Framework Contract SANCO/2008/01/055 Lot 1: Provision of Evaluation, Impact Assessment and Related Services to the Commission in the Area of Public Health

Specific Contract: Mid-Term Evaluation of the EU Health Strategy 2008-2013

EXECUTIVE SUMMARY

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BACKGROUND, OBJECTIVES AND APPROACH

The EU Health Strategy covers the period 2008 – 2013 and aims to address the key challenges facing the EU in the area of health, and give direction to future EU activities in health. Although Member States (MS) have the main responsibility for providing healthcare to European citizens and defining health policy, it is the European Commission (EC)'s role to promote cooperative action, particularly relating to health threats and issues with a cross-border or international impact, and the prevention of illness. This implies working on health issues across all sectors.

The EU Health Strategy sets out four core principles and three strategic objectives, as well as specific action points for the Commission and MS in relation to these. Having reached the half-way point in its implementation, DG SANCO commissioned this evaluation of the EU Health Strategy in order to guide the implementation of the Strategy going forward and take stock of the actions implemented to date. The main purpose of this mid-term evaluation of the EU Health Strategy is to:

1. Evaluate the implementation and impacts of the EU Health Strategy for the period 2008-2010 (ex-post) including the financial and coordination mechanisms (without Health Programme).
2. Carry out an overview to see whether the principles and objectives, as well as the coordination mechanisms, are still equally weighted or whether they should be prioritised for the remaining period of the strategy.

To fulfil this objective, the evaluation team developed a methodology based on a mix of participatory and static data collection tools, namely:

1. **Stakeholder interviews** with five groups of stakeholders, i.e. DG SANCO and other EU institution officials; EU officials involved in EU policies, activities and funding programmes; MS representatives of the Council Working Party on Public Health (SLWP); members of the EU Health Policy Forum (EUHPF); and members of International Organisations (IOs) and further partners. The aim of the interviews was to gather the views of a wide range of actors involved with the EU Health Strategy and/or in the field of health, and information of a mainly qualitative nature in the following areas: awareness of the EU Health Strategy; impact of the EU Health Strategy; the coordination mechanisms; EU Value Added of the EU Health Strategy; and the future of the EU Health Strategy.

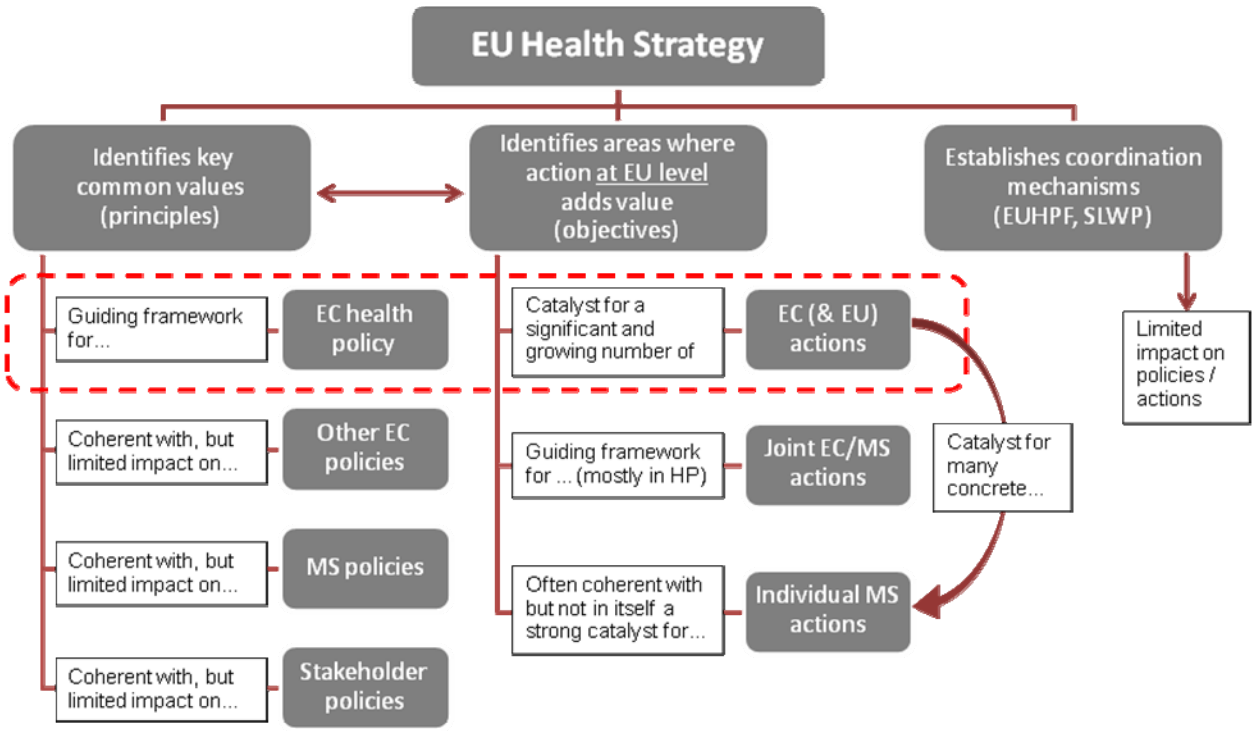
2. **A questionnaire of MS** to gather first-hand information on the outputs and impacts of the EU Health Strategy at MS level. The questionnaire allowed for information to be gathered from MS representatives of the SLWP on: the use MS make of the EU Health Strategy; the relevance of the policy areas it covers; key actions in MS at national or regional level that were undertaken as a direct (or indirect) result of the Strategy (i.e. outputs at MS level); and the extent to which the EU Health Strategy has impacted on MS's overarching policies on public health (i.e. impacts at MS level). In particular, it provided the evaluation team with important information for some of the desk research tasks briefly described below, e.g. the mapping of outputs at MS level in relation to the EU Health Strategy and review a sample of MS health strategies in relation to the EU Heath Strategy.

