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THE EUROPEAN UNION'S PUBLIC HEALTH PROGRAMME (2003–07): AN EFFECTIVE WAY TO IMPROVE HEALTH?

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(pursuant to Article 248(4), second subparagraph, EC)

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EUROPEAN COURT OF AUDITORS
12, rue Alcide De Gasperi
1615 Luxembourg
LUXEMBOURG

Tel. +352 4398-45410
Fax +352 4398-46410
E-mail: euraud@eca.europa.eu
Internet: http://www.eca.europa.eu

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ABBREVIATIONS

ABM: Activity-based management

AWP: Annual work plan

DG JLS: The European Commission's Directorate-General for Justice, Freedom and Security

DG RTD: The European Commission's Directorate-General for Research

DG SANCO: The European Commission's Directorate-General for Health and Consumers

DG TREN: The European Commission's Directorate-General for Transport and Energy

EAV: European added value

EC: European Community

ECDC: European Centre for Disease Prevention and Control

EMCDDA: European Monitoring Centre for Drugs and Drug Addiction

EU: European Union

NGO: Non-governmental organisation

PHEA: Public Health Executive Agency, renamed Executive Agency for Health and Consumers (EAHC) in July 2008

PHP: Public Health Programme (2003–08)

PHP 2: Second Programme of Community Action in the Field of Health 2008–13

RDI cycle: Research – development – implementation cycle

RTD: Research and technical development

WHO: World Health Organisation

EXECUTIVE SUMMARY

I.
The Public Health Programme (PHP) for 2003–07 aimed at complementing the measures taken by Member States to protect and improve public health. It was structured around three programme strands: 'health information', rapid reaction to 'health threats' and health promotion through addressing 'health determinants'.

II.
During this period the programme awarded grants to consortia of organisations for the implementation of some 352 projects, the total Community contribution being approximately 232 million euro.

III.
The Court's audit asked whether the right conditions were set for the projects financed from the EU budget to contribute effectively to improving the health of European citizens, as a complement to measures taken by Member States. In particular, the Court examined whether:

(a) the design of the PHP provided a suitable framework for the effective implementation and monitoring of Community-funded health promotion actions;

(b) the Commission ensured, at the programme implementation and project selection stage, that projects funded under the 'health determinants' strand of the PHP were likely to achieve sustainable results, were complementary and provided EU added value; and

(c) the Commission and project coordinators ensured that projects were managed effectively.

EXECUTIVE SUMMARY

IV.
The Court's findings and conclusions were as follows:

(a) The PHP was set very broad and ambitious objectives that contrasted sharply with the limited means at its disposal. In such a situation it is essential to focus on what can actually be achieved. However, the intervention logic was at no point made explicit, which was not conducive to setting clear, meaningful and logically linked objectives and specifying appropriate performance indicators. As a result, the PHP lacked strategic focus. The programme's 'action areas' established in the annual work plans outnumbered the projects funded to address them. Since project proposers were invited to apply for funding under often very general headings, the multiplicity and diversity of project topics and target groups caused input to be diluted and led to fragmented results.

(b) Project effectiveness was hindered by design weaknesses and implementation problems. With few exceptions, projects did not define what results they intended to achieve, and therefore were unable to demonstrate that they had had any effect. Sustainability was often understood by participants as the continuation of project activities and was therefore heavily dependent on continued Community funding. There was no systematic monitoring of actions already undertaken in the different priority areas, which sometimes led to duplication of work.

(c) On the positive side, the programme brought stakeholders from different countries together. Projects generally had a European dimension and, in many cases, facilitated the sharing of experiences and mutual learning. Networks were the clearest providers of European added value.

V.
In view of its findings, the Court recommends that the programme logic should be made explicit in any similar future legislation. Where the current programme is concerned, the Commission should undertake a mapping exercise to gain an overview of actions already implemented and thus to identify any remaining gaps. The number of annual priorities should be significantly reduced, and they should be focused on strategic topics and activities with an obvious European added value. The Commission should also address the weaknesses identified in project design and implementation.

VI.
More fundamentally, for the period after 2013 the Commission and the Member States are invited to reconsider the EU's funding approach in the field of public health. Other cooperation mechanisms which exist, such as the 'open method of coordination', could be further developed.

INTRODUCTION

1. Article 152 of the EC Treaty sets out the Communities' role in the field of public health, stating that Community activities are directed towards '*improving public health, preventing human illness and diseases, and obviating sources of danger to human health*'. These Community actions are to complement measures taken at national level and need to respect the Member States' responsibilities for the organisation and delivery of health services and medical care.

2. The European Commission's main role in the area of public health is to facilitate cooperation between Member State authorities, and to implement incentive measures. Apart from specific competence for the safety standards of organs, substances of human origin and blood, the EU's legislative power in this area is limited to incentive measures that exclude any harmonisation of the laws and regulations of the Member States.

3. The first Public Health Programme (PHP) was adopted for the 2003–08 period by Decision No 1786/2002/EC of the European Parliament and of the Council[1] and replaced eight action programmes on specific health topics[2]. The PHP addressed three general objectives:

(a) to improve information and knowledge for the development of public health ('health information' strand);

(b) to enhance the capability of responding rapidly and in a coordinated fashion to threats to health ('health threats' strand);

(c) to promote health and prevent disease through addressing health determinants across all policies and activities ('health determinants' strand).

4. To achieve these objectives, the Commission awarded grants to consortia of organisations (governmental, non-governmental, academia) implementing projects which addressed the priority public health issues defined in annual work plans (AWPs) established by the Commission and a committee of Member States' representatives[3].

[1] OJ L 271, 9.10.2002, p. 1.

[2] These were the programmes of Community action on cancer, rare diseases, pollution-related diseases, AIDS and other communicable diseases, injury prevention, prevention of drug dependence, health monitoring, and health promotion, information, education and training.

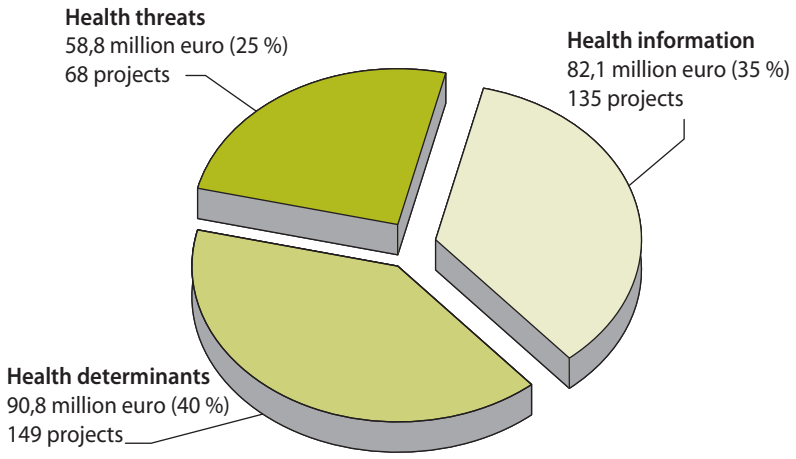
[3] The Programme Committee acts as the management committee referred to in Articles 4 and 7 of Council Decision 1999/468/EC (OJ L 184, 17.7.1999, p. 23) for the annual plan of work for implementing the programme. It oversees the arrangements, criteria and procedures for selecting and financing programme actions, arrangements for implementing joint strategies and actions and evaluating the programme, and certain measures in connection with the coordination of health monitoring and rapid reaction to health threats. Other measures linked to the implementation of the PHP are adopted through the advisory procedure referred to in Articles 3 and 7 of Decision 1999/468/EC.

5. The PHP covered the years 2003 to 2007. Some 352 projects were funded during this period, with the EC contribution totalling 231,7 million euro in commitments[4] (see ***Figure 1***). The 'health determinants' strand was the largest of the three in budgetary terms, with a Community contribution of 90,8 million euro corresponding to 40 % of the total amount committed for projects.

[4] Figures for the 2007 call for proposals are based on the list of accepted proposals. Negotiations for several contracts were still ongoing as of October 2008.

FIGURE 1

TOTAL COMMUNITY CONTRIBUTION (COMMITMENTS IN MILLION EURO AS A PERCENTAGE OF THE TOTAL BUDGET) AND NUMBER OF PROJECTS PER PROGRAMME STRAND



6. Under the PHP, grant agreements were concluded with project coordinators, who received co-financing of up to 60 % (in exceptional cases up to 80 %) of the costs incurred for carrying out project activities. In addition to grants for projects, a minor part (about 3 %) of the PHP's operational budget was used for service contracts through tendering procedures.

7. Projects funded from the PHP were very diverse in terms of size, approach and target group (see ***Box 1***). Consortia varied in size from three to 60 partners, the Community contribution ranged from 45 000 to 2,5 million euro, and types of project activities differed widely.

8. On 1 January 2008 the Second Programme of Community Action in the Field of Health 2008–13 (PHP2) came into force[5]. The Commission had originally proposed to merge the public health and consumer protection programmes[6]. It had also proposed increasing the budget by around 270 % (804 million euro for health for 2008–13), arguing that the PHP budget for health actions was insufficient to respond to the Treaty obligation of countering threats to health[7].

9. However, following the interinstitutional agreement of 17 May 2006 on the 2007–13 financial framework, neither the merger of the health and consumer protection programmes nor the increased budget was accepted by the European Parliament and the Council. The outcome of the legislative process was a second health programme with similar objectives and activities to the PHP, but a reduced budget of 322 million euro, about 9 % per annum less than that of the predecessor programme (see ***Box 2***).

[5] Decision No 1350/2007/EC of the European Parliament and of the Council (OJ L 301, 20.11.2007, p. 3).

[6] COM(2005) 115 final.

[7] *'Le maintien du budget actuel ne permet pas une mise en oeuvre optimale des obligations du Traité, ni de répondre à la volonté politique d'en faire plus pour les citoyens en matière de santé et en matière de protection des consommateurs. En effet, les ressources financières existantes ne permettent pas à la Communauté d'assurer de façon exhaustive les actions nécessaires notamment en ce qui concerne la lutte contre les grands fléaux ou maladies importantes et la coopération entre les États membres en matière de santé.'* (Impact assessment SEC(2005) 0425, p. 29).

BOX 1

PHP ('HEALTH DETERMINANTS' STRAND) — EXAMPLES OF PROJECT ACTIVITIES

- Collecting data on falsified prescriptions as an indicator of drug abuse.
- Organising a scientific symposium on the medical side-effects of doping.
- Preparing a report on compliance with alcohol marketing regulations.
- Producing and disseminating information material for migrant sex workers.
- Organising a competition to promote smoke-free school classes.
- Developing national and regional breastfeeding policy and plans.

BOX 2

COMPARISON PHP (2003–07) VS PHP2 (2008–13)

	PHP (2003–07)	PHP2 (2008–13)
Legal basis	Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002 adopting a programme of Community action in the field of public health (2003–08)	Decision No 1350/2007/EC of the European Parliament and of the Council of 23 October 2007 establishing a second programme of Community action in the field of health (2008–13)
Objectives	• to improve information and knowledge for the development of public health • to enhance the capability of responding rapidly and in a coordinated fashion to threats to health • to promote health and prevent disease through addressing health determinants across all policies and activities	• to generate and disseminate health information and knowledge • to improve citizens' health security • to promote health, including the reduction of health inequalities
Budget according to programme decision	354 million euro (for 2003–08)[8] i.e. 59 million euro p.a. over 6 years	322 million euro (for 2008–13) i.e. 53,7 million euro p.a. over 6 years
Funding mechanisms	Grants for actions Tenders (service contracts)[9]	Grants for actions Operating grants Conferences Joint actions Tenders (service contracts)
Programme implementation	DG SANCO[10]	Fully managed by the PHEA[11]
Impact assessment	Not done	Extended impact assessment (2005)[12]

[8] There are two main reasons for the difference between the indicative PHP budget given in the programme decision and the figure of 231,7 million euro mentioned in paragraph 5 as committed for projects in 2003–07: the indicative budget included about 58 million euro for 2008 (which was then covered by PHP2), and it also covered expenditure for the Executive Agency.

[9] A ceiling of 10 % of the operational budget was set in the AWPs for calls for tenders. This ceiling was increased to 20 % in PHP2.

[10] From 2005, grant management and the organisation of calls for proposals were gradually transferred to the Public Health Executive Agency (PHEA) (fully operational since 1 January 2007).

[11] Commission Decision 2004/858/EC (OJ L 369, 16.12.2004, p. 73). In 2008 the PHEA was renamed the Executive Agency for Health and Consumers (EAHC).

[12] SEC(2005) 0425, annex to the health and consumer protection strategy and programme proposal (COM(2005) 115 final).

AUDIT SCOPE AND APPROACH

10. Health promotion actions can be defined as '*actions which support people to adopt and maintain healthy lifestyles, and which create supportive living conditions (environments) for health*'[13]. Actions of this type were largely covered by the 'health determinants' strand of the PHP. The audit analysed whether the right conditions were set by the European Parliament, the Council and the Commission when designing the programme, and by the Commission and the project coordinators when implementing it, for projects to contribute effectively to the capacity of European citizens to improve their health.

11. The Court examined whether:

(a) the design of the PHP provided a suitable framework for the effective implementation and monitoring of Community-funded health promotion actions complementing measures taken by Member States;

(b) the Commission ensured, at the programme implementation and project selection stage, that projects under the 'health determinants' strand of the PHP were likely to achieve sustainable results, were complementary and provided EU added value; and

(c) the Commission and project coordinators ensured that projects were managed effectively.

12. The audit involved:

(a) an analysis of the programme's legal base and a review of programme evaluations and other relevant documentation;

(b) an analysis of Community actions and policy development in selected areas of the 'health determinants' strand: drugs, alcohol, tobacco, sexual and reproductive health, mental health, and nutrition and physical activity[14]. The analysis included a review of Commission policy papers, WHO policy papers, initiatives and programmes in the Member States and third countries, and academic and scientific literature;

(c) an assessment of a sample of 36 (out of a total of 149) projects funded from the 'health determinants' strand, i.e. one of the three strands of the PHP (2003–07). The sample covered all projects in the six selected areas which had reached a sufficient level of project maturity at the time of the audit[15]. The assessment included a review of the project documentation, interviews with all the project coordinators and an online survey of project partners[16];

[13] Don Nutbeam *et al.*, *The Evidence of Health Promotion Effectiveness — Shaping Public Health in a New Europe*, International Union for Health Promotion and Education (IUHPE), 1999, p. 3.

[14] The selected policy areas comprised all six lifestyle-related priority areas of the 'health determinants' strand. In all these areas projects were selected for funding in each of the years 2003 to 2007 (see ***Annex I***).

[15] The sample included all projects which were either completed or had submitted at least a first interim technical report in the six 'lifestyle health determinants' policy areas: alcohol, tobacco, drugs, nutrition and physical activity, sexual and reproductive health and mental health.

