European Commission

Ex-post Evaluation of the Health Programme (2008-2013)

Final report

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Directorate-General for Health and Food Safety
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List of acronyms

AWP	Annual Work Programme
CF	Cohesion Fund
Chafea	Consumers, Health, Agriculture and Food Executive Agency
CoR	Council of Europe
DG	Directorate-General
DG SANTE	Directorate general for Health and Food Safety
EAHC	Executive Agency for Health and Consumers *(became Chafea in 2014)*
EC	European Commission
EP	European Parliament
ERDF	European Regional Development Fund
ESF	European Social Fund
ESIF	European Structural and Investment Funds
EU-12	EU-12 comprises 'new' (joined 2004-2007) EU Member States and include Bulgaria, Czech Republic, Estonia, Cyprus, Latvia, Lithuania, Hungary, Malta, Poland, Romania, Slovenia and Slovakia
EU-15	EU15 comprises 'old' Member States and include Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and UK
EUR	Euro, currency of the Eurozone
FP	Framework Programme
GDP	Gross Domestic Product
GNI	Gross National Income
HI	Health Information – strand
HP	Health Programme
HP (strand)	Health Promotion
HS	Health Security
HTA	Health Technology Assessment
IO	International Organisation
JA	Joint Actions
JRC	Joint Research Centre
MS	Member States
NFP	National Focal Point
NGO	Non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
SC	Service Contract
SF	Structural Funds
TFEU	Treaty on the Functioning of the European Union
WHO	World Health Organisation
WP	Work Programme

0. EXECUTIVE SUMMARY

0.1. Background and scope

The Health Programme (HP) is the European Commission's main vehicle for funding collaborative actions to support public health in Europe. Its second iteration ran for six years, from 2008 until 2013, and had a budget of EUR 321.5m. The 2nd HP pursued objectives aimed at improving citizens' health security, promoting health and reducing health inequalities and generating and disseminating health information and health knowledge. Funding was disbursed to a variety of beneficiaries via six different instruments (including grants for collaborative projects, joint actions, and conferences, operating grants to NGOs or networks, direct grants to international organisations, and service contracts).

This report forms the ex-post evaluation of the 2nd HP and has as its purpose to assess the main outcomes and results achieved and identify the main problems and solutions with regard to implementation, particularly regarding recommendations from previous evaluations. The research focused on four main thematic blocs, namely programme management, dissemination practices, the impact of the HP and synergies with other programmes and services.

0.2. Approach and validity

The evaluation combined a variety of quantitative and qualitative data collection and review methods and analytical tools to respond to the specific information needs and requirements. These consisted of a review of relevant documentation, analysis of quantitative HP data (e.g. funding and beneficiary trends), an online survey of national officials, interviews with various stakeholders, an in-depth review of a representative sample of 80 funded actions and detailed case studies of 13 actions. The evaluation also included a bibliometric analysis of HP visibility in scientific journals, an analysis of public health capacity and links to HP participation, and a stakeholder analysis of priority audiences.

The diversity of HP objectives, topics and mechanisms, small size of the HP in relation to public health spending overall, lack of Programme and action level indicators and data, time lag before impacts (on health policies, systems or even health outcomes) could be realised and limited size of the evaluation posed numerous challenges. Taken together, they mean that the evaluation was not able to measure (in quantitative terms) the overall impact of the HP or specific actions, and we cannot be absolutely certain of the exact extent to which the generalisations made are applicable to the entirety of HP actions. Despite this, we were able to gain substantial insight on the HP using purposive sampling and the focus on key areas of interest, such as the identification of trends, success factors and barriers to HP effectiveness and lessons that could be applied readily to the next iteration of the HP.

0.3. Key findings

Programme management

Substantial efforts to implement recommendations from the mid-term evaluation

The mid-term evaluation in 2011 found that the HP had become unwieldy and needed to take a step back, consider the principles of sound project management and apply them. During the second half of the HP, steps were taken to implement many of the

recommendations, leading to numerous improvements in programme management. These included more strategic programming, the systematic use of EU added value criteria in grant applications and selection, clearer guidance for applicants and better contact with applicants and beneficiaries.

While stakeholders expressed some confusion about the respective roles of DG SANTE / Chafea, this appeared to be due to communication issues rather than overlapping or poorly defined roles. There were also still some concerns and complaints related to the administrative burden of financial and contract management and the application process.

Trend towards more directive methods of planning

Two changes during the second half of the HP increased the policy relevance of funded actions. Senior-level DG SANTE officials increased their involvement in annual planning, allowing for a greater level of coherence with other policies and programmes. This was accompanied by increased use of joint actions. Unlike projects (which are comprised of smaller groups of partners), each joint action secures buy-in from national governments and participation of key stakeholders from nearly all Member States. Similarly, there was an increase in service contracts, a prescriptive funding mechanism that allows DG SANTE to order studies and other products (like seminars) to meet particular needs.

Programme geographically balanced, but lead beneficiaries concentrated in EU-15

The evaluation sought to determine whether participation in the HP was spread equitably across the EU. While the number of participating organisations and distribution of funding (accounting for wage differences) were equitable, lead beneficiaries (who are responsible for steering actions) were concentrated in the EU-15, indicating discrepancies in capacity. The increased use of joint actions slightly increased participation from EU-12 countries, but it was offset by the rise in service contracts, which disproportionately benefited organisations based in the EU-15 (in particular Belgium and Luxembourg). Looking only at the truly 'collaborative' actions (i.e. projects and joint actions), the participation rates of most countries appear broadly in line with their public health capacity (defined based on an analysis of correlations between participation rates and a number of proxy indicators for which data was available), although there are some that participated significantly more or less than would have been expected.

Provisions for monitoring still problematic

While there had been some improvements to monitoring provisions, they remained problematic. At input and activity levels, comprehensive monitoring data is collected but not systematically organised and used, making it difficult to keep track of key issues in real time. At output and outcome levels, various reports and evaluations that are carried out for each action were too long and formalistic to either serve as genuine communication tools or play a role in monitoring the performance of the HP as a whole.

Dissemination

In spite of progress made, effective dissemination of results remains a challenge

The mid-term evaluation in 2011 concluded that the dissemination of results is one of the main challenges facing the Health Programme. Simply put, if relevant target audiences are not aware of key results of HP-funded actions, the chances that these are accepted and implemented widely across the EU are significantly reduced.

Even though a considerable effort was made during the second half of the HP to enhance dissemination (e.g. by improving the project database, and by publishing brochures and organising meetings on key topics), there remains room for improvement in terms of raising awareness among relevant stakeholders of the results of HP-funded actions, thereby maximising their uptake and impact.

Target audiences vary depending on the action

The responsibility for disseminating the results of individual actions falls mainly on the partners themselves; it is mandatory for all projects and joint actions to include a specific work package dedicated to dissemination. As part of this, the vast majority of projects and joint actions use dedicated websites and conferences / events. Reports / guidelines for specialist audiences and newsletters are also fairly widely used, as are print promotion materials. Other tools, such as briefings for policy makers, press releases or social media activities, are only used by a small minority of actions.

An overall assessment of the effectiveness of the dissemination activities and tools is complicated by the diverse nature of HP-funded actions, which address issues and produce outputs that are of interest to very different groups. The case studies provided examples of actions which produced outputs of a very technical nature that are only relevant to relatively narrow audiences, and others that covered issues that are of potential interest to broader groups, and therefore warrant a more wide-ranging dissemination strategy.

To be effective, communication needs to be tailored to the audiences

In both cases, the evaluation found instances where communication was very effective, and others where it was less so (mainly due to a lack of clarity and focus as to the most relevant target audiences and how best to reach them). The key lesson is that, to disseminate results effectively, actions need to carefully consider which potential target groups are most relevant in terms of both their interests and their ability to use or contribute to the uptake of the results, prioritise accordingly, and tailor the messages, tools and channels to the needs of the key audiences.

One such channel that can be effective in certain circumstances are academic / scientific publications. The bibliometric analysis conducted for this evaluation suggests a reasonable amount of coverage and visibility in terms of articles published in scientific journals, although this varies very significantly from action to action, and – as noted previously – is only appropriate where the specific results in question are apt for such publications.

DG SANTE and Chafea support for dissemination is somewhat effective

Feedback on the dissemination activities by DG SANTE and Chafea was broadly positive. The project database in particular was found fairly useful, but actual usage is low, and there is room for improvement in terms of the content and the way in which it is presented.

When considering the targeting of future dissemination activities at the level of the programme as a whole, the stakeholder analysis conducted as part of the evaluation suggests that the HP's key stakeholders are public health organisations, healthcare providers, funders and commissioners, and health professionals. Academic and research organisations, as well as patients and healthcare users, also tend to be very interested, but their influence when it comes to implementing the results is more limited. On the other hand, policy-makers have significant influence, but their interest is often more limited, which means it is a key priority for the HP to find ways in which they can be engaged effectively. At the same time, it is important to emphasise that this aggregated and therefore simplified analysis should not detract from the need to identify relevant target audiences for each individual action, as discussed above.

Impact

Action focus

Given the EU's supporting role in public health, the evaluation looked at the HP's impact in terms of its ability to support Member State action by facilitating collaboration and strengthening the efforts of key stakeholders. About 75% of HP action was devoted to five key themes, comprised of (1) health determinants and healthy lifestyles; (2) prevention of major and rare diseases; (3) health monitoring and data; (4) health threats; and (5) health safety. The remaining 25% of funding was spread across around a dozen other themes and priorities.

HP-funded actions sought to address research, development and implementation. While the actions were more focused on development than the other aspects of the 'health intervention process', many actions, particularly projects and joint actions, addressed two or even all three aspects. An in-depth review of documentation from 80 actions showed that while most joint actions were conceived to influence policy, the objectives of the majority of service contracts, operating grants and projects were concerned more immediately with other issues, such as conducting rigorous research, despite the importance of policy impact for the HP.

Funding mechanisms

The evaluation used case studies to examine projects, joint actions and service contracts in more depth. The funding mechanisms were shown to be complementary, with all of them potentially useful and effective in the right circumstances, which are summarised in the table below.

Funding mechanism	Ideal circumstances	Risks / challenges
Joint actions	• Clearly established case for pan-European collaboration at a technical (and not only political) level • Buy-in from key stakeholders in (nearly) all Member States • Feasibility of desired results already confirmed from previous work • Political momentum sufficient for results to be applied in practice	• Due to their size and the number of partners typically involved, joint actions are costly to implement and can be difficult to manage • If established prematurely, joint actions can be too unwieldy to provide a forum for exploring new ideas and experimenting • The chances of results being taken up is reduced if a critical mass of Member States is not secured
Projects	• Highly relevant topic but case for pan-European collaboration not fully established, particularly regarding practical solutions • Need for a 'pilot' to ascertain level of interest and feasibility of changing status quo • Availability of strong leadership and established interest from a smaller group of committed partners to pursue a focused set of objectives	• Value of collaboration beyond the level of the partners themselves needs to be established • If the primary focus is on networking and sharing best practices, the need to create more tangible results can be lost • Projects often struggle with national differences in data availability / comparability • Overly ambitious / diverse objectives can reduce effectiveness • If policy links are absent, it is difficult to overcome barriers for EU-wide implementation of results
Service contracts	• Existence of specific and clearly defined DG SANTE needs / ideas • Narrow set of objectives and limited scope	• Level of ambition needs to be aligned with typical budgets (€100-250k). • Clear need for action should be

	• Clear link to specific policy process or initiative	established beyond interest of specific DG SANTE units. • Excessive reliance on service contracts would be detrimental to HP inclusiveness (in terms of types and geographic spread of beneficiaries)

Success factors

The case studies identified key success factors that applied to all funding mechanisms. These included links to identifiable needs and existing initiatives; choice of the 'right' funding mechanism; well-delineated scope and objectives; plausible intervention logic; feasibility of policy change; involvement of relevant partners; strong project management; and constructive engagement from DG SANTE / Chafea. On average, joint actions were the most likely to satisfy the criteria, which is partly due to their tendency to involve key stakeholders from (nearly) all Member States (as designated by national governments) and address issues where the case for action and political momentum had already been established. There were examples among all action types where given criteria were and were not present.

Impact timescale

The path to impact was shown to often follow a typical pattern. Projects and joint actions typically run for about three years, and aim to develop and/or test approaches and/or tools that will only make a tangible impact once they are taken up and used by Member State authorities and other actors. This often entails more than one HP-funded action and can take around ten years, with a project leading into two or more joint actions.

Synergies

Strong synergy effects between the HP and FP7, more limited with the Structural Funds

There were important synergies between the HP and FP7, illustrated by the numerous areas where cross-fertilisation between specific FP7 projects and HP activities has occurred. There are examples of synergy effects working both ways: HP actions building on and using FP-funded research (e.g. on health threats from nanomaterials), as well as the FPs providing a vehicle to further investigate issues and knowledge gaps that arise as a result of HP actions (e.g. on specific HTA methodologies and application areas).

Synergy effects with the Structural Funds were less obvious, as few HP actions produced results that lend themselves to implementation using ERDF, CF or ESF co-funding. However, there were six specific HP-funded actions (a mix of projects, joint actions and service contracts totalling around €5million of HP funding) that addressed the use of the Structural Funds for health, and provided guidance and awareness-raising that should enable those responsible for Operational Programmes (as well as to relevant Commission services and other stakeholders) to more effectively address health-related issues during the current programming period.

0.4. Conclusions

Relevance

The 2nd HP's objectives are very broad and cover the vast majority of MS' and relevant stakeholders' needs. The funded actions are almost without exception directly related and therefore relevant to these overall objectives and priorities. A consequence of the very broad objectives was a certain lack of structure and prioritisation, making it difficult to understand fully what the HP does, why it does it, or – crucially – to what extent actions correspond to the actual concrete and specific needs of stakeholders in a given (broadly relevant but not clearly defined) topic area.

Leading on from this, "relevant" in this context is not synonymous with "potentially impactful". A relevant topic does not necessarily imply a strong case for EU-level cooperation. For this to be the case, relevance and EU added value (see below) need to coincide.

These problems were taken into account in the design of the 3rd HP, which undertook a horizon scanning exercise to identify the key health challenges facing Europe, as well as an analysis of if and how these could or should be addressed by the new Programme. The result is a set of more specific objectives, which cover a slightly reduced (but still very significant) amount of ground in terms of public health issues, and attempt to introduce a better focus in terms of specifically how progress is to be achieved. This promises to provide a stronger focus on those topics that are both relevant to MS and stakeholders, and most promising in terms of the potential added value of cross-border collaboration.

Effectiveness

The 2nd HP aimed to support Member State action in the field of public health by facilitating collaboration and strengthening the efforts of others across three main objectives, which are (1) to improve citizens' health, (2) promote health and reduce health inequalities and (3) generate and disseminate health information and knowledge. The ex-post evaluation found that actions funded by the 2nd HP have contributed to significant progress and results across these three objectives, in ways such as fostering cross-border collaboration, developing and testing common tools and approaches or enhancing the evidence and information base.

Different public health activity areas bring with them different priorities and challenges, depending on e.g. pre-existing levels of collaboration and discrepancies between Member States. The 'toolbox' of funding instruments has allowed the HP to address a variety of subjects, and involve and support different relevant actors, in ways that have often proven to be highly effective.

While the diversity and volume of funded actions makes it impossible to quantify and list all of these contributions, the evaluation highlighted numerous examples. These include common approaches to health technology assessment, the development of common standards of care for musculoskeletal conditions and contributions to EU reports and guidelines on rare diseases. The HP has also been relatively successful (more so than for instance FP7 funding for public health related research projects) in involving partners from relatively lower income (and in particular EU-12) Member States, although there remains room for improvement in this respect.

At the same time, it is important to recognise that not all HP-funded actions were particularly effective when it came to achieving tangible and genuinely useful results and impacts. While joint actions typically achieve a tangible impact, projects relatively often fail to see their results taken forward and put into practice. Reasons for this included poor design, often with unspecific objectives and insufficient attention being

paid to key barriers to implementation and engagement of relevant enablers; and ineffective dissemination strategies. To avoid such shortcomings, efforts are needed to evaluate (ex ante and ex post), support, guide and where necessary challenge individual actions and beneficiaries to ensure the presence of the key success factors mentioned above in the Impact section. In addition, highly effective actions tended to demonstrate EU added value in areas such as economies of scale, innovation and implementing EU legislation.

The evaluation found that the choice of funding mechanism was also an important factor behind the success of a given action. While all funding mechanisms generated policy impact in certain circumstances, the evaluation identified examples where actions were not funded through the most suitable mechanism. To maximise effectiveness, it should be kept in mind that joint actions are suited to scaling up and institutionalising efforts once the case for pan-European collaboration has been established. Projects are useful as 'pilots' for ascertaining the level of interest and testing new approaches and tools (accepting a certain degree of risk and uncertainty), while service contracts can address specific needs for a given policy process or initiative. In a number of cases, it was the combination (over time) of two or more successive actions (using appropriate funding mechanisms) that enabled the HP to progress an issue or intervention through the different stages of development, from research through development to implementation.

Efficiency

Efficiency considers the relationship between the HP's impact and its cost. The Programme's small size, large scope, and lack of clear strategic focus and priorities, imply a risk that resources would be diluted by the number of issues to be addressed. This risk was mitigated to some extent during the second half of the HP by more concrete links to the Europe 2020 strategy, and an increased focus on EU added value. The 3rd HP is building on these changes.

At the same time, the preponderance of actions, especially among projects, whose identifiable EU added value is comprised mainly of criteria like networking or the identification of best practices implies that a considerable amount of Programme funding still leads to few concrete results or outcomes. The fact that more than half of funding was devoted to the Health Promotion objective, where such actions are disproportionately concentrated, amplifies these concerns.

Efficiency is also dependent on well-functioning programme management arrangements. The growing responsibility of Chafea across all manner of administrative functions of the Programme has allowed certain tasks (such as changes to team costs on projects) to be streamlined, increasing their efficiency. While changes were mainly incremental during the second half of the Programme, several major initiatives appear likely to result in substantial gains during the 3rd HP; this includes the abolition of paper-based reporting for beneficiaries. After initial adjustments and reconfigurations, the respective roles of Chafea and DG SANTE had been clearly defined by the end of the Programme period. Despite this, numerous beneficiaries expressed confusion about the division of responsibilities. This led to wasted time and duplicated efforts that could be addressed during the 3rd HP through clear and consistent communication efforts.

The purpose and use of reporting and monitoring data are also problematic. While the considerable burden on action leaders and partners in providing Chafea with regular reports and data can be justified, the lack of common indicators or formats meant that the products of such requirements were not comparable. Moreover, we did not find any evidence of monitoring data actually being fed into processes to improve the Programme's performance. The technical (and often confidential) nature of action

reports also precluded their use for communication purposes. These issues imply a substantial dead weight in addition to hampering evaluation and dissemination efforts.

Finally, the long timescales involved in seeing the outputs of a given action work their way into actual practical changes imply sustained EU funding is needed to realise tangible progress. Funding for a series of successive actions on a topic is frequently needed for the outputs to reach a certain level of maturity. The possibility for the Programme to fund second (and sometimes third) iterations of given actions has led to significant outcomes, but it also creates a double risk. On the one hand, the achievements of some actions would fail to take root without further funding. On the other hand, if the HP focused too much on funding multiple iterations of actions on the same subject, it could miss opportunities to adapt priorities with changing times and to identify meaningful new initiatives.

EU-added value

Chafea has developed a set of eight EU added value criteria for the 2nd HP, which helped inform the scoring of all applications for Programme funding, thereby ensuring that the (potential) EU added value is assessed ex ante for all actions. This is laudable, and the fact that the Regulation which established the third Programme has enshrined the criteria in legislation is an additional positive development.

The evaluation scored a sample of actions against the eight criteria and found that for certain criteria nearly all actions received high scores. However, much of the demonstrable EU added value was concentrated across the three criteria with weak links to tangible policy benefits, namely identifying best practices, benchmarking and networking. For other criteria, like innovation and economies of scale (that unambiguously require more concrete results), we found evidence of substantial added value only in isolated cases, and disproportionately little under the 'project' funding mechanism and within actions aimed at health promotion.

If achievements like building a more European health community (via networking) are to be valued over the short-term, then the Programme has demonstrated significant EU added value. However, the analysis also highlights the importance for actions (and those evaluating applications) to demonstrate credibly how this leads to more concrete benefits over the longer term. This requires a stronger focus, for example, on not only identifying good practices, but also addressing barriers to their implementation across Europe.

Coherence

The Health Programme is highly coherent with the EU's overarching policy objectives embodied in the Europe 2020 strategy, in that it funds actions that have the potential to contribute to a healthier population and workforce (a key prerequisite for smart growth), and/or to reducing inequalities (a key component of inclusive growth). Demonstrable efforts were made during the second half of the programming period to further enhance this coherence, notably by significantly increased funding for actions to address healthy ageing and health inequalities.

While this is commendable, it is important to note that almost any action that contributes to improving the health status of the European population has the potential to contribute to growth and productivity in one way or another. It would therefore be wrong to attempt to focus the HP too narrowly on issues related to health promotion as such. These may be most *directly* relevant for growth, but they also represent an area where the EU added value of collaboration can often be less tangible.

0.5.Options for change

Following on from the findings and conclusions, the following issues and challenges should be addressed to maximise the effectiveness and efficiency of the 3rd HP:

1. **Communicate the division of roles between Chafea and DG SANTE** more clearly, to avoid confusion and misunderstandings among (prospective) beneficiaries about how actions are steered and administered.

2. **Improve Programme monitoring**, so as to facilitate better performance monitoring as well as dissemination of results, by exploring the potential for developing indicators (at programme and action level); adopting an electronic monitoring system; providing more prescriptive guidance; and looking into post-action reporting.

3. **Encourage greater participation from MS that were under-represented during the 2nd HP (which includes some but not all EU-12 countries), inter alia by** targeting key governmental institutions, emphasising the opportunities the HP brings, and bringing on board 'champions'**.**

4. **Clarify whether public health capacity building is a HP objective**, and if so, carefully consider the potential implications for the setting of Programme priorities and the design of individual actions, as well as future evaluations.

5. **Take a more strategic approach to external communication**, so as to provide an impetus to approach the key issue of communication and dissemination head on at Programme level, by clearly defining objectives and the roles of different actors, as well as key priorities and actions.

6. **More insistence on, and greater scrutiny of, systematic dissemination strategy and planning** for individual actions, including a clear definition and prioritisation of stakeholders.

7. **Consider introducing 'cluster projects'** (beyond the HP *cluster meetings* that already exist), borrowing from the experience of other programmes (in particular INTERREG IVB NWE – North-West Europe) that provide a small amount of additional funding to bring together projects on similar topics funded by the programme to network and share knowledge and experience, with a view to maximising their visibility and impact.

8. **Better reporting on action progress and results**, with a view to making the deliverables more useful for dissemination, e.g. by requiring brief and accessible summaries of progress and/or results alongside each interim and final report, and publishing these via the database.

9. **Enhance HP visibility in scientific publications by exploring** whether / how beneficiaries can be brought to explicitly mention the HP co-funding in any publications they write that are directly linked to HP-funded action results.

10. **Emphasise key barriers to implementation and how they can be overcome in evaluating proposals, inter alia by strengthening** risk analysis and making this a clear point of emphasis for Chafea and external evaluators when assessing and challenging proposals.

11. **Review 'soft' EU added value criteria to maximise impact. For example, to receive high scores,** project applications should not only make a good case for how they will identify good practices, but also explain what the key

barriers to the promotion and application of those practices across Europe are, and how they will be addressed.

12. **Strategically assess and define balance between funding instruments,** considering trade-offs between more open, potentially innovative but also inherently risky actions (in particular projects) and more prescriptive ones (in particular service contracts), as well as the desired involvement of different key groups (including public authorities, civil society, and academia).

13. **Maximise synergies by intensifying consultation with other DGs**, in particular more upstream consultation of DG RTD on multi-annual HP priority setting, and consultations with DG REGIO and EMPL to raise awareness of relevant HP actions and results that could be implemented with ESIF support.

14. **Avoid an excessive focus on health promotion to demonstrate coherence with Europe 2020**, as the issues that appear most *directly* relevant for economic growth do not always coincide with those where there is the strongest case for EU-level collaboration.

KEY MESSAGES

Relevance

- The 2nd HP's very broad objectives mean the themes addressed by the actions it funded are all relevant.
- However, the broad objectives – defined in terms of public health issues or themes, rather than desired results – have led to a certain lack of focus.
- The more specific objectives defined for the 3rd HP should address this issue to some extent.

Effectiveness

- The 2nd HP has contributed to significant progress in several areas of public health.
- The 'toolbox' of funding instruments (including projects, joint actions and service contracts) has been useful and appropriate – if the instruments are used 'correctly'.
- The 2nd HP was relatively successful in involving partners from EU-12 countries.
- Beneficiaries, DG SANTE and Chafea could do more to promote sound action design, uptake of results and hence impact.

Efficiency

- The large scope and lack of focus mean the resources are spread very thinly.
- Programme management has been mostly effective.
- However, there are persistent problems with monitoring, communication, and the interplay between the two.
- The timescales to impact are frequently long (sometimes spanning several actions), which means sustainability can be a concern.

EU added value

- The fact that a set of eight criteria has been defined and is built into the proposal evaluation process is a positive achievement, and helps ensure actions deliver EU added value.
- But actions that only / mainly add value by identifying best practices or promoting networking should demonstrate how this will translate into more tangible benefits.

Coherence

- The 2nd HP is highly coherent with the Europe 2020 objectives of smart and inclusive growth.
- From 2011 to 2013, the funding awarded for actions that are directly relevant to Europe 2020 increased significantly, in particular for actions on healthy ageing and inequalities.

Options for change

- Further improve programme management and focus, inter alia by improving the monitoring process.
- Improve communication, inter alia by more insistence on, and greater scrutiny of, systematic dissemination strategy and planning for actions.
- Take steps to maximise impact and synergies, inter alia by strategically assessing and defining the balance between funding instruments.

1. INTRODUCTION: THE HEALTH PROGRAMME

Overview

The Health Programme (HP) is the Commission's main vehicle for funding collaborative actions to support public health in Europe. Its second iteration ran for six years, from 2008 until 2013, and forms the subject of this evaluation.

The 2nd HP had a budget of EUR 321.5 million and pursued three main objectives,[1] as explained in the table below.

