the reporting system are reasonable and kept to the minimum necessary, in order to achieve the expected results? (n=20, only those involved in the management and administration of an action from the Programme (e.g. filled in an application form))

Respondents provided some suggestions on ways in which the reporting system could be more effectively implemented. The most frequent answer was 'simplifying the reporting procedure' (reducing administrative burden, time and efforts required) (13 out of 20 respondents, 65%).

2.5. Relevance

This section invited respondents to assess whether, and how, the priorities and objectives of the Programme addressed needs to problems in society.

A large majority of respondents said that all four of the Programme's specific objectives in relation to EU health needs were relevant at the time of the Programme's development. The specific objective that was said to be most relevant was "Objective 3: Contribute to innovative, efficient and sustainable health systems", with almost all respondents considering it was relevant to at least a moderate extent (31 out of 32, 97%).

The specific objectives "Objective 1: Promote health, prevent disease and foster supportive environments for healthy lifestyles" and "Objective 2: Protect Union citizens from serious cross border health threats" were also deemed relevant by most (respectively 29 out of 32 or 91%, and 30 out of 32 or 94%). However, one academic/research organisation having benefitted from the Programme said they were relevant only to a small extent. Regarding the former specific objective, this respondent explained that it requires strong multidisciplinary action that needs to be promoted systemically at a central level by all EU countries. However, the respondent judged this to be "hardly possible", especially as many countries have a high heterogeneity in the management of health services and a consequent mismatch at country level. They added that the process of cultural change in prevention is a long one and requires joint action at all levels. Regarding the latter specific objective, the respondent stated that the COVID-19 pandemic highlighted the limits of collaboration between Member States on health data, and that knowledge sharing still has many limitations and geographical differences.

The specific objective "Objective 4: Facilitate access to better and safer healthcare for Union citizens" was also deemed relevant by most (29 out of 32, 91%). However, a few respondents raised some concerns. For instance, an EU public authority involved in the Programme design said that means and tools were not appropriate to meet this specific objective. A national public authority involved in the Programme implementation added that they could see no impact of the Programme on the health of their country's citizens (rather that benefits were experienced by other EU countries). Finally, an academic/research organisation having benefitted from the Programme said that the extent to which a population "gains access" to better and safer healthcare depends on a number of factors (e.g. financial, organisational, social or cultural barriers) which may in some way limit the use of services. Access measured in terms of utilisation depends on the economic, physical and acceptable accessibility of services. If the population is to have satisfactory health outcomes, the services available must be relevant and effective. Therefore, availability of services and barriers to access must be considered in the context of the different perspectives, health needs, and material and cultural backgrounds of different groups in society.

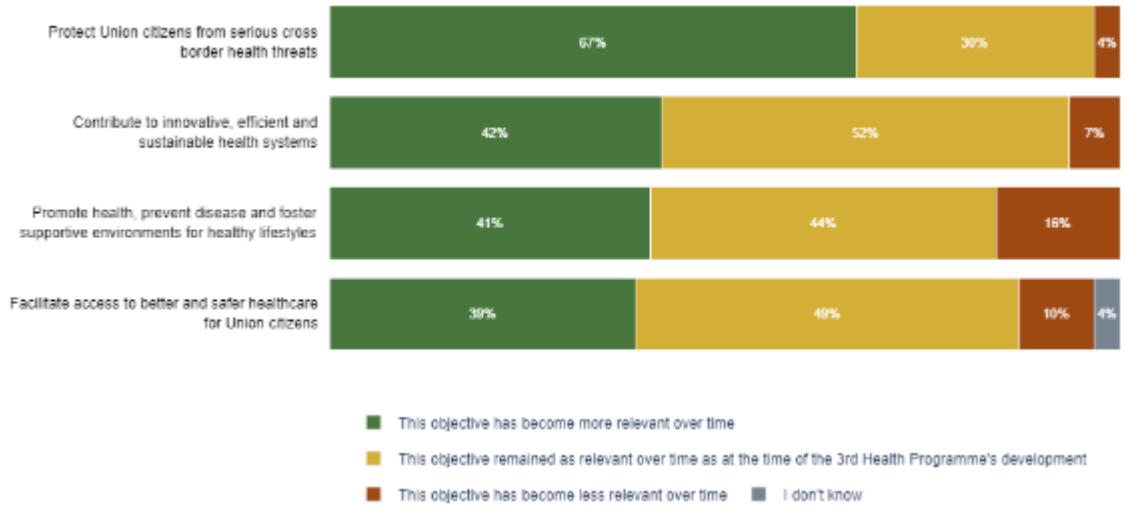
Figure 135. In your view, how relevant were the Programme's specific objectives in relation to EU health needs at the time of the Programme's development? (n=32)

