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## **DISCUSSION PAPER**

**Subject: European health information – objectives and organisation**

### **SUMMARY**

This discussion paper sets out some ideas for the future objectives and organisation for work by the Commission and its partners on European health information. It sets out an overall approach for generating, disseminating and applying information, based on the priorities outlined in the health strategy, and an organisational structure and methods to achieve this in a streamlined and efficient way. The key elements of the approach set out for discussion are:

- a ‘knowledge management’ approach with greater focus on analysing, disseminating and applying health information at European level, including customising information to specific users and issues and ensuring feedback on how useful it is in practice in bringing about improvements in health;
- setting priorities for European health information in order to help measure progress towards improving Healthy Life Years, focusing on the largest parts of the burden of ill-health such as cardio-vascular disease, cancer, accidents and injuries, and mental health;
- developing further information regarding the key determinants of ill-health (in particular tobacco, alcohol, diet, physical activity, as well as determinants of mental health) and interventions to address them;
- working with the European Centre for Disease Prevention and Control as well as other relevant agencies and bodies to ensure that information is provided on threats to health, including but not limited to communicable diseases;
- developing better information on healthcare quality and outcomes, focusing in particular on avoidable mortality due to healthcare, as well as better information on the efficient and effective use of innovations in healthcare, and better information on cross-border aspects of health systems;

- and including in all these priorities key cross-cutting issues, such as better regional information, inequalities, specific population groups such as young people and the elderly, and providing information not only about problems but also key elements of best practice in how to address them.

To implement this, the discussion paper proposes streamlining the previous structures established under the first Health Programme<sup>1</sup> into a single ‘Health Information Committee’, supported by technical groups with specific mandates of limited duration where necessary, and working in close cooperation with other key Commission services, programmes and agencies, as well as external partners such as the WHO and the OECD.

Discussion and consultation on the approach set out in this paper during 2009 should help to develop an overall European health information strategy, which could be set out more formally in 2010 and provide a long-term framework for work in the coming decades.

## 1. OVERALL AIMS

The overall aim of a European health information strategy should be to provide information and analysis for evidence-based development, implementation and evaluation of action for health in the EU, at both Community level and within Member States. European health information can provide added-value through information enabling comparisons in particular, which can in turn support identification, dissemination and application of best practice.

This reflects the mandate for Community action on health set out in Article 152 of the Treaty establishing the European Community:

*“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. Such action shall cover [...] health information and education.”*

Action on health information is part of the overall health strategy set out in COM(2007)630 and endorsed by the Parliament and the Council:

*“..health policy must be based on the best scientific evidence derived from sound data and information, and relevant research. The Commission is in a unique position to assemble comparable data from the Member States and regions and must answer calls for better information and more transparent policymaking, including through a system of indicators covering all levels (national and sub-national).”*

An overall strategy for health information should therefore focus on **generating, disseminating and applying the best information and evidence available to support the health strategy in improving health overall, and in achieving these three specific objectives.**

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<sup>1</sup> See [http://ec.europa.eu/health/ph\\_information/implement/implement\\_en.htm](http://ec.europa.eu/health/ph_information/implement/implement_en.htm).

## 2. PRIORITIES

The scope of potential health information is vast. Given the limited resources available, priorities are essential in order to focus work.

### 2.1. Greater focus on analysis, dissemination and application of information

Effective knowledge management for health information requires more than generating information, such as data or indicators at European level. It also requires mechanisms for providing analysis and highlighting possible areas for action, exchanging and disseminating information in an appropriate way to people who can make use of it; and then supporting and monitoring the application of information in practice. A great deal has already been done with regard to generating information at Community level, and this should be brought together in an overall map of progress so far. Though more will be needed, it should also now be complemented by a greater focus on analysis, dissemination and application of European health information.

#### 2.1.1. *Generating information and analysis*

Providing concrete and comparable data and indicators at European level can enable comparisons of health and the factors affecting it that can provide a strong guide for action. The preferred route for providing such information at European level should be through ensuring comparability of data collected by Member States. This requires continuing effort to improve quality of data and harmonisation of definitions, sources and methods, based on shared understandings of information needs and objectives (which this paper is intended to work towards). This should be carried out in such a way as to minimise the administrative effort required, in particular through collaboration with international organisations (in particular the WHO and the OECD) as well as across the Commission (eg: with ESTAT) to ensure single shared data collection wherever possible. The potential of using data collected anyway (eg: as part of health systems and administrative systems) should also be explored as far as possible, in particular as e-health<sup>2</sup> is more and more used.