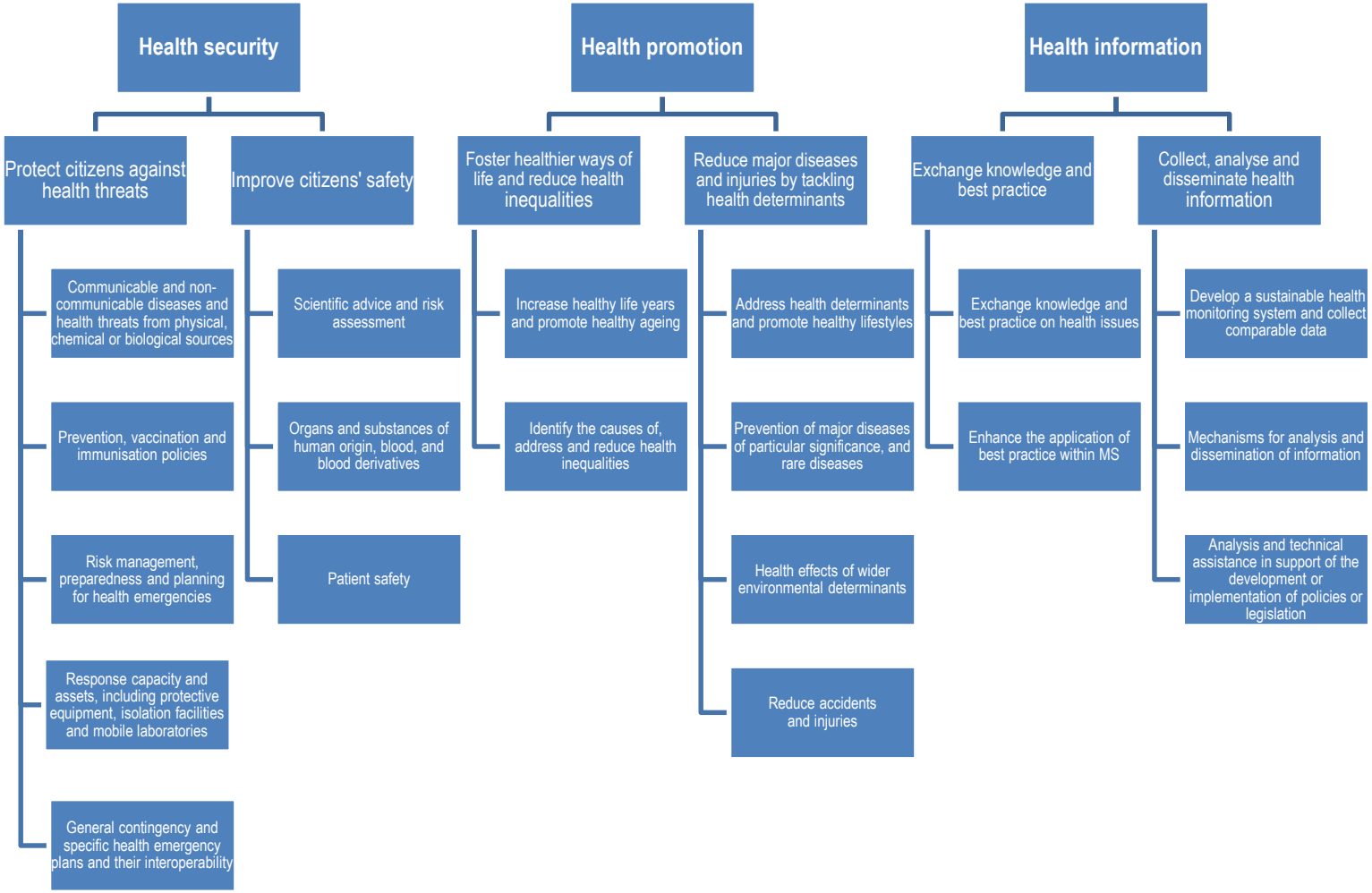
Table 1: Objectives pursued by the second Health Programme (2008 – 2013)

Objective	Explanation
Improve citizens' **health security**	These actions aim to protect citizens from health threats and emergencies, such as pandemics or natural disasters, by improving prevention methods, preparedness, coordinating responses and sharing information across borders, among others.
Promote health and reduce health inequalities	Actions funded under this objective aim to help overcome inequalities in the health of citizens' across Europe, whether they are related to lifestyles, such as in access to opportunities for physical activity, or lifesaving interventions. In addition, actions which promote better choices and healthier lifestyles are also supported by this strand.
Generate and disseminate **health information** and health knowledge	This strand supports the collation of information across borders on the health of citizens, as well as the development of monitoring systems. In addition, it supports actions which communicate health issues to relevant parties, from the general public to policy makers and health professionals.

Within these broad (and sometimes overlapping objectives), the HP sought to address a number of more specific objectives, called priorities and sub-priorities, as shown in the diagram overleaf.

[1] As per Decision No 1350/2007/EU (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32007D1350:EN:NOT)

Figure 1 – The second Health Programme's objectives (strands), priorities and sub-priorities



Source: Annex to HP Decision No 1350/2007/EC (text abridged)

Each year, **Annual Work Plans** (AWP) set out the priorities for actions to be funded by the HP. They are developed by the Commission and adopted through a collaborative process involving consultation with a representative from each Member State (which together form the "Programme Committee"[2]). On the basis of the priorities set out in Work Plans agreed for that year, the agency charged with implementing the HP then issues calls for proposals for the different funding instruments.

There are **six instruments** used to fund different kinds of actions (as explained in the table below). In addition to pursuing (one of) the objectives of the HP, these actions are required to have a European dimension, meaning that they include parties from multiple Member States.

Table 2: The funding instruments of the second Health Programme (2008-2013)

Mechanism	Description
Projects	Grants for collaborative partnerships between organisations from different MS responding to calls for proposals in order to research, develop, explore a public health theme corresponding. As well as covering a wide variety of subject areas, project deliverables range from the creation of networks, research tools, databases or information-sharing platforms, etc. They tend to involve multiple partners from a variety of organisations (research, academic, non-profit, etc.).
Service-contracts	These contracts were used to buy services such as studies, data and training according to a specific need. In this way they enable the gathering of evidence, the implementation of EU legislation and / or other research specifically required by the Commission. Service contracts are the only funding instrument to be fully covered by the Health Programme (as opposed to requiring co-financing).
Joint actions	Partnerships between MS 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. Joint actions typically bring together the key players from Member States, whether it is health authorities or specialised organisations.
Operating grants	Operating grants take the form of a financial contribution for non-governmental organisations or specialised networks in the field of health. These grants operate at the European level and they are expected to have members in at least half of the Member States (which in practice effectively ruled out many organisations from the newer Member States).
Direct grant agreements	These grants were awarded to international organisations, such as OECD and WHO, with the capacities needed to tackle relevant health priorities.
Conferences	These grants were awarded to conferences organised by the Presidency, European public actors and non-profit organisations.

The management of the 2nd HP is the responsibility of the Commission (DG SANTE[3]), but it is the Consumers, Health, Agriculture and Food Executive Agency (Chafea, previously EAHC) which takes charge of its implementation. In addition, so-called "National Focal Point" contacts (appointed by national health ministries) have an informal role (since clarified and formalised under the 3rd HP) that includes:

[2] A so-called Programme Committee made up of representatives of each Member State (MS) and chaired by the representative of the Commission are consulted on measures to be taken based on the opinion of the group (Article 4 and 7) http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31999D0468:EN:HTML

[3] The 2nd HP was managed by the Directorate-General for Health and Consumers (DG SANCO). Following the restructuring of the Commission in 2014, DG SANCO became DG SANTE. For the sake of consistency, we use the new name and acronym throughout this report.

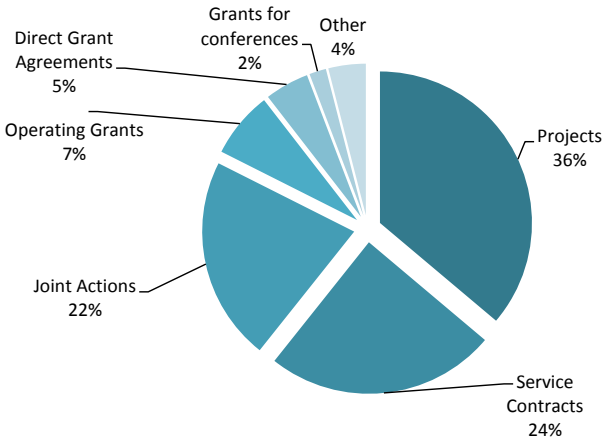
- supporting the promotion and implementation of the HP at national level (for example, through holding information days);disseminatingf results;
- discussing national-level experiences and concerns with Chafea; and
- providing information on the impact of the HP.

Building on the overview of the themes, instruments and management of the HP above, the following paragraphs provide a snapshot of how the funding for the 2nd HP was allocated in practice. This section is structured in terms of allocation across types of funding instruments, priorities and beneficiaries (note that a full analysis of these issues is provided in Annex 2).

Funding by instrument

Overall, three of the six instruments accounted for the vast majority of funding: projects (36%); service contracts (25%) and joint actions (22%). While operating grants, direct grant agreements and grants for conferences received much smaller sums (7%, 5% and 2% respectively)[4]. However, these aggregates mask important trends over time. Indeed, as shown in chapter 3 on programme management (particularly figure 6), funding shifted away from projects after the first years, while service contracts and joint actions gained in relative prominence. The changes reflected shifting priorities of the HP and the complementary nature of the different funding mechanisms that are explored in detail in section 4 of this report.

Figure 2: Health Programme spending by funding instruments (2008 – 2013)[5]



Source: Annual Implementation Reports

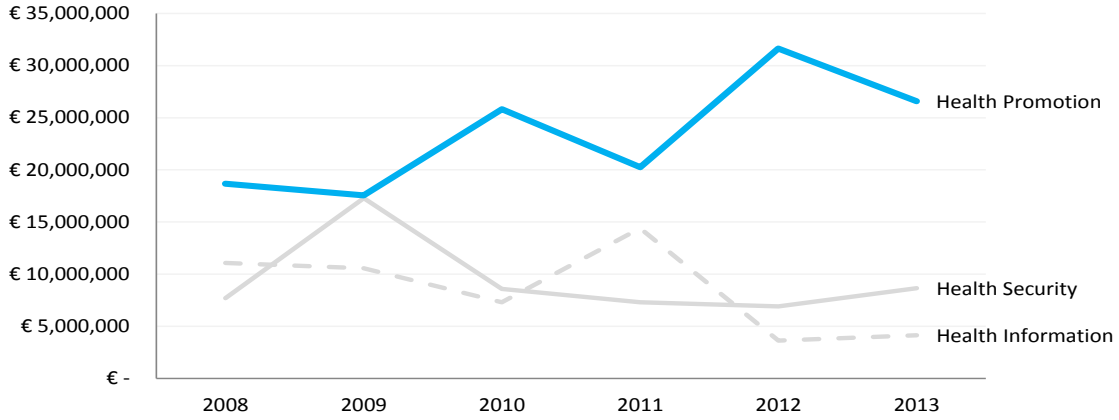
[4] The remainder (4%) was used to finance special indemnities to experts for their participation in and work for EU Scientific Committees, an administrative agreement with the Joint Research Centre (JRC), publications and various communication initiatives to promote the second Health Programme, sub-delegations to Eurostat, etc.

[5] Note "other" includes actions signed and committed by DG SANTE and CHAFEA, such as special indemnities to experts for their participation in and work for EU Scientific Committees, an administrative agreement with the Joint Research Centre (JRC), publications and various communication initiatives to promote the second Health Programme, sub-delegations to Eurostat, etc.

Funding by priorities pursued[6]

Actions supporting health promotion were by far the most funded. In total, this stream received 57% of funds allocated to actions, while the other two, health security and information, received 23% and 21% respectively[7]. As the figure below indicates, actions which sought to promote health (and reduce health inequalities) consolidated their importance over the course of the HP; while those focused on the dissemination and generation of health information declined and provisions for citizens' health security was more or less stable. Broadly speaking, the growing importance in funding actions to support health promotion indicates a corresponding growth in the focus on addressing health determinants and tackling health inequalities.

Figure 3: Spending by thematic priority (2008 – 2013)



Source: Chafea database, Annual Implementation Reports and DG SANTE

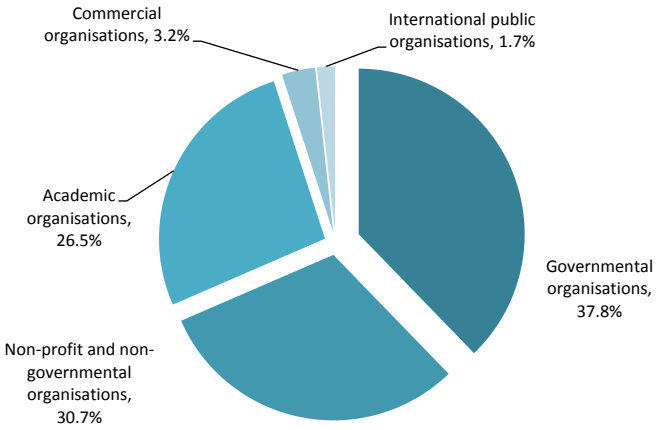
Funding by beneficiary types

HP funding was channelled through a variety of types of beneficiaries. Governmental organisations (ranging from health ministries to public health operators) made up the largest proportion of beneficiaries (37.8%), followed by non-profit and non-governmental organisations (30.7%) and academic organisations (26.5%). Only 3% of beneficiaries are classified as commercial organisations, and less than 2% as international public organisations. The reasons for this breakdown relates to the use of different funding mechanisms. For example, joint actions and projects make up the vast proportion of access grants for government organisations while the majority of international public organisations receiving grants are supported through direct grant agreements.

[6] This classification is not possible for operating grants, conferences and some service contracts which in their large majority could fall under more than one single priority.

[7] Due to rounding, these percentages do not add up to 100%.

Figure 4: Organisations (by type) receiving grant funding from the Health Programme 2008-2013 [8]



Source: Chafea database

[8] Please note that the breakdown includes all funding instruments except service contracts.

2. BACKGROUND TO THE EVALUATION

2.1.Purpose and Rationale

The **legal basis** for the ex-post evaluation is contained in Decision No 1350/2007/EC establishing the Health Programme 2008-2013, which requests the Commission to submit, no later than 31 December 2015, to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions an external and independent ex-post evaluation report covering the implementation and results of the Programme.

According to the Terms of Reference (see Annex 1), the **purpose** of this evaluation is to "inform on main outcomes and results achieved by the second Health Programme 2008-2013 as well as main problems and solutions with regards to its implementation, not least in relation to the taking up of results of the last health programme evaluations."

The evaluation was explicitly tasked to address the functioning of the entire programme, but **avoid repeating earlier evaluation work**. The first and second Health Programmes have previously been evaluated / audited a total of four times.[9] These studies have tended to generate similar conclusions and recommendations, and identified strengths but also recurring weaknesses of the Programmes, including the lack of a clear intervention logic; a weak prioritisation of objectives; burdensome application processes; and problems with the dissemination, sustainability, and monitoring and evaluation of actions and results.

The ex-post evaluation is intended to build on the results of previous evaluations, and address issues that have been insufficiently explored in past exercises and/or appear particularly important for the implementation of the 3rd HP (2014-2020). In particular, it assesses specific questions under **four main thematic 'blocs'**, namely:

- Programme **management** tools: The evaluation assesses how the Programme is managed, in particular the changes made during the second half of its implementation (including the greater use of Joint Actions) and the effects these changes have had.

- Programme **dissemination** practices: As dissemination has been identified as a key weakness of the Programme before, the evaluation set out to provide an in-depth assessment of past and potential future dissemination practices, including a bibliometric analysis of scientific publications based on funded actions.

- Assessing the **impact** of the Health Programme: It is recognised that various factors – in particular the large variety of funded actions, the lack of a clear intervention logic in the sense in which it is commonly understood (i.e. a causal chain leading from inputs and activities to outputs and results that can be more or less clearly defined a priori and across different actions / strands), and the relatively small size of the Programme compared to the problems it addresses – make it very difficult to measure its impacts or attribute any changes in public health to the Programme as such. Nonetheless, the evaluation sought to assess the contribution of the Programme actions to progress in key areas, investigate the key factors that affect its performance, and explore ways in which impacts can be maximised in the future.

[9] Interim evaluation of the (first) PHP (RAND, 2008); ex-post evaluation of the (first) PHP (COWI, 2011); mid-term evaluation of the (second) HP (TEP) 2011; as well as a report by the European Court of Auditors on health promotion projects (2008)

- **Synergies** with other programmes and services: Finally, the evaluation assesses the coherence of the Programme with other EU policies, and explores to what extent potential synergies with other interventions have materialised.

2.2.Evaluation Approach and Methodology

The nature of the 2nd Health Programme, and the specific focus of the evaluation exercise requested by DG SANTE (summarised above) called for a bespoke evaluation approach, combining a variety of quantitative and qualitative data collection and review methods and analytical tools to respond to the specific information needs and requirements. The main methods can be summed up as follows:

- Review of a large number of **relevant documents** concerning the HP (including its legal basis, annual work plans, implementation reports, promotion materials, etc.) as well as a wide range of other relevant issues and topics, including other EU policies and programmes.

- Review of **quantitative data** provided by Chafea and DG SANTE on actions funded by the HP, so as to understand funding levels and trends, both for the HP as a whole and broken down by years, strands, funding instruments, organisations, countries, etc., as well as proposal submission and success rates, and other relevant facets (see Annex 2).

- An **online survey** to gather feedback from National Focal Points (NFPs). 23 out of the 30 NFPs responded to the survey (see Annex 3).

- **Interviews** with key informants, including external stakeholders (MEPs, NGOs and international IOs); National Focal Points (NFPs); and EC officials. A total of 25 interviews were conducted (see Annex 4).

- **In-depth review** of a sample of 80 HP-funded actions, based on a set of publicly accessible information, to investigate and systematically document a range of relevant aspects including typologies of actions and specific objectives, involved partners and target audiences, tools and activities used, etc. This task also involved an assessment of the likely EU added value of each action by a panel of three public health experts (see Annex 8).

- **Case studies** on 13 actions (five projects, five joint actions, and three service contracts), sampled purposively from among the actions reviewed previously, to develop an in-depth understanding of their rationale and background, design, implementation, dissemination, results and impacts, and EU added value. These case studies were based on desk-based research and interviews with partners, Chafea and SANTE officials and, in some cases, other stakeholders (see Annex 9).

- A range of **analytical tasks**, employing appropriate analysis techniques to the wealth of quantitative as well as qualitative data collected. Among these, it is worth highlighting in particular the following techniques that were used to investigate a number of specific issues:

    - **Bibliometric analysis**: To better understand the visibility of the HP in terms of publications in scientific journals, we undertook analysis to (1) identify publications resulting from a sample of 30 HP-funded actions, and (2) assess their impact in terms of citations (see Annex 5).

    - Analysis and correlation testing of a range of indicators related to national **public health capacity**: To investigate the extent to which

differences in HP participation rates of MS may be the result of differences in their public health capacity, and/or factors related directly to the HP itself, we reviewed a significant number of data sets and, where possible, ran statistical analyses to identify possible correlations (see Annex 6).

- **Stakeholder analysis**: To develop a better understanding of priority target audiences for the dissemination of HP results, we undertook a stakeholder analysis of the HP (see Annex 7).

- **Triangulation** of results from various data sources and methodological approaches, to arrive at the summary findings, conclusions and recommendations described in this report.

2.3.Validity and limitations

As has been described at length in previous evaluations, the 2nd HP pursues a set of very broad objectives, and encompasses an extensive list of public health-related topics (but no clear intervention logic in the sense of a causal chain of expected results). As a result, it co-funds a large number of loosely related actions that attempt to foster collaboration and develop solutions to a wide range of health-related issues and problems in a variety of different ways. This means that **assessing the overall impact** of the programme (or even measuring it in quantitative terms) is very challenging. In fact, the Commission's own impact assessment for the 3rd HP, when assessing the option of continuing the status quo, notes that: "For each of [three main objectives of the 2nd HP], there is a long and broad list of actions […] which are not prioritised. No indicators have been provided and none can be found for such objectives that would allow to measure achievements against objectives and thus measure the impact of the programme."

The evaluation therefore had to choose a different approach, in essence attempting to shed light on the effectiveness of the HP by assessing (in various levels of detail) **samples of actions**, so as to understand their key features, successes and failings and (crucially) the main reasons behind these. Given the variety and heterogeneity of HP-funded actions (in terms of funding instruments, strands, priorities and themes, etc.), fully representative samples were unattainable. We therefore chose a **purposive** approach to the sampling (for the in-depth review, case studies, bibliometric analysis, stakeholder analysis etc.), focusing on those actions and facets of the HP that promised to be of most value and interest for the analysis, given the specific evaluation purpose and questions. The choices were made in agreement with DG SANTE, and took into account the fact that the 3rd HP had already been launched, which made certain aspects more pertinent than others depending on their continued relevance for the new Programme.[10]

The consequence is that the evaluation provides a **detailed assessment of certain key instruments and actions.** However, we cannot be certain to what extent the findings and conclusions drawn are applicable to the entirety of HP actions, nor can we simply aggregate results of different actions to try to assess the overall impact of the HP. Nonetheless, the evaluation does draw conclusions and provide insights into a

[10] For example, the funding instrument "conferences" has been discontinued under the 3rd HP (except those organised by the Presidency); an assessment of their merit and worth would have therefore been of limited value, and it was decided to exclude them from the samples for the in-depth assessment and case studies.

number of clearly relevant trends, key success factors and barriers that were identified via the variety of methods employed. It thus pinpoints issues that we as evaluators are convinced are significant and to a large extent 'typical' of the HP as a whole (and largely consistent with previous evaluations), and should be addressed in order to maximise the success of the 3rd HP.

As per the task specifications, the evaluation also endeavoured to use a set of **specific methods** (in particular bibliometric analysis, assessment of national public health capacity, and stakeholder analysis) to investigate issues that were of particular interest to DG SANTE, but not necessarily central to a typical programme evaluation exercise as such. While all of these provided interesting insights, they were also subject to specific challenges, partly because of limitations of the methods (e.g. it was not possible to compile an exhaustive list of all relevant publications) and the available data (e.g. no widely accepted quantitative measure of public health capacity exists), partly because of a less than ideal fit between the method and the nature of the HP (e.g. stakeholder analysis is better suited to interventions with more specific aims and a more limited scope). The challenges we faced in relation to each of these methods are discussed in more detail under the relevant evaluation blocs and annexes.

Finally, in this context it is worth mentioning again that at the time the evaluation was undertaken, the **3rd HP had already been designed and launched**. The evaluation attempts to take this into account to the extent possible, and not put too much focus on issues that have already been addressed or cannot be changed in the near future (because this would require amendments to the legal basis). This may mean that certain key weaknesses of the 2nd HP (in particular the very broad scope and resulting lack of focus, including operational and specific objectives) are not given as much prominence as would have normally been the case, and no recommendations are made on issues that appear to have been addressed in the design of the 3rd HP (e.g. the need for more specific objectives).

3. PROGRAMME MANAGEMENT

Effective programme management forms a necessary bridge between overarching programme design and individual funded actions. While conceptually simpler than the Health Programme's other aspects, management touches on issues ranging from administering contracts for diverse funding mechanisms, translating Programme objectives into practice, assessing applications for funding, applying corrective action to problem actions, ensuring equitable distribution of funding and monitoring as well as continuous performance improvement. As the Programme has matured, numerous changes have been made to the form and function of its management, partly motivated by the recommendations of the mid-term evaluation and other studies and audits. This section takes a fresh look at those recommendations with a view to gauging progress made in their implementation (see section 3.1 for a status update) and assessing their effects on various aspects of the Programme.

It is important to note that the mid-term evaluation's recommendations shared a common theme. The breadth of subject matter, objectives and funding mechanisms, combined with the relatively small budget size, were rendering the Programme unwieldy and causing negative effects. The overarching message was for the need to take a step back, consider the principles of sound programme management and apply them to the Programme. Thus, the recommendations included suggestions for tighter and more tangible objectives, strategic, long-term focus, the mainstreaming of EU added value criteria, more purposeful monitoring, better guidance for funding applicants, more purposeful dissemination of Programme results and the exploitation of synergies across other policies and programmes.

In most cases, the recommendations reflected not issues that DG SANTE had failed to consider, but teething problems indicative of the Programme's period of substantial change. The overarching message, which carries forward to the present evaluation, is that extensive progress has been made, but that there are areas where further improvement is vital for the future success of the Programme. The following paragraphs attempt to discuss both issues based on a survey and interviews with relevant stakeholders in addition to a review of Programme monitoring data and in-depth case studies conducted on a selection of 13 funded actions.

Administration and roles of various actors

Since the mid-term evaluation, Chafea's role in dealing with the administrative aspects of the Programme (e.g. publishing calls for proposals, coordinating the assessment of applications, managing contracts) has been **clearly established**. This led to **incremental changes** that overall served to improve markedly the experiences of applicants and beneficiaries in terms of their dealings with the administrative aspects of the programme. For example, guides for projects and joint actions now provide a greater degree of clarity for applicants than was previously available, while the Chafea officers, specialised in public procurement, were able to provide quick and unambiguous responses to queries posed by applicants and beneficiaries (according to beneficiary interviews conducted for the case studies). Some procedures had also been streamlined, enhancing clarity and precluding (some of) the need for time-consuming contract amendments, for example when changing the cost category of a team member. Moreover, other substantial improvements were scheduled for the third Health Programme, among them a move to an electronic (rather than paper-based) system for managing grants. This was expected to reduce the administrative burden for applicants and increase Chafea's efficiency while improving its ability to manage information.

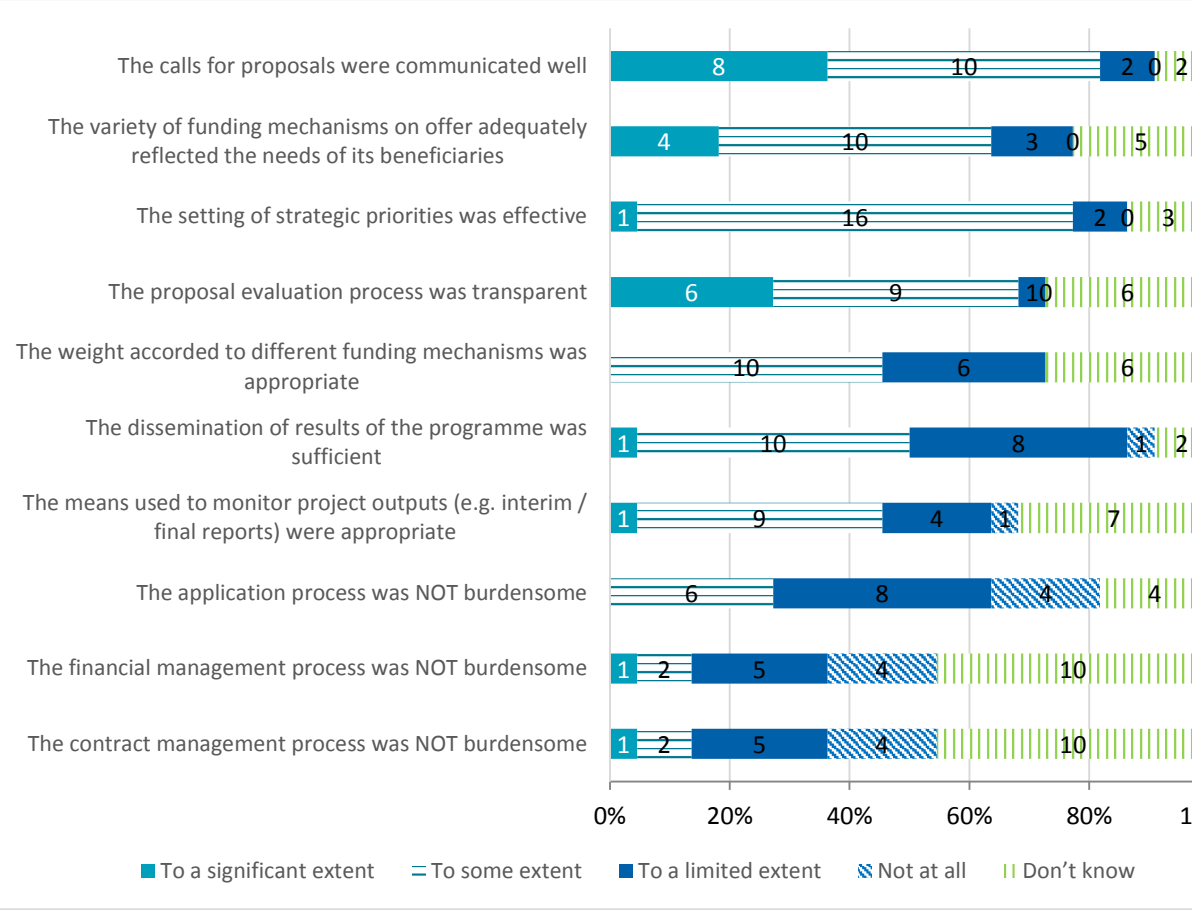
Despite these changes, stakeholders also expressed plenty of **gripes** and concerns. Based on the experiences of most EU programmes, a certain amount of such feedback is to be expected. The need for spending programmes to demonstrate high degrees of accountability, oversight and consistency of treatment necessarily implies a certain

amount of bureaucratic **onerousness**. Some reporting requirements can even enhance the performance of individual actions, by, say, ensuring that beneficiaries collect data on relevant indicators and keep abreast of expenditure by large numbers of partners (this related to the importance of strong project management *within* actions, which is discussed in section 5 on the programme's impact). This raises two issues. First, for the benefits of sound reporting to be realised, they actually have to be *used*, which is discussed in more detail in the subsection below on monitoring and continuous improvement. Second, we should look in particular at areas where other programmes evidently perform better, and thus where improvements in the Health Programme could be expected.