3. **Desk-based research** to:
    a. map the EU Health Strategy's outputs at EU and MS level, linking them back to the Strategy's principles and objectives and categorising them in terms of activity areas (e.g. health information, tobacco, eHealth), date, implementation stage, and different degrees of action;
    b. develop a baseline appreciation of the uptake of HiAP in MS through a review of abstracts in the PubMED database, and assess HiAP in the EC through an assessment over time of the references to qualitative and quantitative health impacts in the EC's Impact Assessments;
    c. review the mandates, compare the outputs and assess the structure and representativeness of the EU Health Strategy's two coordination mechanisms to assess their role and functioning;
    d. compare the overarching national health strategies or policy documents of six MS with the EU Health Strategy for thematic and structural similarities and differences in order to judge the extent to which the EU Health Strategy has had an impact on these;
    e. examine a sample of other EU policies, programmes and activities with conceptual linkages to the EU Health Strategy in order to analyse the extent to which elements of the Strategy have been included or streamlined into other EU policies and activities;
    f. explore and discuss possible implementation indicators which could assist in a future monitoring exercise of the implementation of the EU Health Strategy, in particular at MS level;
    g. conduct a multi-criteria analysis, rating the principles and objectives of the EU Health Strategy in relation to given criteria, with a view to prioritising certain principles and objectives going forward;
    h. and assess the consistency of the EU Health Strategy with the Commission strategic objectives and Europe 2020.

CONCLUSIONS

Subject to the limitations outlined in the evaluation report, the evaluation results suggest that the EU Health Strategy has had varying success in influencing, guiding and encouraging different actors in the public health arena to adopt, adapt or revise policies, or undertake concrete actions. The figure below provides a simplified graphic overview of the key conclusions of the evaluation

Figure 1 – Overview of the conclusions of the evaluation



Legend: White boxes represent key evaluation results, grey boxes the different strategic elements of the EU Health Strategy (top row) and the policies and actions of different actors that were influenced (to a greater or smaller degree) by the Strategy.