This requires appropriate guidelines and data protection frameworks. In particular, the Health and Consumer Protection Directorate-General (SANCO) is developing an overall **data strategy**, in order to ensure better knowledge management and efficient sharing and use of reliable data, in order to deliver results for citizens and ensure accountability. This includes work on developing a Good Practice Model and general rules and principles, as well as recommendations for the use of quality data in policy-making.

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<sup>2</sup> The use of information and communication technologies for health.

Technical assistance and support can be provided to Member States to support information generation, including through quality assurance, peer review and expert advice. In some instances, however, the best solution may be to generate data as part of joint action led at European level, in particular through the Health Survey System.

Information is more than indicators. Providing comparable data and indicators should be complemented by providing broader relevant information, analysis and evidence about what issues the numbers suggest and how to respond. For example, where data and information suggest that there is potential for action, useful information should include not only the identification of a potential problem, but also concrete information about how the problem could be effectively addressed, taking into account best available scientific evidence and instances of existing good practice. This should include systematic analysis of scientific knowledge and developing understandings across Europe. A number of Member States have developed resources to address this. A mechanism to develop such a function could be developed at European level, building on the resources that already exist at national level.

One key area that needs to be further developed is generating information and data not about health itself, but about the measures taken by public authorities that are relevant to health. In particular, from a European perspective, better data is needed with regard to the implementation of European legislation on health (the Community health *acquis*), covering the areas of communicable disease, tobacco, blood, tissues and cells in particular. This should cover both the costs and benefits of implementing legislation (including administrative burden), as well as the outcomes. There are also many other areas of Community legislation which are also relevant for health, from legislation on environmental protection and health and safety at work to financial provisions on the application of the structural funds, the health impact of which should also be monitored.

#### 2.1.2. *Exchanging information*

The SANCO website is the main EU-level route for providing information on health from the Commission, with the European Health Portal providing a route to relevant information from other sources. Reports and publications on specific topics can bring together detailed information on overall health status and trends, or on specific topics such as key policy priorities, country, thematic or population overviews. This works best when there is a clear cycle of reporting on health which is known well in advance. This could be with an approach such as an overall report on "the Health of the Union" regarding health status and trends once every three to five years, with more focused major reports on a different topic each year

in between, supported by smaller reports on shorter-term priorities as needed.

Moreover, it may be helpful for European action to help in exchanging information which it has not itself generated, but where its role is rather to act as a 'clearing house' or central repository and reference point. For example, in the area of rare diseases, it may be useful for the Community to provide a mechanism for pooling and sharing of information on particular condition, to act as a Europe-wide reference point. European action could also help to identify and bring together all relevant actors in health information across Europe. There may also be other partners, such as organisations of patients or professionals, companies or charities, who can also provide information. As indicated above, this also requires clear guidelines about quality, transparency and appropriateness of using such information.

Ideally, for health-related information to be useful at European level, it should be collected on a harmonised basis covering all Member States. But given the expense and difficulty of this approach, this may not always be feasible. Other information which is more geographically limited or less harmonised can nevertheless still be useful. Exchanging health information should therefore include exchanging information such of this type, such as specific projects or reports of national health institutions.

However, by their nature, both the Health Portal and health reports provide general information of relevance to the whole EU. Different users may need more specific information tailored to their specific needs. For example, a regional health ministry may wish to have information specifically focused on those areas where their health status is most different from the EU as a whole.

European health information should thus meet different needs of different users. This itself also requires greater clarity about who the users of European health information are. These include:

- Policy-makers in the Commission;
- Policy-makers in the Member States (national/regional/local);
- Researchers;
- Health professionals;
- Patients (and patients' organisations), and the general public;
- Journalists and the media;
- and other information providers re-using European health information to provide other outputs.

Each of these groups of users has different needs for health information, which therefore needs to be adapted to them if it is to be disseminated successfully. There are some obvious ways in which information should be adapted, such as through different formats or languages. It should also be possible for users to make their own choices about the type of information they are seeking, using dynamic website structures, for example. But the specific content and focus of information may well also need to be different. For example, composite indicators can communicate a clear overall message that may be appropriate for some users, whilst others would be better served with more complex information.