[16] The survey was conducted to obtain the other project participants' views on the partnerships and the management of health promotion projects, and ran from 11 March to 4 April 2008. The questionnaire used by the Court was based on previous surveys in this field (see El Ansari W., 'Educational Partnerships for Health: Do Stakeholders Perceive Similar Outcomes?' in *Journal of Public Health Management and Practice*, Vol. 9(2), 2003, pp. 136–156). Some 505 participants in the sampled projects were surveyed, 242 of whom completed the questionnaire in full — a response rate of 47,9 %. A further 19 participants responded to some but not all of the survey questions.

(d) interviews with staff from DG SANCO and the PHEA;

(e) a quantitative analysis of proposals submitted, projects funded and project budgets;

(f) consultation of stakeholders at national ministries of health and public health institutes, Member States' representatives on the Programme Committee and national focal points in eight Member States (Belgium, Estonia, Finland, France, Germany, Latvia, Sweden, United Kingdom); and

(g) a discussion of relevant issues with a group of experts in the field of health promotion and disease prevention at several stages during the audit. The experts' main input was to contribute to the Court's analysis, for example by suggesting the RDI cycle as a framework for analysis (see ***Box 10***), and to endorse the audit observations set out in this report.

AUDIT OBSERVATIONS

PROGRAMME DESIGN

13. Programmes are more effective if they are properly designed and the intended results are clearly set out. This is more likely to be the case if:

(a) the underlying logic of the intervention is made explicit in the programme decision (or its accompanying documentation);

(b) programme objectives are defined which are specific, measurable, achievable, relevant, and time-dependent (SMART);

(c) priorities are set in accordance with the organisation's strategy; and

(d) performance and achievements can be monitored based on robust and meaningful indicators.

INTERVENTION LOGIC NOT MADE EXPLICIT

14. A key element of programme design is defining the intervention logic — the hypothetical cause and effect linkages that describe how an intervention is expected to attain its global objectives. In the EU context, these overall objectives of policies and programmes are generally defined by the Treaty. Intervention logic provides the conceptual link from an intervention's inputs to the production of its outputs and, subsequently, to its impacts on society in terms of results and outcomes[17]. Making explicit the logic of a planned intervention allows the construction of a hierarchy of objectives and the identification of key indicators for monitoring and evaluation.

15. Logic models showing how inputs into the various activities will lead to the expected results are the most appropriate way of showing the intervention logic. Neither the Commission's legislative proposal for the programme[18] nor the legal basis for the PHP or any other relevant documents (such as impact assessments[19] or AWPs) explicitly described the programme's intervention logic in this way. The situation is unchanged for PHP2.

16. Logic models are used in other areas of EU policy, such as external actions, and are common practice in the public health field in other parts of the world (United States, Canada). For example, logic models were used for programme planning, implementation and evaluation in the Southern Arizona Border Health Careers Opportunity Program[20], the Health Improvement Initiative funded by the California Wellness Foundation[21] and the Calgary Cross-Cultural Mental Health Consultation Project[22].

[17] European Commission, DG Budget, 'Evaluating EU activities: a practical guide for the Commission services', July 2004, p. 87.

[18] COM(2000) 285 final.

[19] The Commission's proposal for the PHP predated the introduction, in 2002, of mandatory impact assessments and consequently was only subject to a limited cost-effectiveness analysis. By contrast, there has been an extended impact assessment for PHP2 (see European Commission, SEC(2005) 0425; IA for the proposed combined health and consumer protection strategy and programme).

[20] 'How Using a Logic Model Refined Our Program to Ensure Success', M. Page, S. H. Parker and R. Renger, in: *Health Promotion Practice OnlineFirst*, published on 28 August 2007.

[21] 'Evaluating the California Wellness Foundation's Health Improvement Initiative: A Logic Model Approach', A. Cheadle, W. L. Beery, H. P. Greenwald, G. D. Nelson, D. Pearson and S. Senter, in: *Health Promotion Practice*, April 2003; vol. 4: pp. 146–156.

[22] 'Evaluability Assessment: A Catalyst for Program Change and Improvement', W. E. Thurston, J. Graham and J. Hatfield, in: *Evaluation and the Health Professions*, June 2003; vol. 26: pp. 206–221.

17. In their report on the mid-term evaluation of the PHP[23], the external evaluators recommended developing such a systematic and reasoned evidence-based description of the links between inputs, activities, outputs and outcomes (see ***Box 3***). The Court has recommended the use of intervention logic for programme design, objective-setting and performance measurement for other budgetary areas[24].

18. In the Court's view, the definition of SMART programme objectives (see paragraphs 19 to 21) and the setting of robust indicators for an effective monitoring of the programme implementation (see paragraphs 70 to 73) is more difficult to achieve in the absence of a conceptual framework.

[23] Wija J. Oortwijn et al, Interim evaluation of the Public Health Programme 2003–08. Final Report, RAND Europe technical report, 2007, p. 6.

[24] See Special Report No 9/2007, 'Evaluating the RTD framework programmes — could the Commission approach be improved?'(OJ C 26, 30.1.2008), paragraphs 34 to 36, and Special Report No 7/2008, 'Intelligent energy (2003–06)' (OJ C 279, 1.11.2008), paragraphs 18 and 21.

BOX 3

RECOMMENDATIONS OF THE INTERIM EVALUATION OF THE PUBLIC HEALTH PROGRAMME 2003–08

'[The PHP] is, at this interim stage, delivering the programme of work identified in its annual work plans. However, this is a good time for building on these achievements by:

- *developing sharper priorities that are driven by stakeholder expectations and citizens' needs as well as meeting policy goals and high standards of probity;*
- *monitoring its activities against not only the aims of each project but also the overall aims of the programme decision;*
- *communicating its priorities and actions more crisply to stakeholders, and targeting tailored messages to members of the wider public health community.*

Understanding what is required to deliver this would be facilitated by developing a logic model capable of tracing the precise causal relationships that are anticipated to connect the programme activities to its intended outcomes.'

(Wija J. Oortwijn et al, Interim evaluation of the Public Health Programme 2003–08. Final Report, RAND Europe technical report, 2007, p. 6).

PROGRAMME OBJECTIVES NEITHER SPECIFIC, NOR MEASURABLE OR TIME-DEPENDENT

19. Objectives are defined, in the Commission's activity-based management (ABM) system, as the desired effects of an activity. They should not be a description of the activity itself, but rather illustrate the change to be achieved by that activity[25]. The setting of SMART objectives for all sectors of EU activity covered by the budget is an obligation under the Financial Regulation[26].

20. Without an explicit intervention logic it is difficult to set coherent programme objectives. In fact, as illustrated by the 'health determinants' strand, the PHP programme decision listed the possible activities in very broad and general terms. The global policy objective, '*to promote health and prevent disease through addressing health determinants across all policies and activities*', was not broken down into specific, measurable and time-dependent targets (see ***Box 4***).

21. It is not obvious from the programme decision how these activities are expected to contribute to the broad policy objective of promoting health and preventing disease, or how achievement of this global objective could be assessed.

ABSENCE OF STRATEGIC PLANNING AND LACK OF PRIORITY-SETTING

22. If spending programmes are to have any measurable impact, they need to be concentrated on selected activities that are identified through strategic planning according to a rigorous set of priorities. The number of priorities should be commensurate with the available budget, as having too many priorities will reduce the chances of achieving impact in any individual area.

23. Each year the EU Member States spend an average of 1 400 euro per capita on health[27]. While this expenditure includes health promotion and health information measures, the bulk of it is related to delivery of health services and medical care, which the Treaty makes the exclusive remit of Member States.

[25] European Commission, SPP/ABM guide, second edition, October 2004, p. 25.

[26] Article 27(3) of Council Regulation (EC, Euratom) No 1605/2002 of 25 June 2002 on the Financial Regulation applicable to the general budget of the European Communities (OJ L 248, 16.9.2002, p. 1).

[27] WHO Regional Office for Europe, Copenhagen, 'Public expenditure on health, purchasing power parity euro per capita, WHO estimates for 2003–05', Health for All database (HFA-DB), (http://www.euro.who.int/hfadb), October 2008.

PHP PROGRAMME OBJECTIVE, 'HEALTH DETERMINANTS' STRAND

Programme objectives — 'health determinants' strand	SMART criteria				
	Specific (so that progress can be checked)	**Measurable** (need to report progress credibly and verifiably)	**Achievable**	**Relevant**	**Time-dependent** (with deadline)
'To promote health and prevent disease through action on health determinants across all Community policies and activities by:					
3.1. preparing and implementing strategies and measures, including those related to public awareness, on life-style related health determinants, such as nutrition, physical activity, tobacco, alcohol, drugs and other substances and on mental health, including measures to take in all Community policies and age- and gender-specific strategies;					
3.2. analysing the situation and developing strategies on social and economic health determinants, in order to identify and combat inequalities in health and to assess the impact of social and economic factors on health;					
3.3. analysing the situation and developing strategies on health determinants related to the environment and contributing to the identification and assessment of the health consequences of environmental factors;	**No**[1]	**No**[2]	**Partly**[3]	**Yes**	**No**[4]
3.4. analysing the situation and exchanging information on genetic determinants and the use of genetic screening;					
3.5. developing methods to evaluate quality and efficiency of health promotion strategies and measures;					
3.6. encouraging relevant training activities related to the above measures.'					

[1] The objective does not specify what should be changed or include targets against which progress can be monitored.

[2] The objective is not measurable or quantifiable, no performance indicators are defined.

[3] On the basis of the 'activities' stated in the programme decision as 'objectives', it is achievable at least to some degree.

[4] No time span is indicated.

24. The PHP budget of approximately 59 million euro per year assigned to health promotion and information measures, and to countering health threats, amounts to 13 cents for each European citizen. In this situation, an appropriate response by the EU would be to target its relatively small budget on a few selected priority activities in areas of clear European added value — those issues which can be most effectively addressed at international level.

25. The priorities to be addressed in the field of public health are set out in AWPs, which provide a source of guidance for project proposers. The AWPs for 2003–07 contained extensive lists of topics for each programme strand, covering a broad range of issues. Each year, nine such topics were proposed under the 'health determinants' strand (with an annual budget of approximately 18 million euro). A further three areas were funded in some but not all years[28] (see ***Annex I***).

26. Between one and seven annual areas for potential action were set, ranging from specific to general, for each of these nine topics (see examples in ***Box 5***). These annual 'action areas' were defined in terms of activities for which project proposals could be submitted, not as objectives towards which progress could be assessed.

27. As a result, the AWPs for 2003–07 set a total of 154 'action areas' for the 'health determinants' strand alone. During the same period, only 149 projects were funded under that programme strand, meaning that, even under optimum circumstances, not all of these areas could be tackled through a project. In reality, coverage of priorities was even lower because several projects addressed the same 'action areas'. Moreover, broad health topics like nutrition, alcohol and mental health were often only addressed by one or two projects in a given year (see ***Annex I***).

28. Since organisations and consortia were invited to apply for funding under often very general headings (see examples in ***Box 5***), proposals submitted to the Commission very often lacked strategic focus. This is a problem in particular in areas where projects were expected to provide background studies or otherwise contribute to policy development. In these areas, tendering (and the use of service contracts) allows for a more precise definition of the expected deliverables. This was however limited to a maximum of 10 % of the PHP budget. This ceiling has been increased to 20 % under PHP2 (see ***Box 2***).

[28] These nine topics were alcohol, tobacco, drugs, nutrition and physical activity, sexual and reproductive health and HIV, mental health, socioeconomic determinants of health, environmental determinants, and disease and injury prevention. In 2003 and 2004, additional topics were training in public health (later changed to capacity building) and health promotion in particular settings. In 2005, the latter topic was discontinued and genetic determinants of health was added.

BOX 5

ANNUAL 'ACTION AREAS' FOR THE PHP 'HEALTH DETERMINANTS' STRAND

Topic	**Annual 'action areas' defined in AWPs (examples)** *(Source:* AWPs for the implementation of the PHP, 2003–07)
Tobacco	'Promote strategies to 'de-normalise' smoking, including strategies and measures to reduce the prevalence of smoking.' (2004)
Alcohol	'To assess the enforcement of national laws and self-regulation on the advertising and marketing of alcoholic beverages.' (2004)
Drugs	'Priority will be given to proposals on: • treatment and reinsertion activities covering all Member States and including both misuse/abuse of legal/illegal drugs; • best practice on improving the availability of prevention and harm reduction services and giving priority to HIV/AIDS and other blood-borne infections.' (2005)
Nutrition and physical activity	'Develop innovative measures to improve dietary habits and physical activity habits in all population groups.' (2003)
Mental health	'Building on the review of existing best practices, develop strategies for implementation of interventions in relevant settings aiming at promoting mental health and preventing depression, suicide and related disorders.' (2003)
Sexual and reproductive health	'Taking account of information from the health monitoring system, develop health promotion strategies and define best practices to address sexual education (teenage pregnancy, family planning) and prevention of sexually transmitted diseases such as HIV/AIDS, including consideration of approaches in school settings and those targeting specific groups.' (2004)
Injury prevention	'Support will be given to exchanging best practice on child safety for all Member States, EEA and candidate countries and to promoting child safety through a European conference. Special attention will be paid to tackling physical violence and danger awareness by organising hands-on injury-prevention activities.' (2006)
Environmental determinants	'Priority will be given in 2004 to actions which support the development of health and environment policies and strategies, and the integration of health and environment concerns in other Community policies. A specific focus will be on the provision of advice and expertise to develop activities, including legislative work and other initiatives on health aspects related to the environment, particularly in relation to air pollution (including indoor air pollution) and electromagnetic fields.'
Socioeconomic determinants	'Tackling socioeconomic determinants will continue to be a key priority for the programme. In 2004, work will be supported on: 1. identifying effective strategies to address inequalities in health and the health impact of socioeconomic determinants in specific settings and for population groups which are particularly affected, in particular in socially excluded, minority and migrant populations; 2. developing strategies to address the health effects of unemployment and precarious employment conditions.'

INDICATORS AT PROGRAMME LEVEL INADEQUATE TO MONITOR ACHIEVEMENTS

29. Under ABM, the Commission DGs are required to define clear, meaningful and logically linked objectives for their activities, and to identify appropriate performance indicators for monitoring achievement. Indicators should be defined both for impact (difference made to the target group) and output (means through which the difference will be brought about)[29].

[29] European Commission, Secretariat General: SPP/ABM guide, second edition, October 2004, p. 26 ff.

30. The absence from the PHP decision or the AWPs of an explicit intervention logic and specific, measurable and time-dependent objectives impeded the development of such performance indicators. For example, DG SANCO's annual management plans did not include any impact indicator for the 'health determinants' objective until 2006. The impact indicator Healthy Life Years (measuring the number of years that a person of a certain age can expect to live without ill health) was the outcome of a project co-financed by the Commission and was specified as a Lisbon structural indicator in 2005.