For example, the Seventh Framework Programme (now in its next iteration as Horizon 2020) is exponentially larger than the Health Programme and places numerous bureaucratic requirements on applicants and beneficiaries. However, stakeholders knowledgeable about both programmes consistently reported that the 7th FP provided more support and conveyed requirements and other key information more clearly. Online tools made available to 7th FP applicants and beneficiaries, such as mini-sites for specific funding packages and detailed FAQs, provided stakeholders with signposting to direct themselves quickly and (relatively) painlessly.

Leading from this, few NFPs (whose opinions of the programme management are partly shaped by the feedback they receive from applicants and beneficiaries in their countries) expressed positive views of programme management processes. While it would have been usual and unexpected to elicit enthusiastic responses on issues such as financial reporting, it is worth noting (as shown in the survey results below) that NFPs regarded the communication of calls for proposals favourably, as well as the proposal evaluation process. This contrasted with views on financial and contract management, as well as the application process, where substantial proportions of respondents expressed negative views or had not formed opinions.

Figure 5: NFP perceptions of a number of elements of HP management



Source: survey of NFPs (n=22)

Case study interviewees elaborated on these issues in more detail, noting several problems in their administrative dealings with Chafea. These related to inflexibility when needing to make adaptations to plans agreed early in action life (usually at the proposal stage), the timing of financial payments and rules regarding financial allocations (and in particularly lack of flexibility to change these) across partners within given actions. For their part, NFPs reported facing time and resource constraints that rendered difficult the provision of substantial support to applicants and beneficiaries.

More feedback addressed the roles of DG SANTE, Chafea and the Programme Committee in the design and implementation of the Programme. While representatives of DG SANTE felt that the respective roles were clear, action leaders, particularly of projects, expressed confusion about the division of responsibilities between these actors that led to delays and reductions in the quality of activities and deliverables. As an example, we identified instances where beneficiaries thought that Chafea was responsible for instigating changes that in fact it was only communicating on behalf of DG SANTE.

It was unclear to the evaluators precisely where and by whom such changes were conceived (indeed, it is possible that Chafea was a 'messenger', acting under the direction of DG SANTE) in specific cases, but part of the confusion may have stemmed

from a change in formal responsibilities enacted during the course of the Programme.[11] In any case, but lack of clarity (at least from the perspective of beneficiaries) raises some concerns about the internal coherence of programme management (for example, it was unclear why DG SANTE managed some service contracts directly, and Chafea others) and the way various aspects of it are communicated. Ensuring that DG SANTE and Chafea are on the same page is vital for the success of the Programme, in terms of both efficient resource management and the ultimate effectiveness of funded actions.

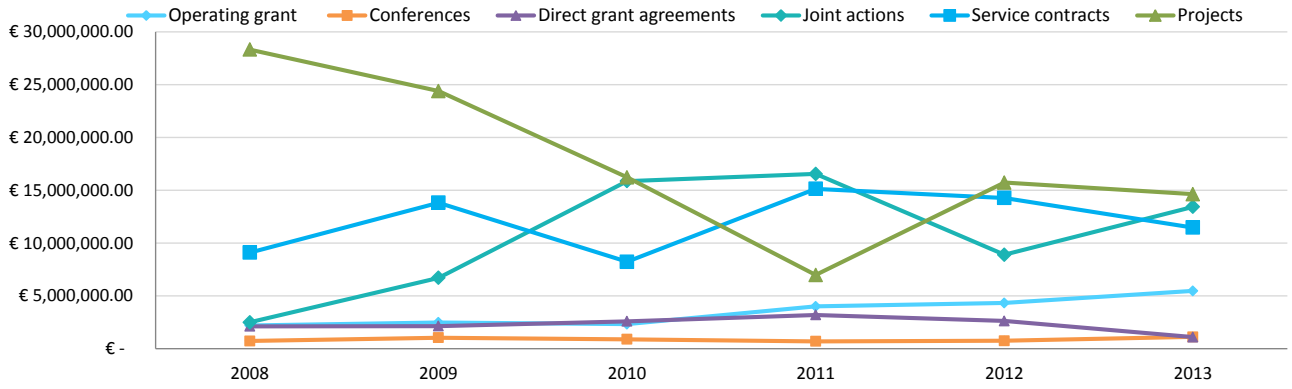
Priority setting and choice of funding mechanisms

Several recommendations from the mid-term evaluation concentrated on the internal coherence and purposefulness of the Programme and the importance of strategic planning. While the scope for improvement here was limited by the Programme's broad scope and relatively small budget (neither of which can be drastically changed), certain adjustments were made during the second half of the Programme. These related to both changes in the formulation of AWPs and choice of funding mechanisms.

In both cases, the key shift was away from a bottom-up approach to Programme development (driven in large part by requests from consulted Member States and units within DG SANTE) and towards more directive methods of planning. As part of this, senior-level DG SANTE officials increased their involvement in and influence over the AWP development, allowing for a greater level of coherence with other policies and programmes. Thus, for 2012 and 2013, AWPs were formulated such as to emphasise links with wider trends and policy initiatives (such as the economic and financial crisis, the Europe 2020 strategy, as explained in more detail in section 6 on synergies and coherence).

Most indicative of this shift was the increased use of joint actions, which generally involve and ensure the buy-in of national governments, and secure the participation of the vast majority of Member States. This was accompanied by a decline for projects, which involve fewer partners and provide significant scope for innovation but typically involve greater risk and chances of failing to generate the momentum needed to achieve wider impacts (see detailed discussion in section 5 on Programme impact). As shown in the figure, the amount of funding dedicated to projects declined dramatically after 2008 and 2009, while other instruments, especially service contracts and joint actions became relatively more prominent.

Figure 6: Health Programme spending by funding mechanism (2008 – 2013)



[11] Until the final (2013) call for proposals, Chafea had considerable scope to influence the focus of projects through a process called 'negotiation'; this was changed to a process called 'adaptation' whereby this scope was reduced to the more procedural aspects of projects.

Source: Annual Implementation Reports

There was also an increase in service contracts (in both number and funding) during the second half of the HP. This highly prescriptive funding mechanism allows DG SANTE essentially to order products such as studies to meet specific needs. Taken together, the proliferation of joint actions and service contracts was indicative of the migration towards a more top-down style of Programme management. As discussed in more detail in section 5 on the Programme's impact and Section 6 on synergies and coherence, the relative shift in projects and joint actions reflects the growing maturity of the HP, increasing its ability to generate policy impact and allowing DG SANTE to focus on certain areas of interest.

Monitoring and continuous improvement

The evaluation revealed two types of problems with the HP's provisions for monitoring. At the level of **inputs and activities** (i.e. resource spend by action type, thematic priority, Member State, etc.), data is collected but not systematically organised and used. Instead, during an analysis carried out for the evaluation (see summary in Annex 2), we found that information was stored in multiple formats, with content that was often inconsistent and left gaps. This makes it difficult to analyse the data without up-front efforts to collate and cross-check the information. While this is possible under the auspices of a triennial evaluation, it would be unfeasible for the purposes of regular performance management. Indeed, the evaluation found little evidence that monitoring data were used beyond the purposes of financial accountability for individual actions. If such data were kept updated and constantly reviewed, managers of the Programme would be able to ascertain the extent to which various strategic aims (e.g. involvement of partners from EU-12 Member States) were being met.

At **output / outcome** level, developing a comprehensive and purposeful monitoring mechanism for an initiative as diverse and multifaceted as the Health Programme is inherently difficult. While data on high-level indicators relating to, say, health outcomes, is sometimes available, it is impossible for numerous reasons to draw concrete links to individual actions or the Programme as a whole. Actions' desired outcomes, even in the best circumstances, take years to materialise and are largely highly specific to the actions in question. Nonetheless (as described in more detail in section 4 on dissemination), more could be done to put to use the various reports and evaluations that are carried out for each action. For the most part, these were far too long and formalistic either to serve as genuine communication tools or to play a role in the effective monitoring of the Programme.

3.1.Implementation of the mid-term evaluation's recommendations

EQ 1: To what extent have the recommendations of the mid-term evaluation concerning the management and the design of the Programme been implemented?

During the second half of the Programme, considerable efforts were made to implement the recommendations made in the mid-term evaluation. Depending on their nature and feasibility of implementation in the short-term, some of these efforts led to immediate changes, while others were built into the design of the 3rd HP. The table below provides a brief overview of the recommendations to complement the more detailed discussions in sections throughout this report. Overall (as summarised in the table), it can be concluded that meaningful steps have been taken towards the

implementation of all recommendations, but that in most cases further progress is both possible and desirable.

Recommendation	Intended effect	Status
Conception		
More tangible and focused objectives (SMART); better defined strategic framework for the HP and the development of indicators	To ensure the programme is focused on certain public health issues (especially those that are difficult for MS to reach individually) and for targets / indicators to be developed to measure the extent to which these objectives / priority areas are achieved as well as greater transparency in how priorities are reached in Annual Work Programmes	• The shift towards JAs and larger role for DG SANTE senior leadership in setting HP priorities have increased the policy focus of the HP and individual actions, but there is still room for improvement (see section 5 on impact). • The coherence of the HP with other policies and programmes has been increased (e.g. links to Europe 2020 in 2012 and 2013 AWPs) (see full discussion in section 6 on synergies). SANTE • The objectives of the 3rd HP are much more closely linked to supporting EU priorities and the pursuit of EU added value. • The nature of the Programme has so far precluded the development of meaningful Programme-level strategic indicators at output and outcome levels. •
Develop long-term planning and targets in consultation with national health experts	To ensure spread of actions and choice of funding mechanisms meet demonstrable needs	• The increased use of JAs and SCs has promoted the involvement of key players and helped the HP to match funding more closely to policy priorities (see discussion in section 5 on impact). • However, there is some evidence that the increased emphasis on the Health Promotion strand may have led to funding less impactful actions (as described in section 5 on impact) • The 3rd HP is exploring multi-annual programming to some extent.
Design		
Emphasise and clarify EU added value, particularly in the proposal / application processes	The promotion of EU added value increases the purposefulness of actions and the HP as a whole.	• EU added value criteria were put to systematic use during the second half of the HP, in particular being built into the application and assessment process for actions. • Definitions of EU added value criteria were provided in the FAQ for the final year of calls for proposals for the 2nd HP (2013). • For the 3rd HP, EU added value criteria are enshrined in the Programme Regulation 282/2014/EC, included in the 2014 AWP and references included in guides for applicants.
Management		
Monitor the organisations applying for funding and carry out a more in depth assessment of sample of actions	To ensure equal access to funding, provide insight into actions funded and have data available for interested parties.	• Relevant data collected by Chafea but collated and analysed by the evaluators, with little evidence that it has been used other than for the purposes of the evaluation.
Provide better	More and stronger	• The guidance document for applicants

Recommendation	Intended effect	Status
guidance for proposals and simplification of application processes	applications with clear outcome-level focus.	developed during the second half of the HP was a step forward, and new tools for the 3rd HP are based on DG RTD templates, providing further improvement. • Evidence (see section 5 on impact) indicates that applications still make insufficient links to policy-level outcomes and tangible benefits. • NFPs report limited resources make it difficult to give applicants adequate support. • For the 3rd HP, an electronic application and management system reduces the amount of time needed to deal with Programme administration and is considered a big step forward for decreasing the administrative burden on applicants and Chafea officials.
Ensure better dissemination of actions and their results, including dedicated budgets, by DG SANTE / action leaders to stakeholders (e.g. Programme Committee, EP, Council, CoR, wider audiences)	Better and more systematic dissemination should increase the HP's reach	• Initiatives such as the Chafea database and communication materials by DG SANTE have enhanced dissemination, but the diversity of target audiences renders systematic efforts to improve dissemination difficult. • Many communication materials are unwieldy, poorly presented or not accessible to target audiences, especially policy makers • Actions aiming for publication in scientific journals tend to do so. • Evidence shows that target audiences are still not sufficiently well defined, and communication efforts are often spread too thinly. *NB: for detailed discussion of all issues relating to dissemination, see section 4.*
Make use of synergies	Multiply the impact of the HP through disseminating results and collaborating with relevant interested parties/organisations	• The HP is highly coherent with the Europe 2020 strategy policy objectives of smart and inclusive growth, and demonstrable efforts were made during the second half of the HP to further enhance this coherence. • There is considerable evidence of synergies and cross-fertilisation between FP7 projects and HP activities. • There is less evidence of synergies between the HP and Structural funds. *NB: for detailed discussion on synergies, refer to section 6.*

3.2.Effects of recent changes in emphasis on funding mechanisms

EQ 2: How effective have recent changes in the emphasis on and use of specific funding mechanisms (i.e. use of Joint Actions, balance between calls for proposals and calls for tender) been in delivering policy-related outputs, and what was the impact on the geographical distribution of beneficiaries?

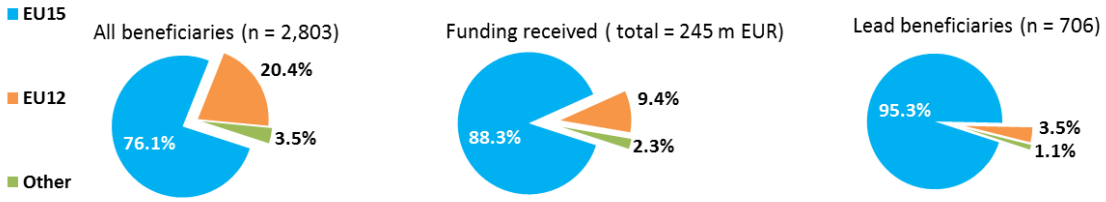
The second half the Programme saw a marked shift towards joint actions and service contracts, while projects assumed a smaller role (see figure 6 above). This allowed for a greater ability to deliver policy-related outputs, because joint actions and service contracts are typically more targeted at a specific policy issue / problem / opportunity

than projects. However, it should be borne in mind that the various funding mechanisms are complementary and each has an important role to play. In particular, many joint actions are preceded by projects, which, while less likely to generate policy impacts on their own, are key for identifying / scoping promising areas for further collaboration. Section 6 on impact contains a more detailed discussion on the respective strengths and weaknesses of the funding mechanisms and their roles within the HP as a whole.

In terms of **geographical distribution** of beneficiaries,[12] the effects of the recent changes are clear-cut, but contradictory and largely self-negating. In brief, joint actions are slightly more equitable than projects in terms of the proportion of funding going to EU-12 countries (13% vs 11%). Service contracts, on the other hand, remain the almost exclusive domain of (a small group of) "old" Member States. Only 2% of the funding for service contracts goes to beneficiaries from EU-12 countries. Leading from this, any increase in the share of HP funding for EU-12 beneficiaries resulting from the greater use of joint actions seems to have been more than cancelled out by the increased use of service contracts, which favour EU-15.

An examination of the data demonstrates this point clearly. While participation in the Programme in terms of number of participants and (accounting for differences in wage levels) funding allocation is roughly proportionate to population across the EU-15 and EU-12, the difference is far more pronounced when considering the spread of *lead* beneficiaries, of which an overwhelming 95% were based on the EU-15, with only 4% based in the EU12.

Figure 7: Proportion of beneficiaries (total/lead) and funding received in EU15/EU12 (2008 – 2013)[13]



Source: Chafea database and DG SANTE

While this trend was exacerbated by the proliferation of service contracts, removing them and operating grants (both of which concentrate funding in Belgium and Luxembourg) does little to alter the overall picture. About 72% of beneficiaries are based in the EU-15, and they account for 86% of funding received and 90% of lead beneficiaries.

Leading from this, overall funding for EU-12 countries has actually declined over time, from 22% for actions awarded funding in 2008, to 14% in 2013 (see Annex 2, figure 7 for chart). The proportion of lead beneficiaries from the EU-12 also fell after initially comprising 8% of the total in 2008. There was also a drop for the EU-12 in terms of funding received, from a maximum of 12% in 2010 to 6% in 2013.

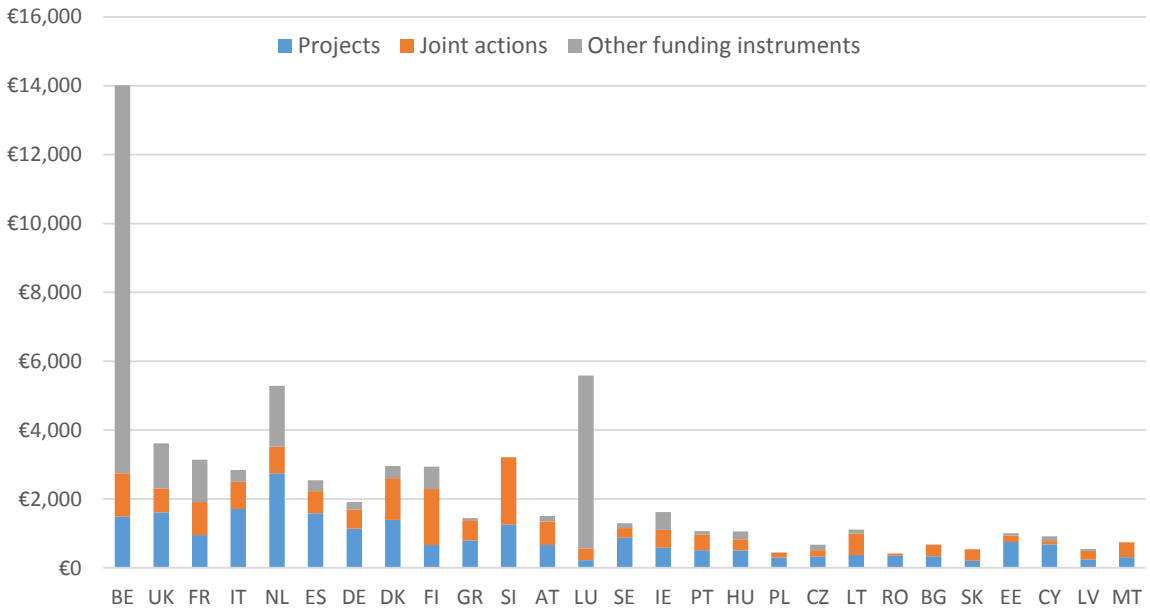
[12] Note that this question discusses participation in the HP rather than impact that is eventually generated by project outputs and outcomes.

[13] As noted in the footnotes on the previous page, the data on which these graphs are based includes a combination of paid and committed amounts for all funding instruments ***except*** direct grant agreements (to IOs, so not attributable to a MS per se) and certain DG SANTE service contracts for which information on the attribution of the funds to a specific country was not available.

Breaking this down further, joint actions tend to involve partners from (nearly) all Member States, and their increased use has helped certain countries, namely Slovenia, Finland, Denmark and Lithuania participate more in the Programme. By contrast, Belgium- and Luxembourg-based organisations (in particular umbrella organisations) benefit disproportionately from service contracts and operating grants, while organisations from countries in the EU-12 received very little funding from these instruments.

This is summarised in the figure below, which depicts Programme funding by funding instrument by square root of population.[14]

Figure 8: HP funding (by square root of population size) per MS



Source: Chafea database and DG SANTE
NB: countries listed in order of amount of funding received in absolute terms

3.3.Effects of recent changes on other Programme operations

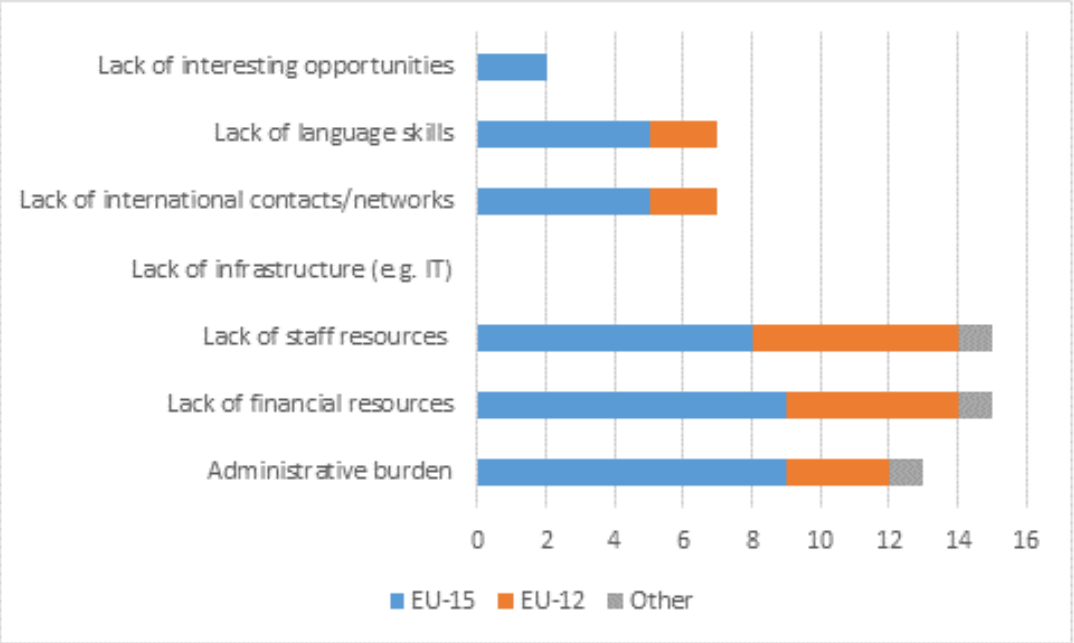
EQ 3: To what extent did the implementation of previous recommendations influence the Programme's other operations, including the recruitment of beneficiaries and the level of participation of all Member States in Programme actions (including the facilitation of participation from low GNI countries)?

As the chart above (as well as the detailed analysis of Programme data in annex 2) demonstrates, while levels of participation in the Programme vary considerably, there is not a straightforward EU-15 / EU-12 split. The picture that emerges is more nuanced. For example, eleven EU-15 Member States receive less funding per square

[14] Since the public health landscape of a given country differs according to its size (among other factors), and this means that the natural (or optimal) level of participation in the Programme is also likely to vary. In order to control for this natural level of variation, it is useful to apply a 'degressively proportional' analysis (like that used for calculating the number of MEPs per MS) that holds up participation in the Programme against the square root of population rather than using per capita terms.

root of population than Slovenia. Accounting for lower wages in the EU-12 further muddles the picture, showing that some EU-15 Member States, such as Austria and Sweden lag behind, while some EU-12 Member States (in particular Slovenia, but also Lithuania, Estonia, Malta and Cyprus) benefit relatively more than others. Indeed, as shown in the chart below, NFPs felt that barriers to participation were mostly internal issues like the lack of financial and staff resources rather than parameters of the Programme as such

Figure 9: The main barriers to the participation of organisations from your country in the Health Programme



Source: survey of NFPs (n=22)

Importantly for the purposes of this question, participation among EU-12 countries, in terms of both funding and number of participating organisations, declined during the second half of the Programme, in large part due to the increased emphasis on service contracts. This more than offset the boost to participation among EU-12 Member States due to the increased emphasis of joint actions.

3.4.Potential improvements to Programme monitoring

EQ 4: What are the state of the art tools in terms of monitoring project outputs that could be applied to the Programme, what are the expected benefits against costs and how could they be implemented?

Current state of affairs

At **input and activity levels**, comprehensive monitoring data is collected but not systematically organised and used, despite improvements since the mid-term evaluation. For example, while DG SANTE / Chafea should have information like that presented in annex 2 at their fingertips, it was only compiled for the evaluation (in collaboration between the evaluators and DG SANTE) based on numerous sources and

a painstaking amount of effort.[15] The costs of the current system are many, and range from wasted time to more dangerous possibilities, like accounting mistakes or programming decisions based on a misunderstanding of allocation across strands and (sub)priorities.

The challenges are greater at **output and outcome** levels, due both to the diversity in form and content of its many funded actions and an inability to draw links between relatively small actions and higher-level public health indicators. It is implausible, for example, that a common set of outcome-level indicators would be applied to the whole Programme in any meaningful way. Instead, the focus should be on basic but systematic monitoring at the level of individual actions in terms of aspects, like budget, funding mechanism, strand, (sub)priority, beneficiaries and geographical and organisational representativeness) that be aggregated and used to keep abreast of performance and ensure alignment with priorities and objectives.

Despite improvements since the mid-term evaluation, the ineffectiveness of provisions for monitoring continues to hold the Programme back and precludes possibilities for continuous improvement.

Potential solutions

In order to identify ways of improving the Programme's monitoring provisions. We undertook a benchmarking study of other programmes and initiatives.[16] Despite the challenges of monitoring the Health Programme, the benchmarking study revealed several practices that could potentially be implemented during the 3rd HP, in particular:

- Development of Programme-level indicators: while their scope would necessarily be limited, the experience of other, similarly diverse initiatives has shown that it would be possible to define a small number of indicators (relating to, e.g. budgetary expenditure, strand, sub-priority, beneficiaries and geographical and organisational representativeness). Recording such data systematically would provide quick and accurate performance updates, enabling DG SANTE to identify deviations from Programme planning and take appropriate action.

- Development of action-level indicators: it would be impracticable to come up with indicators that applied equally to all actions, but applicants could be provided with a long-list of output- and outcome-level indicators and encouraged to include some of them in their provisions for monitoring and evaluation provisions. This would allow for more comparison between individual actions, as well as helping to instil a culture of continuous improvement.

- Adoption of an electronic monitoring system: such a system (as is envisaged for the 3rd HP) would address the problems described above relating to the multiplicity of sources and fragmented nature of data. Since the EC does not have a ready-made electronic monitoring system, it could consider purchasing secure access to an external system such as Researchfish, which provides a simple interface for the collection, organisation and analysis of monitoring data.

[15] While there are detailed Annual Implementation Reports, they do not allow for the types of comparisons and cross-tabulations needed to look in depth at various aspects of the Programme.

[16] The benchmarking study looked at the Seventh Framework Programme, the European Social Fund, Collaborations for Leadership in Applied Health and Research and Care and Researchfish. For more details on aspects of these initiatives that might be applicable to HP monitoring, see Annex 10.

It would also ensure that data is input consistently, using an agreed format. In terms of costs, Researchfish is priced according a proportion of the grant funding entered into the system. For a EUR 300m programme, the cost would be about EUR 200,000 per year.

- Provision of monitoring and reporting tools: more prescriptive monitoring and reporting guidelines (including references to programme- and action-level indicators mentioned above, and best practice examples), as well as support from Chafea, could enhance the ability of action leaders to produce high quality and useful reports (see also discussion on 4.4 on improving dissemination practices).

- Post-action reporting: since most policy impacts are envisaged after the life of a given action, building provisions for follow-up reporting into action budgets could increase the knowledge base about how the Programme generates impacts.