1. Implementation: Outputs

The evaluation attempted to compile an inventory of outputs, i.e. actions undertaken by key actors (namely the EC and MS) in response to or as a direct result of the EU Health Strategy. In the case of EC outputs, this was created using as a basis implementation reports produced by DG SANCO. At the MS level, examples of outputs were provided by MS in response to the questionnaire. This resulted in an inventory of 137 EC outputs and 223 MS outputs covering 17 MS; these outputs ranged from binding legislation to softer measures such as consultations, information provision and events. Although the nature and scope of the exercise means that this inventory is not necessarily complete, and the question of attribution is often difficult to address, together with the results of the stakeholder interviews it provides a useful basis for identifying some key trends and developments.

Thus, in the case of the Commission, there has been an increase in the number of actions being implemented since the inception of the EU Health Strategy, with 52 being implemented in 2008, 65 in 2009 and 80 in 2010. In terms of action areas, both the Commission and MS place particular importance on actions relating to diseases, ranging from pandemics, to communicable, to chronic, to non-communicable diseases, as these represented the highest proportion of actions in both cases. Regarding the EU Health Strategy's principles and objectives, progress has been made in relation to each, but its extent varies. Objective 1 (Fostering good health in an ageing Europe) was an area of particular focus for action at both Commission and MS level. By contrast, Principle 1 (A Strategy based on shared values) was

seen by many of the stakeholders interviewed as an area where limited progress had been made, in particular in relation to health inequalities.

Overall, the evaluation has found a high level of activity by both the Commission and MS, using a wide variety of policy tools, in most of the areas covered by the EU Health Strategy. As such, the EU Health Strategy clearly captures a lot of and is generally aligned with what both the Commission and MS consider a priority in health policy. However, it would be erroneous to assume that all of the actions identified by the evaluation can be directly attributed to the EU Health Strategy; there are many factors that shape health policy, and it seems unlikely that most EC or MS actions occurred only or primarily because of the EU Health Strategy (even though they are in line with its principles and objectives).

That said, there are indications that the EU Health Strategy has been one of the factors that has contributed to the various actors focusing their attention on the issues mentioned therein. Moreover, the evaluation results suggest that the EU Health Strategy has spurred action at Commission level, as the number of actions being implemented has increased year-on-year since the EU Health Strategy's inception. This would fit with stakeholder's views that a key purpose of the EU Health Strategy is to provide a coherent framework for action at Commission level.

2. Implementation: Coordination mechanisms

Two main coordination mechanisms with specific mandates aim to support the implementation of the EU Health Strategy, namely the EU Health Policy Forum (EUHPF), which brings together NGOs, health professionals, health providers and economic operators, and the Working Party on Public Health at Senior Level (SLWP), a Council body formed of MS representatives. The results of the desk research exercise and stakeholder interviews suggest that the coordination mechanisms have fulfilled their roles, as outlined in the EU Health Strategy and in particular in their mandates, to a limited extent only.

According to the interviews with members of both mechanisms, the EUHPF fulfilled its role as a communication channel, even if too "one-way" with information flowing principally from the Commission to members, but it was felt that it did not necessarily achieve its full potential as a tool for proposing policy options and identify emerging health issues and shaping (or giving feedback on) policy proposals and implementing measures. The SLWP was seen as bringing certain key topics for discussion to the table, but as not having the correct working method to ensure continuity in its activities, develop concrete outputs, and ensure the follow-up of its recommendations. Interviewees also felt that the coordination mechanisms have contributed to health policy developments at MS level to a very limited extent only. The same was true of their contribution to increased awareness of the EU Health Strategy at MS level.

The desk research suggests that the EUHPF has only produced a limited number of concrete outputs, while the SLWP's Outcomes of Proceedings are not sufficiently concrete to be defined as outputs in that any conclusions drawn or recommendations made are not followed-up on by a technical body or pursued at Council level. Although the coordination mechanisms are both representative (the EUHPF brings together members from four key sectors in a balanced way and the SLWP is open to all 27 MS and its meeting are generally attended by representatives of 23 to 24 MS), in the case of the SLWP, Director General or

General Secretary level officials are supposed to attend the meetings, but participation of such high-level officials has waned over time.