31. However, even the impact indicator subsequently developed was still too general to be used for monitoring or evaluation and was not linked to any quantified target. As the example illustrates, the impact indicator was framed as an objective rather than a way to measure achievements (see ***Box 6***).

BOX 6

IMPACT INDICATOR FOR PHP 'HEALTH DETERMINANTS' STRAND IN THE 2006 AMP

'Increase awareness and response from stakeholders and public policy, with regard to lifestyle-related health determinants, particularly concerning nutrition and physical activity, alcohol and diseases with a key public health relevance.'

32. The situation has improved recently, in that the activity statements for the 2009 preliminary draft budget set impact indicators and quantified targets in relation to the public awareness of certain health determinants (see ***Box 7***).

33. However, at the time of this report the Commission had not yet used these indicators to assess the effectiveness of the PHP as a whole or of individual projects. In fact, the audit found that the Commission had not set up an adequate monitoring system at any stage which would have enabled it to carry out such a performance measurement (see paragraphs 70 to 73).

BOX 7

SELECTED INDICATORS FOR THE OBJECTIVE OF 'FOSTERING GOOD HEALTH IN AN AGEING EUROPE' IN THE 2009 AMP

- '*Level of public awareness of unhealthy behaviours and lifestyle-related health risks and health determinants, in particular on nutrition, physical activity and alcohol*' to be raised from 66 % to 80 %;
- '*Share of citizens who have their blood pressure measured each year*' to be raised from 59 % to 80 %;
- '*Share of population aware of the health risks of tobacco smoke for non-smokers*' raised from 75 % to 80 %.

PROGRAMME IMPLEMENTATION: FROM PROJECT DESIGN TO RESULTS

34. For a programme to be effective, its projects need to achieve positive results. This is more likely to be the case if, before a project is launched, its objectives, target groups and intended results have been defined and it has been identified how the results will produce the intended impacts.

In this policy area, effective implementation also requires from the Commission, as programme manager, that

(a) it has an adequate overview of its project portfolio to ensure coherence and consistency; and

(b) the projects funded clearly demonstrate European added value (EAV).

[30] 'Rules, criteria and procedures for the selection and funding of actions under the public health programme' (OJ C 62, 15.3.2003).

PROJECT OBJECTIVES NOT SPECIFIC, VERIFIABLE AND QUANTIFIABLE

35. Projects should be designed in a way that makes it likely they will be effective. As at programme level, an important part of project design is to set SMART objectives; these should be logically derived from the policy objectives as defined in the programme decision. The PHP award criteria required proposers to define '*specific and realistic objectives ... The project must set verifiable and quantifiable objectives*'[30].

36. The Court's analysis of the grant agreements for the audited projects showed that promoters presented a mixture of activities and outputs rather than objectives when submitting their proposals. Typical project 'objectives' were the exchange of information between organisations in the field, capacity-building and the promotion of 'good practices' (see ***Box 8***). However, the Commission took no corrective measure to address this shortcoming before entering into the grant agreement.

37. The Court's detailed analysis of whether the project objectives stated in the grant agreements were to qualify as being SMART is presented in ***Annex III***. It concludes that not one sampled project had objectives that were fully SMART. Objectives were not stated in a measurable and time-dependent format, and it was unclear to what degree they were attainable. They were not expressed in terms of targets towards which progress could be monitored at a later stage. However, where projects did define a specific target group, the stated objectives were generally relevant to the target group (see paragraph 40).

BOX 8

PHP ('HEALTH DETERMINANTS' STRAND) — EXAMPLES OF PROJECT OBJECTIVES FROM GRANT AGREEMENTS

A & M ('European Centre AIDS and Mobility'):

- '*To stimulate collaboration and networking between European Member States and applicant countries on the issue of (young) migrants*'
- '*To assess and document best practice with respect to prevention, care and support in Europe in the field of HIV/AIDS and migrant, mobile and young people*'

CHOB ('Children, obesity and associated avoidable chronic diseases'):

- '*To measure and analyse the impact of food marketing to children and young people*'
- '*To determine and consider policy options aimed at addressing obesity in children*'

ELSA ('Enforcement of National Laws and Self-Regulation on Advertising and Marketing of Alcohol'):

- '*To create an expert network of partners from 28 European countries, to train the partners in the assessment of national laws and self-regulation and to convene three meetings of the network*'
- '*To prepare a report on the existing national laws, structures and regulation and self-regulation mechanisms on the advertising and marketing of alcoholic beverages*'

38. However, this does not imply that it is impossible to set SMART objectives in this field. Within the sample audited, the audit also found an example of a project with specific objectives which could have achieved full compliance with the SMART criteria after only minor adjustments (see ***Box 9***).

[31] 'Rules, criteria and procedures for the selection and funding of actions under the public health programme' (OJ C 62, 15.3.2003).

DEFINITION OF EXPECTED PROJECT RESULTS, IDENTIFICATION OF TARGET GROUPS AND PLANNING FOR SUSTAINABILITY THE EXCEPTION RATHER THAN THE RULE

39. The PHP award criteria required project proposers to aim at '*... producing lasting results conducive to the realisation of the programme's objectives*'[31]. Projects were thus expected to specify the intended target group and to define what results they intended to achieve and how those results would be sustained beyond the project term.

BOX 9

PHP ('HEALTH DETERMINANTS' STRAND) — 'PEER DRIVE CLEAN! PROJECT' — EXAMPLE OF SMART OBJECTIVES NEARLY ACHIEVED

'*The global objective is to sensitise young adults between 18 and 24 years to the dangers of alcohol and drug use and to achieve a modification of the eventual high risk drug use of the target group at an early stage.(...) The target group should be convinced through face-to-face actions of PEER educators to abandon the consumption of intoxicating substances while driving a motorised vehicle*.'

Is the formulation of the objectives SMART?

- **Specific**: yes (target group and what should be changed is clear)
- **Measurable**: no ('to sensitise', 'to convince')
- **Achievable**: yes
- **Relevant**: yes (young drivers have a higher risk of drink-driving accidents)
- **Time-dependent**: no

This project's objectives meet the SMART criteria in all except the measurable and time-dependent aspects. These two dimensions could have been satisfied by setting a target for awareness (e.g. '*by the end of the project, X % of the students taking the driving exam in the participating driving schools should be able to name X dangers of alcohol and drug use*') or, better still, for behavioural change (e.g. '*none of the participants to be caught drink-driving in the first year after obtaining their driving licence*').

TARGET GROUP NOT SPECIFIED IN A MAJORITY OF CASES

40. Only 16 of the grant agreements for the sampled health promotion projects clearly specified a target group in the grant agreements. Of these, only nine specified what changes the project intended to bring to that target group. Typically, PHP projects do not directly address European citizens as the ultimate target group of health promotion actions (e.g. people living with HIV, overweight young people, drug users, people at risk of becoming alcohol addicts) but work through 'intermediate' groups of health professionals or policymakers. However, nine out of the 36 projects audited by the Court were set up from the outset to have a direct health impact on the population. They represented more than half of the projects (56 %) specifying a target group.

EXPECTED RESULTS NOT LINKED TO INTENDED IMPACTS

41. Grant agreements stated each project's 'expected results' under a separate heading. However, the Court's audit of a sample of projects found that this amounted to a list of project outputs, deliverables and activities (e.g. 'a meeting will be held', 'a training manual will be developed'), with no explanation how these activities would achieve change for the direct addressees. The poor definition of expected results and the absence of indicators meant that achievements could be neither demonstrated nor disproved.

42. The Court also found that proposals did not clarify the logical links between projects and their possible social benefits; nor was the existence of such links ascertained by the Commission or the project coordinators during the selection process or prior to the signature of grant agreements. The underlying assumption seems to have been that positive effects would follow from placing the health promotion issue on the political agenda, building networks and exchanging information. However, at no stage was it explained how project activities might have a trickle-down effect that would actually improve people's capacity to choose healthy lifestyles. This also underlines the importance of having an intervention logic in place.

PLANNING FOR SUSTAINABILITY OF RESULTS IN VERY FEW CASES

43. When assessing health promotion projects, the different stages of the cycle can be classified as: study and research projects, development projects, implementation projects and 'going-to-scale' projects, known as the RDI cycle (see ***Box 10***).

44. PHP projects, with their limited duration (two to three years in most cases) and limited resources, are not designed to cover the full cycle of health promotion actions from setting up an evidence base to developing and implementing public intervention and creating a lasting health impact. They can only address part of this process. Nonetheless, there should be an indicative plan of how the results of a project can be taken up at the next step in the cycle.

45. None of the audited projects had a plan for the take-up of their results by the next level in the RDI cycle or how their results could be sustained over time. The project coordinators interviewed usually understood sustainability to mean the continuation of project activities rather than the effective use of results after the project term. In all cases audited, the outputs created during the project, such as websites or databases, were not updated after project closure.

46. With a few exceptions, it was found that projects did not even contain a plan for sustainability and take-up of their results beyond the end of the project funding period. They focused on obtaining a follow-up grant from the Commission so that project activities could be continued. The most common attitude was that project results could be sustained only if the partners could continue to secure Community funding.

BOX 10

THE RDI CYCLE

The research–development–implementation (RDI) cycle is a concept describing the sequence of steps in public health programme development, from fact-finding and creating an evidence base to developing a strategy or work plan, pilot testing and finally full-scale implementation.

Projects covering only one of these steps can be considered sustainable if their results are taken up and used by the next step in the cycle. For instance, research projects should ensure that results will be taken to the development stage, and projects developing an intervention should use the evidence base previously established by research projects and plan for (pilot) implementation.

The following project categories were used for this audit:

- Study and research projects (e.g. collection of data);
- Development projects (e.g. policy, guidelines or programme development);
- Implementation projects (e.g. piloting, training and capacity building); and
- 'Going-to-scale' projects (e.g.dissemination, implementation on a wider scale).

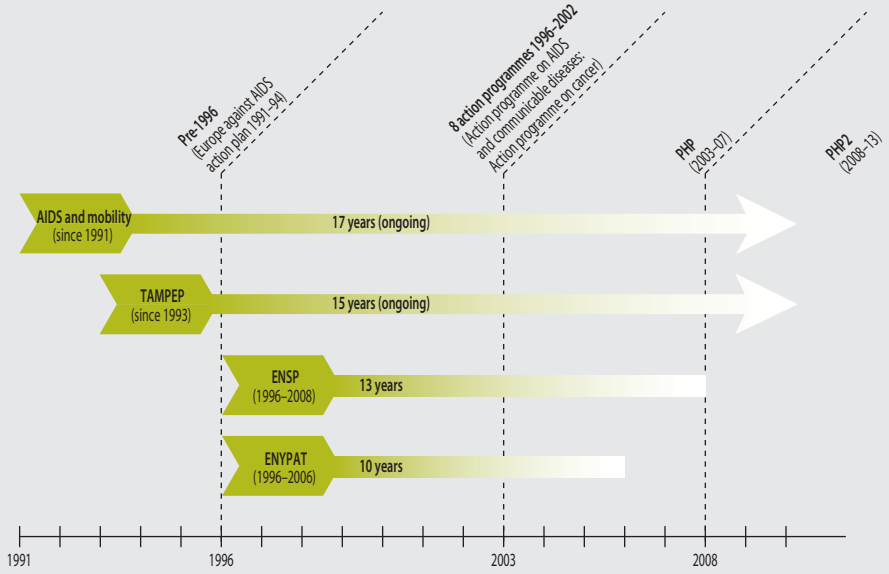
CONTINUOUS FUNDING OF NETWORKS FOR MORE THAN 10 YEARS

47. Networks of health professionals and organisations from different Member States provide platforms for pooling experience and exchanging best practices; they are thus a tool for achieving certain results but not strictly a result in themselves. Due to their nature, they cannot be classified neatly as belonging to any one stage of the RDI cycle. The sample of projects audited contained 13 networks. When interviewed, coordinators stated that building the network was the essential purpose and outcome of their respective projects.

48. Networks were particularly dependent on continuous Community funding. Some networks had received funding under the PHP and its predecessor programmes for more than 10 years (see ***Figure 2***). When no follow-up grant was awarded by the Commission, the network activities ceased and the network dissolved.

FIGURE 2

PHP ('HEALTH DETERMINANTS' STRAND) — EXAMPLES OF RECURRENT NETWORKING PROJECTS



49. It should also be noted that none of the PHP funding mechanisms lent themselves to continuous financing of the operating expenditure of networks. The PHP calls for proposals offered grants for actions (Article 108(1)(a) of the Financial Regulation), but not operating grants. As a consequence, networks had to be designated as one or the other type of project and grant agreements had to include project activities through which operating expenditure could be covered. Networks also had to respond to calls for proposals and submit to the same selection procedures as other projects. This situation placed an unnecessary administrative burden on both the participants and the Commission. Under PHP2, networks can now be funded via a dedicated operating grant mechanism (see ***Box 2***).

COMPLEMENTARITY OF PROJECTS AND CONSISTENCY OF PROJECT PORTFOLIO NOT ADEQUATELY MONITORED

50. Effective programme implementation requires the programme manager (i.e. the Commission or the executive agency) to have an accurate and up-to-date overview of the project portfolio. This enables overlap and duplication of effort to be avoided, synergies to be created between the actions undertaken, and programme planning, implementation and follow-up to be executed in a coherent and consistent manner.

NO MONITORING OF PROJECT PORTFOLIO

51. At the time of the audit, neither DG SANCO nor the PHEA could refer to a monitoring tool which provided an overview of projects undertaken, in terms of the priorities they addressed, the activities they encompassed and the results they achieved (see paragraphs 70 to 73). This created an obstacle to ensuring consistency over time in the implementation of the programme. In the absence of such consolidated information, the Commission made decisions on its AWP priorities without knowing which projects already existed in each policy area or which activities were covered.

FRAGMENTATION, OVERLAP OF PROJECTS AND PARALLEL IMPLEMENTATION OF SIMILAR ACTIONS

52. With a view to obtaining a conclusion on complementarity in the absence of such an overview, the Court analysed all projects addressing one of the six lifestyle-related health determinants (alcohol, tobacco, drugs, nutrition and physical activity, sexual and reproductive health, mental health) (see ***Annex II***). This detailed analysis was complemented by a quantitative analysis, stakeholder interviews and consultation of experts.