4. DISSEMINATION OF RESULTS

The mid-term evaluation concluded that the dissemination of results is one of the main challenges facing the Health Programme. The ex-post evaluation broadly confirms this; even though a considerable effort was made during the second half of the HP to enhance dissemination, it remained a weakness. For example, in their survey responses the vast majority of NFPs thought the dissemination of programme results was only sufficient "to a limited extent" (40%) or "to some extent" (45%). Most interviewees from across the various groups also saw room for improvement. The main problem is not dissemination for the sake of promoting the HP as such; it is that if relevant target audiences are not aware of key results of HP-funded actions, the chances that these are accepted and implemented widely across the EU are significantly reduced. For this reason, (strategic) dissemination plays a very important role in ensuring the HP can make an impact on public health policy and practice in spite of its relatively limited budget.

When assessing the dissemination of HP results, it is important to distinguish between two main levels:

- Dissemination of the results of individual actions, undertaken mainly by the partners themselves, usually based on a specific dissemination work package, which is mandatory for all projects and joint actions. Examples of tools and channels used by actions include websites, events, newsletters, and publications in scientific journals.

- Dissemination of the HP results as a whole (or parts thereof), which is mainly the responsibility of DG SANTE and Chafea and, to a lesser extent, NFPs. The efforts by Chafea in this area were stepped up during the second half of the Programme, and now include the following main tools and channels:

    - The Chafea project database,[17] which contains summary information on HP-funded actions, including links to key deliverables.

    - Publications / brochures that bring together information on groups of HP-funded actions, be it around a specific theme (e.g. Transplantation and Transfusion, December 2013), funding instrument (e.g. EU support for key public health initiatives 2008-2011 – Joint Actions, May 2013), or success stories (e.g. Health for the EU in 33 success stories, September 2012).

    - So-called Media Cluster Meetings, which are organised around a specific topic (and a corresponding set of HP-funded actions), and are specifically aimed at generating coverage in the media. At least one such cluster meeting was organised in each of the last four years, covering rare diseases (2011), vaccines and preventable diseases (2012), transplantation and blood transfusion (2013), HIV/AIDS prevention, and patient safety (2014).

Dissemination of results by beneficiaries

In principle, each HP-funded project or joint action is required to develop a dissemination plan, and carry out relevant activities to ensure its results are communicated to relevant audiences. These activities are typically carried out under a

[17] URL: http://ec.europa.eu/chafea/projects/database.html

dedicated dissemination work package, which is one of three mandatory 'horizontal' work packages (alongside coordination and evaluation). As HP-funded actions vary significantly (in terms of topics addressed, types of activities, objectives, involved partners, size, etc.), the scope and nature of the dissemination effort naturally also varies.

The review of a sample of 80 actions provides an indication of some broad trends as to the main target audiences and the most frequently used tools for dissemination.[18] As regards the most frequent **target groups**:

- Government organisations were most frequently among the target audiences, across all four types of action in the sample (projects, joint actions, operating grants and service contracts). Within this group, policy makers and regulators (e.g. ministries of health) predominated, followed by healthcare providers and commissioners (particularly by projects), and then (general or specialised) public health organisations / institutions (particularly by joint actions).

- Health and social care professionals (and NGOs representing these) were the second largest target audience on the whole, and were targeted especially often by projects.

- Academic and research organisations were the third largest target audiences across all action types.

- Patients and service users (and NGOs representing these) were only targeted by a minority of actions.

- Commercial organisations were less of a target audience priority, although they were identified as a relevant target by a few service contracts (particularly private healthcare providers) and projects.

- Finally, the general public was included among the target audiences of a majority of the projects and operating grants that were reviewed, but to a much lesser extent by joint actions or service contracts.

The **communication tools and methods** employed by the 80 actions that were reviewed are shown in the table below. It shows that the vast majority of projects and joint actions use dedicated websites and conferences / events. Reports / guidelines for specialist audiences and newsletters are also fairly widely used, as are print promotion materials (especially by joint actions). On the other hand, the review suggests that tools such as briefings for policy makers, press releases or social media activities are only used by a small minority of actions. It is also interesting to note (although perhaps not surprising given their typically larger budgets) that joint actions often employ a wider range of dissemination tools and techniques than other action types. For service contracts, dissemination usually plays only a very minor role.

[18] It is important to note that this analysis is based on a review of what was *explicitly* stated in basic documentation and websites, and may therefore not capture all audiences and tools that were used by all actions, or their relative significance. Nonetheless, it provides a useful overview of the approximate prevalence of different target groups and approaches. For more details see Annex 8.

Table 3: Dissemination activities and tools used by a sample of HP-funded actions

Dissemination activities and tools	TOTAL (n=80)	Joint Actions (n=21)	Projects (n=39)	Service contracts (n=10)	Operating grants (n=10)
Dedicated website	70%	90%	77%	0%	70%
Conferences / events	58%	76%	62%	10%	50%
Reports / guidelines for specialist audiences	48%	67%	41%	40%	40%
Newsletter	44%	67%	33%	0%	80%
Print promotion materials (brochures, leaflets)	29%	52%	26%	0%	20%
Presence on other websites (e.g. Wikipedia)	24%	33%	21%	20%	20%
Scientific publications	20%	29%	23%	0%	10%
Social media activities	10%	24%	5%	0%	10%
Press releases	9%	19%	3%	10%	10%
Briefings for policy makers	9%	19%	3%	0%	10%
Other	8%	0%	15%	0%	0%
Audiovisual materials	3%	5%	3%	0%	0%
Average number of activities and tools per action	3.3	4.8	3.1	0.8	3.2

Dissemination via scientific publications

Although the HP is not a research programme as such, some of its actions contain elements of (applied) research (see chapter 5, Figure 13). The evaluation set out to explore to what extent the results of such actions are disseminated via scientific / academic publications. The data shown above suggests that around a quarter of all joint actions and projects explicitly state their intention to disseminate their results via **articles published in scientific journals**. This aspect was investigated further by means of a bibliometric analysis, which was undertaken in three steps (for more details on the approach and results see annex 5):

- Selection of a sample of 28 projects and joint actions[19] that were deemed to have at least a medium likelihood of producing scientific publications, based on their objectives and topic areas.

- Search for articles related to these actions on PubMed (a database of biomedical literature) via the definition of specific key words, authors and time periods, followed by a manual screening of the results to determine whether they could plausibly be linked directly or indirectly to the actions in question.

- Search for citations of a sub-sample of the relevant articles related to 11 HP-funded actions via ISI Web of Science, to determine their visibility / impact.

[19] We originally selected 30 actions, but two of these could not be included in the analysis because the names of potential authors (WP leaders) were not provided by the respective coordinators.

In total, we identified 151 relevant articles. At least one article was found for 19 out of the 28 actions, including all but one of the joint actions. On average, 5.4 publications were identified for each action in the sample, with a slightly higher number for joint actions than for projects (which may be partly due to the typically higher budgets and numbers of participants in joint actions). While the data should be interpreted with a degree of caution[20], they nonetheless do provide an indication of a considerable level of activity in terms of scientific publications. At the same time, it is worth highlighting that only a minority of the articles (43 out of the 151) made an **explicit reference to the Health Programme** and/or the action acronym in their titles or abstracts. This raises the question of in how far the authors could or should be obliged to mention the source of the funding in their publications if these are directly based on EU-funded research.[21]

Table 4: Scientific publications by a sample of HP-funded actions

Action type / strand		Number of actions reviewed	Actions for which at least 1 publication was found	Total publications	Avg. publications per action
By funding instrument	Projects	21	13	103	4.9
	Joint Actions	7	6	48	6.9
By strand	Health Security	8	6	29	3.6
	Health Promotion	16	10	77	4.8
	Health Information	4	3	45	11.3
All actions		**28**	**19**	**151**	**5.4**

The mere fact that an article has been published does not mean it was an effective means for disseminating relevant results. Some articles are more widely noticed and read than others (partly depending on the journal in which they are published). The impact / influence of scientific publications is often measured in terms of the extent to which they are cited by other articles. The headline results for the articles we identified in relation to 11 HP-funded actions (each with between one and 20 articles) are shown below. 57% of all articles we identified were cited at least once; this figure rises to 70% if we look only at publications related to actions that ended in 2008 and 2009 (unsurprisingly, since these articles have been 'around' for longer). Of all the articles that were cited at least once, around a quarter can be classified as relatively impactful based on their h-index of 3 or higher.[22] Six out of the 11 actions in the sample (all of which ended in 2010 or before) had at least one such article. This

[20] It is important to acknowledge that the method for the bibliometric analysis was imperfect for a number of reasons, including the small sample size (especially when assessing the results for different funding instruments and strands); the fact that the actions in the sample were awarded funding between 2008 and 2012, and were therefore at different stages of implementation; the fact that the search had to be limited to a few key words and potential authors (namely the WP leaders); and that the assessment of whether or not a given article could plausibly be classified as being directly or indirectly the result of a HP-funded action inevitably involved an element of subjectivity in some cases.

[21] A mandatory mention of the HP is more difficult to justify or implement in practice if the link is only indirect, i.e. a HP-funded action was one of the (but not the only) sources of inspiration and/or knowledge that fed into the research for a given article.

[22] The h-index (named after its inventor Jorge E. Hirsch) is an attempt to measure both the productivity and the citation impact of a published body of work. Put in simple terms, articles with an h-index of 3 or higher were cited by at least three articles, each of which in turn was cited at least three times by other articles.

suggests a reasonable amount of coverage and visibility overall, although it should also be noted that this varies very significantly from action to action.

Table 5: Citation analysis of a sample of relevant articles

Action Acronym	Instrument	Strand	Year funding awarded	Relevant articles found on PubMed	Articles with 1 or more citations	% articles cited	Total number of citations	Number of articles with h-index of…			Citations per article	Citations per *cited* article
								5 or higher	3 or higher	1 or higher		
EPAAC	JA	HP	2010	20	8	40%	108	0	2	7	5.4	13.5
EUnetHTA JA	JA	HP	2009	10	5	50%	30	0	2	5	3.0	6.0
MODE	JA	HS	2010	10	9	90%	121	3	4	7	12.1	13.4
BISTAIRS	PJ	HP	2011	8	2	25%	10	0	0	2	1.3	5.0
INEQCITIES	PJ	HP	2008	8	6	75%	16	0	0	3	2.0	2.7
EUMUSC.NET	PJ	HI	2008	7	5	71%	35	0	1	4	5.0	7.0
BENCH-CAN	PJ	HP	2012	6	2	33%	7	0	0	1	1.2	3.5
NANOGENOTOX	JA	HS	2009	6	5	83%	62	1	3	4	10.3	12.4
PHASE	PJ	HS	2010	6	4	67%	16	0	0	3	2.7	4.0
RDPortal2	PJ	HP	2009	2	2	100%	29	1	1	2	14.5	14.5
PARENT	JA	HI	2011	1	0	0%	0	0	0	0	0.0	N/A
Totals				**84**	**48**	**57%**	**434**	**5**	**13**	**38**	**5.2**	**9.0**

Findings from the case studies on a sample of actions

The in-depth **case studies** on 13 HP-funded actions served to shed further light on the dissemination efforts and illustrate the diversity of approaches. They highlighted how each action is different in terms of exactly what it aims to achieve and how, as well as who is involved and who needs to be aware of the results to facilitate their take-up and use. It is therefore difficult to draw conclusions as to the most appropriate approaches and tools for actions in general. Still, the case studies highlight a number of key themes and issues that are important to consider when assessing engagement, dissemination and communication strategies. The concrete experiences we investigated via the case studies were also instrumental in informing our thinking on key stakeholders and target audiences, which is summarised further below.

The case studies covered highly instructive examples of **projects**. Some of these produced only outputs that were of a very technical nature, and therefore only relevant to relatively narrow audiences. Others covered issues that are of potential interest to broader groups, and therefore warrant a more wide-ranging dissemination strategy. The latter category includes projects on prevention (e.g. of cardiovascular disease) and quality of care (e.g. for musculoskeletal conditions), both of which developed and implemented a wide range of tools to address audiences such as healthcare professionals but also patients, including layman's versions of technical deliverables, and in one case even seminars for patient organisations. Factors which favoured such a broad and ultimately successful dissemination effort included an early identification and prioritisation of key audiences, partners' networks and experience with advocacy and communication work, the streamlining of dissemination activities into all relevant work packages (rather than only the horizontal dissemination WP), the use of various languages, but most importantly, content (in terms of project outcomes) that is of actual relevance and interest to non-specialist audiences.

On the other hand, the case studies also included projects that worked on very technical issues, such as evaluation of organ transplants, or indicators on neonatal

care. Their results are only of interest to relatively narrow specialist audiences (at least in the first instance). This is not to say that the *topics* as such (e.g. organ transplants) are not of interest to a broader public, but the specific objectives of the projects (e.g. a registry for post-transplant outcomes) were not. In these cases, tools and channels such as publications, congresses and conferences were typically used and found (somewhat) effective to reach the relevant specialist audiences. Problems tended to arise with the engagement of such specialist audiences in countries that were not directly involved in the projects; partners often lacked the means (including resources, but also contacts, knowledge and language skills) to engage these effectively.

There were also examples of projects of a very technical nature that tried to reach wider groups (e.g. patients) with dissemination activities, but (unsurprisingly in view of the nature of the information) failed to engage them effectively. In another case, an unclear (and possibly overly ambitious) definition of project objectives at the outset (as a result of which the audience for eventual results was difficult to determine) led to an overly broad dissemination strategy, including both specialist and non-specialist audiences, which meant that some of the communication materials and approaches did not meet the needs of any specific audience. This highlights a **key risk**: an effective dissemination strategy needs to carefully consider the interests and information needs of different potential target groups and how they can be reached, and prioritise accordingly.

Furthermore, the case study research points to cases where potentially relevant information produced by projects was **not presented well**, e.g. scattered across numerous reports, poorly-designed websites and / or inappropriate (e.g. academic) sources, making it unlikely that policy makers and other audiences would find it. The fact that websites and formal deliverables in particular are often structured by work packages may be useful from the perspective of project management and formal reporting to Chafea, but is not necessarily ideal for external communication purposes. Some case studies also highlighted problems with the timing of and resource allocation for dissemination activities: when a project comes to an end, and the final results are available, there is often no time or funding left to promote them as intensely as some partners would have liked.

A common theme across most of the case studies on projects (whether aimed at specialist and/or more generalist audiences) was **access to and targeting of policy-makers**. Some level of awareness-raising of the results among policy makers seems desirable for nearly all projects, as it enhances the chances of eventual implementation. Nonetheless, most projects struggled to effectively target policy-makers, partly because they were not prioritised, partly because none of the tools and channels used (e.g. websites, technical reports) were tailored to the needs of this audience. The only notable exception was a project that undertook a systematic mapping of audiences (including relevant policy makers) early on, and effectively used relevant events, fora, networks and multipliers to bring across easily accessible key messages. Projects that failed to do so sometimes showed a surprising lack of awareness of potentially relevant EU groups or fora where the results could have potentially been presented. In such instances, better guidance from DG SANTE and/or Chafea could have potentially addressed this issue.

The **joint actions** that were reviewed as case studies, on the other hand, typically produce relatively technical content that is only directly relevant for specialist audiences, most of which are (ideally) already involved in the JA. Dissemination to wider audiences is rarely a key success factor. Nonetheless, some JAs develop and implement very effective plans to engage with / communicate to / consult / inform wider stakeholder audiences as well, which can help to foster acceptance and buy-in. Some JAs also created effective links with policy makers. However, as with projects, there were also cases of JAs where there was not enough engagement of the policy

level – due to insufficient dissemination efforts, and/or to results that are so technical and narrow that they're not seen as relevant for policy makers.

Finally, on **service contracts**, dissemination was not part of any of the contracts we assessed. Instead, it was up to DG SANTE to use them, and ensure the studies were fed into the relevant policy processes and discussions. The extent to which this occurred in practice appeared to vary extensively, as discussed below in section 5 on the Programme's impact.

Dissemination of results by DG SANTE and Chafea

Work on a database of HP-funded actions began during the first half of the 2nd HP. Currently the **Chafea database** provides access to information (including summaries, the name and contact details of the project leader, names of all partner organisations, and links to reports and other deliverables) about all projects, joint actions, operating grants and conferences (but notably not direct grant agreements or service contracts) funded by the 1st and 2nd HPs. It is searchable in various ways. In the last few years, a significant effort was reportedly made to bring it (more) up to date and add the backlog of projects which were not previously included. Also, the functionality was expanded so that the database contents now reportedly show up in Google searches (although not necessarily on the first few pages, based on several searches carried out by the evaluators). It is also still the case that many deliverables are listed but not accessible via the database. In many cases this is justified by a note claiming that these contain confidential information. While this is undoubtedly appropriate in some cases, it appears that this justification has sometimes been used rather too liberally: there are finalised actions for which every single deliverable apparently contains confidential information, and hence no information at all is available from the database;[23] while in a few other cases, some of the presumably confidential deliverables can in fact be downloaded freely from the respective project websites.[24] Clarity and transparency would be improved if the policy for publishing documents were reviewed, and where deliverables are not available because they are not yet finalised, this should be stated explicitly.[25]

Feedback from NFPs on the database was mainly positive. In the survey, more than three quarters of respondents felt that the increased focus on dissemination through the introduction of the online database had enhanced the effectiveness of the HP to a significant extent (36% of respondents) or at least to some extent (41%). However, when asked how often they themselves have used the Chafea project database for dissemination or engagement purposes, NFP responses indicated a low usage – typically 1-2 times per year. While NFPs are obviously not the main intended user group for the database, one might expect them to have a need for information on specific actions from time to time, and their low usage of the database could be indicative of a wider problem. In interviews, a few NFPs stated their view that the database was not particularly sophisticated or user-friendly. It was noted that in order to be (more) useful as a dissemination tool, the database would have to contain information on progress and results, ideally in an easily accessible format. The current presentation (only description of plans and objectives, even for finalised actions, and information on progress only in the form of formal, often hard to read deliverables,

[23] E.g. EURONEOSTAT II.

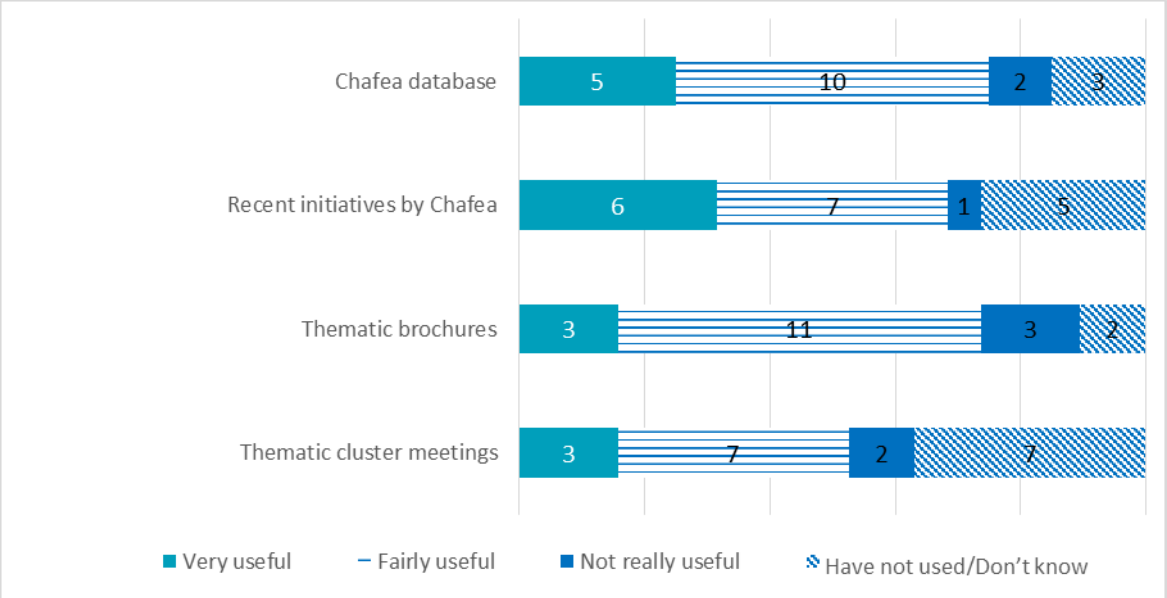
[24] E.g. EFRETOS deliverable 11: Report on the use of the European Registry of Registries

[25] According to Chafea, this issue has been addressed, and under the 3rd HP, starting from 2014, all deliverables should be public except where beneficiaries make a well-justified request to keep them confidential.

many of which are not even available) is clearly not ideal. Other NFPs (from EU-12 MS) felt that in particular more information on all partners (including contact details) would add significant value, so that the database could also be used to identify and contact potential collaborators and providers of further information. Other stakeholders that were interviewed (including NGOs and IOs active in the field of public health) typically had no comment on the database.

The **cluster meetings** (and the **thematic publications** that often accompany them) seem to be well-received overall, although the majority of NFPs felt they were "fairly" rather than "very" useful (see the graph below). They are typically two-day events, usually organised in collaboration with the competent authorities of a MS that is particularly active in the topic area (e.g. Spain on organ donation), and aim to provide attending journalists and other interested audiences with an opportunity to learn about EU policy as well as a portfolio of relevant HP-funded actions in a given topic area. Attendance is usually good, and there is typically decent press coverage (in some cases up to 50-60 articles in the national or health related press, although it should also be noted that not all of these make explicit mention of the HP or even the EU), albeit predominantly in the MS where the meeting takes place, whereas the resonance elsewhere appears more limited (based on a selection of clippings collected by Chafea itself).

Figure 10: The usefulness of different dissemination channels according to NFPs



Source: evaluation e-survey (n=20)

It is also worth briefly discussing the **role of NFPs**. During the 3rd HP, NFPs have a formal role (reflected in the legal basis) in assisting the Commission in the promotion of the Programme at national level, including the dissemination of the results and measurement of Health Programme outcomes. This was not the case during the 2nd HP. Nonetheless, in a survey conducted by DG SANTE in 2013 with the purpose of informing its future dissemination strategy, most NFPs reported they had been involved (53%) or slightly involved (13%) in previous dissemination activities of HP results in their country. The survey carried out for this evaluation suggests that the main audiences targeted for this were government organisations (in descending order of priority: health policy makers, healthcare providers and commissioners, and public health institutions), followed by universities and research organisations. Other groups, such as NGOs, commercial organisations, the media or general public, were only targeted by a small minority of NFPs when it came to disseminating results. During the interviews with NFPs, it became clear that most perceive dissemination of results as a major challenge. Their communication efforts tend to be focused on general awareness raising of the HP and provision of information in funding opportunities,

rather than disseminating results. Many stated that they lack the time, resources, knowledge of the full range of HP actions and results, and/or stakeholder networks to play this role effectively.

In this context, it is also worth noting that a strategic **reflection process on dissemination** was launched by Chafea in 2013, which involved consultation of NFPs to (1) identify and analyse dissemination initiatives, constraints, challenges, needs and opportunities, and (2) develop a dissemination road map as a strategic management tool and practical guide. The main result of this was a list of 30 specific actions (including a mix of seminars, conferences, publications, social media campaigns) on specific topics, to be carried out in collaboration between Chafea, a communication agency contracted for this purpose (via a framework contract that runs from 2014), NFPs and relevant project managers.[26] Four main types of dissemination activities were foreseen, namely (1) the use of an information booth at third party events identified with the help of NFPs), (2) the organisation of conferences, exhibitions and other events (Chafea events), including the continuation of the cluster meetings mentioned above, (3) information sheets on key results following the thematic priorities, and (4) a competition for young people with a focus on healthy life styles. The vast majority of NFPs who were aware approved of these initiatives, and rated them ('recent initiatives by Chafea') as more useful than the channels in use previously (see Figure 10 above).

Stakeholder analysis

The preceding sections have made clear how important it is to identify and prioritise target audiences for HP-funded actions and their results, and tailor the dissemination efforts to these. At the same time, it has become clear how different HP-funded actions produce a variety of results across a wide range of public health areas, some very technical for use by specialist audiences, others more accessible and potentially relevant for a wider audience. This makes it difficult to generalise about key target audiences for the programme as a whole.

Nonetheless, we have attempted to conduct a stakeholder analysis for the HP, in order to illustrate some general issues and trends, and develop and pilot test a conceptual framework that may be applied to conduct a more detailed analysis of specific actors and audiences in more discrete fields, e.g. priorities or specific objectives of the 3rd HP (which differ somewhat from those of the 2nd HP that was the subject of this evaluation, and are therefore more pertinent when it comes to guiding future dissemination efforts).

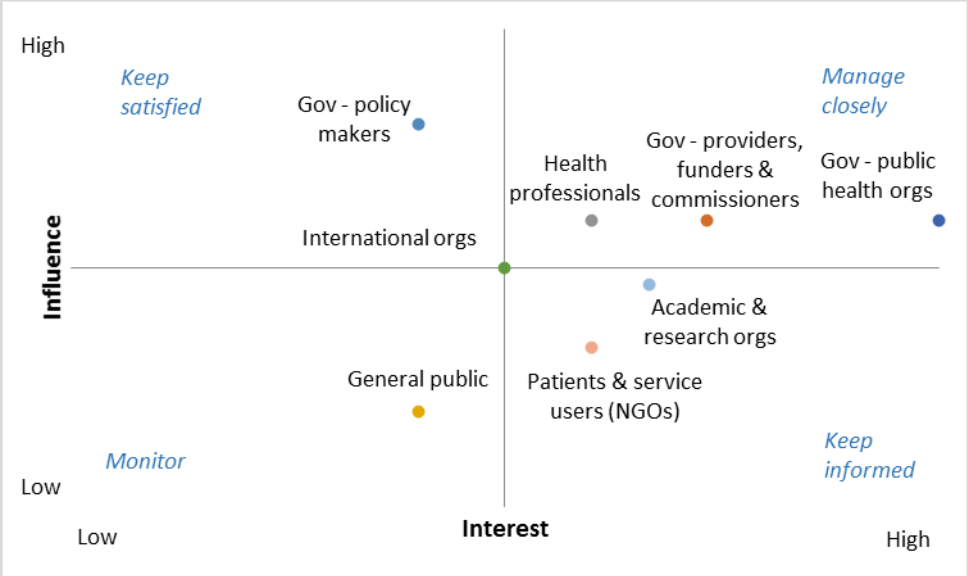
Analysing stakeholders for the HP as a whole is a challenging endeavour in view of the variety of HP actions and the breadth of topics it addresses, as well as the fact that most stakeholders are active at the national level, and there are significant differences in terms of the specific institutional landscape in each country, the political priorities, technical capacities, and the way roles and responsibilities are distributed across organisations and actors. In light of this, the approach we chose for the stakeholder analysis was "bottom-up" (from individual actions to strands, and finally the HP as a whole). We used the case studies (4-5 per strand, sampled purposefully so as to cover a broadly representative cross-section of "typical" HP topics within each strand – although of course they cannot do justice to the full breadth and diversity) to map relevant stakeholders, and assess their *interest* in the results of the actions in question, and their *influence* on the take-up and use of these results. We then

[26] Development of a Road Map to Disseminate the Results of the EU Health Programme at National Level. Second draft version, 15 October 2013. EAHC/2012/HEALTH/20

extrapolated from the individual actions to the three strands (health security, health promotion and health information).

More details on the approach, as well as the full results of this analysis (including examples of relevant organisations in each group and strand, as well as an indication of relevant dissemination strategies and tools) are presented in annex 7. The diagram below provides an average of the "stakeholder maps" that emerged for the three separate strands. Although this implies an additional layer of generalisation and abstraction, it allows us to identify some key issues that are applicable across a number of HP-funded actions and themes.