Overall, the evaluation has found that the EU Health Strategy's coordination mechanisms have not been able to live up to their full potential, in terms of meeting all the terms of their respective mandates, producing a significant number of concrete outputs, attracting the higher-level target audience for the SLWP, and contributing to policy developments and increased awareness of the EU Health Strategy at MS level. This is in part a result of the working methods of these bodies, which need to be reviewed in order to provide the SLWP and EUHPF with more vitality and dynamism. However, the evaluation results show that these shortfalls are also a result of the fact that the EU Health Strategy itself does not set clear, concrete, timely and measurable targets for individual stakeholders to work towards.

3. Impact

The evaluation examined the EU Health Strategy's policy impact by focusing on two main areas, namely (1) the impact on EU policies, activities and funding programmes in areas other than public health, and (2) the impact on the health policies of MS.

a. Impact on other EU policies and activities, funding programmes

According to stakeholders, the EU Health Strategy is relevant to EU policies, activities and funding programmes, with a number of examples provided of work undertaken by a variety of Commission DGs that integrated a health element or made reference to the EU Health Strategy. The EU Health Strategy was seen as particularly relevant to the work of DG INFSO and DG RTD. However, the review of key policy documents in a small sample of areas (social, cohesion, development and research policy) suggests that the EU Health Strategy's impact on such policies has been limited. Based on the examples that were reviewed, the EU Health Strategy is relevant for and coherent with EU policies, activities and funding programmes in other areas, in that health is taken into account in ways that fit with the EU Health Strategy's principles and objectives. However, there has been no discernable direct impact of the EU Health Strategy on these policies.

The evaluation also analysed the extent to which health impacts are considered in EC Impact Assessments (IAs). In principle, IAs were expected to be one of the key tools for implementing the Health in All Policies (HiAP) principle at Commission level. However, the evaluation results suggest that the EU Health Strategy has not led to an increased consideration of health impacts IAs. The analysis shows that the percentage of Commission IAs that included an assessment of health impacts peaked in 2007/08, but since then it has declined again.

b. Impact on MS's national health strategies

In the first instance, the impact of the EU Health Strategy on national policies was assessed based mainly on the MS's responses to the questionnaire. In their responses, the vast majority of MS stated that the EU Strategy reflected their key national priorities in health policy, and nearly half of all MS claimed that the EU Strategy has exerted a significant influence on their respective national health strategies. The questionnaire responses also show that since the adoption of the EU Health Strategy, seven MS have adopted new national health strategies, and four MS have revised their pre-existing national health strategies. In their questionnaire

responses, representatives of these specific MS rated the influence of the EU Health Strategy on the development of their national health strategies as ranging from significant to minor.

In order to further test the extent to which the EU Strategy influenced those national health strategies that were adopted or revised recently, a sample of such national strategies were examined in more depth. The results of this review suggest that the degree of influence of the EU Health Strategy is likely to be less important than the questionnaire responses mentioned above suggest. Most of the thematic or structural similarities identified between the EU Health Strategy and MS's national health strategies are more likely to be a reflection of aligned priorities than of a significant influence of the EU Health Strategy. In fact, any such similarities support the MS questionnaire finding that MS believe that the EU Health Strategy is in line with their key health priorities. Thus, it can be concluded that while there often exist a number of similarities between the national strategies assessed and the EU Health Strategy, a direct causal link can only be established in a few specific cases.

4. Added Value

Based on the assessment of the level of action taken by different actors as a result of the EU Health Strategy (outputs), of its impacts on policy-making in the EU and MS, and of the views and perceptions of relevant stakeholders, the evaluation concludes that the EU Health Strategy's main added value is that it identifies in a comprehensive, coherent way those health-related issues and problems that can and should be tackled at the EU level. As such, it acts as a guiding framework and – to some extent – as a catalyst for actions at the EU level (i.e. principally by DG SANCO and by MS jointly). In this sense, it seems to have been a success as it has led to a number of outputs at Commission level (principally by DG SANCO), as well as Joint Actions between MS through the Health Programme, its main funding mechanism. Moreover, it identifies areas where "MS cannot act alone effectively", and proposes actions (mainly for the Commission) to tackle these areas.