Achieving this requires consultation and collaboration with the stakeholders concerned. It also needs technical support in order to ensure the necessary flexibility in the provision of information to enable it to be adapted in different ways for different users, eg through customisable web-based tools, or sufficient technical support structures to enable adaptation of general information to specific questions within a reasonable time, taking account of the type of the information sought. Providing the right information may in some instances require quite long lead times (in some instances, months or years). This means that information requirements need to be part of future planning mechanisms at least for the Commission, and ideally also for other key stakeholders.

It also requires consideration of what the appropriate role of the Community is in providing information to them, as compared to other actors (eg: national authorities, the specialists on particular conditions within the health professions, or academic centres). For example, individual members of the public will normally seek information from the authorities and health professionals within their own country, not from the European Commission.

Moreover, even where data has been brought together by the Community, other actors may be able to add value to its analysis or dissemination through their own further work. This can be supported by maximising the possibilities for use and re-use of European data by users to enable other outputs to be created as well.

### *2.1.3. Using information*

The key way of assessing whether information is being used successfully is whether it is being acted on and bringing about change that in turn is improving health. There is a substantial body of evidence about this process, focusing on issues such as diffusion of innovations, knowledge management and evidence-based practice. A European health information strategy should draw on this to ensure that the information we provide is successful in providing evidence about issues, different experiences of how to respond to them and the relative advantage different approaches, and how to go about trying out responses and measuring whether they help.

Whether or not European health information is successful in achieving this also requires its own evaluation and feedback mechanism to see whether and how the information that we provide is being used. This would also enable adjustment of the work on generating and disseminating health information to ensure its ultimate effectiveness. A key first area to test this should be the European Community Health Indicators, and their use in practice.

**Discussion points:** What should be the overall focus for a European health information strategy? What should be the key components of generating, disseminating and applying health information at European level? Who are the main users of European-level health information, what do they need, and how can it best be provided? Where are the areas of European added-value? How can sustainability of European actions be ensured?

## 2.2. Support to the health strategy

The health strategy sets out an overall goal of improving health with three specific objectives of:

- 1) Fostering good health in an ageing Europe;
- 2) Protecting citizens from health threats;
- 3) Supporting dynamic health systems and new technologies.

As set out above, an overall strategy for health information should therefore **focus on the best information and evidence available to support the health strategy in monitoring progress in improving health overall, and in achieving these three specific objectives.**

Providing appropriate health information therefore means providing different types of information responding to these different objectives. Much progress has already been made on overall monitoring of health through the system of European Community Health Indicators (ECHI), which provide a core set of indicators of health for the EU as a whole. But each of the specific objectives requires its own specific types of information for different aims and users, as discussed above.

Much has already been achieved. Deciding on what further work is needed therefore also needs a mapping of what already exists, in order to focus on filling the gaps where needed and establishing a multi-annual plan for doing so. This mapping and its updating will clearly need input from a wider range of stakeholders. However, some initial directions for discussion are set out below.

### 2.2.1. *Overall health status – mortality*

The starting point for information on overall health status is causes of death. Of the three principal causes of death in the EU:

- **cardiovascular** disease is the main cause of death, but is not as well covered as it could be in terms of information about incidence, prevalence, or how well people are identified and treated. This should be a priority for the immediate future;
- **cancer** is already well covered in terms of data and indicators at European level;
- **accidents and injuries** are less well covered than they should be, despite a major cause of death throughout the EU and one with substantial inequalities between Member States. Although the Injury Database project has made good progress as a developmental idea, data and indicators for the EU as a whole and to sufficient quality standards for integration in the European statistical system are needed.

As a first priority, we should aim to ensure good information is available regarding these principal causes of death in the EU. Thereafter, it would seem logical to focus efforts for additional information on areas of **avoidable mortality with significant variation between Member States**, in order to maximise the likely benefit of providing EU-level comparable information.

At a technical level, priorities should take into account likely developments in the coming years, including the census timetable, development of the eleventh version of the International Classification of Disease, and the potential for greater use of information technology ("e-health") in collecting and sharing data related to mortality on an automated basis.