Figure 11: Stakeholder map for the 2nd Health Programme



Key messages that emerge from the analysis include:

- The key HP stakeholders are those in the **top right quadrant**, which have both a high level of interest in the results, and some level of influence over their implementation. These are the "natural" (and also *relatively* easy to reach) target audiences for the dissemination of HP results.

    - Public health organisations (including both general public health institutes and more specialised organisations) play a key role both in implementing HP actions and in the uptake of the results. Although the exact institutions involved differ, as a group they play a key role across all three strands. Their influence depends on a number of factors, among them the MS in question. In those countries with a strong public health tradition, their resources and technical capacity as well as their influence (including on policy) can be considerable, but in other MS a strong prerogative of the political over the technical / scientific sphere limits the autonomy and hence influence of many public health institutions.

    - Healthcare providers, funders and commissioners include a wide range of actors from public hospitals to national health services or insurance funds. They tend to be particularly interested in health security and health promotion actions, and to a slightly lesser extent in health information. Depending on the action in question, they can be key partners for the delivery of results.

    - Health professionals (individual doctors, nurses and other professionals, and/or the organisations representing them) are the only non-

government stakeholder group in this quadrant. They are a particularly important partner (in terms of both interest and influence) for health promotion actions, but much less so for health information (for which they actually sit in the lower left quadrant).

- The groups in the **bottom right quadrant** are (potentially) interested, but their influence is limited, which means that their engagement is strategically less important.
    - Academic and research organisations are one of the groups whose positioning varies depending on the strand. The nature of many health information actions (involving indicator development, data collection and analysis) means that researchers can have considerable influence on their success. In the other two strands, however, their influence is more limited, although their interest can be high.
    - Patients and healthcare users tend to have an interest in health promotion and (some) health security issues, but they have a limited amount of influence in most areas (mainly due to their lobbying power).
- The stakeholders in the **top left quadrant** are of particular interest, as their high level of influence coincides with relatively low levels of interest.
    - Although it is particularly difficult to generalise about this group, the analysis suggests that, this is the overall situation of policy makers. Although there are of course specific issues (e.g. HTA) that are of high interest to policy makers, and the attitude towards a given topic or intervention obviously depends on the political priorities of each government, overall it would seem that most HP results do not register very high on policy-makers' lists of priorities. At the same time, the case studies suggest that a failure to effectively engage policy-makers when this would have been desirable is a common thread across many projects and joint actions. It is therefore a key priority to find ways in which their (often limited) interests can be taken advantage of in order to raise their awareness and ideally secure their backing for the implementation / use of the various novel approaches, interventions, data sets etc. produced by the HP.
- Finally, the **bottom left quadrant** contains the stakeholders that combine low levels of interest with a low level of influence.
    - This is the case of the general public, for which most HP results are not immediately relevant (although there are of course some exceptions, especially in the health promotion strand). For most actions, disseminating results to the general public would most likely be a wasted effort.

4.1.Publication of results

EQ 5:

a) To what extent have the actions/ outcomes/ results of the Second Health Programme been published? To what extent are they (made) accessible to the international scientific and health community, to health policy makers, civil society, and to the wider public in the EU?

b) Are the results published and disseminated in a sustainable way?

c) How useful is the EAHC database in this context? How can it be improved?

d) Which other tools would be useful in this context?

The response to the question of the extent to which HP results have been published and made accessible to the various stakeholders needs to take into account the broad scope of the programme. As discussed in the previous pages, this means that HP-funded actions and their respective target groups are very diverse, and the onus for disseminating the results to the appropriate audiences is mainly on beneficiaries themselves (with support from Chafea and others).

As the **most appropriate audiences** for the dissemination of results vary, so do the most effective tools and channels for reaching these audiences. Some actions and their results are relevant for specialist (health / scientific) audiences only; others have wider relevance and count groups such as patients and healthcare service users among their target audiences. Overall, however, the evaluation research suggests that the most frequently targeted audiences are governmental organisations, healthcare professionals, and academia and researchers (in this order). These can sometimes be reached via publications in scientific journals (which result from some HP-funded actions), but it is important to note that research is not the main focus of the HP, and scientific publications are not always the most effective way of disseminating results.

How successfully the partners involved in actions manage to disseminate their results to the different audiences depends on the action in question. Thus, *some* results are disseminated and made accessible to relevant stakeholders very effectively, while others are not. Projects in particular provide examples of both very good and not so good practices. Arguably the **key factor in the development and implementation of an effective dissemination strategy** is a very clear understanding of the project objectives and who they are likely to be useful and relevant for, as well as what the key barriers to the use and take-up of the results are and who has the influence to overcome these. Successful projects frequently prioritise stakeholders based on such an (explicit or implicit) assessment. Less successful ones often define their target audiences too broadly, and then struggle to find the right tools and channels (and indeed the resources) to address them effectively.

At the same time, it is important to recognise that **not all failings are the result of ineffective dissemination**. In some cases, the results of actions are not fully in line with the original intentions and expectations, and/or turn out to be of limited usefulness (and/or inappropriately presented) for the intended audiences. Better dissemination is one of the keys to maximising the HP's impact, but it is not the only one.

DG SANTE and Chafea provide support for the dissemination efforts of individual actions in a number of ways, including the database, publications and events. These are no doubt useful and help to extend the reach of relevant results. However, in light

of the diversity and breadth described previously, they cannot make up for the relative failure of some actions to sufficiently promote their results to the specific audiences they are most relevant for. Overall, progress has been made since the mid-term evaluation, but not to the extent that fully effective dissemination can be guaranteed.

As regards the **sustainability** of the dissemination, the answer is once again "it depends". There is a recurrent problem with actions that are finalised and no longer have any budget available for further dissemination, just at a time when the final results are available and could in theory be promoted more widely. On the other hand, many actions do find ways of ensuring some level of continuity (sometimes in the form of a HP-funded follow-up action). Ultimately, the question of what is considered sustainable depends on the nature of an action; for example, in the case of research-focused actions, a publication in a scientific journal would typically be considered sustainable (and the bibliometric analysis suggests that publications result from at least a quarter of projects and joint actions). In other cases, the actual take-up of the results by a core group of key stakeholders – rather than any sustained dissemination activity – is the key measure of sustainability. Dedicated action websites also ensure some level of sustainability, and such websites do seem to still exist even for most finalised actions, although the interest they generate almost inevitably drops off over time.

The **Chafea** (previously EAHC) **database** is useful in terms of providing a readily available and searchable repository of basic information about each action funded under the various iterations of the HP. At the same time, it does not seem to be widely used beyond a core group of "insiders", and is still subject to a number of issues that limit its usefulness as a genuine dissemination tool. Most importantly, the information contained in it is too static. Even for actions that were finalised years ago, the database only contains summary information on objectives and *expected* methods and outcomes. It would immediately become more interesting and attractive to actors other than HP "insiders" if it provided information on actual progress and results. Also, the access to deliverables via the database is patchy at best; in any case, most formal deliverables tend to be too lengthy and 'technocratic' to be suitable as dissemination tools. It may therefore be useful to request action leaders to submit a one-page summary of progress and results along with each (interim or final) report. This should be uploaded consistently and quickly onto the database, and could provide a very useful entry point for interested parties. The "Results in Brief" published on CORDIS on FP-funded research projects could serve as a model to emulate.

Other tools that could be useful are discussed in section 4.4. below.

4.2.HP participation and national public health capacity

EQ 6: What is the relation between the publications/activity reporting and the Member State participation in the Second Health Programme, the number of health scientists, public health specialists and physicians per Member States? Are patterns identifiable? Have dissemination activities been undertaken in a way to overcome possible geographical imbalances in certain actions?

The implicit premise of this question is that imbalances continue to exist in terms of the participation of institutions from different MS in the HP, and that these might be due to differences in the public health capacity of MS, and/or dissemination activities. The analysis in section 3 of this report shows that the participation of different (groups of) Member States varies considerably, and that the concerns around the participation of organisations from "new" Member States have only partly been addressed. At the

same time, it is important to recognise that (a) the extent to which presumably "weaker" MS (predominantly in Southern, Central and Eastern Europe) benefit from the 2nd HP compares favourably to their participation rates in public health-related research under FP7, and (b) part of the differences in funding levels are likely to be due to the lower wages in lower-income countries.[27]

To address the last part of the question first: the evaluation found no evidence that any factors related to **dissemination / publication of results**, and or activity reporting, played a significant role in determining participation rates. None of the actions assessed as case studies undertook dissemination activities specifically to overcome geographical imbalances. Nor were such activities organised at the programme level; cluster meetings have typically been held either in Luxembourg, or in countries that benefit to a relatively large extent from the HP (Italy, Spain and, to a somewhat lesser extent, Greece), and most publications, guidance documents etc. are only available in English.

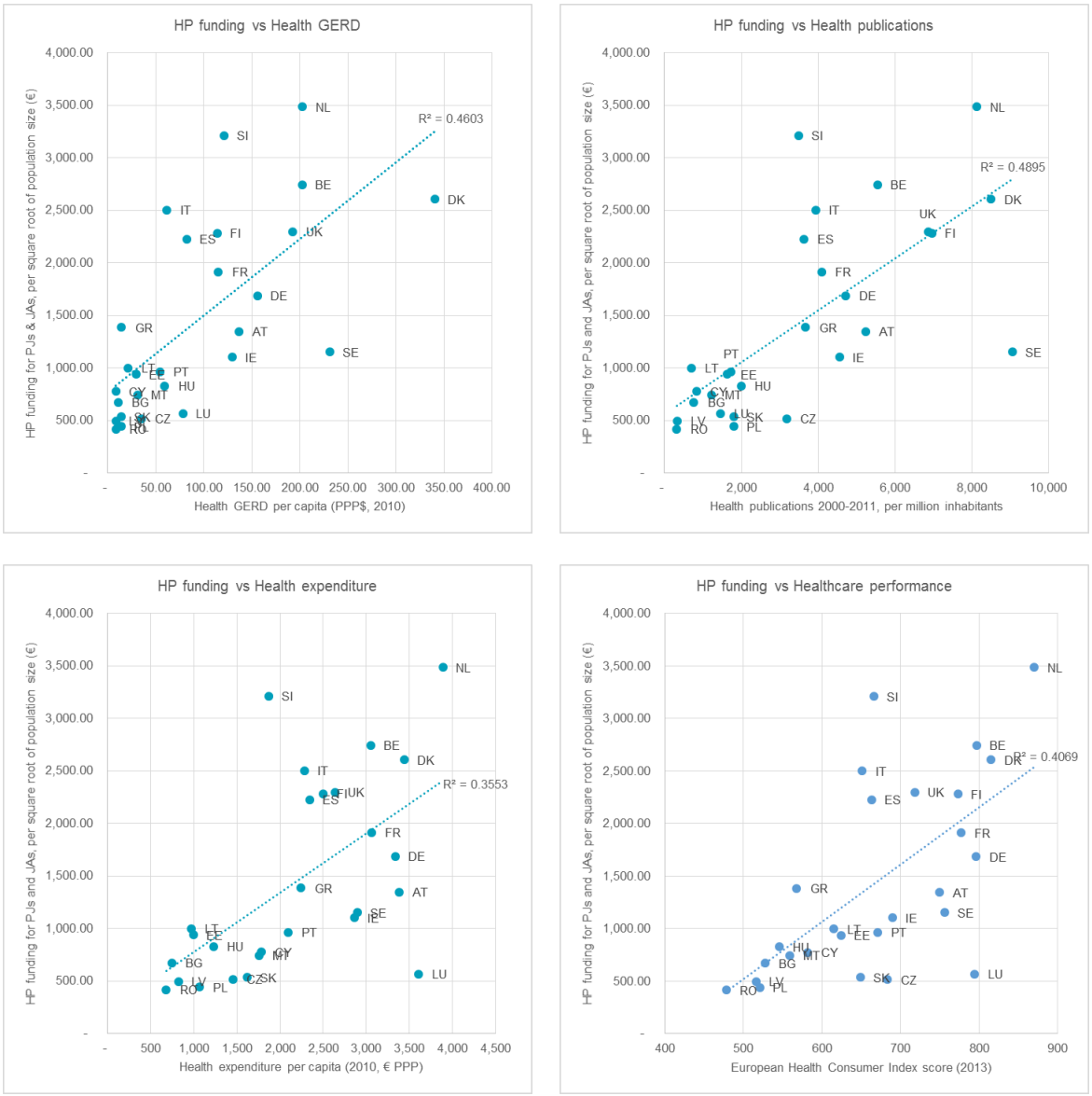
The evaluation set out to explore further the statistical relationship between the **public health capacity** of EU Member States and their HP participation rates (i.e. the amount of funding that organisations from a given country were able to obtain), and assess whether any patterns could be identified. It should be emphasised that "public health capacity" is not an easy concept to pin down, and there is no widely accepted practical way of measuring it. We have therefore conducted desk-based research to identify potentially relevant indicators in a number of areas,[28] and review and compile existing data from various sources. This data was assessed and tested for correlations between the different indicators and HP funding awarded to different participating countries. For this analysis, only project and joint action funding was taken into account, and analysed in relation to the square root of the size of the population of each EU MS (for more details on the methodological approach and the results see annex 6).

This approach revealed a **relatively strong correlation** between funding patterns and indicators related to health *research*, and (to a slightly lesser extent) healthcare systems (see the diagrams below). All of these provide a better correlation with HP funding than the Gross National Income (GNI). The best correlation is with the number of health publications.

[27] According to Eurostat, the average hourly labour costs in EU-15 countries in 2013 were more than three times those in EU-12 countries. The costs in the most "expensive" country (Sweden) were more than ten times those in the "cheapest" country (Bulgaria).

[28] Those indicators included in the evaluation question turned out to be either impossible to obtain robust data on (number of health scientists, public health specialists), or irrelevant (number of physicians). Instead, we looked into various measures related to wealth (GNI / GDP), health research spending, health publications, health expenditure, healthcare resources, health outcomes, and healthcare performance. In some of these areas, the data quality and availability allowed for correlation testing, in others it did not.

Figure 12: Correlation between HP funding and various indicators related to public health capacity[29]



It is important to note that this statistical analysis **does not allow us to draw any definitive conclusions** about causation. The dataset is too small (one observation per MS) for this to be the case, and as noted above, the available indicators only provide imperfect proxies of public health capacity. If one wanted to take the analysis a step further (which was not possible within the scope of the present evaluation), it is recommended to further explore the feasibility of constructing a single composite indicator for public health capacity (which could include trends in the prevalence rates of key preventable diseases) and using longer time series (potentially going back to the 1st HP).

[29] For more details on the methodological approach and data sources, please see Annex 6. It should be noted that the indicator for healthcare performance (EHCI) is subject to some controversy. We have included it in the analysis, as it is the only available quantitative indicator covering all EU Member States, but it is important to acknowledge its limitations.

In spite of the methodological limitations, the results of the analysis so far **suggest that public health capacity** (and health research capacity in particular) **does affect** the extent to which countries are able to benefit from HP funding, and explains some of the differences in participation rates. Even so, some countries (predominantly but not exclusively EU-15 MS) manage to obtain a greater share of HP funding than might be expected based on their health research (and more generally public health) capacity. These are the ones that lie above the trend line in the diagrams. Others fare less well than might be expected based on this analysis (those that lie below the line). We therefore set out to investigate further **what factors may explain these higher or lower participation rates** of some of the main outliers[30], based on HP-related data sources, interviews and case studies conducted as part of this evaluation, and relevant literature on public health capacity.

As might be expected, the results are not fully conclusive, as both public health capacity is a multi-faceted and not easily comparable concept, and HP participation rates are clearly based on a complex interaction between various factors. Nonetheless, a few interesting findings emerged. Firstly, if we break down funding patterns by instrument, we find that the most successful countries (in terms of funding levels that would seem to be in excess of their capacity) are very active participants in **joint actions**, whereas the opposite is true of the least successful ones.

On **projects**, the successful countries tend to have above-average success rates on the proposals they lead (with the exception of Italy, which makes up for its low success rate by submitting by far the highest number of proposals of all countries), while the less successful countries submit few project proposals as lead partners, and when they do, their success rate is consistently below average (which may be due to a typical 'chicken and egg' problem, as the lack of experience with proposal writing is likely to negatively affect success rates, and thereby further exaggerate existing capacity problems).

This suggests that **low levels of engagement typically go hand in hand with low levels of capacity**. In other words, to help the worst performing MS to achieve higher levels of HP funding, one would need to address both their engagement (in terms of applying for funding, especially in a lead role) and their capacity to submit winning proposals. If deemed appropriate (and if building capacity in 'weaker' MS is recognised as an explicit or implicit programme objective), awareness raising, coaching and/or support specifically tailored at relevant organisations in countries with lower proposal submission and success rates could be envisaged. This could result in a 'snowball' effect, whereby lessons learned from proposal writing experience over time help to drive up response rates.

The review of relevant literature[31] provided few insights beyond the relatively obvious. The "high performing" MS all seem to have relatively well-developed public health institutions, as well as explicit policies and objectives that make public health a priority. On the other hand, the literature identifies problems with the public health workforce in many (but not all) of the countries with lower than expected participation rates, in particular regarding a lack of strategies to guide its systematic development and deployment, and/or a definition of competencies and/or career paths. When

[30] Outliers in the positive sense – i.e. countries that manage to obtain significantly more HP project and JA funding than their public health capacity (based on the proxies used for the analysis) suggests include Belgium, the Netherlands, Slovenia, Italy and Spain. Outliers in the negative sense (i.e. receiving less funding than would seem to correspond with their capacity) include Sweden, Poland, the Czech Republic, Slovakia and Romania.

[31] Mainly based on Aluttis CA, Chiotan C, Michelsen M, Costongs C, Brand H, on behalf of the public health capacity consortium (2013). Review of Public Health Capacity in the EU. Published by DG SANTE. Luxembourg, 2013.

comparing the EU-12 MS, it seems that health promotion and health determinants, including social determinants / health inequalities, seems to be a higher priority in Slovenia (by far the most successful of them) than in any of the other "new" MS.

The fieldwork conducted for the evaluation points to various contributing factors, including issues related to capacity but also **administrative / organisational culture.** It seems that the extent to which relevant national authorities "push" institutions or individuals in their respective countries and organisations to get involved varies significantly. This – i.e. the existence of a culture within key public health organisations that actively promotes participation in EU programmes as desirable – may be the one key factor that rivals public health capacity as a determinant of success (in terms of funding levels).

4.3.Dissemination by stakeholders other than governments

EQ 7: To what extent do stakeholders other than Member State governments (subnational regional organisations, civil society, social partners etc.) promote Programme outcomes and results, and via which channels? This should consider both organisations funded by the programme, and others.

The dissemination of action results, and the tools and channels that are most frequently frequently used, are discussed at length above (see inter alia

Table 3). Non-governmental stakeholders that are partners in HP-funded actions (in particular universities and research organisations, organisations representing health professionals, patients and service users, and other NGOs) contribute to the dissemination of the results of the actions (in particular projects) in which they are involved in a number of ways. In fact, in four of the five projects assessed as case studies, the dissemination work package was led by a non-governmental (including academic or commercial) organisation. Their contributions included organising events, hosting websites, and publishing written material (including scientific publications where relevant).

As for organisations that are not directly involved, the evaluation has not found any instances where such organisations play any role in HP promotion. While it is possible that some such organisations have acted as multipliers in specific cases that are of high interest to them, they typically lack any incentives for promoting the HP as such.

4.4.Improving dissemination practices

EQ 8: How could the current dissemination practices be improved to increase return on investment?

When considering improvements, it is important to recognise that most dissemination activity will continue to take place within the framework of individual actions, and because of the diversity described previously, this is the most sensible approach. The main objective of dissemination is facilitating the implementation of the relevant results, and no-one is ever likely to know the specific results in question better, and therefore be in a better position to identify and engage relevant audiences, than the partners themselves.

In light of this diverse reality, the effectiveness of dissemination activities is dependent on the specific objectives set, results obtained, and challenges faced by each action. The return on the investment made in dissemination therefore depends to a large extent on the choice of the right channels and tools to send the right kinds of messages to those audiences that need to be aware of the results (because they are most likely to be able to use the results themselves, and/or facilitate their use by other relevant groups). In order to ensure this happens as effectively as possible, DG SANTE and Chafea could consider the following options:

- More insistence on, and greater scrutiny of, systematic dissemination strategy and planning within funded actions:
    - Actions (in particular projects) should be encouraged, incentivised or even obliged to take the need to develop a relevant and realistic dissemination plan at the outset. This should ideally involve a clear definition and prioritisation of stakeholders (possibly using a similar analytical framework as that used for this evaluation). In this context, beneficiaries should be reminded that less is often more; there is little point in spreading themselves too thinly and attempting to reach groups that have neither an interest in nor influence over the results.
    - Closely related to this, it is also important that dissemination strategies and plans are seen as a working document – i.e. they need to be updated when key parameters of an action change, and should inform delivery, rather than being produced at the start of an action and then just sitting on a shelf.

    - Ways should be explored in which there can be better consideration of what happens in terms of dissemination after projects end. Where relevant, budget could be reserved for events or other activities within a 6-12 month period after the deliverables have been finalised.

- Better reporting on progress and results:

    - It is worth considering whether it can be made mandatory for beneficiaries to submit (very) brief and accessible summaries of progress and/or results alongside each interim and final report (and possibly other key deliverables). These could be disseminated inter alia via the database, and serve as a genuine communication tool.

    - In order to ensure that such summaries are appropriately written and understandable to relevant audiences, it may be possible for the communication framework contract holder to become involved in reviewing / editing some or all of these summaries.

- It should be explored if / how beneficiaries can be brought to explicitly mention the HP co-funding in any publications they write that are directly linked to HP-funded action results. This would enhance visibility as well as facilitate effective monitoring of the extent and impact of such publications.

Above and beyond the dissemination of the results of actions (with the primary objective of facilitating their take-up and use), a secondary communication objective is to raise the profile of the HP, and more broadly, of the contribution the EU makes to public health in Europe. In this context, the launch and use of the framework contract for communication, and the stronger engagement of NFPs in the dissemination effort, including the identification of relevant national events, is a promising approach that should be fully exploited in order to intensify and professionalise the efforts.

5. THE PROGRAMME'S IMPACT

In this section, we examine the impact of the Programme. It is not possible to do this in the formal sense, whereby change over time would be attributed to an initiative, normally in quantitative terms. This is due to the Programme's small size in the face of much larger factors affecting public health in Europe, in addition to the diversity of the programme in terms of objectives, funding mechanisms and the types of organisations it supports. Instead, we look at the Programme's impact in terms of its *contribution* to Member State action. This considers the EU's supporting role in public health (as defined in Article 168 TFEU[32]) and for the purposes of the Programme consists of facilitating collaboration and strengthening the efforts of key stakeholders. In other words, since ultimate responsibility for public health is (mostly) left to other organisations (in particular national health authorities), the success of the Programme derives from its ability to make those other organisations (which range from international organisations and national health ministries to universities and NGOs) do their jobs better and more effectively. This also means examining impact (mostly) through the lens of its contribution to public health *policy*, even though many actions also could conceivably have impacts in other areas.

The ensuing subsections elaborate on this from several angles. Firstly, we discuss in general terms the focus of Programme actions and their potential ways of generating an impact. This is followed by an assessment of the actions' EU added value, which is crucial given the supporting role of the Programme. Finally, we discuss each of the funding mechanisms in detail to expand on the factors behind their success and their relative strengths and weaknesses.

Potential impact

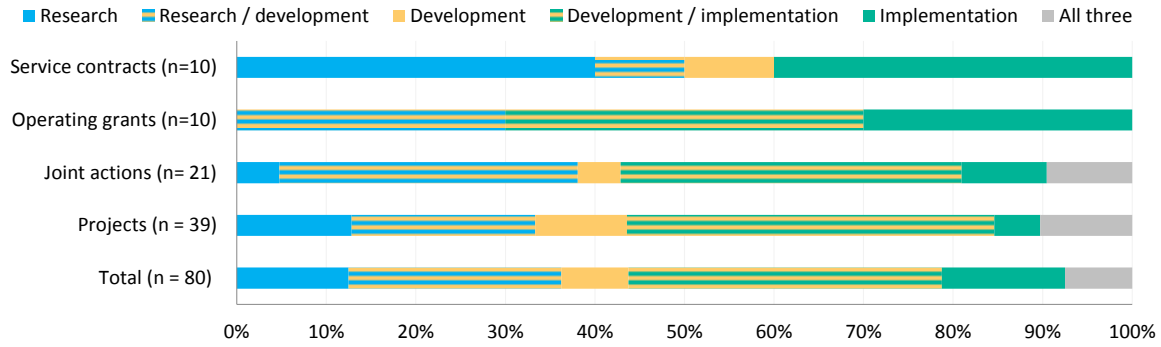
There are essentially three stages to the 'health intervention process' where HP actions can intervene (see also section 6 on synergies):

- **Research**: to increase knowledge that can serve as a basis for evidence-based decisions.
- **Development**: to develop and pre-test an intervention to address a particular problem in a particular population or target group.
- **Implementation**: to achieve wider dissemination and implementation of an existing intervention in a particular population or target group.

In order to deepen our understanding of this dynamic, we carried out an in-depth review of documentation for a representative sample of 80 actions, providing for each action their indication of where impact was most likely. Since many actions did not fit neatly into a single category, we treated them more as a spectrum, with some actions being classified as 'research/development' or 'development/implementation', or indeed all three. The figure below summarises the findings.

[32] Article 168 TFEU stipulates "The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action."

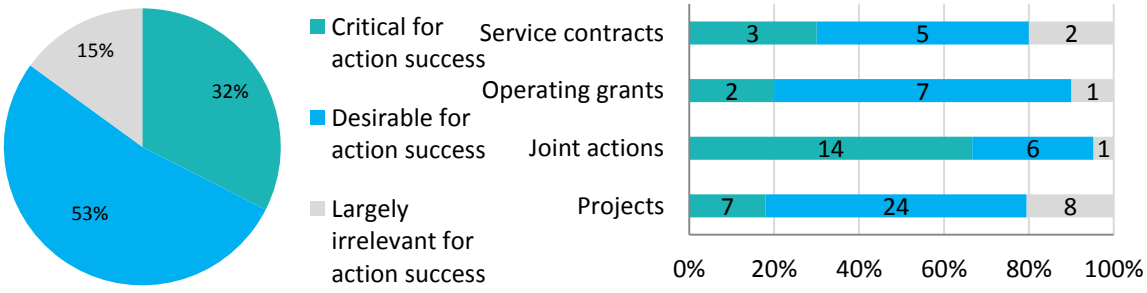
Figure 13: Potential impact of actions, overall and by action type



Several issues are noteworthy here. First (in accordance with its stated objectives), Programme actions are more likely to generate an impact in the development of interventions (75%) than in research or implementation, though relatively few actions were concerned *exclusively* with development (8%). More interesting was the variation by funding mechanism. Joint actions were more concerned with development than other funding mechanisms, with nearly 9 in 10 having a development component. Projects and operating grants were not far behind, while service contracts mostly addressed other stages of the health intervention process, particularly research.

Given the Programmatic emphasis on (in addition to the EU's facilitating role in) health *policy*, the success of individual actions should in theory depend in large part on their ability to generate national policy impacts. Looking at this in more detail (as part of the in-depth review mentioned above), we found that, in terms of individual objectives set for each action, policy impact was, in most cases, *desirable* rather than *critical* for action success, despite the importance of policy relevance in selecting beneficiaries. Crucially, variation between funding mechanisms suggests that while joint actions were conceived *mainly* to influence policy, according to action proposals and other documentation, the success of service contracts, operating grants and projects were concerned more immediately with other issues, such as conducting rigorous research.