53. The analysis showed that complementarity between projects and consistency within the overall project portolio were lacking because of:

(a) *fragmentation*: in the 'drugs' policy area, projects funded from the PHP were few in number and addressed very diverse aspects of the drugs problem, ranging from doping in leisure sports to falsified prescriptions as an indicator for the abuse of legal drugs, and to drug prevention in prisons. A similar situation was found in the 'nutrition and physical activity' policy area, where the few PHP projects were very dissimilar in terms of objectives and activities;

(b) *activity overlap and the duplication of work*: PHP projects in the 'alcohol' policy area were characterised by a great deal of overlap in the partners involved and the information produced, not only between the projects in the sample but also with regard to a project funded from the predecessor Community Action Programme on Health Promotion and a report produced following an earlier call for tender. In the 'mental health' policy area, two projects with identical activities were funded under consecutive calls for proposals;

(c) *parallel implementation of similar actions*: in the 'tobacco' policy area, the main projects financed from the PHP were two large networks established to combat smoking, one targeting the general population and the other young people only. In the 'sexual and reproductive health' policy area, the PHP funded many networks whose objective was to strengthen the capacity of the participating NGOs. They found their 'niche' by focusing on different direct and indirect addressees: NGOs in central European countries, or NGOs working with migrants, migrant sex workers, local sex workers, injection-drug users or people living with HIV/AIDS.

54. In all these areas there are already other mechanisms which could take the place of the PHP: platforms, working groups, agencies (EMCDDA, ECDC), WHO and other EU programmes such as the RTD framework programmes or the Drugs Prevention and Information Programme (see paragraph 64 and ***Box 12***).

LIMITED EUROPEAN ADDED VALUE

55. In accordance with the principles of subsidiarity and proportionality set out in the Treaty, Community action on matters which do not fall within the exclusive competence of the Community, such as public health, should be undertaken only if and in so far as, by reason of its scale or effects, its objective can be better achieved by the Community[32].

[32] See Articles 2 and 5 of the Treaty on European Union, together with paragraph 5 of the Protocol (No 30) on the application of the principles of subsidiarity and proportionality.

EAV BY PROGRAMME STRAND: 'HEALTH DETERMINANTS' STRAND LEAST LIKELY TO PROVIDE EAV

56. A key ramification of the subsidiarity principle is that EU health policy should consist only of actions delivering output which cannot be achieved by Member States acting individually, or which deliver economies of scale. The 'health threats' strand deals with the surveillance of communicable diseases, and the 'health information' strand with the collection of comparable data and the development of common indicators. These two strands thus focus on issues which clearly cannot be managed by Member States acting individually. However, in the Court's view other mechanisms for cooperation between Member States could equally play this role (see paragraphs 64 and 65).

57. In contrast, tackling health determinants to promote health and prevent disease is not a cross-border task per se. In particular, direct health promotion — health education and influencing lifestyles — is a culture-specific activity which needs to take account of the specificities of the national public health system and local characteristics and needs. Therefore, when comparing the three strands of the PHP, the 'health determinants' strand appears to have the least potential for providing EAV.

EAV BY PROJECT TYPE: NETWORKS MOST LIKELY TO PROVIDE EAV

58. At the level of health promotion projects under the 'health determinants' strand, the Court has assessed EAV by taking into consideration a range of arguments why a measure could only be taken — or would be better taken — at European level. The analysis took account of the four project categories defined by the RDI cycle framework, while networks were considered separately (see ***Box 10***).

59. There is a requirement for all projects to involve partners from several European countries. A a result of their cross-border nature, *networks* are most likely to exhibit EAV through sharing of expertise, consensus-building and exchange of 'good practices' across countries.

60. The EAV of the other project types is less obvious.

(a) *Study and research projects*: EAV lay mainly in the fact that data were collected from several countries and subject to a comparative analysis. These projects sought to develop a common terminology, set common standards and ensure the comparability of data and methods between Member States. However, there was some overlap with activities carried out under the 'health information' strand, as well as under other EU programmes such as the RTD framework programmes[33] or the Drugs Prevention and Information Programme (see paragraph 54 and ***Annex II***).

(b) *Development projects*: these projects' EAV was their link to the development of EU policy. They sought to further the development of their respective priority areas at European level and to contribute to agenda-setting across Europe.

(c) *Implementation and 'going-to-scale' projects*: the EAV of these projects was least apparent. This is because, by their very nature, the related activities (such as piloting, training and capacity building, dissemination and implementation on a wider scale) have to happen on the ground, i.e. not at European level but in a particular region or country. For this category of projects, it could be argued that activities should be funded by the region or country where they take place. For some projects this was indeed the case: Community funding was used only for 'European activities' (e.g. meetings between national coordinators) and not for actual interventions or daily country-based activities. However, in other cases funding from the PHP was used for national or regional activities.

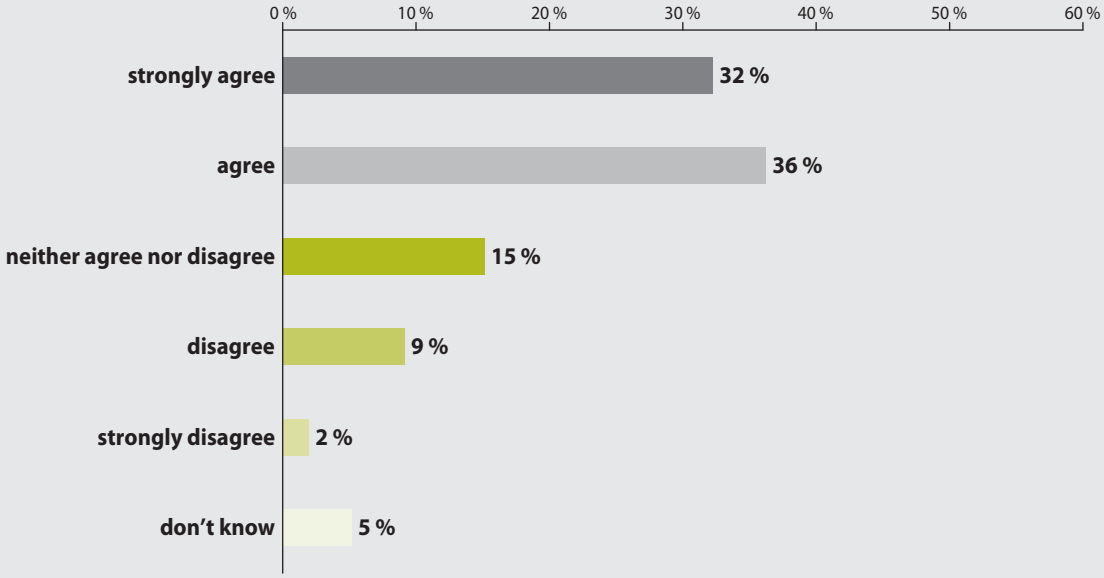
61. The Court considers that all types of projects under the 'health determinants' strand have the potential to deliver EAV to some degree, by bringing together partners from different EU Member States. However, applying the criteria used by the Court, the most obvious providers of EAV in the sample were networks.

[33] During the period 2003–06, 'Life sciences, genomics and biotechnology for health' is one of seven major thematic research priorities of the European Union's sixth framework programme (FP6) aiming at the generation of new knowledge and translating it into applications that enhance human health. To this end research organisations carrying out both fundamental and applied research were supported with an indicative budget of 2 514 million euro. Such funding opportunities existed in the fields of genomic approaches to health and disease, biotechnology, cancer, HIV/AIDS, malaria and tuberculosis. Similar funding opportunities existed under the FP5 and the current FP7.

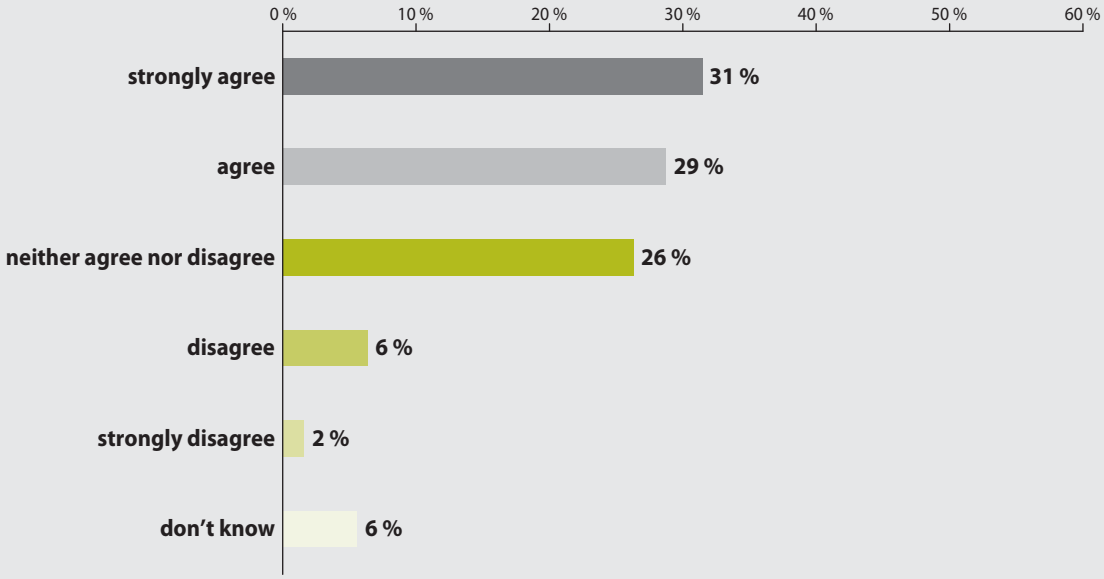
BOX 11

SURVEY OF PROJECT PARTNERS

'The project's objectives could only be realised by participating in the European Public Health Programme.'



'Participating in the European Public Health Programme is more effective than participating in a national health project.'



STAKEHOLDERS POSITIVE ABOUT THEIR PARTICIPATION IN THE PROGRAMME

62. Participants widely affirmed the European dimension of their projects. A large majority (68 %) of project partners responding to the Court's survey agreed or strongly agreed that their project objectives could only be realised by participating in the PHP. Some 60 % considered participation in the PHP to be more effective than participation in national projects (see ***Box 11***).

63. Stakeholders in the Member States found that the programme as a whole was also a source of EAV in that it provided an opportunity to pool knowledge and share 'good practices'. The representatives of national authorities who were interviewed in the framework of the audit (Programme Committee members and national focal points) agreed that the PHP addressed the need for Member States to cooperate by exchanging information, experience and guidelines on public health problems of concern to all. The mid-term evaluation of the PHP concluded that the rationale for European intervention in public health is widely accepted and supported[34].

[34] Wija J. Oortwijn *et al.*, Interim evaluation of the Public Health Programme 2003–08. Final Report. RAND Europe technical report, 2007, p. 63.

BOX 12

EXAMPLES OF EXISTING COORDINATION MECHANISMS (see *Annex II* for details)

- European Monitoring Centre for Drugs and Drugs Addiction (EMCDDA)
- European Alcohol and Health Forum
- EU Platform on Diet, Physical Activity and Health
- European Centre for Disease Prevention and Control (ECDC)
- Think Tank on HIV/AIDS
- HIV/AIDS Civil Society Forum

64. However, the exchange of information and cooperation among Member States in the field of public health is not limited to the PHP. Other mechanisms exist which can deliver this EAV. There are a number of fora, working groups and platforms in most public health policy areas that address not only health determinants but also health information and health threats. They facilitate consultation between stakeholders — especially governmental organisations, but also civil society, industry, etc. — and provide a 'meeting place' where common approaches can be developed and coordinated (see paragraphs 54 and 60(a)). The existence of alternative mechanisms raises the question whether such activities should continue to be carried out under the PHP.

65. In its current EU health strategy published in October 2007 the Commission has proposed setting up a 'structured cooperation mechanism' to identify and promote the necessary coordination activities among the Member States[35]. A dedicated 'Council Working Party on Public Health at Senior Level' was set up in December 2008 to assist the Commission in identifying priorities, defining indicators, producing guidelines and recommendations, fostering exchange of good practice and measuring progress.

[35] European Commission, White Paper, 'Together for health: A strategic approach for the EU 2008–13', COM(2007) 630 final, p. 10.

PROJECT MANAGEMENT

66. Project design is crucial, but projects must also be managed in a way that increases their chances of being effective. A project can ultimately contribute to progress towards the overall goal if the intended results are achieved and are used by the target group. This is more likely to be the case if:

(a) the partnership works well;

(b) projects are adequately monitored during implementation, enabling the Commission to be informed about project activities, outputs, potential overlap and opportunities for synergies between projects, and to provide feedback to the project coordinators;

(c) the expected outputs are produced and disseminated appropriately; and

(d) projects are ultimately evaluated, allowing the Commission and other project promoters to learn from experience.

PARTNERSHIP FUNCTIONED WELL

67. The functioning of the partnership is an important factor in the effectiveness of any project implemented by several actors. All projects in the sample were implemented by a number of organisations in different Member States and, sometimes, candidate countries. Typically, they consisted of a main project coordinator and, on average, 12 associated partners from different countries.

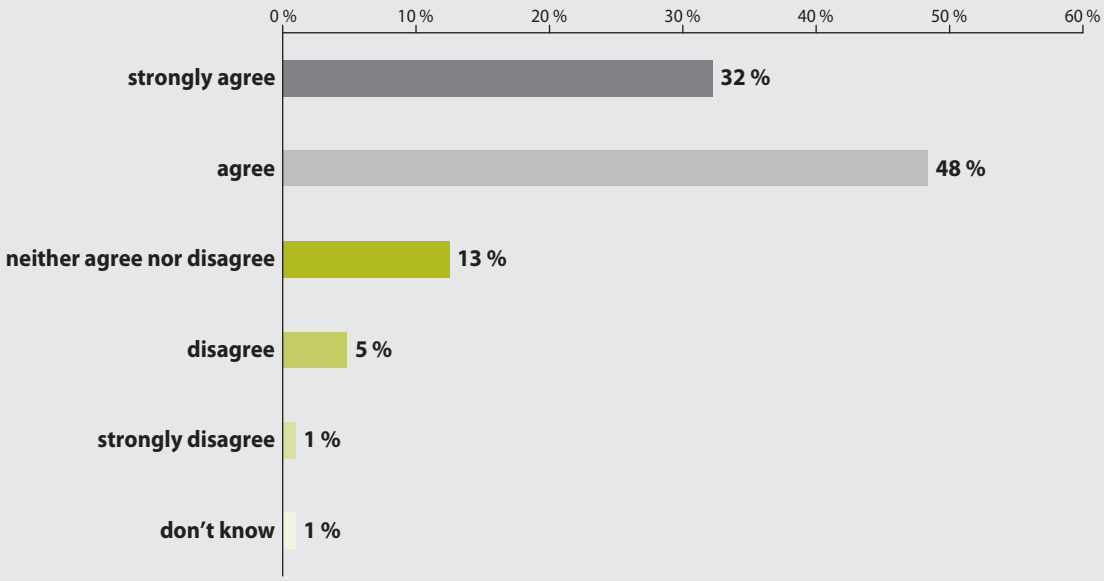
68. In most cases, responsibilities were clearly assigned among coordinator and partners. In nine out of the 36 cases audited, however, it was found that the partnership was very imbalanced, with the project coordinator and/or one other partner carrying out the bulk of the project activities and limited involvement by the other partners.