#### 2.2.2. *Overall health status – morbidity*

The Healthy Life Years indicator already provides information including a morbidity dimension. In order for the indicator to be most helpful in guiding action, however, it would be useful to break down the causes of that morbidity, ie: **breaking down limitations on activity by disease or condition**, as well as by other key factors such as socio-economic group. The current work by ESTAT to develop morbidity statistics giving an overview of morbidity for major diseases and conditions will be vital. One particular priority would be **mental health**, given both its importance as an issue and the lack of current information. For much such data, the methodological and development work carried out by many projects under the health monitoring programme and the health information strands of the first and second health programmes should be taken into account, at both national and European level.

At a technical level, this is an area where the need to resolve data protection issues is particularly important, in order to enable the use of mechanisms such as patient registries to provide data. The planned European Health Examination Survey will also be a critical tool in this area in particular.

### 2.2.3. *Determinants of health*

Beyond the immediate concerns of current mortality and morbidity, health information should be able to provide information to support action on long-term trends and emerging risks. Supporting the objective of “Fostering good health in an ageing Europe” requires better information on how the health of people in Europe is affected by different determinants, in particular with regard to the consequences for demographic ageing. This could cover areas such as:

- Information on the nature and impact of **key determinants of health**, such as tobacco, alcohol, nutrition, physical activity, and factors affecting mental health, as well as wider determinants such as the natural and built environment, socio-economic status, and genetic determinants of health;
- Sustained large-scale, Europe-wide **cohort studies** to track overall changes in population health;
- Identification and **cost-benefit analyses of preventive interventions** that can maximise healthy life years.

It will also be important to provide information on the specific health issues linked to ageing. These could include:

- **neuro-degenerative conditions?**
- **musculo-skeletal health?**

### 2.2.4. *Threats*

The principal area of information with regard to protection citizens from health treats concerns the monitoring of communicable diseases, and this is covered by other mechanisms, in particular the European Centre for Disease Prevention and Control (the ECDC). **Food safety** is another key area of possible threats to health, and this is also covered by existing information systems and the European Food Standards Agency.

The other key issue regarding threats to health concerns **climate change**. Climate change can bring threats to health within Europe concerning issues such as extreme weather events or floods, changing patterns of disease or their vectors, or exposure to changing patterns of ultra-violet radiation from sunlight, for example. Information needs can be identified more clearly following the Commission communication on adaptation to climate change. There are also other information needs linked to **environment and health** more generally, which should be explored in particular cooperation with the European Environment Agency.

### 2.2.5. *Innovation in healthcare*

Supporting dynamic health systems and new technologies will mean providing information on health systems that is adapted to the health system of the future. This is likely to mean healthcare that is more patient-centred and decentralised (eg: local health centres, telemedicine, greater use of e-health), though with very complex care more centralised and concentrated to ensure quality and efficiency.

In terms of relevant information, much progress has been made with regard to information on inputs and access to healthcare, in particular through the System of Health Accounts. In the future, there should be a greater **focus on outcomes and quality of healthcare**, rather than only inputs or processes. As well as specific information on issues such as **quality indicators** and **patient safety**, this could focus on providing information regarding **avoidable mortality due to healthcare**.

For new technologies, work should include **information and evidence concerning new technologies** (such as genomics), and also information on **how established evidence and best practice is applied in practice**, and how new technologies are being integrated into healthcare (eg: e-health). In the long term, e-health could provide the potential for integrated databases of data down to individual level, toward which several Member States are working. If these could be linked at European level (whilst respecting all privacy and confidentiality requirements, of course), this would represent an enormous and highly efficient resource for comparative information.

There are also specifically European-level information issues concerning **cross-border aspects of healthcare**, whether it be providing information on the nature and size of cross-border healthcare as such, or related issues such as **movements and skills of health professionals** within the Union. Other EU processes also need health information in this area, in particular the ‘open method of coordination’ on healthcare and long-term care.

### 2.2.6. *Horizontal issues*

There are also some cross-cutting issues that are relevant to all of these objectives. These include:

- **Regions:** many of the factors affecting health are determined not at national level, but at regional or even local level. Likewise, in many Member States, much of the responsibility for health and health systems is also primarily at regional or local level. This suggests that it is important to include a regional dimension in European health information, such as providing information that is broken down to regional level, adapting more general information to the specific issues facing individual regions, and engaging with regions to see how such information can best be

used. A relevant regional-level focus for health issues may also cross national boundaries, covering areas which face similar health challenges even though they are in different countries. Examples include the many 'Euregio' cross-border regions which already have cooperation on health issues;