Figure 14: Extent to which "Impact on national policy" determines the success of an action, overall and by action type



As explained in detail below, the disconnect between action design and a direct influence on health policy explains the difficulty for many actions in demonstrating impact in concrete terms (though we also argue below that there are plausible policy-focused roles for all funding mechanisms). Nonetheless, this finding reflects positively on the shift towards joint actions (and away from projects) during the second half of the Programme. Evidence gathered through numerous stakeholders contacted for the evaluation, including surveyed national focal points, Commission officials and external stakeholders, also emphasised the more direct applicability of joint actions for policy-making in comparison with other funding mechanisms.

EU added value

Another way to look at the impact of the Programme is in terms of EU added value, which, in simple terms, seeks to gauge the underlying rationale for funding actions through the Programme. The principle of subsidiarity implies that EU action is only justified as a last resort, when initiatives at local, regional or national levels would be unable to achieve similar results. The case is self-evident in areas where the EU has exclusive competence, like the single market or external trade. In public health, the EU's supporting competence necessitates a strategic approach that limits the EU role and focuses on specific initiatives that maximise its added value.

With this in mind, the European Agency for Health and Consumers (EAHC, now Chafea) developed a set of EU added value criteria that the evaluation team built on and subsequently applied by having our expert panel score the potential EU added value of a sample of 80 actions on a three-point scale.[33] The table below lists and defines the eight EU added value criteria.

Table 6: Definition of the EU added value criteria

Criteria	Definition
Implementing EU legislation	To ensure that the funded actions are contributing to the development and/or implementation of EU legislation
Economies of scale	To save money and provide a better service to citizens by avoiding a duplication of efforts and by cooperating across national health systems
Promotion of best practice	To apply best practice in all participating Member States, e.g. by identifying procedures, approaches, methods or tools that could be applied by healthcare professionals or others
Benchmarking for decision making	To facilitate evidence-based decision making, e.g. by providing scientific information, real time data for comparison, and/or indicators that can impact on decision making at a higher political / policy level
Cross border threats	To reduce risks and to mitigate the consequences of cross border health threats by establishing relevant structures for coordination
Free movement of persons	To increase the movement of patients and healthcare personnel between EU Member States, thereby contributing to a better match between supply and demand
Networking	To make sure that networking activities among stakeholders, which contribute to knowledge sharing and building health capacity in the EU, are supported and sustained
Unlocking the potential of innovation	To support the deployment of innovative solutions for healthcare provision, in terms of both products and services

The scoring exercise served to highlight several issues relating to the likely EU added value of Programme-funded actions. Echoing the findings reported above on potential impacts, first among these was the relatively high EU added value of joint actions and their ability to contribute to several criteria at once. While this partly reflects their

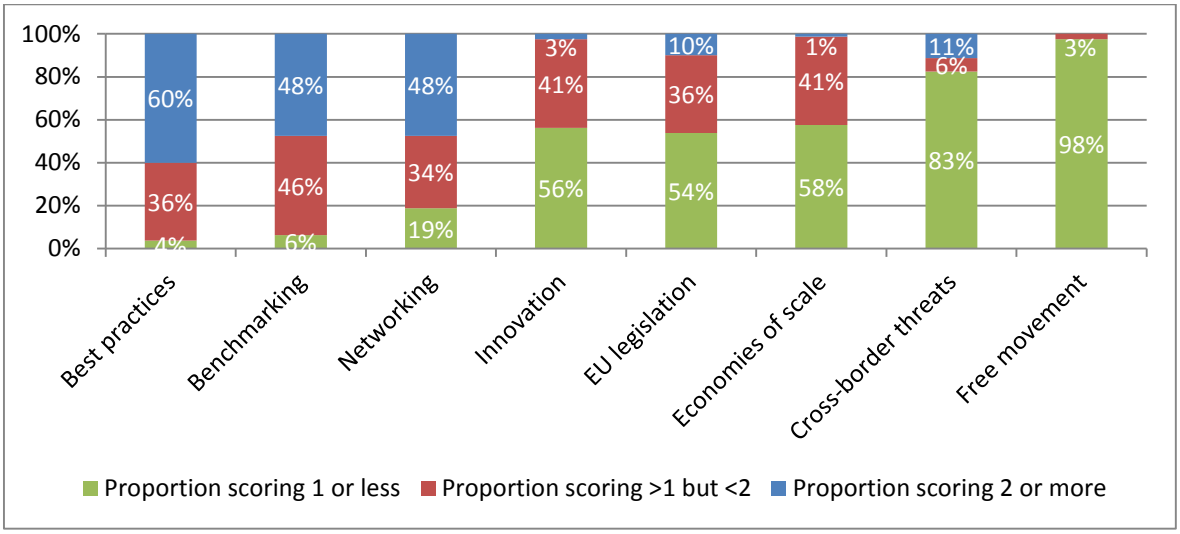
[33] The scoring scale ranged from 0-3 as follows: 0 indicated 'no EU added value foreseen';1 indicated 'EU added value possible'; 2 indicated 'EU added value likely' and 3 indicated EU added value almost certain.

larger size and greater number of partners, it is noteworthy that no other funding mechanism averaged high scores for more than one criterion.

Moreover, projects, which received less emphasis during the second half of the programme, tended to concentrate their EU added value in the spreading best practices criterion, which is undesirable for reasons discussed below. Average scores for service contracts and operating grants were lower, but in the cases of a small number of individual actions, they allowed the programme to add value against certain criteria, such as cross-border threats, where other actions appeared unlikely to contribute strongly in terms of the scores allocated by the expert panel.

The spread of scores across the eight criteria is also important. While we identified some variation among funding mechanisms and strands, actions in general scored highly in promoting best practices, benchmarking for decision-making and networking, with relatively low scores for the other criteria. This trend was more pronounced among actions for which very high or very low scores were awarded, showing that hardly any actions received very high scores for innovation, implementing EU legislation, economies of scale, cross-border threats and free movement of persons.

Figure 15: Proportion of actions averaging scores of 2.0 or more and 1.0 or less (out of a maximum of 3), by EU added value criterion



Low scores were expected and justifiable in some instances. For example, cross-border health threats, and, to some extent, implementing EU legislation are highly specific criteria that simply were not addressed by a large proportion of actions. Free movement of persons (i.e. patients and healthcare professionals) in particular has not been on the political agenda in recent years, and was therefore only addressed by very few HP-funded actions.

The remaining five criteria are more general and applicable to a wide cross-section of actions. Here, it is worth pointing out some differences in the nature of the criteria. Trans-national, collaborative actions involving many partners often involve an inherent degree of sharing best practices, benchmarking and networking. More importantly, these criteria are mostly about *identifying* relevant information. For example, the formation of a network (even a sustainable one) does not necessarily imply that the information shared between partners will result in real policy improvements. The innovation and economies of scale criteria, however, set a higher bar, referring directly to the *application and implementation* of improved practices.

Since scores were awarded based on documentation available before given actions' implementation, we would expect higher scores for the more *output-like* criteria (e.g. spreading best practices) than for *outcome-like* criteria (e.g. economies of scale)

whose **achievement is difficult to assess in the absence of concrete results**. Nonetheless, this led us to conclude that *real* added value for actions scoring highly for only output-like criteria would depend on their ability to convert them into more concrete outcomes, such as the actual application of best practices (rather than their mere identification). We used the in-depth case studies to look in more depth at how such dynamics evolved in practice.

Funding mechanisms in practice

Rather than providing conclusions, the analysis presented above led us to identify issues for further investigation in the 13 case studies of joint actions, projects and service contracts.[34] We then used the case studies to delve deeper into how the actions related to the broader public health agenda and contributed to it strategically. We were able to parse the relative strengths and weaknesses of each funding mechanism with some precision, leading to some conclusions about the conditions necessary to maximise the former and minimise the latter. We also found numerous factors whose presence (or absence) could partly explain action impact and success, regardless of funding mechanism.

The following tables outline our key findings from the case studies per funding mechanism. While the information presented touches on issues falling under other evaluation blocs (particularly dissemination, but also Programme management), we have included it in order to provide a holistic view of the three funding mechanisms. This is especially important because the results and ultimate impact of given actions can be conceptualised as dependent on the other areas. In other words, we would expect an impactful action to address a relevant topic, have a rigorous design, be well implemented and so on.

[34] Taken together, these three mechanisms accounted for over 80% of funding under the Second Health Programme.

Joint actions

Relevance / rationale

- JAs can add significant value when they address issues where the added value of pan-European collaboration is clear and readily applicable results can be produced.
- JAs often grow out of smaller projects funded through the HP that have already confirmed their relevance / potential added value.
- The highly specific parameters of JAs mean they are not the most appropriate instrument for all purposes (particularly exploring new areas for potential collaboration), creating a risk that some will be selected mainly due to the vocal interests of a (small number of) Member States.
- JAs are not well suited to areas where significant flexibility is likely to be needed in response to changing / emerging needs and issues.

Design

- Designing JAs is typically a very intense process, involving substantial deliberation between the Member States and Commission, potentially leading to very relevant and well-reasoned plans.
- However, this necessitates substantial scoping work, which is not done in all cases, leading to situations where the feasibility of certain elements, and their connection to demonstrable needs, is not established from the outset. This is especially the case for JAs with strong research components without a clear policy link.
- The complexity of JAs and the possibility to make minor adaptations in situ also requires an engaged and expert interlocutor in DG SANTE / Chafea, the precise mandates and roles of which are sometimes unclear.

Implementation

- Ideally (as was usually the case), involvement from relevant institutions from most or all Member States ensures JAs can draw on sufficient expertise and influence to produce relevant results and work towards their implementation.
- Implementation was weaker in cases with partners from only a minority of Member States (which also seems contrary to the inclusive nature of the JA mechanism).
- While a strong government (rather than JA coordinator) role in designating partners seems unavoidable, this sometimes led to performance issues with certain partners who lacked the necessary expertise and commitment to perform well.
- The involvement of partners from new Member States is uneven and often limited in terms of both numbers of partners and actual contributions to JAs. Moreover, these Member States often lack institutional capacity to participate effectively, with insufficient separation between the technical and political levels sometimes compromising effective participation.
- Very strong project management skills and commitment from the coordinator are essential given the JAs' huge size and complexity.

Dissemination

- JAs typically produce relatively technical content that is mostly directly relevant for specialist audiences, many of which are (ideally) already involved in the JA. Reaching wider audiences is rarely prioritised.
- In cases where wider dissemination is relevant, some JAs develop and implement effective plans to communicate to / consult / inform wider groups of stakeholders.
- Dissemination often suffers when other success criteria are unmet, especially those relating to engagement at the policy level or the production of results with readily applicable policy uses.

Results / impact

- JAs typically develop / share / refine / test tools, methods and approaches to specific issues or activities, and engage in capacity building to a greater or lesser extent. This focuses their EU added value more in innovation and economies of scale than networking and the promotion of best practices (which often occur but not as a primary focus).
- JAs often generate substantial added value for those involved, in some cases leading to tangible cost savings in addition to learning effects.
- JAs generate maximum impact when they focus on technical work that has a demonstrable link to policy development and need for policy coordination.
- Less successful JAs showed weak links to policy and policy makers, and made little lasting impact beyond participating institutions.
- The need to overcome inertia, build mutual trust and commitment and move from tool development and testing to real-life application (and subsequent economic and other benefits) mean that policy impacts take significant time to materialise.
- Since testing, fine-tuning, continuing coordination, capacity building and reporting all take substantial time and on-going funding, sustainability can be an issue even for relevant, well-designed and implemented JAs.

Projects

Relevance / rationale

- Projects provide a relatively flexible outlet for the exploration of a wide range of subject areas and delivery mechanisms, almost as 'pilots'.
- In addition to producing meaningful results, where successful these can lead to future actions on a larger scale, notably through JAs or further projects.
- Projects tend to address topics which are highly relevant and which fit with the wider EU policy context. Although they seldom establish a direct policy link at the outset.
- Care needs to be taken that well-connected and strong organisations do not use their might to steer the agenda in their favour and that projects do actually add value rather than covering topics where intense collaboration and research already exists.
- Regarding EU added value, the potential EU added value beyond the "soft" criteria of networking and sharing best practices is often unclear for projects. This is especially problematic in cases where there is a weak policy link and / or the treatment of topics where overcoming status quo biases and implementing (identified) policy changes would require intense, sustained efforts and buy-in from many stakeholders.

Design

- Projects can have unclear, overly ambitious and diverse objectives making them unfocused and the outcomes somewhat unclear. Moreover, they sometimes fail to account for difficulties in overcoming national differences in data availability or comparability which undermines the plausibility of project objectives.
- In some cases projects could have had more success by using existing data rather than trying to develop new sources.
- It was rare that projects actually focused on policy change. In general projects sought to perform research or collect and disseminate information to less certain ends, mainly from researcher or scientific perspectives.
- There was little consideration of policy-makers' needs and what / how information could most effectively be presented to them, leading to the design of numerous, relatively unfocused activities. Policy steer from DG SANTE could have helped avoid these situations.

Implementation

- Most projects were implemented and delivered as planned, though sizable consortia and ambitious schedules led several projects to suffer (minor) delays.
- Strong leadership, as well as dedicated staff for operational functions, tended to support successful collaboration.
- Projects led exclusively by academics potentially lack the relevant project management skills.
- While most projects involved large numbers of MS, partners from the EU15 tended to be responsible for the main deliverables.
- Several projects experienced difficulties dealing with Chafea (for example, reporting requirements, administrative inflexibility and/or difficulties getting reports approved and payments made).

Dissemination

- Large and highly developed networks (of partners) allowed some projects to build a strong project identify and disseminate results widely.
- However, the target audiences of some projects were very diverse, making it difficult to develop and disseminate appropriately tailored communication materials.
- While some projects produced relevant information, it was commonly scattered across numerous reports, poorly-designed websites and / or inappropriate (e.g. academic) sources, making it difficult for relevant audiences to find and use it.

Results / impact

- While all the projects produced at least some potentially useful and high-quality deliverables, none led to significant discernible impacts in the short- and medium-term. There was – just - one example of a project which could plausibly achieve a substantial impact later, drawing on sustainable policy-focused follow-up activities (such as advocacy) as well as the strength of project deliverables.
- Some projects lost momentum on when it became clear that objectives were unrealistic or strong leaders became unavailable.
- Given the scale of the ambition of most projects and the difficulty in achieving policy change, it may be unrealistic to expect measurable impact in the short- to medium-term in the context of the available budgets and timescales. Instead, successful projects might be judged on the basis of their ability to pave the way for further action through, for example, joint actions.
- Nonetheless, when projects did not realise their full potential, it was due to several factors that were experienced by several actions. These included lacking policy focus, overly ambitious, varied and unclear objectives (in some cases partly due to the way in which calls for proposals were phrased) and a failure to root those objectives in demonstrable (policy) needs and plausible intervention logics.
- Project evaluations were generally process-oriented rather than assessing or attempting to measure and describe impact.

Service contracts	
Relevance / rationale • SCs typically respond to specific DG SANTE needs / ideas, and pursue a relatively narrowly defined objective, such as to gather specific evidence to inform a given policy process, or facilitate the implementation of a piece of EU legislation. • As such, the relevance of all three SCs that were assessed is high, however, the potential concern with the proliferation of SCs is the extent to which SANTE officials use HP funds to pursue their own agenda, which may not always have wider applicability.	**Design** • Objectives were well defined and realistic, while the terms of reference were well-written and focused leading to well-designed studies / projects. • The budgets for SC are typically limited (€100k-250k), reflecting a relatively narrow scope of the studies / seminars.
Implementation • There were no significant issues with delivery and contracts met expectations. • The working relationship between DG SANTE, Chafea and the contractors was found to be constructive and effective by all involved	**Dissemination** • Dissemination was not part of any of the contracts assessed. Rather DG SANTE determined how they were used, and ensured the studies were fed into the relevant policy processes and discussions.
Results / impact • SCs typically produced the envisaged results / deliverables to a sufficiently high standard. • However, the actual impact (on policy development / implementation of legislation) appears very limited; the deliverables were found useful, but did not lead to any major developments (i.e. provide a major impetus to the policy process in question, or address most of the key factors that are required for successful implementation of legislation). • Nonetheless, the SCs were found to be useful and arguably, the results were proportionate to their limited budget and mandate.	

Leading from this, the examination of Programme impact led us to identify **numerous commonalities** that related to all actions. Actions were more successful when they addressed identifiable **policy needs**, had a well-delineated scope and produced results that could be readily applied in practice. While joint actions and service contracts met these criteria to a greater extent than projects, there were examples among all action types where this was not the case. Actions of all types appeared more likely to generate impacts in the presence of clear links to existing policy initiatives and plans for sustained follow-up efforts.[35] The difficulties inherent in overcoming inertia, building mutual trust and commitment meant that even in the best cases real benefits in terms of improved practices or economic gains take considerable amounts of time (far beyond the scope of a single action).

The **concept of relevance** also played an important role in the impact of individual actions. While it could be argued that (nearly) all funded actions dealt with important issues, actions were more successful when they addressed topics where the **surrounding context rendered policy change feasible** based on action outputs; this in turn depended on adequate scoping work and (in the case of many joint actions, momentum and relevance established through previously-funded projects).[36] Similarly, actions with clear and relatively focused target groups and well-delineated intervention logics were likelier to generate impacts than those that were more ambitious but spread their (limited) efforts across too many activities. In this vein, dissemination efforts were more effective when tailored to the needs of specific groups, particularly policy makers, whose time and attention is often extremely limited.

[35] Best practice examples from the case studies include EJA (joint action) and EUMUSC.NET (project), which both generated high added value partly due to clear links with existing policy initiatives.

[36] This was the case in particular for EUnetHTA, which provided the sustained effort (over multiple HP-funded actions) necessary to test and tailor results to the policy context.

The appropriateness of **action scope** depended not only on action leaders and partners, but also on how precisely DG SANTE / Chafea defined their requirements. This was most evident in relation to calls for project proposals, where DG SANTE faces a delicate **balancing act**. Highly specific / focused calls for proposals can undermine one of the key advantages of projects, namely their capacity to incentivise innovation, by (inadvertently) encouraging applicants to try to figure out exactly how to meet expectations. In cases where DG SANTE has a specific set of identified needs, service contracts (which are highly prescriptive by nature) might be better suited to meeting them.

Administrative practicalities also affected the likely impact of actions. From the side of individual actions, strong project management, organisational and coordination skills were crucial, particularly but not only for large and complex joint actions. By supporting / encouraging / incentivising sound project management approaches, Chafea can also promote the ability of the Programme to generate impact. In many instances, it appeared to have done so, but the lack of clarity around its role and funding delays raised concerns for some actions.

The **relationship between the different funding mechanisms** is also important (see summary table in section 5.5). Joint actions, projects and service contracts were all shown to be highly appropriate conditions that played to the relative strengths described in the tables above (particularly relating to how concretely objectives are defined, and on the nature and use of desired results). By contrast, opting for the wrong funding mechanism in given circumstances (e.g. using a project when DG SANTE's needs and desired product are well defined, which is better suited to service contracts) severely undermined actions' potential effectiveness (and cost-effectiveness).

Projects can be conceptualised almost as 'pilots' that provide the Programme with a flexible means to explore a wide range of subject areas and mechanisms and thereby identifying areas of potentially high EU added value (and impact). Projects also represent a way of involving civil society and non-governmental actors, and give the HP an opportunity to draw on their insights and skills. It should be noted that this entails a degree of in-built risk that DG SANTE can adjust depending on the steer provided in calls for proposals. However, getting the balance right is far from an exact science.

During the first Health Programme (2003-2007), calls for proposals were very broad, resulting in a lack of focus. Some of the case studies conducted for the current evaluation demonstrated the opposite problem; overly prescriptive calls pressed applicants into tasks they were not (sufficiently) invested in, where their knowledge and skills were not put to the most effective use. As described above, such conditions are better suited to service contracts, , which among other things tend to spend much less effort establishing networks and building an understanding of partners' local policy contexts. That being said, the case studies and EU added value analysis serve to highlight the importance of project proposals demonstrating a credible policy link. The EU added value analysis showed that identifying best practices was the most typical way for projects to provide EU added value, while the case studies showed that often there were not concrete plans to see such practices applied. Together these two findings raised concerns as to their potential impact.

Leading from this, **joint actions** are suited to scaling up and institutionalising efforts once a sufficiently high chance of policy-related success has already been determined, and the relatively large size (and relatively low flexibility) is no longer problematic. This was especially evident in situations where joint actions brought together core relevant institutions with a high level of technical expertise from most or all Member States to work towards practical outcomes that clearly lie within their interest, and provide links with the policy dimension.

Successful joint actions tended to develop, share, refine, and test tools, methods or approaches in areas where the case for closer collaboration has already been established. While this does not guarantee that all barriers to implementation are overcome, the probability of generating a tangible impact in this way appears substantially higher than for other actions, at least in the short- to medium-term. Key dimensions here are (immediate) policy relevance and wide participation, as joint actions concerned (mainly) scientific research or involving only a minority of Member States did not gain sufficient traction to generate substantial impacts.

Unlike the other funding mechanisms, service contracts provided an outlet to address the immediate and discrete needs of DG SANTE, allowing it to gather evidence about specific subjects (whether it be for internal purposes or to feed into policy discussions with MS) or facilitate the implementation of a piece of EU legislation. While such actions can be valuable, their impact was diminished in cases where the intended use was unclear. Moreover, the proliferation (in terms of number and funding allocation) of service contracts tends to direct Programme funding away from Member States, stakeholders, priorities and objectives at which it is ostensibly aimed, raising some concerns about the ultimate beneficiaries of the Programme. While service contracts clearly have a role to play in the Programme, their fit could be clarified in order to address this partial incongruity.

5.1.Support for Member State health policy and actions

EQ 9: How and to what extent has the Second Health Programme supported Member States' health policy and actions (in relation to the provisions on support, cooperation and coordination in Article 168 of the Treaty)?

We found that under certain conditions, Programme-funded actions were capable of making a substantial contribution to Member State policies and actions. While concentrated in the area of intervention development, this contribution covered the spectrum of the 'health intervention process' discussed at the beginning of section 5, addressing policy research and implementation to a considerable extent. However, we also found that, despite the appropriateness and potential impact of all funding mechanisms in certain circumstances, some were relatively more impactful. Moreover, case study evidence, while not representative, indicates that the likelihood of significant policy impact for some types of actions was quite rare.[37]

Typically, successful actions demonstrated a high degree of purposefulness that consisted of a clear link to identifiable policy needs, defined scope and ideas about how to see outputs (like tools, methods or approaches) applied in practice, in addition to plans for sustained follow-up. Other factors, like a coherent intervention logic, level of ambitiousness proportionate to action size, strong project management (characterised by dedicated staff experienced in managing grants and partners as distinct from sector expertise) and the identification of relevant target groups were also helpful.

[37] In particular, the majority of projects in the sample were deemed unlikely to generate a significant policy impact, for a variety of reasons including a lack of clear links to policy initiatives, an inability to engage policy makers and insufficient plans for sustained action beyond the life of the project. Joint actions, which typically demonstrated clearer policy links (e.g. EUnetHTA) generally appeared more impactful.

While these factors conform to general best practice (and are discussed in the subsection above on funding mechanisms in practice), they were often absent. For example, among the five projects examined in depth as part of the evaluation, only one demonstrated a convincing case for impact in the short- to medium-term. The others were mostly competently executed and delivered high-quality deliverables, but failed to achieve significant impacts, mostly owing to the lack of clear policy links.

Our observations, as well as interviews with various stakeholders, showed that joint actions were more likely to satisfy the mentioned criteria and thereby generate impacts. Partly, this can be attributed to the composition of joint actions. Compromised mainly of the key stakeholders in a given field, as designated by (and usually including) government, one would expect relatively clear policy links. However, two points merit emphasis. First, even in the best circumstances, policy-level outcomes take a significant amount of time to materialise (as explained below in section 5.3).

Second, it does not follow from the relative success of joint actions that the balance of Programme funding (36% of which went to projects, and 22% to joint actions) should be profoundly altered. On contrary (as described above in detail), both mechanisms occupy a particular niche. Joint actions are suited to scaling up and institutionalising efforts in areas where the rationale for EU action has been unambiguously determined. Projects allow for a degree of innovation and therefore entail more innate risk. The challenge relates more to adjusting the parameters of projects in order to improve the chances of success. In particular, this could include a shift in emphasis in the way EU added value criteria for project proposals are scored, to ensure that either spreading best practices is not the main highly scoring criterion, or that its scope is expanded to require credible plans for the application of the practices in question.

Service contracts funded through the Programme were very diverse and commonly stemmed more from the needs of the Commission than of Member States and other public health stakeholders, implying a smaller expected impact in this area. Despite this, the needs of the Commission and Member States are clearly overlapping, and many service contracts addressed subjects of wider applicability, such as the implementation of EU legislation or research into future policies. However, as with other funding mechanisms, the policy links and aims were often not clear enough to for service contracts to generate substantial impact.

The other mechanisms (operating grants, direct grant agreements and conferences, collectively representing 14% of Programme funding) were not included in the case studies, making it difficult to gauge their policy impact with a high degree of certainty. Among the operating grants that we scored for EU added value, average scores were somewhat lower compared with joint actions, projects and service contracts, suggesting that their potential impact was smaller. The exception was in the criterion of networking, where operating grants received, on average, the highest scores.

5.2.Main policy areas of progress

EQ 10: Which are the main health policy areas in which progress has been achieved due to the support of the Health Programme, and what constitutes this progress?

The diversity of case study actions conceivably would have allowed us to establish a relationship between actions addressing certain policy areas and given levels of impact. Such relationships were not evident. Instead, it was evident the ability of actions to generate impact depended far more on the key success criteria described above (most importantly links to identified policy needs). Nonetheless, shares of funding (and likely impact) varied substantially across actions addressing different types of issues, as summarised in the table below.

Table 7: Proportion of funding by strand, priority and sub-priority (2008 – 2013) based on total of 248 million EUR[38]

	Priority	Sub-priority	Funding awarded (%)		
Health Security	Health threats	**(Non-) communicable diseases & health threats**	**6%**	**13%**	23%
		Prevention, vaccination & immunisation policies	2%		
		Risk management / preparedness health emergencies	3%		
		Response capacity & assets	1%		
		General contingency & specific health emergency plans	1%		
	Improve safety	Scientific advice & risk assessment	2%	10%	
		Organs & substances of human origin, blood & blood derivatives	**4%**		
		Patient safety	**4%**		
Health Promotion	Healthy lifestyles & reduced health inequalities	Increase healthy life years & promote healthy ageing	**8%**	15%	**57%**
		Identify the causes of, address & reduce health inequalities	7%		
	Health determinants	**Address health determinants & promote healthy lifestyles**	**24%**	**41%**	
		Prevention of major & rare diseases	16%		
		Health effects of wider environmental determinants	1%		
		Promote actions to help reduce accidents & injuries	1%		
Health Information	Exchange knowledge	Exchange knowledge & best practice on health issues	2%	2%	21%
		Enhance the application of best practice within MS	0%		
	Collect, analyse & disseminate	Health monitoring & comparable data	**11%**	**18%**	
		Mechanisms for analysis & dissemination of information	5%		
		Development / implementation of policies / legislation	2%		

It is instructive to look in more detail at five key areas that collectively accounted for about three quarters of Programme spending. Taking each of these in turn:

- Health determinants and healthy lifestyles: The HP funded a large number and variety of actions aimed at tackling key health determinants such as nutrition, alcohol, tobacco and drug consumption, as well as other determinants more related to social and environmental factors. Actions addressing these issues examined for the case studies included Salux, a project working on the identification and exchange of good practices for food reformulation; EuroHeart 2, a project aimed at stimulating debate on cardiovascular disease prevention policies; and Harm Alcohol, a service contract consisting of a study on the state of play in the use of alcoholic beverage labels.

