Health & Consumer Protection
Directorate-General

Health and Consumer Protection Directorate-General, European Commission

Summary Report of the responses to

Health in Europe: A Strategic Approach

Discussion Document for a Health Strategy

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SUMMARY

At the end of 2006, the Commission launched a consultation process based on a paper, 'Health in Europe: A Strategic Approach - Discussion Document for a Health Strategy'[1]. This consultation was to enable stakeholders to provide input into how a new Health Strategy should be developed and implemented.[2] The consultation ended in February 2007. The Commission received 153 responses. The contributions welcomed the proposal for a new overarching, strategic and coherent framework for health policy in the next decade. Health was seen as valuable in its own right, but also as a key factor supporting European economic growth, and was therefore recognised by many respondents as an important investment for the European Union.

Contributors generally expressed support for the approach proposed by the Commission: working on a number of core health issues, developing a stronger approach to health considerations in all policies and engaging more strongly in global issues. Most respondents stressed the importance of taking action where European added value is clear, and where challenges are of a cross-border nature.

Many respondents said that European cooperation should be enhanced in a number of fields including health threats, health inequalities, health information and the promotion of healthy lifestyles. The burden of non-communicable disease was particularly highlighted. Contributors also stressed the need for the development of a European health information system with an open access to comparable data. In terms of implementation, the establishment of a mechanism of structured cooperation with the Member States using methods that have been tried and tested under the Open Method of Coordination was welcomed by many respondents. However, alternative approaches were also proposed, including the development of existing or new European-level structures to oversee the implementation of the Strategy.

Setting objectives was considered to be of major importance for the Health Strategy, and a number of proposals were made for short term and long term objectives. Respondents called for outcome and process indicators to monitor progress towards the objectives of the Health Strategy. These should be defined in cooperation with Member States. Member States would be responsible for providing data, while the Commission would provide a mechanism for monitoring and evaluating progress

Finally, many responses stressed that the success of the Strategy would be linked to its being seen as having clear links with the actions being undertaken in Member States. This would require that there was a clear sense of ownership and active involvement in its development by health authorities and other stakeholders. To that end, some respondents recommended the development not only of a European Community strategic approach, but complementary action plans in the Member States.

[1] http://ec.europa.eu/health/ph_overview/Documents/strategy_discussion_en.pdf

[2] The Commission had previously launched a reflection process "Enabling good health for all" in 2004 which set out some general concepts about the contents and scope of a health strategy for consideration by stakeholders. http://ec.europa.eu/health/ph_overview/strategy/reflection_process_en.htm.

A. THE CONSULTATION PROCESS

The need for a new Strategy for health was clearly recognised in the response to the Commission consultation 'Enabling Good Health for All – A Reflection Process for a new EU Health Strategy'[3], in late 2004. About 200 contributors responded to this consultation, and the consensus view was in favour of the development of an EU Health Strategy, which would address certain key challenges including mainstreaming health, health inequalities, and global health. The reflection process document and report on the consultation can be found on the Commission's Europa website[4].

At the end of 2006, the Commission launched a further consultation process based on the paper, 'Health in Europe: A Strategic Approach- Discussion Document for a Health Strategy'[5]. The aim was to enable stakeholders to provide input on how a new Health Strategy should be developed and implemented. The participants in this discussion process were asked to comment upon and to develop proposals based on the three broad elements of the Strategy, addressing core health issues, Health in All Policies and global health. They were also asked to consider ways of addressing the practical challenges including prioritisation of issues, potential actions at the EU level, objective setting, and possible tools for implementation, including options for how the EU should work with Member States and Stakeholders to ensure the effectiveness of the new Strategy. The questionnaire which accompanied the discussion paper is at Annex 1.