However, the EU Health Strategy is far less clear about the role of other actors in relation to it. In fact, most actors outside of the EU institutions do not see it as an invitation or an inspiration for them to become active. While a number of national policy makers and stakeholders reported having used the EU Health Strategy as a reference document, it has not promoted a significant amount of cross-stakeholder actions and a lot of the work on health is being conducted outside the coordination mechanisms in other fora, bodies and working groups on given topics. Aside from for the Commission and, to lesser extent, for MS, it does not specify what actions different stakeholders should undertake to help implement the EU Health Strategy or identify concrete targets and timelines for action. Moreover, the EU Health Strategy's added value at the national level is not significant in that it has had a limited impact on most MS's national health strategies. Instead, it tends to reinforce what already exists in the MS, and is not seen by stakeholders as being the driving force behind action at national level.

As a result, if the intention of the EU Health Strategy is to raise awareness further and get others to act, there is a need to be clearer as to who is to do what, and develop a mechanism to ensure follow-up and monitoring of progress. The EU Health Strategy does not clearly identify specific areas for stakeholder action (be it joint MS action or cross-stakeholder action), which it was felt by stakeholders was where part of its added value should lie, i.e. in spurring coordination, cooperation, joint action and exchange of best practice across sectors

and bodies at EU-level and among MS. This, in turn, is likely to indirectly have an impact on MS policy/actions at national level.

RECOMMENDATIONS FOR POSSIBLE ADJUSTMENTS

Given that the EU Health Strategy has been quite effective in some ways, but less so in others, a number of adjustments can be envisaged for the future. The respective advantages and disadvantages of each proposed adjustment are discussed in the evaluation report.

1. No adjustments : Status Quo

Allowing the Health Strategy to continue to function as a reference framework and inspiration for health policy primarily for the EU institutions would, as the evaluation suggests, bring a number of benefits in terms of a continuation of the wide breadth of actions at EU-level (in particular DG SANCO, but also MS), but it would also mean that the Health Strategy would not be implemented as effectively as it could be, be it by the Commission, the coordination mechanisms or other stakeholders.

2. Adjustments: Reinforcements

a. Increase multi-stakeholder action

The results of the evaluation showed that few public health stakeholders aside from DG SANCO have taken many actions that can be directly and unequivocally linked back the EU Health Strategy. Therefore, DG SANCO could engage directly with selected key policies or funding programmes at a sufficiently early point in time (i.e. during the programming design phase), or define more specific targets and priorities in consultation with Member States.

b. Further prioritise policy areas where EU added value is greatest

The very broad nature of the EU Health Strategy means that the focus on the key areas where there is the greatest EU added value is not always very clear. In order to increase the impact and sharpen the profile of the Health Strategy, a focus could be placed on a few key areas where the value of joint action is greatest.

c. Make the current coordination mechanisms more effective

The evaluation suggests that the coordination mechanisms have, to date, not been used to their full potential, and have sometimes struggled to fulfil their mandates. A number of recommendations were made by stakeholders with a view to making the EUHPF and SLWP more effective going forward; these are outlined in Chapter 8.0.

3. Adjustments: Creating new tools or mechanisms for implementation and/or coordination

a. Devise a clearer framework for action

Unlike many other EU Strategies, the EU Health Strategy is not accompanied by another more operational document that outlines key actors and actions, responsibilities and targets. Better planning and task distribution among actors is needed to move towards more systematic and all-encompassing implementation of the EU Health Strategy. In order to

achieve this, the Commission, in consultation with other relevant actors and stakeholders, could set:

- Key principles and objectives to focus actions on and/or, within these, areas of focus with the highest level of EU value added or where stakeholders perceive further action as key;
- Concrete targets per principle and objective;
- Clear timelines for the achievement of the pre-defined targets;
- Which stakeholders and in what capacity they are expected to implement the activities.

b. Employ a different means to implement/coordinate the EU Health Strategy

The evaluation results suggest that the impact of the EU Health Strategy on MS health policies has been limited in that it is not a key driver of MS action and MS policies (although these are often coherent with it). In order to promote increased coordination and alignment of national health policies around the principles and objectives of the EU Health Strategy, other forms of coordination mechanisms could be considered, including those which already exist on a voluntary basis.