- Prevention of major and rare diseases: somewhat incongruously, this sub-priority funded on the one hand on actions relating to major diseases like cardiovascular disease, cancer and HIV/AIDS prevention, and on the other hand actions relating to very rare diseases. Here, contributions were relatively wide-ranging and included support in developing recognised expert reference groups, assistance to MS in developing and taking forward rare disease strategies, and contributing to WHO international classifications of rare diseases. An action addressing these issues examined for the case studies was

[38] Please note percentages are given to nearest whole number. Due to rounding, the totals do not necessarily add up to 100%.

EJA, which was a joint action established in 2012 to support the body responsible for overseeing the implementation of EU priorities on rare diseases.

- Health monitoring and data: this funded support for actions to create an effective and sustainable network for health technology assessment (HTA) across Europe so as to help develop reliable, timely, transparent and transferable information to contribute to HTAs in European countries. This included the joint action EUnetHTA, which was examined in a case study for the evaluation. It also funded actions relating the European Core Health Indicators that allow for monitoring and comparison between EU countries, thereby serving as a basis for policy-making.

- Health threats: this priority related to actions to e.g. facilitate collaboration between laboratories and develop common testing methods, with the aim of developing strategies and mechanisms to respond to health threats and emergencies. Actions addressing these issues examined for the case studies included QUANDHIP, a joint action that created a network of laboratories working on high-threat bacteria and allowing them to exchange information and learn from each other; and RFS 2, a service contract that allowed for the organisation of training seminars relating to the implementation of new legislation on addressing cross-border health threats.

- Safety: this priority funded a variety of actions relating to issues such as organ donation and transplantation as well as patient safety. Actions addressing these issues examined for the case studies included FOEDUS, a joint action to facilitate the exchange of organs donated in EU Member States; NANOGENOTOX, a joint action dealing with the evaluation of and data concerning manufactured nanomaterials; and EFRETOS, a project seeking to establish a European framework for the evaluation of organ transplant results

5.3.Impact timescales

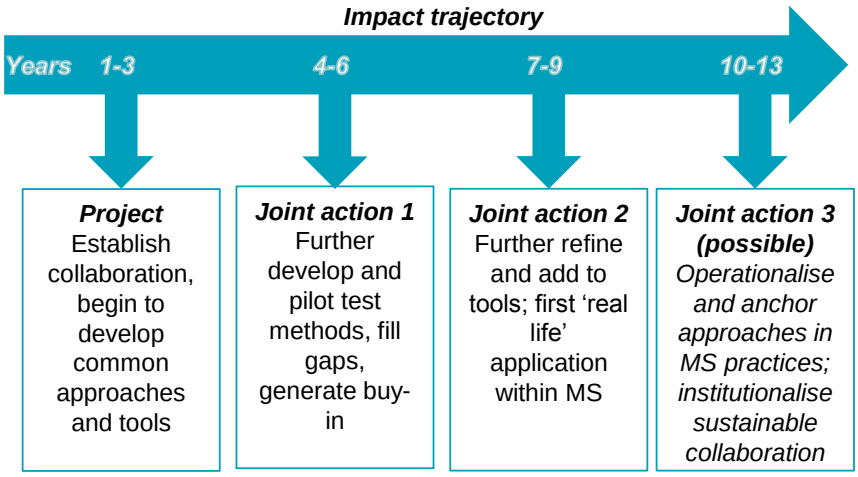
EQ 11: What are reasonable assumptions on the way to measure the impact of the programme in terms of timelines a) short-term, b) middle-term, c) long-term and d) in relation to average project trajectories?

While there is some variation in the amount of time required for policy impact to materialise (due to the diversity of funding mechanisms, policy areas and stakeholders addressed by the Programme), the case studies showed that the path to generating impact usually follows a similar pattern. Projects and joint actions typically run for about three years, and aim to develop and / or test approaches and / or tools that will only make a tangible impact once they are taken up and used by Member State authorities and other actors. Getting to this point requires overcoming inertia and building mutual trust and commitment among stakeholders with their own (potentially competing) interests. This does not usually happen during the course of an action, but later, often after a follow-up action is also funded through the HP.

This is reflected in Programme funding patterns and pathways. For example, joint actions demonstrated the highest level of impact partly because they represented the culmination of years of collaboration between relevant stakeholders whose potential impact often stemmed from previous work, typically carried out under the auspices of a project. Even in such circumstances, several iterations of projects and / or joint actions were frequently needed before sufficient momentum could take root. An example from the case studies provided an instructive example, indicating that for

some issues observable impact in terms of improved practices can take over ten years to materialise, as shown in the diagram.

Figure 16: Potential impact trajectory for funded actions (based on the case study of EUnetHTA)



Leading from this, it can be concluded that actions capable of generating short-term impacts were rare (if indeed they exist), with more potential concentrated in the medium- to long-term.

5.4.Key factors influencing Programme impact

EQ 12: Which factors/reasons may intervene and influence positively or negatively the impact of the Programme?

We found that the impact of the Programme depended on numerous factors. Since the vast majority of actions addressed relevant and important topics, most of these critical factors can be categorised under the broad heading of project management best practice whose presence influences the programme positively (and absence negatively). The 13 case studies conducted for the evaluation showed the following factors to be of vital importance:

- clear links to existing policy initiatives,
- plans for sustained follow-up efforts,
- feasibility of policy change (considering the surrounding context) in the medium-term,
- well-delineated action scope and objectives,
- plausible intervention logic,
- involvement of relevant partners,
- strong project management and
- constructive engagement from DG SANTE / Chafea.

5.5.Relevant lessons for transition to the Third Health Programme

EQ 13: What are the main lessons than can be drawn to ensure an overall successful transition from the second to the third Health Programme?

The main lessons that can be drawn based on our examination of Programme impact fall into essentially four categories. The first of these relates to the key factors outlined under question 12 and explained in detail throughout this section. In simple terms, actions were successful when these factors were present but less so when they were not, regardless of the funding mechanism involved. DG SANTE / Chafea could adjust various aspects of Programme parameters and application and selection procedures to ensure (or, more realistically, increase the chances) that they are in place. As a starting point, this should include stringent requirements concerning the establishment of clear links between action deliverables / outputs, relevant actors and target audiences, and desired policy impacts, including an appreciation of the main barriers to implementation of the results and if/how they can be addressed / overcome.

The second relates to EU added value. While the description of EU added value is a welcome addition to the Regulation establishing the third Health Programme, the evaluation found that some of the eight criteria (namely economies of scale and innovation) demonstrated a more credible and direct link than others to eventual action impact. On the other hand, the path from high EU added value in best practices, networking and benchmarking to impact was often broken. This does not necessarily imply that these criteria are less worthy, but it sends a signal that they could be developed and further defined. For example, a project application receiving high scores for best practices should not 'merely' make a good case for how it will *identify* such practices, but should also explain how it will see them *disseminated* among relevant stakeholders, *tailored* to highly diverse circumstances and *applied*. Moreover, necessary conditions like political will and the need for follow-up funding should be defined in advance and discussed in probabilistic terms.

The third lesson relates to making the most of the available funding mechanisms. While we found that all funding mechanisms generated policy impact in certain circumstances, we also identified examples where actions were not funded through the most suitable mechanism. The table below summarises the circumstances that are most conducive to the success of given funding mechanisms and outlines some of the risks involved when such conditions are not in place.

Table 8: Conditions of success for given funding mechanisms

Funding mechanism	Ideal circumstances	Risks / challenges
Joint actions	• Clearly established case for pan-European collaboration at a technical (and not only political) level • Buy-in from key stakeholders in (nearly) all Member States • Feasibility of desired results already confirmed from previous work • Political momentum sufficient for results to be applied in practice	• Due to their size and the number of partners typically involved, joint actions are costly to implement and can be difficult to manage • If established prematurely, joint actions can be too unwieldy to provide a forum for exploring new ideas and experimenting • The chances of results being taken up is reduced if a critical mass of Member States is not secured
Projects	• Highly relevant topic but case for pan-European collaboration not fully established, particularly regarding practical solutions • Need for a 'pilot' to ascertain level of interest and feasibility of changing status quo • Availability of strong leadership and established interest from a smaller group of committed partners to pursue a focused set of objectives	• Value of collaboration beyond the level of the partners themselves needs to be established • If the primary focus is on networking and sharing best practices, the need to create more tangible results can be lost • Projects often struggle with national differences in data availability / comparability • Overly ambitious / diverse objectives can reduce effectiveness • If policy links are absent, it is

		difficult to overcome barriers for EU-wide implementation of results
Service contracts	• Existence of specific and clearly defined DG SANTE needs / ideas • Narrow set of objectives and limited scope • Clear link to specific policy process or initiative	• Level of ambition needs to be aligned with typical budgets (€100-250k). • Clear need for action should be established beyond interest of specific DG SANTE units. • Excessive reliance on service contracts would be detrimental to HP inclusiveness (in terms of types and geographic spread of beneficiaries)

Leading from the table, it is important to note that any mix of funding mechanisms implies a series of trade-offs in terms of objectives, levels of risk and the involvement of different groups of actors. For the 3rd HP, DG SANTE should consider these trade-offs in order to arrive at a balance that corresponds to the Programme's needs and priorities.

The final lesson relates to Chafea and the realisation that its role is still being developed and defined. While the Agency has without a doubt improved the programme management and monitoring practices (though there is some work to go), Chafea has a role in monitoring and managing actions, but the line between procedural / administrative tasks, and technical / thematic guidance / support, can sometimes be blurred. This evaluation suggests that, in a few instances, this has led to some confusion / frustration on the part of beneficiaries. We recognise that this may be indicative of teething problems due to Chafea having relatively recently begun administering the Programme. Nonetheless, greater clarity on these issues as the Programme moves into its third iteration would enhance the effectiveness of all aspects of the management process.

6. SYNERGIES AND COHERENCE

The fourth and final evaluation bloc concerns synergies between the Health Programme and other relevant programmes, as well as its coherence with general EC policy objectives. This bloc only contained one evaluation question, as shown below. The response to this question is provided in the ensuing sub-sections, the first of which covers coherence, the second synergies.

EQ 14: What synergies are there with other policies and programmes of the Commission such as the European Structural and Cohesion Funds, the programmes managed by DG RTD, other DGs (in particular EMPL, CNECT) and to what extent did the Health Programme underpin the Commission's general objectives – focus on Europe 2020 and their objectives related to social policy (e.g. the renewed Social Agenda) and economic growth (research and innovation, competitiveness)?

6.1. Coherence of the Health Programme with Europe 2020

Europe 2020 and the role of health

The most significant overall objectives of the European Commission for the period covered by the evaluation – and hence the main reference point for assessing the coherence of the 2nd Health Programme with broader EU policy – are contained in the Europe 2020 strategy for smart, sustainable and inclusive growth.[39] Europe 2020 was proposed by the European Commission in March 2010, and subsequently discussed by the European Parliament and endorsed at the meetings of the European Council in March and June 2010, respectively. Against the backdrop of the deep financial and economic crisis that existed in Europe at the time (and also of lower growth and productivity levels than in many other developed countries), and drawing on the lessons learned from its predecessor (the Lisbon strategy for growth and jobs, which was launched in 2000 and renewed in 2005), Europe 2020 was intended to provide a new impetus for the EU to "take charge of its future", tackle its structural weaknesses, and thereby achieve sustainable growth.

Crucially, Europe 2020 advocates a growth model that goes beyond simply increasing GDP. The aim of Europe 2020 is to improve the EU's competitiveness ("smart" growth) while maintaining its social market economy model ("inclusive" growth) and improving significantly its resource efficiency ("sustainable" growth). The strategy was conceived as a partnership between the EU and its Member States. At its heart lie a set of five headline targets that all partners have signed up to achieving by 2020. In order to catalyse progress at EU level, the Commission launched seven flagship initiatives, which included specific objectives, actions and work programmes in areas identified as important levers for growth.

Health policy objectives are clearly relevant within Europe 2020; the strategy inter alia emphasises the importance of Europe's "ability to meet the challenge of promoting a healthy and active ageing population to allow for social cohesion and higher productivity." Specific references to health are included under two of the three broad growth objectives, namely:

[39] European Commission: Europe 2020 – a strategy for smart, sustainable and inclusive growth. COM(2010) 2020 final

- Under the "smart growth" objective, the aim of the Innovation Union flagship initiative is to re-focus R&D and innovation policy on the challenges facing our society, such as climate change, energy and resource efficiency, health and demographic change. Another flagship initiative, A Digital Agenda for Europe, includes a call for MS to promote the deployment and usage of modern accessible online services in a number of areas, including health.

- Under the "inclusive growth" objective, Europe 2020 emphasises the need to combat poverty and social exclusion and reduce health inequalities to ensure that everybody can benefit from growth, as well as promote healthy ageing and ensure adequate access to health care systems.

The Health Programme and Europe 2020

Europe 2020 played a significant role in Health Programme priority setting during the second half of the funding period. The Annual Work Plan for 2011, the first that was adopted following the publication of Europe 2020, included several references, and attempted to explicitly link specific HP priorities and actions to the overall growth objectives. It claimed that actions in the work plan "are based in particular on two of the priorities of that strategy: Smart growth and Inclusive growth. They seek to address, among others, the challenge of promoting an active and healthy ageing population, and reducing health inequalities."[40] More specifically, references are made to the following particularly relevant priorities of the Health Programme:

- Under Smart Growth (with particular reference to the European Innovation Partnership in the field of active and healthy ageing, which was set up under the Innovation Union flagship initiative):

    - Action to address health determinants such as nutrition, tobacco and alcohol which underlie many age-related chronic diseases
    - Work on cancer and rare diseases
    - EU cooperation on health technology assessment (HTA)
    - Work on the safety of blood, tissues, cells and organs (which contributes to improving health across the lifecycle thereby contributing to healthy ageing)
    - Measures that apply information and communication technologies in the area of health

- Under Inclusive Growth, reference is made to action aimed at bridging health inequalities to ensure better health for all and better access to health care systems.

Similar references were included in the following years. The Work Plan for 2012 picked up broadly the same areas listed above, and also mentioned work on the health workforce (relevant under the Flagship Initiative Agenda for new skills and jobs), as well as actions on health threats and patient safety, claiming that a "safe and secure society is a prerequisite for economic growth and the well-being of citizens." The Work Plan for 2013 continued in a similar direction, listing many of the same issues, as well as making the broader assertion that the economic and financial crisis "underscores the need to invest effectively in health, in order to deliver better services with sustainable health budgets", and listing as particularly relevant issues (in relation to Europe 2020) "active and healthy ageing, sustainable health systems, health workforce, health threats and patient safety."

[40] European Commission Decision 2011/C 69/01

It is important to note that none of the actions and areas mentioned as particularly relevant for Europe 2020 in the 2011-2013 Work Plans were new; all of them had been funded since the inception of the HP in 2008, so there was no fundamental re-orientation of the Programme, but a possible shift in emphasis. In order to investigate the extent to which Europe 2020 had an effect on funding patterns, it is worth comparing the amounts spent on actions under the most relevant priorities in the first half (i.e. before Europe 2020) and the second half of the Health Programme (after Europe 2020 was adopted and referenced in Annual Work Plans, as noted above). For this purpose, we have looked at those (sub)priorities that correspond most closely with the actions mentioned, based primarily on what was laid out in the 2011 Work Plan. As can be seen in the table below, there were very significant increases in funding for two highly relevant priorities, namely healthy ageing (2.1.1) and health inequalities (2.1.2). The other areas remained relatively stable, although there was a decrease of over 20% for health monitoring (3.2.1), which includes HTA.

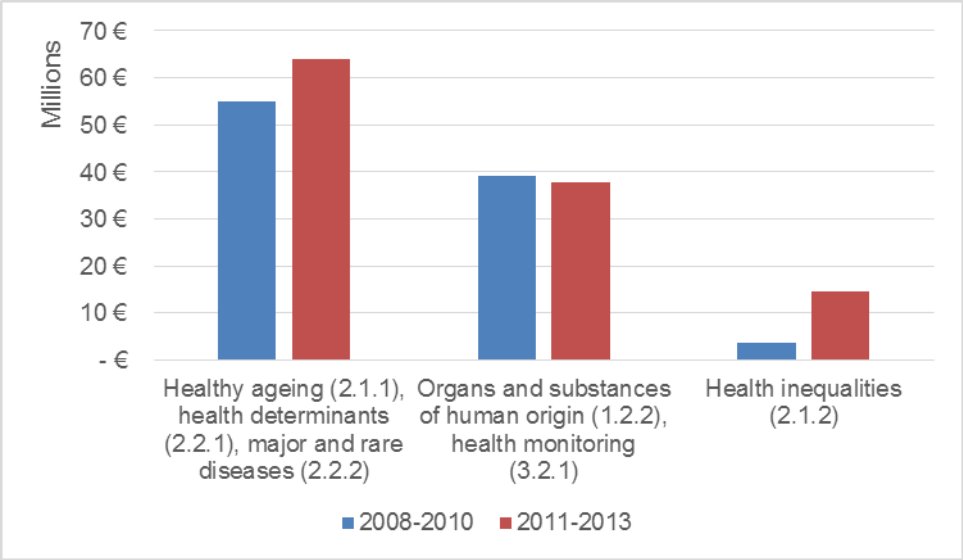
Table 9: Evolution of funding for key priorities related to Europe 2020

Europe 2020 objective	Priority	HP funding 2008-2010 (€)	HP funding 2011-2013 (€)	Change
Smart growth	Organs and substances of human origin, blood, and blood derivatives (1.2.2)	4,213,499	5,239,964	+24%
	Increase healthy life years and promote healthy ageing (2.1.1)	2,887,184	16,893,162	+485%
	Address health determinants and promote healthy lifestyles (2.2.1)	32,897,669	27,221,835	-17%
	Prevention of major diseases of particular significance, and rare diseases (2.2.2)	19,103,140	19,920,192	+4%
	Develop a sustainable health monitoring system and collect comparable data (3.2.1)	15,719,845	12,490,561	-21%
Inclusive growth	Identify the causes of, address and reduce health inequalities (2.1.2)	3,552,153	14,440,968	+307%

Some care should be taken when interpreting this data. First, there are some grey areas between (sub)priorities. For instance, it is not always clear how exactly 2.1.1 differs from 2.2.1 and 2.2.2, and one can safely assume that some actions could sensibly be classified under more than one of these. Secondly, the trends in funding can be influenced greatly by a few large actions (in particular Joint Actions) that were funded in a given year. It may therefore be more instructive to further aggregate (some of) the sub-priorities.

The results (shown in the diagram below) suggest that there was indeed an increase in the total funding for actions related to the broad area of healthy ageing (including the closely related priorities of health determinants and major / rare diseases) of approximately 17%; over the duration of the Programme, these three sub-priorities taken together accounted for over 40% of all funding. The funding for actions to address health inequalities (and thereby foster inclusive growth) increased dramatically; it accounted for approximately 3% of HP funding during the first half, and 10% during the second half of the programming period. On the other hand, the "ancillary" smart growth-related priorities saw a slight decrease.

Figure 17: Evolution of funding for key priorities related to Europe 2020 (aggregated)



Based on the above, it seems that the publication of Europe 2020 has led to a certain shift in HP funding, particularly with a greater share of the funding allocated to actions related to healthy ageing and health determinants, as well as health inequalities. This can be seen as enhancing the HP's coherence with broader EU policy objectives. At the same time, it seems important to draw attention to what was outlined in the 2012 and 2013 Work Plans, namely that a number of other public health areas, including health security and health workforce, are also relevant for the achievement of Europe 2020 objectives. For example, whether an action to address smoking cessation has a greater or lesser impact on the health of the workforce than an action to protect citizens from communicable diseases or other health threats seems impossible to say a priori (as it depends mainly on what threats actually materialise). The latter certainly seems relevant in view of events such as the recent Ebola outbreak, and underlines that security from health threats can indeed be an important prerequisite for economic growth. Incidentally, this is an area that has also seen a marked increase in funding during the second half of the HP (1.1.1 Communicable and non-communicable diseases and health threats from physical, chemical and biological sources: +10%; 1.2.3 Patient safety: +154% funding).

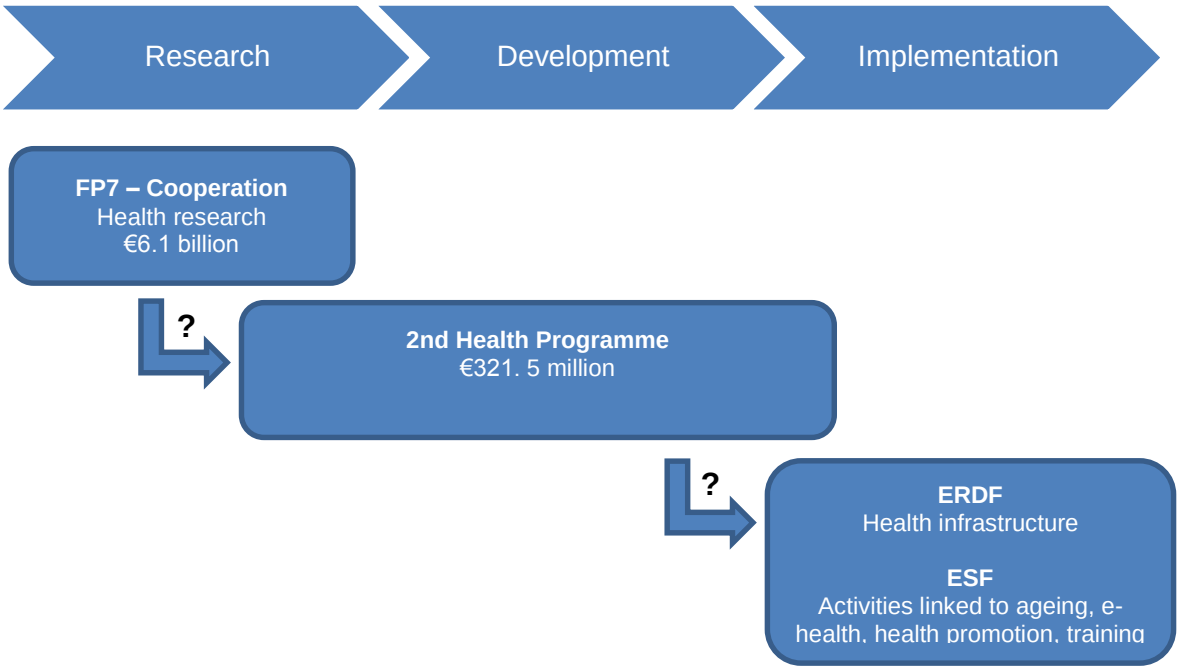
In concluding, the Health Programme is highly coherent with the Europe 2020 policy objectives of smart and inclusive growth. Demonstrable efforts were made during the second half of the programming period to further enhance this coherence, notably by significantly increased funding for actions to address healthy ageing and health inequalities. At the same time, it is important to note that almost any action that contributes to improving the health status of the European population has the potential to contribute to growth and productivity in one way or another. It would therefore be wrong to attempt to focus the HP too narrowly on issues related to health promotion as such. These may be most *directly* relevant for growth, but they also represent an area where the EU added value of collaboration can often be less tangible.[41]

[41] This point is also made in the IA for the 3rd HP, where the "prevention" specific objective – which includes a large part of what was categorised under health promotion in the 2nd HP – is the only objective that relates to only one way of generating EU added value, namely promoting best practices.

6.2.Synergies with other EC programmes

Synergies are the interaction or cooperation of two or more organisations, programmes or other agents to produce a combined effect greater than the sum of their separate effects. The potential synergy effects between the 2nd HP and the most relevant other EU programmes can be conceptualised as per the diagram below. In essence, FP7 and ERDF / ESF funding are each focused on one end of the 'health intervention process', whereas the HP sits somewhere 'in the middle', and thus has the potential to build bridges between research on the one hand, and the implementation of effective health interventions on the other.

Figure 18: Schematic overview of potential synergies of the HP with FP7 and Structural Funds



Synergies with the Seventh Framework Programme for Research

Important synergies could potentially arise if HP actions were able to draw on relevant evidence generated as part of FP7-funded research projects. The 2011 HP work plan notes that the HP "aims to promote synergies with other Community Programmes active in the field of health, notably the 7th Research Framework Programme under its Health Theme. Proposals submitted under [the HP] should not contain significant elements which relate to research. Efforts will be made to avoid overlap and duplication between the [HP], FP7 and other Community programmes." In practice, however, it is often difficult to strictly make this distinction, as the pathways from research to development to implementation are not always linear. The 2013 work plan recognised this; rather than ruling out research under the HP, it stipulated that "whilst avoiding any duplication, actions funded from this work plan should capitalise on on-going research and innovation projects or on those funded in the past, foster their implementation in clinical practice and make use of their results and outcomes."

Based on a review of documentation and interviews with DG RTD and DG SANTE officials, as well as some HP beneficiaries (in the context of the case studies), the evaluation found a considerable amount of evidence of synergies and cross-fertilisation between specific FP7 projects and HP activities. Relevant examples include:

- Health threats from nanomaterials: A series of relevant projects were funded by FP6 and FP7 which included, for example, investigations into methods for testing toxicity and eco-toxicity and risk assessment, and helped lay the foundation for the NANOGENOTOX Joint Action on "Safety evaluation of manufactured nanomaterials by characterisation of their potential genotoxic hazard", launched under the HP in 2009. In turn, another FP7 project[42] that began in 2013 builds on NANOGENTOX with a specific focus on regulation.

- Health Technology Assessment: This is an area that has been addressed by HP-funded actions for several years. Based on needs expressed by the resulting EUnetHTA network, several projects[43] have recently been launched under FP7 on specific HTA methodologies and application areas, and there are annual coordination meetings between these and EUnetHTA.

- Health workforce: There were three FP7 projects on analysing the EU health workforce.[44] The findings were an input to DG SANTE's work, and have resulted inter alia in the set-up of a Joint Action. This is an example of an area where research was used for policy development.

- EU Alcohol Strategy: There was one FP7 project[45] that provided input for the Strategy, and the results were reportedly used as part of the Joint Action on reducing alcohol-related harm and other HP-funded actions.

These examples clearly illustrate the actual synergy effects, and the list could easily be expanded. It is interesting to note that, further to the conceptual model shown above, there are examples of synergies working both ways: HP actions building on and using FP-funded research, as well as the FPs providing a vehicle to further investigate issues and knowledge gaps that arise as a result of HP actions.

Interviewees did acknowledge that the fact that health-related research is funded – to a greater or lesser extent – by both sets of programmes does bring with it a potential for overlaps or duplication of efforts. It was noted that certain projects could have sensibly been funded by both programmes, and some scientists may well have taken an opportunistic approach to seeking funding from wherever it was available (normally with a preference for the FPs, since they are both larger and better known to researchers). At the same time, it was widely felt that this had not led to any significant problems in practice, and that the mutual consultation between DG RTD and DG SANTE (via the regular inter-service consultation process on the annual work plans), as well as the fact the DG RTD is a member of the evaluation committee for HP actions, largely eliminated the risk of double-funding, and helped flag up opportunities for maximising synergies.