69. The majority of project coordinators and partners gave a very positive assessment of cooperation in the partnership (see ***Box 13***). Many respondents to the survey stressed the partnership as one of the most important aspects of the project because of the possibility of making contacts, exchanging ideas and sharing experience and 'good practices'.

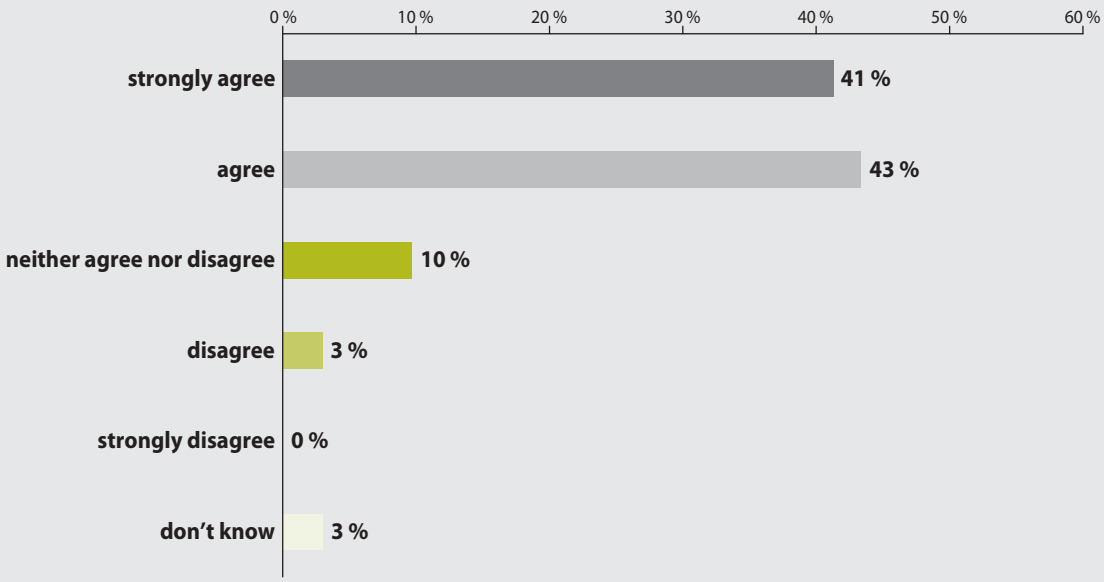
BOX 13

SURVEY OF PROJECT PARTNERS

'I am satisfied with how the project partners cooperate(d).'



'The project coordinator involves all partners in the work.'



PROJECT MONITORING BY COMMISSION 'AD HOC' RATHER THAN SYSTEMATIC

70. Neither DG SANCO nor the PHEA has written guidelines for monitoring projects or documenting the monitoring process[36] (see paragraph 51). Consequently, what was done depended on the individual project officer. In general, monitoring consisted of using the coordinator's interim and final reports to verify whether the contract requirements had been met, giving the financial officer the green light to proceed with payment. As a rule, the Commission gave the project coordinator no written feedback on the content and the achievements of their projects.

[36] For most of the projects in the audit sample, technical monitoring was still the responsibility of the DG SANCO project officers; for 12 projects selected following the 2005 call for proposals monitoring responsibility had been transferred to the newly created Public Health Executive Agency (PHEA) after contract signature.

71. Many project coordinators were dissatisfied with the Commission's project monitoring, particularly in the case of projects contributing to policy development. Seventeen of the 32 coordinators interviewed reported never having discussed the technical aspects of their project with representatives of the Commission during the project term. Most coordinators had invited the Commission's project officer to project meetings, but such invitations were rarely taken up.

72. DG SANCO officers confirmed that project monitoring was a very minor part of their activity and that normally they had no time to follow projects closely. Moreover, due to staff turnover, in some cases three or four different project officers were assigned to a project during its lifetime, and projects were left for several months with no designated project officer.

73. The Commission's monitoring of the technical aspects of ongoing projects was ad hoc rather than systematic, not based on common minimum requirements and not providing formal feedback to participants. This should also be considered alongside the lack of an overview of projects undertaken, which would have enabled the Commission to avoid duplication of work and to ensure that potential synergies between projects were fully exploited (see paragraphs 50 and 51).

OUTPUTS DELIVERED, BUT NOT ACTIVELY DISSEMINATED

74. Outputs, or deliverables, are defined as that which is produced with the resources allocated to an intervention. In general, the contractually agreed outputs of the audited health promotion projects were produced. Common output categories included reports on specific issues, training courses, databases, websites, newsletters and information material such as leaflets.

75. Projects mostly used the Internet for dissemination. Almost all projects uploaded their outputs to a website — either the project coordinator's home website or a dedicated project site. This led to the simultaneous creation of a number of similar websites in each field, making it harder for any interested party to find pertinent information.

76. Other dissemination channels included conferences, newsletters, contributions to scientific journals and press releases. Project partners played a significant role in dissemination, as they were familiar with national and regional conditions and possibly already had an established network of contacts in their country or region.

77. While the audit found that outputs were produced and disseminated, project coordinators could not demonstrate 'take-up' by the target group for any of the projects audited. Projects did not even collect information of this sort[37]. Neither was dissemination sustainable, as websites and databases were generally not updated after the end of the funding period (see paragraph 45).

78. Moreover, the representatives of national ministries and health institutes interviewed were often not aware what projects had been undertaken, still less of the results obtained. Most of the national stakeholders interviewed expressed criticism of the dissemination of project results and considered that too little information on the outcomes of projects (whether ongoing or completed) was available to them.

[37] It should be noted that it lay outside the scope of this audit to determine the effects on target groups of the dissemination of project outputs — for example, to investigate whether a newsletter was read and appreciated or a database was consulted by health professionals.

PROJECT EVALUATION NOT YET COMMON PRACTICE

79. Without robust evaluation the effectiveness of projects cannot be demonstrated. According to WHO, health promotion initiatives should be evaluated in terms of processes as well as outcomes[38]. Project evaluation was however not a legal requirement under the PHP.

80. Nevertheless, the Commission announced as early as 2003, in its first call for proposals, that it would give priority to projects which '*devote[d] appropriate attention to the [self-] evaluation of the process and results*'[39]. From the 2005 call for proposals onwards, a work package entitled 'Evaluation of the project' was a compulsory section of grant agreements, but project coordinators were given no further instructions as to what this should entail.

81. The Court examined whether evaluations of the audited health promotion projects had been carried out that met the criteria of usefulness, coherence, robustness, impartiality, clarity and cost-effectiveness[40]. This analysis showed:

— Of the 24 projects in the sample which were selected before 2005, three had conducted a comprehensive self-evaluation. Of these only one met all the criteria specified above;

— Nine of the 12 projects selected following the 2005 call for proposals included plans for limited self-evaluations, such as collection by the coordinator of feedback from the project partners, in the form of survey sheets, on project meetings or workshops. In the other three cases, there were plans for evaluations to be carried out by an external evaluator.

82. While the Commission has encouraged and, more recently, required health promotion projects to conduct a comprehensive self-evaluation, this has not yet become common practice among participants — owing partly to the lack of Commission guidance for project coordinators and the absence of follow-up by the Commission or the PHEA (see paragraphs 70 to 73).

[38] 'Health promotion evaluation: Recommendations to policy-makers.' Report of the WHO European Working Group on Health Promotion Evaluation, p. 4.

[39] 'Rules, criteria and procedures for the selection and funding of actions under the public health programme' (OJ C 62, 15.3.2003).

[40] ECA Audit Guidelines on Evaluation, November 2005, p. 7.

CONCLUSIONS AND RECOMMENDATIONS

PROGRAMME DESIGN

83. The Court considers that the design of the PHP did not provide a suitable framework for an effective implementation and monitoring of Community-funded health promotion actions. The fact that the underlying intervention logic of the PHP was not made explicit was not conducive to setting specific, measurable and time-dependent programme objectives and specifying appropriate indicators to measure achievements.

84. The audit also found weaknesses in the Commission's strategic planning and a lack of priority setting. The diversity of topics and the multiplicity of annual 'action areas' caused input to be diluted and led to fragmented results, particularly in view of the limited budget available. The programme followed many different paths and lacked strategic focus.The Court finds that the PHP (2003–07) did not make a major contribution to health promotion in the European Union.

RECOMMENDATION 1

In order to address the current imbalance between objectives and means, any successor programme should be assigned better-targeted programme objectives which are more in line with its budgetary means.

For any future generation of programmes, the underlying intervention logic should be stated in an explicit manner, setting out specific, measurable, achievable, relevant and time-dependent objectives at policy and programme level, illustrating the links between them and defining indicators to measure their achievement.

PROGRAMME IMPLEMENTATION: FROM PROJECT DESIGN TO RESULTS

85. The Court finds that the Commission's project selection and programme implementation did not ensure complementarity between projects, the overall consistency of the portfolio of projects undertaken and the funding of the type of projects that provided the highest likelihood of EAV.

86. Project objectives (as proposed by promoters) were neither logically derived from the programme objectives, nor in compliance with the SMART requirement specified by the Financial Regulation. The Commission took no corrective measure to address this shortcoming before entering into the grant agreements audited.

87. Expected project results were not defined as impacts on target groups and the sustainability of the results is considered to be low. Projects generally produced the planned outputs, but the audit found no demonstrable take-up of project results. Very often the relevance of these outputs for the target group and their take-up by actors 'downstream' was unclear from the beginning. Sustainability was often understood by participants as the continuation of project activities and was therefore heavily dependent on continued Community funding.

88. The Court recognises that the programme brought stakeholders from different countries together. Projects generally had a European dimension and, in many cases, facilitated the sharing of experiences and mutual learning. However, Article 152 of the EC Treaty gives the EU only limited competence for public health policy. The Lisbon Treaty (currently under ratification) would not substantially alter this. Accordingly, the added value of EU activities in the field of health promotion, including those carried out under the PHP, lies above all in facilitating cooperation between the stakeholders in different Member States. Of the types of projects carried out under the PHP, networks provide the highest likelihood of EAV and most clearly address the need of actors in the field to share 'good practice', develop common standards and guidelines and exchange knowledge.

89. However, the main implementation mechanism of the PHP (i.e. grants for actions awarded through calls for proposals) is not the most appropriate mechanism for funding such networks. This is also the case for activities that are supposed to contribute to the Commission's policy development.

PROJECT MANAGEMENT

90. With regard to project management, the Court found that partnerships generally worked well. The Commission's monitoring of ongoing projects was however ad hoc rather than systematic and did not provide formal feedback to participants. Projects did produce the deliverables set out in the grant agreement, but promoters rarely disseminated results actively.The *ex post* evaluation of projects has not yet become common practice among participants.

RECOMMENDATION 2

Where the current PHP (2008–13) is concerned, the Commission should undertake a mapping exercise in order to gain an overview of projects undertaken and their results to identify the existing overlaps and any remaining gaps in its project portfolio.

The number of annual 'action areas' should be significantly reduced, and they should be focused on strategic priorities.

The Commission should also address weaknesses in project design and implementation by:

- bringing project objectives into line with programme objectives and the refocused 'annual priorities' recommended above. In addition, grant agreements should establish not only which activities are to be undertaken, but also the desired results of those activities, the target groups and how the results will be used in a sustainable manner after project completion;

- setting quantified targets and performance indicators wherever possible in order to facilitate the monitoring of progress towards objectives;

- evaluating projects *ex post* in order to improve the design of forthcoming projects (and putative successor programmes) by applying 'lessons learnt'.

Finally, the Commission should fully exploit the existing PHP (2008–13) funding mechanisms for networks (ie. operating grants) in the current programming period, since they are more suitable for such activities than grants for actions. For service contracts, the Commission should make use of the increased ceiling (20 % rather than 10 % of the available budget) to carry out activities contributing to policy development. However, this will require a more rigorous definition of terms of reference than in calls for proposals.

OVERALL CONCLUSION

91. The PHP was set very broad and ambitious objectives that contrasted sharply with the limited means at its disposal. This imbalance has widened further since the current PHP (2008–13) was launched.

92. The Court calls into question the utility of certain components of European public health programmes such as the PHP. The audit suggests that it is difficult for such programmes to have a demonstrable impact on citizens' health. Where there is 'European added value', it lies primarily in enabling intermediaries to network and to exchange 'good practice' with a view to complementing national programmes and activities. Moreover, the Court notes the existence of cooperation mechanisms such as the 'open method of coordination' which permits such networking and exchanges.

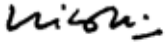
RECOMMENDATION 3

For the period after 2013, the European Parliament, the Council and the Commission should reconsider the scope for EU public health activities and the approach to EU funding in this area. This should be done bearing in mind the budgetary means available and the existence of other cooperation mechanisms (such as the 'open method of coordination'[41]) as a means of facilitating collaboration and the exchange of information among stakeholders throughout Europe.

The current budget review provides a first occasion for this reflection process.

This report was adopted by the Court of Auditors in Luxembourg at its meeting of 5 March 2009.

For the Court of Auditors



Vítor Manuel da Silva Caldeira
President

[41] This is a method of cooperation based on the principle of voluntary intergovernmental cooperation. It relies in particular on mutual learning, benchmarking and the sharing of best practice.