Respondents were asked about the extent to which the Programme's specific objectives had remained relevant over time. More than two thirds (20 responses, 67%) said that the specific objective "Objective 2: Protect Union citizens from serious cross border health threats" had become more relevant over time, mainly due to new and emerging cross-border health threats during the time of the Programme[611] and severity of communicable diseases. This was a higher proportion than for the other three specific objectives (between 12 and 13 responses, or between 39% and 42%).

Five respondents (16%) said that the specific objective "Objective 1: Promote health, prevent disease and foster supportive environments for healthy lifestyles" had become less relevant, mostly due to the demographic context (noting for instance that demographics is a major challenge for financial and organisational sustainability of health and social care systems in the EU).

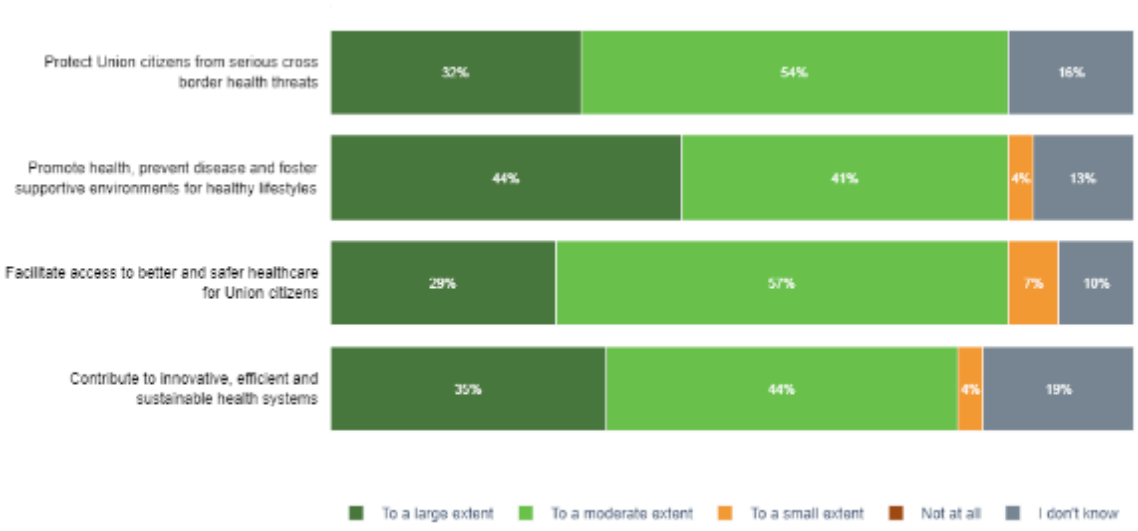
[611] A note in the survey indicated to respondents that Covid-19 was not in the scope of this study. However, respondents did mention Covid-19 as a factor explaining why this specific objective became more relevant over time. Other factors mentioned by respondents included cross-border movement/migrations, globalisation and environmental threats.

Figure 136. To what extent have the Programme's specific objectives (and associated actions) remained relevant? (n=32)