- **Inequities in health:** as set out in the health strategy, there are major inequalities in health across the Union across a range of factors, in particular socio-economic status. These affect all aspects of health: determinants of ill-health, overall population health, inequalities for specific diseases and population groups. This suggests that EU health information should aim to provide information which also highlights relevant inequalities, in order to build on the added value of comparative information at EU level;
- **Well-being and wealth:** health is one of the key components of overall well-being and happiness of people, as well as of economic growth and sustainable development. An EU health information strategy should ensure that information on health is integrated into overall information on well-being and wealth at EU level, including projections of the overall economic growth and sustainable development of the Union;
- **Young and old age:** it is increasingly clear that many of the factors affecting our physical and mental health as adults are strongly shaped in childhood, and alongside the focus on ageing should be a balancing degree of attention to the early phases of life. Collecting data and indicators for children and young people is particularly difficult, but seems likely to be increasingly important in helping to improve health for the population as a whole in the future;
- **Information on health policies and interventions:** a wide variety of interventions are already being undertaken throughout the European Union and beyond. However, it remains difficult for policy-makers evaluating existing actions or considering new ones to have a solid evidence base for their decisions. EU action can help to bring together knowledge about what works and at what cost in order to support future decision-making, at Community, national, regional and local level.

**Discussion points:** this section sets out priorities for health information in support of the health strategy in six areas – are these the right priorities? Are there other areas missing, or areas mentioned here that should not be a priority? In the context of very limited resources, which are the two or three priorities that should be addressed first, and what should follow?

### 3. ORGANISATION

As set out in the health strategy and cited above, “*health policy must be based on the best scientific evidence derived from sound data and information, and relevant research*”, and health information should aim to provide this. This work should be based on clear principles and working methods, as described above.

This requires involvement of **different actors with different roles**. The current implementation structure is structured around the Network of Competent Authorities, which is supported by seven working parties and other specific taskforces and steering committees. This should be reviewed as part of the implementation of the new health programme, and as part of the Commission’s commitment to streamlining and rationalising structures in the health field in order to ensure efficient implementation of the health strategy.

Within the Commission, information requirements should also be incorporated as part of the **Commission’s multi-annual planning process**, in order to identify and meet information needs in a timely way. However, there will always be shorter-term information needs which must also be accommodated. Work on health information must therefore combine a long-term vision and overall strategy with mechanisms to gather and share the best available information rapidly when necessary.

#### 3.1. Working methods

It is useful to distinguish several different roles that external structures in the health information area should play, such as:

- policy consultation and political involvement of the Member States;
- technical and scientific advice and analysis;
- coordination and cooperation between relevant projects under the health programme as well as with actions funded by other parts of the Community budget;
- coordination and cooperation between different European and international agencies involved in generating and disseminating health information;
- consultation and involvement of wider users of health information;
- and involvement of interested countries from outside the EU, in particular the European Economic Area countries and the countries of the European Neighbourhood Policy.

These roles do not necessarily need to be combined in a single structure. For example, one working method would be to have only one group involving Member States to provide overall direction, supported by small technical groups to take forward specific mandates in individual areas and report back. Some other stakeholders might not need to be involved in specific meetings

as such – other tools such as following work through internet-based mechanisms or other updates could be used.

### **3.2. Structure**

This section sets out some ideas for a structure for organising work on health information at European level.

#### *3.2.1. Health information committee*

This could be a committee made up of Member States which would fulfil the key role of the Network of Competent Authorities in ensuring consultation and involvement of Member States with regard to health information. The committee would support the overall implementation mechanisms for the health strategy with regard to health information, in particular as part of the multi-annual planning process. This would ensure that health information oversight reflecting good governance principles with the active participation of the Member States.

In particular, the Health Information Committee could:

- work together with the Commission to agree on needs and solutions for European health information and to reconcile the technical issues and resource constraints of this information with the overall policy and strategic needs as described in this paper;
- assist in defining and overseeing technical work needed to help achieve this work, in particular through the mechanisms described below;
- and to act as a platform for cooperation and collaboration on health information at European level.

This Health Information Committee would itself need substantial technical and administrative support in order to carry out this role, which could be provided by a combination of direct Commission support from the health information unit, plus the Health and Consumers Agency and external technical expertise.

#### *3.2.2. Technical groups*

Technical groups made up of a limited number of experts would be established to take forward work in specific areas, and would report back to the health information committee. These would replace the existing taskforces. These technical groups should have a specific and time-limited mandate to achieve a specific result, rather than becoming a standing structure. These could be example be financed through calls for tender, perhaps within an overall framework contract for technical support.