PHP 2003–07 ('HEALTH DETERMINANTS' STRAND) — FUNDED PROJECTS BY TOPIC

Year	Topic	Tobacco	Alcohol	Drugs	Nutrition and physical activity	Sexual and reproductive health, HIV/AIDS	Mental health	Social determinants of health	Environmental determinants of health	Health promotion in particular settings	Training in public health	Disease and injury prevention	Genetic determinants	Capacity building	Total
2003	Projects funded	2	1	1	2	3	2		2	1	1	4			**19**
	Number of action areas	7	2	3	2	1	1		3	2	1	1			**23**
	Projects funded/action area	0,29	0,50	0,33	1,00	3,00	2,00		0,67	0,50	1,00	4,00			**1,33**
2004	Projects funded	2	1	2	2	4	1	3	2	5	3	2			**27**
	Number of action areas	7	1	1	3	1	1	2	1	2	1	1			**21**
	Projects funded/action area	0,29	1,00	2,00	0,67	4,00	1,00	1,50	2,00	2,50	3,00	2,00			**1,81**
2005	Projects funded	5	4	2	2	2	3	3	2			4	1	1	**29**
	Number of action areas	5	4	2	3	5	5	4	3			3	1	2	**37**
	Projects funded/action area	1,00	1,00	1,00	0,67	0,40	0,60	0,75	0,67			1,33	1,00	0,50	**0,81**
2006	Projects funded	4	2	5	5	4	5	11	3			4		2	**45**
	Number of action areas	3	3	3	5	4	3	4	4			2		2	**33**
	Projects funded/action area	1,33	0,67	1,67	1,00	1,00	1,67	2,75	0,75			2,00		1,00	**1,38**
2007	Projects funded	10			11			4				3		1	**29**
	Number of action areas	3	5	4	6	5	3	4	4			4		2	**40**
	Projects funded/action area	0,83			0,79			0,50				0,75		0,50	**0,67**
Total projects funded															**149**
Total number of action areas															**154**
Total funded projects/action areas															**0,97**

ANNEX II

PHP ('HEALTH DETERMINANTS' STRAND) — ANALYSIS OF SIX POLICY AREAS

DRUGS

1. In December 2004 the European Council endorsed the EU drugs strategy (2005–12), a framework for two consecutive four-year action plans on drugs. The strategy's two general aims cover public health (prevention of drug use, harm reduction and treatment) and security (enforcement of laws prohibiting drug production and trafficking). DG SANCO is a minor player in drugs policy at EU level. Policy development is led by DG JLS, and the bulk of project funding goes to research projects managed by DG RTD and DG TREN. A Drugs Prevention and Information Programme has been set up for 2007–13 and is managed by DG JLS (budget 21 million euro). This has similar objectives and target participants to the PHP.

2. The European Monitoring Centre for Drugs and Drugs Addiction (EMCDDA) provides the EU and its Member States with a common information framework on drugs. The EMCDDA collects information on all aspects of drug use based on a network of national monitoring centres. It has also set up a database of best practices in drug prevention.

3. The drugs projects funded from the PHP were few in number and covered a wide range of aspects and contexts of the drugs problem. However, they shared a common focus on research/collection of information and the exchange of best practices. The Court noted that some of their objectives and activities, for example data collection and setting up a database of best practices, overlapped with the EMCDDA's field of activity. They could be carried out more cost/time-efficiently by the EMCDDA. In view of the existence of the EMCDDA and the dedicated Drugs Prevention and Information Programme, the value of including drugs projects in the EU's health programmes should be reconsidered.

ANNEX II

ALCOHOL

4. Alcohol is more difficult to tackle as a health topic than other addiction-related health determinants, because it is socially acceptable and does not pose a health risk as such if consumed moderately. However, harmful alcohol consumption is estimated to be responsible for about 10 % of the total disease burden, as well as creating or aggravating other social or economic problems such as accidents and violence. The most (cost-)effective alcohol control policies are legal restrictions, which come under the remit of Member States (higher purchase tax, reduced availability and measures to combat drink-driving and underage drinking).

5. In response to conclusions published in 2001 by the Council, in October 2006 the Commission produced a strategy for reducing alcohol-related harm. The strategy offers support for harm-reduction projects, data collection and the development of information and education measures in cooperation with Member States. Where industry is concerned, the EC alcohol strategy relies on voluntary codes and self-regulation rather than legal restrictions. In June 2007 the EC set up a European Alcohol and Health Forum with representatives from the business sector (alcohol producers, the advertising industry, the media, retailers and caterers) and public health and civil society organisations. Forum members are invited to commit to stepping up actions to reduce alcohol-related harm, for example by promoting responsible commercial communications.

6. The PHP projects addressing alcohol were characterised by a great deal of overlap in the partners involved and the information produced. Three of the five projects in the sample collected data and produced reports on the alcohol policy situation in each EU Member State. Meanwhile, a major comprehensive report on 'Alcohol in Europe' was produced for the Commission, as well as a report entitled 'Alcohol policies in EU Member States and Norway', which was produced using funding from the former Community Action Programme on Health Promotion. This overlap can be explained by the absence of an EU alcohol strategy to orientate priorities in the years before 2006 and the lack of a mapping exercise of previous activities in this field.

ANNEX II

TOBACCO

7. According to WHO, tobacco use is a leading cause of preventable premature death in the world today. The most (cost-)effective health promotion measure in connection with tobacco is legislation (higher purchase tax, restrictions on smoking in the workplace, advertising bans), which should be combined with consumer education through health warnings and campaigns.

8. Community support for anti-tobacco organisations began as early as 1987 with the Europe Against Cancer programme. The EU has also adopted legislative measures on tobacco control. They are based on the EU's competence in the internal market as laid down in Article 95 of the EC Treaty. In particular, two major directives were adopted in 2001 and 2003 on tobacco products and advertising respectively. More recently, the Green Paper 'Towards a Europe free from tobacco smoke: policy options at EU level' was published at the beginning of 2007.

9. This legislative action has been accompanied by Community support for Europe-wide prevention and cessation actions, in which the PHP projects are a minor budgetary player. More important programmes are public anti-smoking campaigns financed by the Community Tobacco Fund, which derives its resources from a levy on subsidies awarded to the EU's tobacco producers. To date the Tobacco Fund has financed two large awareness-raising campaigns. The latest campaign, 'HELP — For a life without tobacco', was launched in 2005 with a budget of 72 million euro over four years. It was devised for the Commission by a consortium of health experts and PR professionals, and includes a roadshow and TV spots broadcast in all EU Member States.

10. The tobacco projects financed from the PHP consisted mainly of two large networks which had already been receiving funding since 1996 under the predecessor action programmes. One dealt with smoking prevention in general, but with a strong focus on tobacco-control advocacy and lobbying, and the other focused on young people. As these networks were not officially eligible for financing, they were turned into 'framework projects' coordinating several sub-projects. In 2005 this structure was abandoned, and some sub-projects continued as stand-alones.

11. While the effect of the PHP projects is not measurable, the Community funding indirectly enabled the general network and its member organisations to conduct successful tobacco-control advocacy and lobbying activities at both EU and national level. One example is recent legislation in several Member States banning smoking in public places.

ANNEX II

NUTRITION AND PHYSICAL ACTIVITY

12. Rising public concern about the increasing obesity rate, especially among children, has been reflected in several Commission actions in recent years. In 2006 the Commission published the White Paper 'A strategy for Europe on nutrition, overweight and obesity-related health issues'. A key tool for implementing this strategy is the EU Platform on Diet, Physical Activity and Health, which was established in 2005 as a forum for stakeholders from civil society and industry who are willing to commit themselves to taking steps that can reduce obesity. Member State authorities are linked in the European Network on Nutrition and Physical Activity. To further the exchange of policy ideas and practices between Member States, in 2007 the Commission also set up a high-level group focused on nutrition and physical activity-related health issues.

13. Apart from these platforms, the strategy emphasises EU activities in related policy areas such as consumer policy (labelling), agriculture (distribution of fruit in schools) and urban transport (stimulating physical activity). The PHP plays only a very limited role in the strategy[1].

14. There are not many PHP projects in the area of nutrition and physical activity, and they have very diverse objectives and activities, which gives a fragmented picture. Several individual projects audited either were unable to demonstrate achievement of results or delivered low EAV. For example, one project was funded with the purpose of finding partners for a follow-up project, a proposal for which was never submitted. Another project, a study on the impact of food marketing to children, was found by the auditors to partly duplicate a similar WHO study. A third project financed activities which were implemented individually by the project partners, in a number of schools, around the themes of nutrition and physical activity. These local activities were devised by the children themselves to increase their commitment and could be anything from organising a sports festival in the park to decorating the school walls with pictures of fruit. While this might have some health impact in the participating schools, the EAV and the need for EU funding for these local activities are questionable.

[1] It is mentioned only once: '*The Commission will continue to support the monitoring function through its projects under the Public Health Programme, which support networking actions and sharing of information in the area of good practice in nutrition and physical activity, and obesity prevention.*' (White Paper, p. 9).

ANNEX II

SEXUAL AND REPRODUCTIVE HEALTH

15. The PHP marked a break from the Commission's 'disease-specific' approach (which had characterised its 1996–2002 AIDS/communicable diseases programme). The sexual and reproductive health policy area has become broader. However, HIV/AIDS is still the focus of most projects in this area[2].

16. In 2005 the Commission adopted its Communication on combating HIV/AIDS within the EU and in the neighbouring countries, 2006–09. This provided an action plan, an essential document which identified existing needs and necessary actions. The Commission has also launched several initiatives to consult relevant stakeholders in the field. The Think Tank on HIV/AIDS is a forum in which the Commission, the Member States and candidate and EEA countries can exchange information. The HIV/AIDS Civil Society Forum (CSF) is an informal advisory body that was established in 2005 to facilitate the participation of NGOs and networks.

17. The European Centre for Disease Prevention and Control (ECDC) was set up in 2005 as a Community agency for monitoring communicable diseases. Its action extends to HIV, and it runs a programme on HIV, sexually transmitted infections (STIs) and blood-borne viruses.

18. PHP projects in the area of sexual and reproductive health were the largest group in the audit sample. Most of these projects were networks with the shared objective of strengthening the capacity of the participating NGOs. They found their niche by focusing on different direct and indirect addressees: NGOs in central European countries, or NGOs working with migrants, migrant sex workers, local sex workers, injection-drug users or people living with HIV/AIDS.

19. Some of the networks collected data and monitored prevalence or other aspects of HIV/AIDS among their target groups. In future, these activities could be taken over by the ECDC.

[2] Since its emergence in the 1980s, HIV/AIDS has caused more than 25 million deaths worldwide. In the 1990s its spread was temporarily halted in Europe. The situation changed in the new century, when WHO reported that HIV was spreading rapidly in eastern Europe and was on the rise again in western Europe.

ANNEX II

MENTAL HEALTH

20. Mental health has been increasingly recognised as a public health issue in recent years. Unlike the current EC Treaty, the Treaty of Lisbon explicitly mentions mental health as an area for EU action[3]. However, successive past public health programmes have already co-funded projects in the fields of mental health promotion and prevention of mental disorders.

21. In September 2005, following the WHO European Ministerial Conference on Mental Health, the Commission published a Green Paper on mental health ('Promoting the mental health of the population: Towards a strategy on mental health for the EU') which launched a consultation on possible actions to be included in a planned mental health strategy. However, the Member States were unable to agree on the strategy and it had to be abandoned. For this reason, the planned EU platform on mental health also failed to take shape. After several attempts to take the issue further, in June 2008 the Commission organised a high-level conference which agreed on a European Pact on Mental Health and Well-being.

22. In the absence of a mental health strategy to orientate EU action, and given the broad nature of the mental health priorities set in the AWPs and the lack of an overview of existing activities, three of the four sampled projects in the mental health area overlapped significantly. Two projects funded under consecutive calls for proposals conducted identical activities, with a focus on policy development and data collection. There was also partial duplication of work with other actors. Several databases of mental health programmes have been created in parallel (e.g. the EU Agency for Health and Safety at Work in Bilbao has a database on stress), but they are not well interlinked.

23. Another project, funded to support the Commission in the development of the mental health strategy, never materialised. The project was then reorientated and given the task of coordinating the other mental health projects and helping to disseminate their outputs — in this role it overlaps with another, RTD-funded project.

[3] Article 152 of the EC Treaty: '*Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health*'. Article 168 of the Lisbon Treaty: '*Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health*'.

ANNEX III

PHP ('HEALTH DETERMINANTS' STRAND) — APPLICATION OF THE SMART CRITERIA TO THE PROJECT OBJECTIVES STATED IN THE GRANT AGREEMENTS OF THE 36 AUDITED PROJECTS

SMART criteria[4]	**Analysis of project objectives**
Specific (Do they specify the target group and the factors that need to change?)	Few grant agreements clearly specified the target group in terms of direct and indirect addressees and the changes which the project intended to bring. Often, while the objectives did not mention the target group, it could be inferred from the project activities (implicit target group).
Measurable (Are they written in a measurable format, e.g. magnitude of effects, numbers to be reached?)	None of the projects gave measurable objectives. Where performance indicators were defined in quantitative terms, they related to outputs to be produced, not objectives (typically, they referred to 'X copies of a report to be printed', never e.g. 'share of school children reporting they have performed some physical activity over the last 7 days to be raised to X %').
Achievable (Are they feasible given the available time, money, staffing?)	For most projects it was unclear whether the objectives had been achieved. Performance indicators complementing the objectives were largely absent; progress towards achieving them was usually not monitored. On the other hand, it could be argued that objectives such as 'exchange of information', 'increase knowledge', 'promote cooperation' are almost impossible not to achieve.
Relevant (Are they relevant for the target group/s?)	It lay outside the scope of the audit to verify this question for all projects down to the ultimate target group. However, direct addressees such as NGOs and health professionals were often involved as project partners. In the survey of project partners, 88 % of respondents said that the project objectives were relevant for their country or region and 86 % said they were relevant for their organisation.
Time-dependent (Do they state the time frame within which the objectives must be reached?)	Timescales were almost never applied to objectives, but only to outputs (e.g. a report to be produced by month X).

[4] Auxiliary questions in brackets are taken from Kok, H., Bollars,C., Molleman, G. and Van den Broucke, S., The European Quality Instrument for Health Promotion (EQUIHP), 2005.

REPLY OF THE COMMISSION

EXECUTIVE SUMMARY

IV.
As regards the Court's findings and conclusions,

(a)
In accordance with Article 152 of the Treaty, all actions of the Commission in the domain of public health aim at complementing the measures taken by Member States to protect and improve health. The Public Health Programme (PHP) 2003–07 is only one of the instruments used in this context.

The Commission agrees that a higher budget would achieve more, but the implementation of the PHP 2003–07 reflects the budgetary means granted by the European Parliament and the Council as well as the priorities and objectives both institutions approved for it.

The underlying logic of PHP 2003–07 is based on the health strategy adopted in 2000 by the Commission (COM(2000) 285 final), and takes into account the subsidiarity principle specified in the Treaty. Specific priorities are set in the annex to the programme decision. The programme primarily aims at the achievement of intermediate indicators, such as the identification and dissemination of 'good practice', the networking of EU public health expertise and the mapping of the European public health realities to prepare common approaches.

The priorities for the PHP as set out in Decision No 1786/2002/EC of the European Parliament and of the Council adopting a programme of Community action in the field of public health for 2003–08 were defined in line with the requirements of Article 152 of the Treaty and in accordance with the health strategy approved in 2000.

The Commission accepts that further progress is needed to specify in the AWP a number of such priority areas and areas for potential action which is commensurate with the available budgetary appropriations.

REPLY OF THE COMMISSION

(b)
Audited projects were selected in the initial phase of the PHP (2003–07). The situation changed significantly in the last two years of the programme audited, and this change has been maintained under the current PHP (2008–13). Since 2006, the 'guide for applicants' used for the calls for proposals has contained detailed instructions to applicants to use the latest generally accepted principles for project management for developing their application. The negotiation process ensures that these are actually fixed as such in the grant agreement, and the PHEA, now EAHC, ensures their application throughout the project duration. Since 2007 the executive agency carries out an annual mapping exercise.