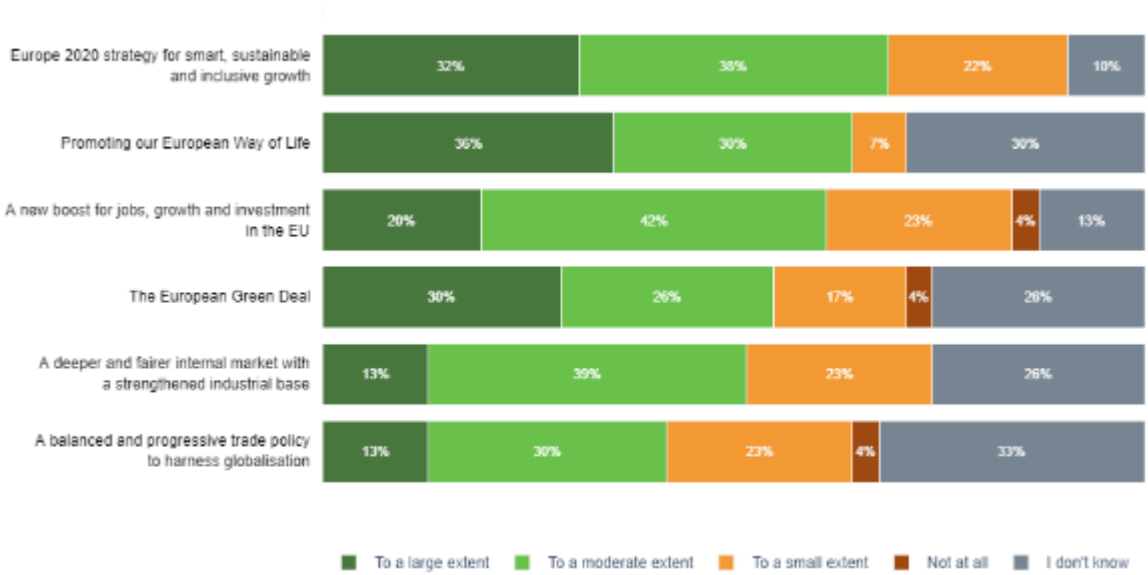
A large majority of respondents said that the Programme's funded actions were aligned with the Programme's four specific objectives. In particular, 14 respondents (44%) said actions were aligned to a large extent with the specific objective "Objective 1: Promote health, prevent disease and foster supportive environments for healthy lifestyles".

Figure 137. To what extent were the Programme's funded actions aligned with the Programme's specific objectives? (n=32)



A large majority of respondents said that the Programme's thematic priorities were relevant to the Commission's wider priorities over the implementation of the Programme. In particular, more than 30% of respondents said the Programme's thematic priorities were relevant to a large extent to the following two Commission's wider priorities: "Promoting our European Way of Life" and "Europe 2020 strategy for smart, sustainable and inclusive growth".

Figure 138. To what extent were the thematic priorities relevant to the Commission's wider priorities over the implementation of the Programme? (n=32)



Almost 90% of respondents believed that the Programme's thematic priorities were relevant in light of citizens' perceptions of key health issues in the EU, to at least a moderate extent (28 responses, 89%). Similarly, almost nine in ten respondents believed that the Programme responded to citizens' health needs, to at least a moderate extent (27 responses, 86%).

A national public authority involved in the Programme implementation said that these were not relevant at all due to a mismatch of health priorities between the Programme and the national context, citing that, in their country, the waiting list to receive medical services was a greater problem and that this was not resolved by the Programme thematic priorities. Two other EU-level NGOs who benefitted from the Programme noted that the funding opportunities for childhood cancer were valuable but insufficient to address the magnitude of the issues in this disease area. They added that more dedicated and sustainable funding streams are needed to further support the European Reference Network on Paediatric Cancer (ERN PaedCan) and other pre-existing paediatric cancer structures in Europe as well as to introduce additional initiatives to ease the burden of childhood cancer.

Figure 139. To what extent are the thematic priorities relevant in light of citizens' perceptions of key health issues in the EU? (n=32)

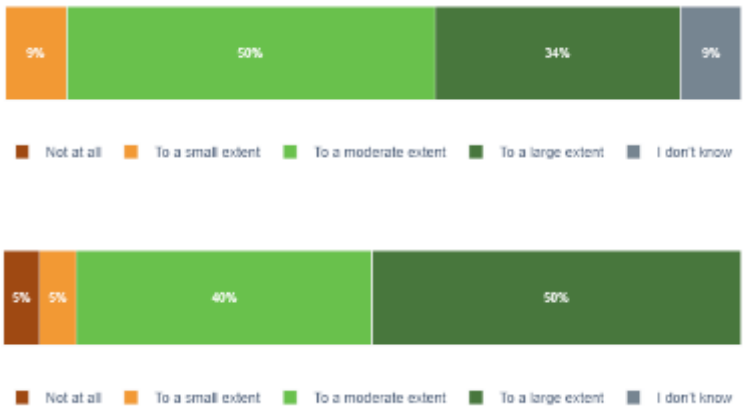
Figure 140. In your opinion, to what extent has the Programme responded to citizens' health needs? (n=32)

2.6. EU added value

This section invited respondents to indicate changes which can reasonably be argued to be due to the Programme, over and above what could reasonably have been expected from national actions alone.