B. RESPONSES TO THE CONSULTATION

In response to the consultation document, more than 150 contributions were sent to the Commission, from a wide range of stakeholders. The Ministries of Health of 16 EU Member States Belgium, Bulgaria, Cyprus, Germany, Estonia, Finland, Hungary, Ireland, Italy, Latvia, Netherlands, Poland, Romania, Spain, Sweden, and the United Kingdom, as well as Turkey, participated in the discussion process. Third countries Norway and Switzerland also contributed. Moreover, two international organisations, the World Health Organisation and the World Bank shared their views. In addition, many regional and local administrations responded, as well as 16 professional organisations and 2 students' organisations at European and national level. About one third of the responses were from patient organisations and public health NGOs, most at national or European level. 24 contributors were members of the Health Policy Forum. 15 individual citizens also contributed directly to the consultation.

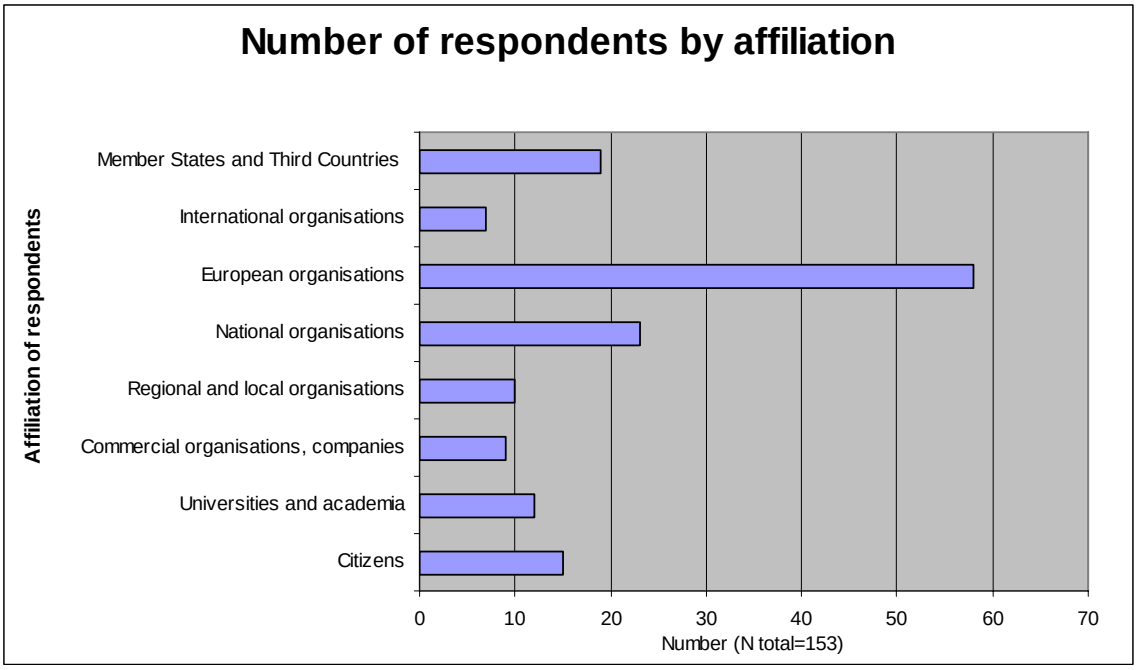
In terms of geographical representation, 39% of the responses were sent by European organisations. The largest number of responses was from the UK (17%) followed by Germany and Finland. On the other hand, relatively few contributions were received from other Member States, and none at all from the Czech Republic, Luxembourg and Slovenia. The list of all contributors is at Annex 2. The individual contributions are available on the Commission's Europa website[6], except for a few cases where respondents requested that their response was not published.