(c)
The Commission welcomes the audit finding that stakeholders confirmed the 'European added value' (EAV) and usefulness of the PHP. It should also be noted that the existence of EAV has been an award criteria for grants since the start of the PHP (2003–07).

V.
In the EU context, the Commission's legislative proposals are generally accompanied by an *ex-ante* impact assessment which analyses the economic, social and environmental impacts of possible policy options. This is where the Commission intends to set out the programme logic of any putative successor programmes to the current PHP (2008–13).

The interim evaluation of the PHP (2003–07) performed in 2007 identified a certain number of areas for improvement. Several of these measures have been implemented, or are being implemented, in the management of the Public Health Programme (2008–13), including the recommended mapping exercise.

Since 2006, and in particular for the current PHP (2008–13) the guide for applicants used for the calls for proposals contains detailed instructions to applicants to use the latest generally accepted principles for project management for developing their application. The negotiation process ensures that these are actually fixed as such in the grant agreement, and the PHEA, now EAHC, ensures their application throughout the project duration.

VI.
The Commission agrees with the Court that the limited funding available at EU level needs to be focused on strategic topics and activities with an obvious European added value.

The Commission also shares the Court's view that the open method of coordination and other forums and platforms in the health field that facilitate collaboration and the exchange of information between Member States and stakeholders throughout the European Union could be further developed.

However, the Commission considers that such cooperation mechanisms can (and should) not replace a dedicated European funding programme in the area of public health. While such instruments facilitate collaboration and the exchange of information, they do not provide the necessary funding for EU-wide public health initiatives (e.g. for the start-up and maintenance of networks).

In addition, the PHP provides the Commission with the necessary means to initiate actions to support and underpin policy development in key areas of public health policy through successive call for proposals.

REPLY OF THE COMMISSION

AUDIT SCOPE AND APPROACH

10.
Article 152 stipulates that 'Community action shall complement national policies, [and] shall be directed towards improving public health' thereby making a distinction between the responsibility of Member States to implement their health promotion programmes and the responsibility of the Community to complement their action.

In this sense, the Commission underlines that the PHP primarily aims to target intermediaries — Member States, key stakeholders and actors — network them at EU level and help to identify and test 'good practice' in order to underpin and support public health policy development.

See also replies to paragraphs 14, 21, 40 and 60(c).

AUDIT OBSERVATIONS

14.
The intervention logic which underlies the PHP is based on Article 152 of the Treaty, which clearly stipulates that 'Community action shall complement national policies, [and] shall be directed towards improving public health', thereby making a distinction between the responsibility of Member States to implement their health promotion programmes and the responsibility of the Community to complement their action.

The PHP therefore aims to target intermediaries — Member States, key stakeholders and actors — network them at EU level and help to identify and test 'good practice' in order to underpin and support public health national policy development. In this context, it should also be noted that the practical guide 'Evaluating EU activities' was published in 2004 and could therefore not have been used in 1999–2000 when the PHP (2003–07) was designed.

Moreover, the PHP (2003–07) as adopted in Decision No 1786/2002/EC reflects the views expressed by the European Parliament and the Council in terms of priorities and objectives during the approval process.

See also replies to paragraphs 10, 21, 40 and 60(c).

The Commission accepts however that the intervention logic of the PHP (2003–07) has not been made fully explicit in the programme decision. It should be noted, havener, that this programme was designed in 1999–2000 and approved in 2002, i.e. in a period when the Commission´s current programming, monitoring and evaluation methods were not yet fully deployed.

15.
The benefits of a logic model approach will become increasingly apparent now that the PHP has become more established and its outputs clearer. As suggested in the 2007 interim evaluation report, a first attempt at modelling the potential benefits of the PHP for European citizens could be made in the *ex post* evaluation [to be carried out in 2010] (Wija J. Oortwijn et al, Interim evaluation of the Public Health Programme 2003–08. Final Report, RAND Europe technical report, 2007, section 2, p. 100).

16.
In the Commission's view, public health cannot directly be compared to other EU policy areas due to the limited scope of competences of Community action under the Treaty. Equally, Commission interventions in public health cannot be compared to those of institutions quoted by the Court. It is obvious that The California Wellness Foundation (which is a private foundation) has a more specific mandate and a direct access to final beneficiaries of its actions (Californian citizens) and can only be compared with regional bodies in Member States.

REPLY OF THE COMMISSION

17.
The action plan defined after the 2007 interim evaluation of the PHP (2003–07) has confirmed that logical models are to be used in the evaluation of the PHP.

See also reply to paragraph 15.

In addition, the application forms for projects require since 2006 that project design follows a logical model. Since the PHEA, now EAHC, was created, this has been reinforced and ensured in project negotiation and follow up, as documented by the agency's negotiation guidelines.

18.
The Commission agrees to the necessity of establishing indicators for an effective programme monitoring. The development of adequate indicators at policy, programme and project levels, together with the collection of data, is one of the objectives of the 'health information' strand of the PHP.

See also replies to paragraphs 30 and 31.

19.
PHP (2003–07) was designed in 1999–2000 and approved in 2002, i.e. in a period when the Commission´s current programming, monitoring and evaluation methods were not yet fully deployed.

It should also be noted that the SPP/ABM guide referred to was only published in 2004.

At the level of projects, the setting of SMART objectives has been gradually enforced in the two last years of the PHP (2003–07) and its current successor programme. Since 2006, the guide for applicants used for the calls for proposals instructs applicants to use the latest generally accepted principles for project management. The PHEA, now EAHC, ensures their application throughout the project duration.

See also reply to paragraph 86.

20.
As a matter of principle the Commission considers that the intervention logic of the PHP cannot easily be made as explicit as the intervention logic for a health promotion programme within a Member State or a third country. This is due to the fact that the PHP is not intended to be a health promotion programme targeted to citizens. This is also the reason why the global policy objectives cannot easily be broken down into specific targets at the level of programmes and projects.

See also replies to paragraphs 14 to 16.

21.
The activities of the PHP flow from the 2000 health strategy adopted by the Commission (COM(2000) 285) which sets the link with the activities of other actors (such as Member States). The PHP therefore aims to target intermediaries like Member States, key stakeholders and actors, to network them at EU level and to help identify and test 'good practice' in order to underpin and support public health policy development.

Moreover, the PHP (2003–07) as adopted in Decision No 1786/2002/EC reflects the views expressed by the European Parliament and the Council in terms of priorities and objectives.

See also replies to paragraphs 10, 14, 40 and 60(c).

22.
The Commission has made major efforts to set out its priorities in a precise and detailed way in the AWP.

23.
The Commission's financial intervention in public health cannot be easily compared to that of Member States as the respective domains of competence differ in shape and coverage.

REPLY OF THE COMMISSION

24.
The Commission agrees that a higher budget would achieve more, but the implementation of the PHP 2003–07 reflects the budgetary means granted by the European Parliament and the Member States and the priorities and objectives both institutions approved for it.

The PHP is a catalysator for creating the conditions for the development of improved health promotion activities. Calculating an average per European citizen is not particularly relevant for a programme such as the PHP.

25.
The Commission has made constant efforts to set out funding priorities in a precise and detailed way in the AWP in order to clarify the kind of work required, the policy link and the link to previous work. The selection of topics is influenced by Member State representatives in the Programme Committee which agrees the annual work programme.

See also reply to paragraph 78.

26.
In establishing the AWP, under each topic the Commission has detailed specific areas illustrating where actions would be of particular relevance.

27.
The Commission accepts that further progress is needed to specify in the AWP a number of such topics and areas for potential action which is commensurate with the available budgetary appropriations.

28.
In many cases the creation of links between actors in different areas of public health policy and the development of networking structures across Member States are also to be considered to be the principal objectives of most projects co-financed by the PHP. Such activities are mainly implemented through grants awarded through 'calls for proposals' procedures.

The use of tendering is often difficult, in particular in those domains where the number of potential bidders for such service contracts is limited.

30.
PHP 2003–07 was designed in 1999–2000 and approved in 2002, in a period when the Commission's current programming, monitoring and evaluation methods, such as activity-based management, had not yet been fully deployed.

The PHP was the first programme to provide for the definition, through its 'health information' strand, of strong and common indicators and for the collection of pertinent data in all Member States. It should also be noted that the Commission's Healthy Life Years indicator is the first and only global public health indicator available at EU level.

31.
The Commission considers that the setting up of indicators for an effective programme monitoring strongly depends on availability of pertinent data at project level. Developing appropriate indicators and data collection methods is one of the objectives of the PHP`s 'health information' strand.

See also reply to paragraph 18.

REPLY OF THE COMMISSION

32.
New AMP indicators (such as 'level of public awareness of unhealthy behaviours and lifestyle-related health risks', 'share of citizens that have their blood pressure measured each year', 'share of population being aware of the health risks of tobacco smoke for non-smokers', 'share of population knowing that balanced diet means eating a variety of different foods') were developed during preparation of the 2009 activity statement in the framework of the 2009 preliminary draft budget, and they were recognised by the Council Budget Committee as a significant improvement (Council document 13895/08 FIN362 dated 7 October 2008 — p. 23, 'COMBUD assessment report of the PDB 2009 activity statements — note d'introduction').

In addition, the Commission has set up a working group for the further definition of indicators to be used in the frame of APS and AMP with a view to systematising the collection of the related pertinent data on a more regular basis for APS and AMP exercises from the year 2010.

33.
During the period audited by the Court, the Commission has provided formal feedback to participants on a case-by-case basis at the interim and final reporting stages, both on operational and financial considerations.

Since the creation of the PHEA, now EAHC, the monitoring of projects has further improved.

See also replies to paragraphs 51, 53 and 70 to 73.

36.
The projects audited by the Court were selected in the starting phase of the PHP (2003–07). The Commission notes that it took applicants time to get used to requirements to specify objectives, activities and actions in more detail. In the Commission's view, the situation is however constantly improving.

The guide for applicants used for the calls for proposals since 2006 instructs applicants to use the latest generally accepted principles for project management (including definition of objectives) for developing their application. The negotiation process ensures that these are actually fixed as such in the grant agreement, and the project officers of the PHEA, now EAHC, ensure their application throughout the project duration.

38.
See also replies to paragraphs 19 and 86.

40.
The PHP primarily aims to target intermediaries — Member States, key stakeholders and actors — and to network them at EU level. It also helps to identify and test 'good practice' in order to underpin and support public health national policy development.

See also replies to paragraph 10, 14, 21, 36 and 60(c).

41.
This only applies to the 2003, 2004 and 2005 projects and has since been corrected with the issuance of a more directive guide for applicants as of 2006.

See also reply to paragraph 36.

REPLY OF THE COMMISSION

42.
In selecting projects, relevance to EU policies is a main criterion for funding. Projects have an impact on the policies cycle in several ways, for example by:

— feeding outcomes into technical bodies of Member States and stakeholders;
— promoting sustainable networks of expertise;
— providing the background for recommendations on good practice.

The impact on people's lifestyle is achieved indirectly.

45.
The RDI cycle is not fully applicable as projects could only be targeted towards the intermediate level. The action was therefore limited to research followed by development and in some cases pilot projects but the Commission is in no position to reach the stage of full-scale implementation.

The Commission can point to several examples of a successful uptake of results of projects financed under the PHP (2003–07), such as the following:

— Work on the impact of advertising on young people (children,obesity and associated avoidable chronic diseases) fed into the Commission's round table on advertising self-regulation (from 2005) which produced a code of conduct for self-regulation in the EU advertising Sector. It also contributed to the concept of the EU Platform on Diet, Physical Activity and Health where the European Heart Network is still an active member.
— The Shape-up project contributed to the development of innovative examples of good practices to promote healthy behaviours in school settings and of public–private partnership approaches that are promoted in the Strategy for Europe on Nutrition, Overweight and Obesity-related health issues adopted by the Commission in 2007. Shape-up leaders are currently part of a group of actors convened by the Commission for the promotion of good practice examples and of community-based approaches based on public–private partnerships.
— Good practice and policy recommendations on sexual education and sexual health developed by the SAFE project were presented to the HIV/AIDS Think Tank and the Civil Society Forum. Key elements of their conclusions were taken up in the discussion document developed by the sexual health round table on potential future EU action in this area and discussed in a workshop in May 2008.
— On drugs in prisons, ENDIPP provided background information for follow-on work which in turn led to the preparation of country reports on prevention, treatment, and harm reduction services in prison, on reintegration services on release from prison and on methods to monitor/analyse drug use among prisoners, and fed into preparatory work towards a proposal for a Council recommendation.
— SUPPORT has been reoriented to enable more transparency and synergies between mental health projects and help using and disseminating their outputs. SUPPORT provided input to the preparation of the European Pact for Mental Health and Well-being and into the June 2008 high-level conference and organised related workshops.

REPLY OF THE COMMISSION

— 'Eurocare — Closing the gap' contributed to creating a level playing field for discussions on alcohol policy with stakeholders, as it allowed non-industry players to develop common positions and take these forward in discussions involving economic operators organised by the Commission. The project allowed the public health community to provide substantial structured and coordinated input into the Community's alcohol strategy, which was adopted in October 2006, and its implementation.
— Input was provided to the Commission's Green Paper 'Towards a Europe free from tobacco smoke' (through various projects funded by DG SANCO and referenced in the Green Paper). Input was also provided to the Framework Convention on Tobacco Control (FCTC) through a position paper of the Framework Convention Alliance (an international network of more than 200 non-governmental organisations) drafted under ENSP — the European Network for Smoking Prevention.

The creation of the ECDC in Stockholm has been pushed forward and its work priorities developed on the basis of projects on communicable disease surveillance supported under the 'health threats' strand.

More broadly, the Healthy Life Years indicator in the Lisbon strategy — which is an important reference for intervention on health determinants — has been developed on the basis of projects on health indicators under the health information strand, and is still calculated and being further developed on the basis of such projects, as are other key benchmark indicators of health at Community level in the European Community Health Indicators (ECHI) list. The relevance of these at national level is clear, with the Healthy Life Years indicator being adopted as the key benchmark for the national health strategy in Estonia, for example, and the Netherlands using the more detailed ECHI list to benchmark its national policies in a specific publication 'Dare to Compare'.

46.
Generally national funding sources are available only for national components of networking activities across Member States. This explains the need for a European PHP to finance such activities, which are clearly in the overall EU interest.

See also replies to paragraphs 56 and 64.

Under the first PHP (2003–07) funding mechanisms were not adapted to provide longer-term financial support. Under the current PHP (2008–13) other, more appropriate, tools and financing mechanisms are available, mainly operating grants and joint actions financing.