### 3.2.3. *Health programme project coordination and cooperation*

Specific structures could be established to ensure appropriate coordination and cooperation between projects financed under the health programme, as well as with other relevant projects financed by the Community budget. This would be taken forward by the Health and Consumers Executive Agency, in close collaboration with the Commission and with the structures described above. These could include an annual conference bringing together all relevant health information projects (both within and beyond the Health Programme), as well as more focused workshops on particular topics. The 'Health Information Committee' and the programme committee of the Health Programme should also ensure appropriate liaison mechanisms.

### 3.2.4. *Involvement of wider health information users and partners*

There are many other partners who should also be involved in some way within these structures. These include:

- European agencies, in particular the ECDC but also others such as the European Environment Agency, the European Monitoring Centre for Drugs and Drug Addiction, the European Medicines Evaluation Agency, and the European Foundation for the Improvement of Living and Working Conditions;
- partner organisations at international level, in particular the WHO and the OECD;
- members of the other European Institutions with an interest in health information;
- stakeholders in health information within Member States, such as regions, health professionals and their professional bodies, healthcare purchasers and providers, and patients' organisations;
- expert organisations such as universities, think-tanks and health institutes within Member States and at European level;
- and interested associated countries outside the EU.

Of course, other Commission services are also vital partners. ESTAT in particular is crucial, as the collection of Community statistics is their responsibility. RTD, EMPL, ENV, ECFIN, ENTR, REGIO and TREN also cover crucial areas for health information overall. Consideration could be given to developing a specific general cooperation mechanism on health information within the Commission, or continuing cooperation on particular issues.

### **3.3. Transition from current structure to new approach**

The current health information structure (the Network of Competent Authorities, the Network of Working Party Leaders, and the working parties and taskforces established under them) were established as part of the implementation of the previous Public Health Programme. They have been continued on a temporary basis during 2008, although the related provisions for external support have been drawing to a close.

These structures have provided enormous support in developing health information at European level, and this should be built upon. To this end, each of the working parties and taskforces could be invited to identify their own identification of key needs to be taken forward as part of the health information strategy, which can then be considered by the Health Information Committee.

A Health Information Committee can be established on a provisional basis as from 2009, initially taking over the work of the Network of Competent Authorities. Finalisation of its mandate and working methods, together with a formal decision establishing the Committee could be incorporated as part of a final European health information strategy in 2010.

### **3.4. Resources and sustainability**

Projects under the Health Programme can help to develop information, identifying needs and how to fill them. Projects under the current and previous health programmes have created a substantial body of information and outlined potential for further development in the future.

However, projects by their nature are limited in time and scope, and although they can play an important developmental role, sustained information systems that can realise the potential generated by those projects require alternative solutions. Part of generating health information at European level must therefore be establishing a roadmap for each area from initial development to **long-term sustainable implementation of ongoing information systems**, for example through integration into the European statistical system when the criteria for doing so are met. Neither the resources of the Health Programme nor its mandate in relation to the statistical system allow it to be a mechanism for sustained data collection. However, the resources of the statistical system are also limited. In the medium term, other solutions should be explored.

Moreover, the current volume of resources available through the current Health Programme is unlikely to be sufficient to achieve the overall health information objectives outlined above, given the projected costs of information systems and data collection based on experience to date, for example in the area of cancer. The potential for other sources of funding should also be explored, such as from the research area, as well as the scope for demonstrating the need for greater resources in future allocation exercises. However, this also underlines the importance of setting clear priorities for best use of the resources that are available, as described above.

**Discussion points:** this section sets out different actors and roles with regard to health information – are these the right ones? What structure is needed for involvement of external partners with the Commission? Which actors should be involved in which parts, and with what aim? Is the possible structure outlined above sufficiently streamlined and effective to allow effective implementation?

#### 4. CONCLUSION

Given long-term nature of information work, it requires a long-term planning framework. The health strategy provides a policy basis for doing so, and the aim is to work from this basis and set out a long-term framework for future development of EU health information in 2010. This discussion paper is the first step towards that, and is intended to be the first basis for widespread consultation of all relevant partners between now and the end of 2009.

**Discussion:** Specific discussion points have been highlighted throughout the paper – any other comments would also be very welcome.

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