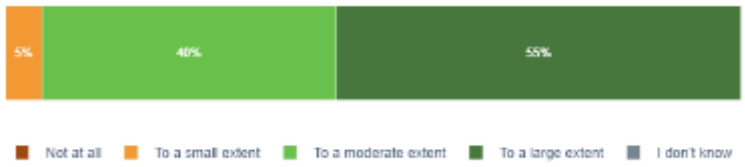
Almost 90% of respondents believed that the Programme provided added-value, beyond what Member States could have achieved acting alone (28 responses, 88%).

Figure 141. To what extent do you believe the Programme provided added-value, beyond what Member States could have achieved acting alone? (first graph: n=12, all but public authorities; second graph: n=20, only public authorities)



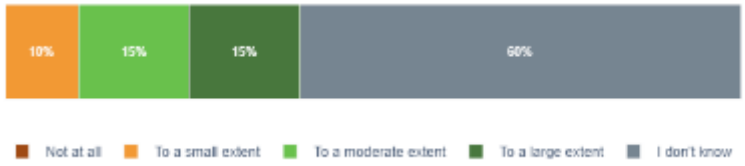
Almost all public authorities said that Member State actions were helped or incentivised by the Programme (19 responses, 95%).

Figure 142. To what extent do you think Member State actions have been helped or incentivised by the Programme? (n=20, only public authorities)



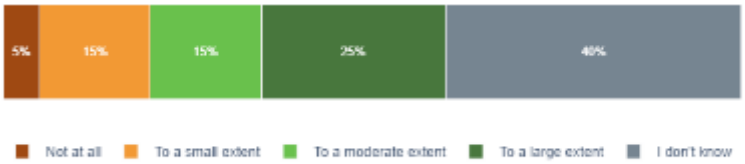
When asked about the extent to which the seven added value criteria were used in funding decisions, a majority of respondents who were involved in the management and administration of an action from the Programme said they did not know (12 out of 20 respondents, 60%). Among those who did provide an answer, six (30%) said the criteria were used to at least a moderate extent, and two (10%) said they were used to a small extent. One of them, a national public authority involved in the Programme implementation stated that there appeared to be overlaps between some actions/programmes, resulting in duplication of resources thus not fully optimising financial resources.

Figure 143. To what extent were the seven added value criteria used in funding decisions? (n=20, only those involved in the management and administration of an action from the Programme (e.g. filled in an application form))



When asked about the extent to which the seven added value criteria were well-defined in funding proposals, a large proportion of respondents who were involved in the management and administration of an action from the Programme said they did not know (eight out of 20 respondents, 40%). Among those who did provide an answer, eight (40%) said the criteria were well-defined to at least a moderate extent.

Figure 144. To what extent have the seven added value criteria been well-defined in funding proposals? (n=20, only those involved in the management and administration of an action from the Programme (e.g. filled in an application form))



When asked about the extent to which the seven added value criteria remained relevant, a large proportion of respondents who were involved in the management and administration of an action from the Programme said they did not know (six out of 20 respondents, 30%). Among those who did provide an answer, 13 (65%) said the criteria remained relevant to at least a moderate extent.

Figure 145. To what extent have the added value criteria remained relevant to what you see as key health needs and priorities during 2014-2020? (n=20, only those involved in the management and administration of an action from the Programme (e.g. filled in an application form))

When asked whether the seven added value criteria should be retained in future health programmes, all respondents answered yes. More than half (18 responses, 57%) said they should be retained as they are, a few said that they should be modified somewhat (6, 19%), and one (4%) said they should be significantly modified. Suggestions for improving these criteria included: ensuring the involvement of civil society actors (NGOs) throughout the programme; putting a stronger focus on health equity, health promotion and education; including evidence-based work (activities, policies); and allocating funding to areas of unmet needs where EU action has particular added value, such as rare diseases including childhood cancers.