48.
See reply to paragraph 46.

51.
The Commission considers that its monitoring of projects undertaken has significantly improved since the period covered by the audit. Nevertheless, information on previously funded projects has always been available. In particular, lists of previously funded projects with links to their reports were made public either on the DG SANCO or the PHEA, now PHEA, websites. Since 2008, such monitoring information is also encoded in a comprehensive database.

This tool will further enhance the Commission's monitoring of its project portfolio.

See also replies to paragraphs 33, 52 and 70 to 73.

REPLY OF THE COMMISSION

52.
As regards the complementarity between projects, the Commission has required project proponents to put their project into the context of existing projects and build on results already achieved. This has also been specified as one of the award criteria for grants.

In certain cases, the Commission required proponents to cooperate with other projects and to make documentation on previously funded work publicly available.

In addition, as a general procedure, lists of selected projects for funding are submitted to the Commission-wide interdepartmental consultation procedure.

See also reply to paragraph 51.

53
(a)
It should be noted that the scope for actions when considering 'health determinants' is large. The PHP aimed at pioneering different approaches while avoiding overlaps. The Commission considers that the fact that projects were diverse and covered different aspects of the 'drugs' or 'nutrition and physical activity' areas shows that efforts to avoid overlap were successful.

Projects like 'Shape up' or 'EPODE' funded under the PHP fed into the 2007 White Paper on nutrition, overweight and obesity-related health issues. The EU drugs strategy calls for a multidisciplinary approach (EU drugs strategy 2005–12 Council document 15074/04 dated 22 November 2004).

53
(b)
All projects audited fulfilled the PHP selection and award criteria. While different projects may have dealt with similar issues, they did so from different perspectives and with different methodologies.

In the field of the reduction of alcohol-related harm, there were only a limited number of organisations operating at European level, and/or capable of leading projects with a European dimension. It is to be noted that the different country reports on the situation regarding alcohol policy in the EU Member States on the one hand, and the 'Alcohol in Europe' report on the other, served different purposes, and are different in content (see Annex II, point 6).

53
(c)
The Commission considers that the two tobacco networks clearly addressed different target groups.

In the 'sexual and reproductive health' area the Commission has a dedicated policy on HIV/AIDS, including an action plan which is partially implemented through PHP funding. Such funding results in improved prevention of HIV transmission across Europe (see Annex II, point 15).

The advisory bodies referred to by the Court play an important role in the coordination of EU policy on HIV/AIDS, but have no financing capacity (see Annex II, point 16).

In the Commission's view it is important to support and to strengthen specialised NGOs and networks acting on the ground or on political levels, and supporting PLWHA or working towards the prevention of new HIV infections. NGOs or networks have to reach their counterparts — be they patients, people belonging to risk groups, local or national authorities, or politicians. A specialisation, or, as the report states, a 'niche', is consequently an asset for an NGO working in the field of HIV/AIDS. Taking into account, for example, the costs for a lifelong antiretroviral treatment in the EU at an average price of 10 000 euro per person per year (only for medication), an investment in specialised and professional NGOs reaching people who are most at risk of attracting HIV is justified and reasonable (see Annex II, point 18).

REPLY OF THE COMMISSION

The European Centre for Disease Prevention and Control (ECDC) in Stockholm became fully operational with respect to HIV/AIDS epidemiology as from 2008 onwards (see Annex II, point 19).

54.
Only the RTD framework programme and the drugs programme, and the ECDC as concerns communicable diseases surveillance, provide funding for cooperation at European level. In these cases the Commission has put in place mechanisms to ensure coordination and to avoid overlap with the PHP.

Through the PHP, the Commission has initiated actions in several domains which supported and underpinned policy development in key areas of European public health policy. This has been done bearing in mind the existence of other cooperation mechanisms.

The ECDC was created based on the results of PHP (2003–07) projects. Furthermore the Commission funds PHP projects with international organisations like the WHO (such as 2007WHO02 'Nutrition and physical activity surveillance') and the OECD (such as 2006OECD02 'Health workforce and international migration').

See also reply to paragraph 45.

56.
The existence of 'European added value' (EAV) has always been a key criterion for making award decisions for PHP projects.

The existence of other cooperation mechanisms (such as the open method of coordination) for facilitating collaboration and exchange of information among stakeholders throughout Europe does not exclude action by the PHP. Most of these other mechanisms do not provide financing necessary for start-up and maintenance of initiatives at European level.

See also replies to paragraphs 46 and 64.

57.
The vast majority of projects consisted of networks, as one of the award criteria was the involvement of partners from different European countries.

58.
See reply to paragraph 45.

60.
(a)
See reply to paragraph 52.

60.
(c)
The PHP does not in general fund going-to-scale implementation projects. This is the responsibility of Member States.

See replies to paragraphs 10, 14 and 40.

62.
The Commission welcomes this confirmation of the 'European added value' (EAV) and the usefulness of the PHP.

REPLY OF THE COMMISSION

64.
Other existing mechanisms of cooperation, in particular with Member States, cannot replace the PHP's action in underpinning and supporting policy development in some domains or activities for which actual financial support is crucial.

See also replies to paragraphs 46, 54 and 56.

65.
The activities resulting from this Council working party are to be funded through the current PHP (2008–13).

69.
The Commission shares the view that partnerships generally worked well.

It particularly welcomes the positive assessment by project coordinators of large-scale networks to bring together knowledge and expertise at the EU level.

70–73.
During the period audited by the Court, the Commission has provided formal feedback to participants on a case-by-case basis at the interim and final reporting stages, both on operational and financial considerations. Where necessary, corrective actions on reports were taken through withholding payment for a period pending provision of complementary information.

The Commission considers that since the creation of the PHEA, now EAHC, the monitoring of projects has been further improved.

See also replies to paragraphs 33, 51 and 52.

78.
Member States are officially informed of the list of selected projects (see for example C(2008) 6180 for the year 2008) after evaluation of the proposals through their representatives in the PHP Committee. This list is formally reviewed by the programme committee before submission to the European Parliament for scrutiny and then to Commission for formal approval.

See also reply to paragraph 25.

CONCLUSIONS AND RECOMMENDATIONS

Programme design

83.
Article 152 of the Treaty stipulates that 'Community action shall complement national policies, and shall be directed towards improving public health' thereby clearly making a distinction between the responsibility of Member States to implement their health promotion programmes and the responsibility of the Community to complement their action.

The PHP was designed in accordance with the health strategy adopted in 2000 by the Commission (see COM(2000) 285) and taking into account the limited scope of competences of Community action under the Treaty.

The PHP primarily aims to target intermediaries — Member States, key stakeholders and actors — and network them at EU level. It also helps to identify and test 'good practice' in order to underpin and support public health national policy development.

REPLY OF THE COMMISSION

The Commission accepts that the intervention logic of the PHP (2003–07) has not been made explicit in the programme decision. It should be noted, however, that this programme was designed in 1999–2000 and approved in 2002, i.e. in a period when the Commission´s current programming, monitoring and evaluation methods were not yet fully deployed.

The benefits of a logic model approach will become increasingly apparent now that the PHP has become more established and its outputs clearer. As suggested in the 2007 interim evaluation report, a first attempt at modelling the potential benefits of the PHP for European citizens will be done.

See replies to paragraphs 10, 14, 15, 19, 21, 40 and 60(c).

Developing appropriate indicators and data collection methods is one of the objectives of the PHP`s 'health information' strand. The Commission considers that setting up of indicators for an effective programme monitoring strongly depends on availability of pertinent data at project level.

New indicators were developed in the frame of the 2009 preliminary draft budget. In addition, the Commission has set up a working group for the further definition of indicators to be used in the frame of APS and AMP for the year 2010.

See replies to paragraphs 31 and 32.

84.
The Commission has made major efforts to set out its priorities in a precise and detailed way in the AWP. The Commission accepts that further progress is needed to specify in the AWP a number of such topics and areas for potential action which is commensurate with the available budgetary appropriations.

The final evaluation of the PHP (2003–07) will be available in 2010 — when the majority of the projects will be finished — and will allow overall conclusions to be drawn on the effectiveness of the programme in reaching its objectives.

See replies to paragraphs 22, 25 and 27.

Recommendation 1

While the Commission has the right of initiative, it is the European Parliament and the Council which adopt the programme decision, including the objectives to be achieved and the budgetary appropriations to be made available for achieving these objectives.

Since 2002, the Commission's legislative proposals are generally accompanied by an *ex ante* impact assessment which analyses the economic, social and environmental impacts of possible policy options.

This is where the Commission intends to set out the programme logic of any putative successor programmes to the current PHP (2008–13).

See reply to paragraph 15.

85.
It should be noted that the scope for actions when considering 'health determinants' is large. The PHP aimed at pioneering different approaches while avoiding overlaps.

All projects audited fulfilled all the selection and award criteria. While different projects may have dealt with similar issues, they did so from different perspectives and with different methodologies, thus increasing the significance of the results produced.

REPLY OF THE COMMISSION

The Commission considers that the fact that projects were diverse and covered different aspects in a given area shows that efforts to avoid overlap were successful.

As regards the complementarity between projects, the Commission has required project proponents to put their project into the context of existing projects and build on results already achieved before. This has also been specified as one of the award criteria for grants.

In addition, the Commission refers to its general interdepartmental consultation procedure which was applied to the PHP.

Ensuring complementarity will be made easier with the creation of a comprehensive database for project monitoring information.

The existence of 'European added value' (EAV) has always been a key criterion for making selection and award decisions for PHP projects.

See replies to paragraphs 46, 51, 52, 53 and 56.

86–87.
PHP 2003–07 was designed in 1999–2000 and approved in 2002, i.e. in a period when the Commission's current programming, monitoring and evaluation methods had not yet been fully deployed.

The projects audited by the Court were selected from the starting phase of the PHP (2003–07).

The Commission notes that it took applicants time to get used to requirements to specify objectives, activities and actions in more detail. In the Commission's view, the situation is however constantly improving. The guide for applicants used for the calls for proposals since 2006 instructs applicants to use the latest generally accepted principles for project management (including definition of objectives) for developing their application. The negotiation process ensures that these are actually fixed as such in the grant agreement, and the project officers of the PHEA, now EAHC, ensure their application throughout the project duration.

See replies to paragraphs 19 and 36.

88.
The Commission welcomes this confirmation of the 'European added value' (EAV) and of the usefulness of the PHP. The existence of EAV has always been a key criterion for making award decisions for PHP projects.

The vast majority of projects consisted of networks, as one of the award criteria was the involvement of partners from different European countries.

See replies to paragraphs 56 and 57.

89.
The Commission accepts that under the first PHP (2003–07) funding mechanisms were not adapted to provide longer-term financial support. Under the current PHP (2008–13) other, more appropriate, tools and financing mechanisms are available, mainly operating grants and joint actions financing. Generally national funding sources are available only for national components of networking activities across Member States. This explains the need for a European PHP to finance such activities which are clearly in the overall EU interest.

See replies to paragraphs 46, 56 and 64.

REPLY OF THE COMMISSION

90.
The Commission shares the view that partnerships generally worked well. It particularly welcomes the positive assessment by project coordinators of large-scale networks to bring together knowledge and expertise at the EU level.

During the period audited by the Court, the Commission has provided formal feedback to participants on a case-by-case basis at the interim and final reporting stages, both on operational and financial considerations. Since the creation of the PHEA, now EAHC, the monitoring of projects has been further improved.

Member States are officially informed of the list of selected projects after evaluation of the proposals through their representatives in the PHP Committee. This list is formally approved by the Committee before submission to the European Parliament for scrutiny and then to Commission for formal approval.

The Commission intends to implement the recommendation of the Court to reinforce dissemination activities for projects funded under the PHP.

See replies to paragraphs 33, 51, 69, 70 and 78.

Recommendation 2

Reply to the first subrecommendation
The interim evaluation of the PHP (2003–07) performed in 2007 identified a certain number of areas for improvement, including the mapping exercise recommended by the Court of Auditors for the current PHP (2008–13).

See reply to paragraph 51.

The Commission intends to carry out such a mapping exercise annually for the current PHP (2008–13). This will complement those carried out in 2007 and 2008 for projects undertaken under PHP (2003–07).

Reply to the second subrecommendation
The Commission accepts that further progress is needed to specify in the AWP a number of topics and areas for potential action which is commensurate with the available budgetary appropriations.

See reply to paragraph 27.

Reply to the third subrecommendation
Since the creation of the PHEA, now EAHC, the design and monitoring of projects undertaken has improved. The new funding possibilities for networks will be consistently used.

See replies to paragraphs 33 and 46.

Overall conclusion

91.
The Commission agrees that a higher budget would have allowed more to be achieved, but the PHP 2003–07 reflects the budgetary means granted by the European Parliament and the Council and its priorities and objectives for this programme.

92.
The impact on citizens' health of any health promotion initiative can only be assessed through changes in citizens' behaviour, which can only be assessed over the long term. The Commission considers that current and previous PHPs made a significant contribution to foster a modern, participative public health policy at EU level.

REPLY OF THE COMMISSION

Recommendation 3

Reply to the first subrecommendation
Through the PHP the Commission has been able to initiate actions in several key areas of public health which supported and underpinned policy development. This is being done bearing in mind the budgetary means available and the existence of other cooperation mechanisms (such as the open method of coordination) which, although facilitating collaboration and exchange of information among stakeholders throughout Europe, do not provide financing necessary for start-up and maintenance of networks.

Reply to the second subrecommendation
The Commission considers that the best opportunity to review the current health programme will be provided when the results of the evaluation of the PHP (2003–07) are available, in 2010.

For any putative successor programme to the current PHP (2008–13) after 2014, the Commission, in accordance with its procedures, is to carry out an *ex ante* impact assessment which will analyse the different policy options and their respective impacts.

European Court of Auditors

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IN THIS REPORT, THE EUROPEAN COURT OF AUDITORS ANALYSES THE EUROPEAN UNION'S PUBLIC HEALTH PROGRAMME (PHP) FOR 2003–07. THE COURT'S AUDIT ASKED WHETHER THE RIGHT CONDITIONS WERE SET FOR PROJECTS FINANCED FROM THE EU BUDGET TO COMPLEMENT THE MEASURES TAKEN BY MEMBER STATES TO PROTECT AND IMPROVE PUBLIC HEALTH. THE REPORT DETAILS CONCLUSIONS AND RECOMMENDATIONS IN PROGRAMME DESIGN, IMPLEMENTATION AND MANAGEMENT. IN VIEW OF ITS FINDINGS, THE COURT CALLS INTO QUESTION THE UTILITY OF CERTAIN COMPONENTS OF EUROPEAN PUBLIC HEALTH PROGRAMMES SUCH AS THE PHP. THE COMMISSION AND THE MEMBER STATES ARE INVITED TO RECONSIDER THE EU'S FUNDING APPROACH IN THE FIELD OF PUBLIC HEALTH.

EUROPEAN COURT OF AUDITORS

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