Mapping the Responses to the Consultation

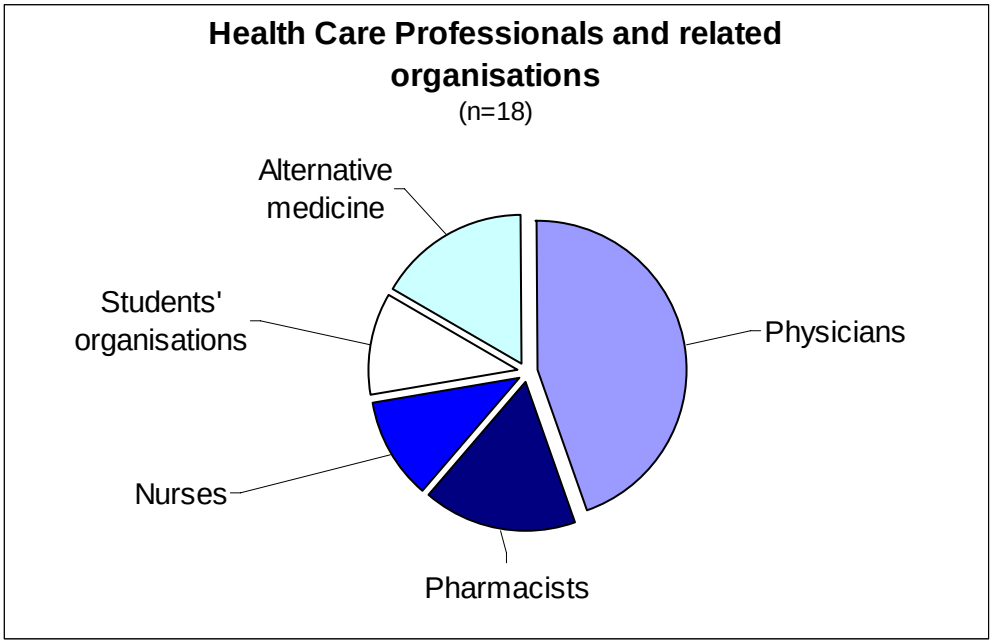
[3] http://ec.europa.eu/health/ph_overview/strategy/reflection_process_en.htm
[4] http://s-sanco-wcm/health/ph_overview/strategy/reflection_process_en.htm
[5] http://ec.europa.eu/health/ph_overview/Documents/strategy_discussion_en.pdf
[6] http://s-sanco-wcm/health/ph_overview/strategy/health_strategy_en.htm

1. Affiliation and Nature of Respondent to the Consultation

Number of Responses by the country of origin of the respondent	
European level	59
Austria	1
Belgium	1
Bulgaria	1
Cyprus	1
Denmark	3
Estonia	1
Finland	5
France	3
Germany	6
Greece	2
Hungary	2
Ireland	3
Italy	2
Latvia	1
Malta	1
Netherlands	4
Poland	2
Portugal	2
Romania	1
Spain	4
Sweden	3
United Kingdom	26
Non- EU country	19



3. Healthcare Professionals and related organisations



C. SUMMARY OF THE CONTRIBUTIONS

1. Introduction

The announcement of a Health Strategy at European Community level was welcomed by all respondents. Most responses called for a document that would set up a strategic and coherent health policy agenda for the EU for the coming years.

In terms of major themes for the Strategy, many contributors highlighted the importance of designing a strategy that would respond to challenges while respecting the competencies of the Member States. In addition, many said that the Health Strategy should focus attention on issues with cross border aspects and those that had clear European added value.

A number of respondents said that the Strategy should stress the importance of health for economic development and as a crucial factor for the well-being of the population. Respondents recommended that the Strategy should be clearly linked with other key strategic projects at European level including the Lisbon Strategy, the Sustainable Development Strategy and the Open Method of Coordination on Social Protection and Social Exclusion (led by DG EMPL).

Some respondents said that an EU Health Strategy could help to support the integration of health in the work of other Commission services and that this would also assist DG SANCO in prioritising projects for funding and in establishing future public health programmes. At the same time, some Member States, regional and local administration and stakeholders said that the Health Strategy could potentially act as a guide for some of their own activities.

Finally, some contributors recommended identifying common European values relating to health, building on the Council Conclusions on common values and principles in EU health systems[7] which were adopted in 2006. It was also suggested that the Strategy should make explicit reference to the 'Health for All' policy of the World Health Organisation (WHO).