Figure 146. To what extent should the added value criteria be retained in future health programmes? (n=32)

2.7. Coherence

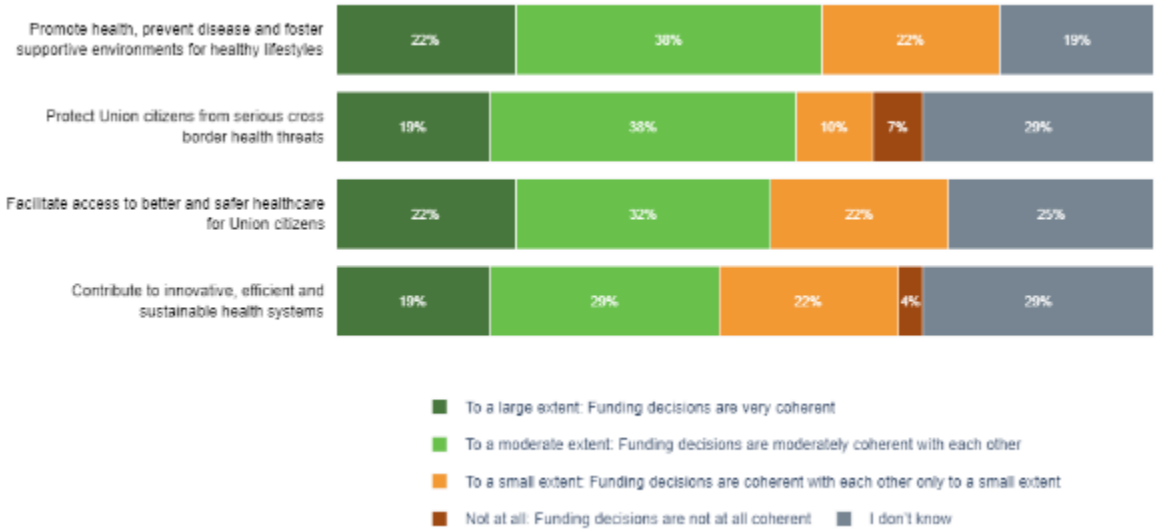
This section invited respondents to indicate the extent to which the Programme complemented and created synergies internally and with other actions outside of the Programme. Specifically, this targeted survey focused on the internal coherence of the

Programme and its coherence with national health priorities and initiatives within the Programme period (2014-2020).

Among respondents who were able to answer this question[612], a majority said that all four of the Programme's specific objectives enabled consistent and coherent funding decisions across actions during the Programme period. In particular, seven respondents (22%) said that there were synergies which improved overall performance between actions and the following two specific objectives: "Objective 1: Promote health, prevent disease and foster supportive environments for healthy lifestyles" and "Objective 4: Facilitate access to better and safer healthcare for Union citizens".

A few respondents said that funding decisions were not at all coherent with the specific objectives "Objective 2: Protect Union citizens from serious cross border health threats" and "Objective 3: Contribute to innovative, efficient and sustainable health systems" (i.e., that there were inconsistencies between actions, gaps, duplications or contradictions, which lead to inefficiencies). This was mainly due to issues linked with relationships between different actors/beneficiaries, Programme management and communication with core stakeholders, and the lack of national political uptake or capitalisation of findings arising from the Programme funding actions.

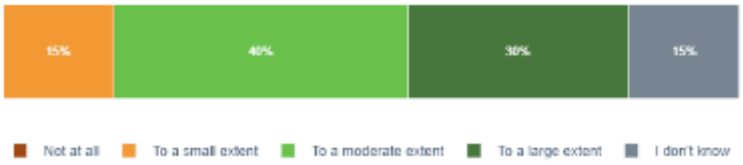
Figure 147. To what extent did the Programme's specific objectives enable consistent and coherent funding decisions across actions during the Programme period? (n=32)



A majority of public authorities said that the Programme was aligned with and addressed national health priorities during the Programme period to at least a moderate extent (14 responses, 70%). Among the three respondents (15%) who said this was true only to a small extent, one cited the structure of the Programme (e.g., definition of the scope and of the priorities), another explained this was due to the changing needs and priorities in health during the Programme period, and another stated that too many key stakeholders saw the Programme as supporting what they wanted to do rather than meeting the health objectives defined.

[612] I.e. who did not reply "I don't know"

Figure 148. To what extent has the Programme been aligned with and addressed national health priorities during the Programme period? (n=20, public authorities only)



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