Furthermore, it appears that coordination and consultation has been further strengthened under Horizon 2020 and the 3rd HP. Under H2020, health research and

[42] 310584 NANOREG – A common European approach to the regulatory testing of nanomaterials

[43] 305018 ADHOPHTA - Adopting Hospital Based Health Technology Assessment in EU; 305983 ADVANCE_HTA - Advancing and strengthening the methodological tools and practices relating to the application and implementation of Health Technology Assessment (HTA); 306141 INTEGRATE-HTA - Integrated health technology assessment for evaluating complex technologies; 305694 MEDTECHTA - Methods for Health Technology Assessment of Medical Devices: a European Perspective

[44] 223468 RN4CAST- Nurse Forecasting: Human Resources Planning in Nursing; 223383 HEALTH PROMETHEUS - HEALTH PROfessional Mobility in THe European Union Study; 223049 MOHPROF - Mobility of Health Professionals

[45] 223059 AMPHORA - Alcohol Measures for Public Health Research Alliance

ICT for health have been brought together under one "flag", and DG SANTE is part of the team that is involved in the development of the biannual work programmes. In other words, the coordination and consultation now takes place more "up-stream", and goes beyond the normal inter-service consultation processes. It would be worth considering whether a similar mechanism for the 3rd HP – i.e. consultation of DG RTD on multi-annual HP priority setting – might add value and further strengthen synergy effects in the future.

Synergies with the Structural Funds

As briefly described above, synergies between the HP and the Structural Funds (called European Structural and Investment Funds, ESIF, during the new 2014-2020 funding period) could arise primarily if the latter were used to fund and support the implementation of relevant approaches, interventions, best practices etc. developed as part of HP-funded actions. The evaluation was not in a position to systematically assess the extent to which this is happening in practice. This would have required a comprehensive review of national, regional and transnational ERDF, CF and ESF Operational Programmes and the interventions they fund, and consultations with managing authorities, which would have far exceeded the scope of this evaluation. .

Nonetheless, the research conducted for this evaluation (including the case studies and stakeholder interviews) suggests that the nature of HP-funded actions, the results they typically produce, and the nature of the Structural Funds, all mean that opportunities for creating direct synergy effects have been limited. It seems that HP results as such typically do not lend themselves easily to implementation via ERDF, CF or ESF-funded projects. As described elsewhere in this report, they are often not quite ready for direct implementation; they often concern networking or joint solutions (and therefore cannot be easily implemented by a single MS or region); and in most cases they relate to areas such as good practice methods or approaches, rather than the types of health-related topics in which the Structural Funds most often invest, such as infrastructure, e-health, or education and training.[46]

On the other hand, there were a number of HP-funded actions that directly address the use of the Structural Funds for health, and provide guidance to those responsible for Operational Programmes (as well as to relevant Commission services and other stakeholders) on how to effectively invest in health, whether directly or indirectly. These can lead to potential synergy effects in the wider sense: rather than seeking to implement the results of HP actions as such with ESIF funding, they are aimed at ensuring that health investments through the ESIF in general are in line with EU health policy objectives, Europe 2020 and the investing in health[47] approach.

Six specific HP actions – totalling a little over €5million of HP funding – are relevant in this context:

- Euregio III: Health investments in Structural Funds 2000-2006: learning lessons to inform regions in the 2007-201 3 period (project, 2009-2011). This project evolved significantly over its lifetime to respond to emerging issues and needs, and ended up generating evidence from existing SF projects that can show how to improve the effectiveness, efficiency and sustainability of *direct*

[46] Cp. Watson, J: Health and Structural Funds in 2007-2013: Country and regional assessment

[47] The Staff Working Document ''Investing in Health' [SWD(2013)43] accompanied the Commission Communication on a 'Social Investment for Growth and Cohesion', (COM/2013/083 final)

health system investments using SF in the next cycle (2014-2020). The results have been relatively widely used, inter alia for training sessions and a guide for desk officers in or with DGs REGIO and EMPL, and as input for the discussions of subgroup 2 of the Council reflection process on health systems.

- Healthgain: Guide to Health Gains from Structural Funds (service contract, 2011-2012): This contract focused in particular on identifying and linking the health gains that come from *non-health (i.e. indirect)* investments. While potentially useful, there are some concerns that the focus on indirect investments has meant the guide was too general to be operational.

- Study on the use of ESIF for health investments in the new programming period (service contract, 2013-2015): This study is expected to culminate in the publication of guidance documents (providing guidance on ESIF funding in pursuit of EU health policy goals) and a technical toolkit primarily for the use of the Ministries of Health and Managing Authorities with competencies in the area of health care. A number of dissemination activities were also undertaken, including a series of national workshops, which were described as very timely, as they coincided with the negotiation process for the new generation of OPs, and therefore their potential to have a tangible impact is high.

- Three separate actions on inequalities in health and work, where ESIF is one of the aspects addressed: Equity Action (joint action, 2011-2014); Action for Health: Reducing health inequalities: preparation for action plans and structural funds projects (project, 2012-2014); and HealthEquity-2020: Reducing health inequalities - preparation for regional action plans and structural funds projects (project, 2013-2015). The Equity Action JA produced a number of results that seem to be useful for national and regional authorities, as well as the Commission and stakeholders, and are being referenced inter alia in the Study on ESIF use (see above). Concerning the two projects, at first sight there are significant overlaps and duplication of efforts (both were awarded funding under the same call for proposals to address the same priority); however, there are also differences in terms of the chosen approach and results. Action for Health focused more on capacity building and developing and pilot testing strategic actions plans to reduce health inequalities, while the main output of HealthEquity-2020 is a toolkit to assist evidence-based regional planning.

Overall, there is significant potential that through the combination of these actions the HP will eventually lead to a more widespread and/or effective use of the ESIF for health during the current programming period. The extent to which this will be the case is impossible to predict within the scope of the current evaluation. However, it does confirm that there has been an element of cross-programme fertilisation that could be viewed as synergy effects, even if not in the strict sense described above. Synergies in this case are less the result of specific interventions developed with HP funding being implemented with ESIF co-financing, but rather of a relatively small (>2%) part of the available HP budget having been used to raise awareness, develop guidance and provide support for Managing Authorities to use the ESIF to invest in health according to the objectives and principles of EU health policy.

7. OVERARCHING CONCLUSIONS AND OPTIONS FOR CHANGE

The following pages bring together findings from across the four key issues addressed by this evaluation (management, dissemination, impact, and synergies) to draw overall conclusions on the second Health Programme and the way it was implemented. These are structured around the key evaluation issues of relevance, effectiveness, efficiency, EU add value and coherence.

Two issues are worth noting:

- The ex-post evaluation focused on exploring and assessing specific aspects under the four blocs of questions, rather than the overall relevance, effectiveness etc. of the Programme, to avoid duplication with the mid-term evaluation and expanding disproportionate efforts on issues that had already shown to be impossible to assess fully. This means that certain aspects that would typically be analysed extensively in a final evaluation were only treated from a particular angle.

- The evaluation cannot ignore the fact that the 3rd HP is already in existence, and has brought a number of changes, many of which partly in response to the results of previous evaluations. As a result, some of the conclusions and recommendations this evaluation would have otherwise arrived at seem tautological to some extent. We therefore include references to the 3rd HP in the conclusions and recommendations, where relevant and appropriate.

7.1. Overarching conclusions

Relevance

The ex-post evaluation confirms the broad conclusions already reached by the mid-term evaluation. The 2nd HP's objectives are so broad that they cover the vast majority of Member States' and relevant stakeholders' needs. The funded actions are almost without exception directly related and therefore relevant to these overall objectives and priorities. At the same time, it is important to emphasise that "relevant" in this context is not synonymous with "potentially impactful". The fact that an action addresses an important public health issue or concern does not always mean that action at the EU level can successfully tackle the underlying problems. In other words, a relevant topic does not necessarily imply a strong case for EU-level cooperation. For this to be the case, relevance and EU added value (see below) need to coincide.

Previous evaluations emphasised the need for more focus and a better concentration of the scarce resources available on those issues where they can add the most value. With the way the 2nd HP's objectives were defined, nearly any topic related to public health in Europe could be considered relevant. The consequence of this was a lack of structure and prioritisation, making it very difficult for all but the most closely involved individuals to have a full understanding of what the HP does, why it does it, or – crucially – to what extent actions correspond to the actual concrete and specific needs of stakeholders in a given (broadly relevant but not clearly defined) topic area.

These problems were taken into account in the design of the 3rd HP, which undertook a horizon scanning exercise to identify the key health challenges facing Europe, as well as an analysis of if and how these could or should be addressed by the new Programme. The result is a set of more specific objectives, which cover a slightly reduced (but still very significant) amount of ground in terms of public health issues they address, and attempt to introduce a better focus in terms of specifically how progress is to be achieved. While it was not within the scope of the present evaluation to assess this new approach, it certainly seems to be a step in the right direction in

terms of ensuring that relevance is tackled from both key angles – i.e. a stronger focus on topics that are relevant to Member States and stakeholders, as well as promising in terms of the potential added value of cross-border collaboration.

Effectiveness

The 2nd HP aimed to support Member State action in the field of public health by facilitating collaboration and strengthening the efforts of others across three main objectives, which are to improve citizens' health, promote health and reduce health inequalities and generate and disseminate health information and knowledge. The ex-post evaluation found that actions funded by the 2nd HP have contributed to significant progress and results across these three objectives, in ways such as fostering cross-border collaboration, developing and testing common tools and approaches or enhancing the evidence and information base.

Different public health activity areas bring with them different priorities and challenges, depending on e.g. pre-existing levels of collaboration and discrepancies between Member States. The 'toolbox' of funding instruments has allowed the HP to address a variety of subjects, and involve and support different relevant actors, in ways that have often proven to be highly effective.

While the diversity and amount of funded actions makes it impossible to quantify and list all of these contributions, case studies carried out for the evaluation highlighted numerous examples. These include common approaches to health technology assessment, the development of common standards of care for musculoskeletal conditions and contributions to EU reports and guidelines on rare diseases. The HP has also been relatively successful (more so than for instance FP7 funding for public health related research projects) in involving partners from relatively lower income (and in particular EU-12) Member States, although there remains room for improvement in this respect.

At the same time, it is important to recognise that not all HP-funded actions were particularly effective when it came to achieving tangible and genuinely useful results and impacts. The case study research showed that while joint actions typically achieve a tangible impact, many projects often fail to see their results taken forward and put into practice. Reasons for this included poor design, often with unspecific objectives and insufficient attention being paid to key barriers to implementation and engagement of relevant enablers; and ineffective dissemination strategies. To avoid such shortcomings, efforts are needed to evaluate (ex ante and ex post), support, guide and where necessary challenge individual actions and beneficiaries to ensure the presence of key success factors. These include 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 / Chafea. In addition, highly effective actions tended to demonstrate EU added value in areas such as economies of scale, innovation and implementing EU legislation.

The evaluation also found that the choice of funding mechanism was an important factor behind the success of a given action. While all funding mechanisms generated policy impact in certain circumstances, the evaluation identified examples where actions were not funded through the most suitable mechanism. To maximise effectiveness, it should be kept in mind that joint actions are suited to scaling up and institutionalising efforts once the case for pan-European collaboration has been established. Projects are useful as 'pilots' for ascertaining the level of interest and testing new approaches and tools (accepting a certain degree of risk and uncertainty), while service contracts can address specific needs for a given policy process or initiative. In a number of cases, it was the combination (over time) of two or more successive actions (using appropriate funding mechanisms) that enabled the HP to

progress an issue or intervention through the different stages of development, from research through development to implementation.

Efficiency

Efficiency considers the relationship between the HP's impact and its cost. The Programme's small size, large scope, and lack of clear strategic focus and priorities, imply a risk that resources would be diluted by the sheer number of issues to be addressed. This risk was mitigated to some extent during the second half of the HP by more concrete links in the 2012 and 2013 AWPs to the Europe 2020 strategy, and an increased focus on EU added value. The 3rd HP is building on these changes.

At the same time, the preponderance of actions, especially among projects, whose identifiable EU added value is comprised mainly of 'softer' criteria (such as the identification of best practices) rather than more tangible, outcome-based ones (such as economies of scale) implies that a considerable amount of Programme funding still leads to few concrete results or outcomes. The fact that more than half of funding was devoted to the Health Promotion objective, where such actions are concentrated, amplifies these concerns.

Efficiency is also dependent on well-functioning programme management arrangements. The growing responsibility of Chafea across all manner of administrative functions of the Programme has allowed certain tasks (such as changes to team costs on projects) to be streamlined, increasing their efficiency. While changes were mainly incremental during the second half of the Programme, several major initiatives appear likely to result in substantial gains during the 3rd HP; this includes the abolition of paper-based reporting for beneficiaries. After initial adjustments and reconfigurations, the respective roles of Chafea and DG SANTE had been clearly defined by the end of the Programme period. Despite this, numerous beneficiaries expressed confusion about the division of responsibilities. This led to wasted time and duplicated efforts that could be addressed during the 3rd HP through clear and consistent communication efforts.

The purpose and use of reporting and monitoring data are also problematic. While the considerable burden on action leaders and partners in providing Chafea with regular reports and data can be justified, the lack of common indicators or formats meant that the products of such requirements were not comparable. Moreover, we did not find any evidence of monitoring data actually being fed into processes to improve the Programme's performance. The technical (and often confidential) nature of action reports also precluded their use for communicating about specific actions or the HP more generally. Taken together, these issues imply a substantial dead weight in addition to hampering evaluation and dissemination efforts.

Finally, the long timescales involved in seeing the outputs of a given action work their way into actual practical changes are worth mentioning, as they imply sustained EU funding is needed to realise tangible progress. Funding for a series of successive actions on the topic is frequently needed for the outputs to reach a certain level of maturity. The possibility for the Programme to fund second (and sometimes third) iterations of given actions has led to significant outcomes, but it also creates a double risk. On the one hand, the achievements of some actions would fail to take root without further funding. On the other hand, if the HP focused too much on funding multiple iterations of given actions it could miss opportunities to adapt priorities with changing times and to identify meaningful new initiatives.

EU-added value

EU added value gives us a conceptual framework to operationalise the principle of subsidiarity and gauge the rationale for EU action in a given area. For public health, where the EU has only a soft competence, it is especially important that necessarily limited resources be deployed as strategically as possible. With this in mind, for the 2nd HP, EACH (now Chafea) developed a set of EU added value criteria which helped inform the scoring of all applications for Programme funding. This ensures that the (potential) EU added value is assessed ex ante for all actions, even those such as projects where DG SANTE (sometimes) issues relatively open calls for proposal to spur innovation in terms of precise activities, methods and outputs. This is laudable, and the fact that the Regulation which established the 3rd has enshrined the criteria in legislation is an additional positive development.

Our assessment of EU added value (which was carried out for a representative sample of 80 funded actions) also produced broadly encouraging results. On average the actions demonstrated substantial amounts of EU added value for the majority of the eight criteria considered, and for certain criteria nearly all actions received high scores. However, the extent to which scores varied against the criteria served to raise some broader points about what the criteria really mean and how they should be assessed.

In short, much of the demonstrable EU added value was spread across the 'softer' criteria, namely those relating to identifying best practices, benchmarking and networking. For 'harder' criteria like innovation and economies of scale (that unambiguously require more tangible results), we found discrete cases of substantial added value, but they were in a clear minority, especially for certain funding mechanisms (projects) and strands (health promotion).

Assuming that achievements like building a more European health community (via networking) are to be valued over the short-term, then the Programme has demonstrated significant EU added value. However, the analysis also serves to highlight the importance for actions (and those evaluating applications) to demonstrate credible plans for more concrete benefits over the longer term. This requires a stronger focus, for example, on not only identifying good practices, but also addressing barriers to their implementation across Europe.

Coherence

The Health Programme is highly coherent with the EU's overarching policy objectives embodied in the Europe 2020 strategy, in that it funds actions that have the potential to contribute to a healthier population and workforce (a key prerequisite for smart growth), and/or to reducing inequalities (a key component of inclusive growth). Demonstrable efforts were made during the second half of the programming period to further enhance this coherence, notably by significantly increased funding for actions to address healthy ageing and health inequalities. While this is commendable, it is important to note that almost any action that contributes to improving the health status of the European population has the potential to contribute to growth and productivity in one way or another. It would therefore be wrong to attempt to focus the HP too narrowly on issues related to health promotion as such. These may be most *directly* relevant for growth, but they also represent an area where the EU added value of collaboration can often be less tangible.

There were also important synergies between the HP and FP7, illustrated by the numerous areas where cross-fertilisation between specific FP7 projects and HP activities has occurred. There are examples of synergy effects working both ways: HP actions building on and using FP-funded research, as well as the FPs providing a

vehicle to further investigate issues and knowledge gaps that arise as a result of HP actions. Synergy effects with the Structural Funds were less obvious, as few HP actions produced results that lend themselves to implementation using ERDF, CF or ESF co-funding. However, there were a series of specific HP-funded actions that addressed the use of the Structural Funds for health, and provided guidance and awareness-raising that may well enable those responsible for Operational Programmes (as well as to relevant Commission services and other stakeholders) to more effectively address health-related issues during the current programming period.

7.2.Options for change

In addition to the various positive changes already introduced, including more specific objectives and a slightly reduced list of topics and funding instruments, as well as a formal role for NFPs in delivery and dissemination, the following issues and challenges should be addressed under the 3rd HP:

1. **Communicate the division of roles between Chafea and DG SANTE**: Chafea's growing role represents a positive development that has increased the effectiveness and efficiency of the management of the Programme. While respective responsibilities for the two organisations were adjusted and eventually set during the 2nd HP, beneficiaries continued to express confusion that wasted time and diminished efficacy of individual actions. DG SANTE and Chafea should communicate clearly to (prospective) beneficiaries about how actions are steered and administered. Posting relevant information on the Programme website as well as in the guide for applicants would go some way to addressing this, as would more clarity in direct engagement with stakeholders. Such efforts would reduce perceived ambiguity and increase the chances of constructive dialogue between actors involved in the Programme.

2. **Improve Programme monitoring**: Monitoring the Health Programme is inherently difficult due to the diversity in form and content of the many funded actions. Despite improvements since the mid-term evaluation, provisions for monitoring continue to hold the Programme back and preclude possibilities for continuous improvement. A review of comparable programmes and initiatives identified several potential solutions that could plausibly be tailored to the 3rd HP:

    a. Development of Programme-level indicators: while their scope would necessarily be limited, it would be possible to define a small number of indicators (relating to, e.g. budgetary expenditure, strand, sub-priority, beneficiaries and geographical and organisational representativeness). Recording such data systematically would provide quick and accurate performance updates, enabling DG SANTE to identify deviations from Programme planning and take appropriate action.

    b. Development of action-level indicators: applicants could be provided with a long-list of output- and outcome-level indicators and encouraged to include some of them in their provisions for monitoring and evaluation provisions. This would allow for more comparison between individual actions, as well as helping to instil a culture of continuous improvement.

    c. Adoption of an electronic monitoring system: such a system would address the problems described above relating to the multiplicity of sources and fragmented nature of data. Since the EC does not have a ready-made electronic monitoring system, it could consider purchasing secure access to a relatively inexpensive external system such as Researchfish, which provides a simple interface for the collection,

organisation and analysis of monitoring data. This would help DG SANTE / Chafea to keep better track in real time of information like that presented in annex 2, particularly regarding such issues as budgetary commitments, funding mechanisms, (sub)priorities, beneficiary organisations and the relative benefits of different Member States.

d. Provision of monitoring and reporting tools: more prescriptive monitoring and reporting guidelines (including references to programme- and action-level indicators mentioned above, and best practice examples), as well as support from Chafea, could enhance the ability of action leaders to produce high quality and useful reports.

e. Post-action reporting: since most policy impacts are envisaged after the life of a given action, building provisions for follow-up reporting into action budgets could increase the knowledge base about how and to what extent the Programme generates impacts.

3. **Encourage greater participation from Member States that benefited less from the 2nd HP than their public health capacity would have warranted**: Our analysis suggests that the main factors influencing the different participation rates of MS are public health capacity on the one hand, and administrative / organisational culture on the other. To address the latter, and encourage greater participation from countries that 'under-performed' in the past (which includes some but not all EU-12 MS), DG SANTE and Chafea in collaboration with NFPs should strategically target key governmental institutions in specific Member States, emphasise the opportunities the HP brings, and seek to bring on board 'champions' that can inspire and motivate others to participate in and, where appropriate, lead actions or work packages. This is particularly relevant in the context of capacity building (see the next recommendation).

4. **Clarify whether public health capacity building is a HP objective**: This evaluation has investigated the question of if and how Member States' public health capacity affects their participation in the HP. This seems to follow from an implicit assumption that the Programme is meant to help build public health capacity particularly in the 'weaker' countries. However, this was not an explicit objective of the 2nd HP, meaning that it was not systematically assessed as part of this evaluation. With a view to the future, and given that capacity building is now explicitly included in the legal basis of the 3rd HP (as part of the third specific objective), it may be worth clarifying the concrete implications of this for the setting of Programme priorities and the design of individual actions (including the potential for specific support mechanisms for 'weaker' MS), as well as for future evaluations.

5. **Take a more strategic approach to external communication**: The reflection process on dissemination launched by Chafea in 2013, and the communication framework contract that was signed to implement some of its outcomes, are positive steps towards making dissemination a greater priority. Leading from this, DG SANTE and Chafea should develop a formal communication strategy to define key communication objectives, actors, messages, audiences and channels. This would provide an impetus to approach the issue of external communication head on, thereby also providing a framework to ensure the dissemination issues and options identified in this evaluation are addressed.

6. **More insistence on, and greater scrutiny of, systematic dissemination strategy and planning**: Actions (in particular projects) should be encouraged, incentivised or even obliged to take the need to develop a relevant and realistic dissemination plan at the outset seriously. This should ideally involve a clear definition and prioritisation of stakeholders. In this context, beneficiaries should be reminded that less is often more; there is little point in spreading

themselves too thinly and attempting to reach groups that have neither an interest in nor influence over the results. It is also important that dissemination strategies and plans are seen as a working document that needs to be updated when key parameters of an action change, and should inform delivery. Ways should also be explored in which there can be better consideration of what happens in terms of dissemination after projects end. Where relevant, budget could be reserved for events or other activities within a 6-12 month period after the deliverables have been finalised.

7. **Consider introducing 'cluster projects'**: A series of cluster meetings on specific topics were organised under the 2nd HP, and evaluated positively. It may therefore be worth considering the merit of going one step further by strengthening the role and level of institutionalisation of such clusters. The INTERREG IVB NWE (North-West Europe) programme has introduced an interesting innovation in the form of cluster projects. These provide a small amount (1%) of additional funding to bring together projects dealing with similar topics that are already funded by the programme to network and share knowledge and experience, with a view to maximising their visibility and impact.[48] A similar approach could be applied to HP-funded actions on certain themes, and could address several of the shortcomings identified by this evaluation, including the challenge of dissemination and follow-up after an action has formally ended (as the cluster project funding could potentially extend beyond the duration of the project itself).

8. **Better reporting on action progress and results**: Reporting is currently based primarily (if not exclusively) on the information needs of Chafea in terms of monitoring actions. As discussed previously, there are significant *potential* synergies between monitoring and dissemination. It is worth considering whether it can be made mandatory for beneficiaries to submit (very) brief and accessible summaries of progress and/or results alongside each interim and final report, that are always publishable (i.e. contain no confidential information). These could be disseminated inter alia via the database, and serve as a genuine communication tool. In order to ensure that such summaries are appropriately written and understandable to relevant audiences, it may be possible for the communication framework contract holder to become involved in reviewing / editing some or all of these summaries.

9. **Enhance HP visibility in scientific publications:** It should be explored whether / how beneficiaries can be brought to explicitly mention the HP co-funding in any publications they write that are directly linked to HP-funded action results. This would enhance visibility as well as facilitate effective monitoring of the extent and impact of such publications.

10. **Emphasise key barriers to implementation and how they can be overcome in evaluating proposals:** The evaluation found that critical factors for action success included clear links to existing policy initiatives, plans for sustained follow-up efforts, feasibility of and essential preconditions for policy change (considering the surrounding context) in the medium-term, well-delineated action scope and objectives, plausible intervention logic, involvement of relevant partners, strong project management and constructive engagement from DG SANTE / Chafea. To increase the chances that such factors will be present, programme managers should, as a starting point, introduce more stringent requirements concerning the establishment of clear links between action deliverables / outputs, relevant actors and target

[48] For more information, see: http://www.nweurope.eu/index.php?act=page&page_on=about&id=1600

audiences, and desired policy impacts, including an appreciation of the main barriers to implementation of the results and if/how they can be addressed / overcome. This should help prevent the funding of actions that address important topics but where real impact in the short- to medium-term is not realistic. Potentially useful tools for achieving this include stakeholder analysis and risk analysis. A section on "External and internal risk analysis and contingency planning" is already a mandatory part of proposals. This could be made much more relevant, forcing applicants to focus more on key barriers and risks to the wider uptake of results, and think about appropriate mitigation strategies from the outset. This would require clearer guidance for applicants on what is expected, and clear instructions to Chafea and external evaluators to pay sufficient attention to the risk analysis when assessing and challenging proposals.

11. **Review 'soft' EU added value criteria to maximise impact:** Leading from the above, it is also important that DG SANTE / Chafea take forward the debate on the Programme's EU added value. While the description of EU added value is a welcome addition to the Regulation establishing the 3rd HP, the evaluation found that some of the eight criteria (namely economies of scale and innovation) demonstrated a more credible and direct link than others to eventual action impact. On the other hand, the path from high EU added value in best practices, networking and benchmarking to impact was often broken. This does not necessarily imply that these criteria are less worthy, but it sends a signal that they could be developed and further defined. For example, a project application receiving high scores for best practices should not 'merely' make a good case for how it will identify such practices, but should also explain how it will see them disseminated among relevant stakeholders, tailored to highly diverse circumstances and applied. Moreover, necessary conditions like political will and the need for follow-up funding should be defined in advance and discussed in probabilistic terms.

12. **Strategically assess and define balance between funding instruments:** Funding should be awarded such as to accentuate the strengths and minimise the weaknesses of the various funding mechanisms, as well as to maximise the internal coherence of the Programme. While we found that all funding mechanisms generated policy impact in certain circumstances (see table in section 5.5), we also identified examples where actions were not funded through the most suitable mechanism. In particular, the work carried out for some projects where the requirements were defined in a very specific and narrow way might have been channelled more effectively and efficiently through service contracts, while some joint actions could have benefited from the flexibility and experimental nature of projects. It is important to note that any mix of funding mechanisms implies a series of trade-offs in terms of objectives, levels of risk and the involvement of different groups of actors. For the 3rd HP, DG SANTE should consider these trade-offs in order to arrive at a balance that corresponds to the Programme's needs and priorities.

13. **Maximise synergies by intensifying consultation with other DGs**: During the current programming period, DG RTD involves DG SANTE more 'upstream' in the development of the biannual work programmes for Horizon 2020 health research. It would be worth considering whether a similar mechanism for the 3rd HP – i.e. consultation of DG RTD on multi-annual HP priority setting – might add value and further strengthen synergy effects in the future. Similarly, consultations with institutional stakeholders in MS, and with DG REGIO and EMPL could be held to raise awareness of relevant HP actions and results that could be implemented with ESIF support (in particular in areas related to the 3rd HP's specific objective of Innovative, efficient and sustainable health systems, e.g. on e-health or health workforce).

14. **Avoid an excessive focus on health promotion to demonstrate coherence with Europe 2020**: Ultimately, almost any action that contributes to improving the health status of the European population has the potential to contribute to growth and productivity in one way or another. It would therefore be wrong to focus the HP too narrowly on health promotion issues that appear most *directly* relevant for growth, since these do not always coincide with areas where there is the strongest case for EU-level collaboration.

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