It is important to stress that this report attempts only to give a summary account of the responses presented to the Commission services. It does not set out the views of the Commission.

For the sake of clarity, the analysis of the responses has been grouped around several themes: the priorities of the Strategy, the objectives for the Strategy, the implementation mechanisms proposed, the involvement of Member States and of other health stakeholders (i.e. other organisations playing a key role in health, including health professionals, the voluntary sector, service providers and payers, and industry), and lastly, how the progress of the Strategy could be ensured.

[7] http://www.eu2006.at/en/News/Council_Conclusions/0106HealthSystems.pdf

2. Priorities in the Strategy

The consultation respondents identified priorities for the next decade including combating health threats, tackling inequalities, working on quality and safety in healthcare in relation to cross-border issues, health promotion and looking at key determinants of health, information on health, and ensuring innovation and research in the field of health. Respondents put the concept of 'Health in all policies' at the centre of the Strategy to ensure coherence in policy development at all the levels, from European to local. Respondents also welcomed the inclusion of a Global dimension in the Health Strategy.

In light of the 2004 reflection process ' Enabling Good Health For All', three main priorities were identified for a new Health Strategy: working on a number of core health issues, developing the approach to health considerations in all policies and engaging more strongly on global issues. This Consultation goes further, asking Member States and stakeholders, about prioritisation of areas of focus.

A number of respondents, including several Member States, made the point that the Strategy should clearly set out the respective competencies and responsibilities of Member States and the EU in the field of health.

Different approaches for the definition of priorities were recommended. One approach would be to select priorities according to Member States' needs and expressed national priorities; in this context a few contributors pointed out that regional priorities were also important. Another approach would be to prioritise according to overarching goals, taking the burden of the disease in the EU into account.

Most contributors said that the EU should concentrate on a small number of strategic themes, selected because of their relevance across the EU, the potential added value of tackling the issue at European level, and inequities across the EU in relation to the issue. The importance of mainstreaming health was also stressed.

The focus on global health was welcomed, particularly by those organisations involved in development issues and relationships with third countries, and also by some Member States and other respondents. This issue was considered to be an essential focus for action of the European Union in terms of solidarity and supporting health improvement in other parts of the world.

2.1. Core issues

Most of the respondents commented on the core issues described in the discussion document which relate to the protection and improvement of health across the EU, namely, combating health threats, tackling inequalities, working on quality and safety in healthcare in relation to cross-border issues, health promotion and tackling key determinants of health, information on health, and finally, ensuring innovation and research in the field of health.

A number of respondents stated that a focus on non-communicable disease was important, as current trends are alarming. Obesity, cardiovascular disease and cancer, were some of the key concerns raised by respondents. It was also suggested that the Strategy should also mention specific commitments already made by the Member States within WHO, on, for instance, nutrition, mental health, and smoking.

Health threats

Health threats were identified by many respondents as one of the main priorities for the Health Strategy. The need to ensure preparedness for health threats and protection of European citizens through enhanced cooperation between the Member States was recognised in most of the contributions. Many noted that health threats are not limited to major communicable diseases, and advised including actions on emerging diseases and rare diseases. In a small number of contributions, a clarification of the roles of Member States and the Commission in terms of tackling health threats was recommended.

Some respondents recommended focusing more strongly on the international dimension, and liaising more closely with the World Health Organisation.

A number of respondents identified vaccination as a particular field of action where the EU could add value to the efforts of Member States. Bioterrorism preparedness was also mentioned as a key issue for the EU, as well as generally taking an innovative approach to health prevention of populations at risk (e.g. children and migrants).

Health inequalities

Reducing health inequalities was considered by many respondents to be a very important objective for the Strategy. Inequalities should be seen as including not only differences between Member States, but also differences within them including, for example, social inequalities in education or employment status which have a clear impact on health. In addition, a number of respondents stressed that particular attention should be given to gender issues by, for instance, undertaking gender specific health promotion actions or gender monitoring. Representatives of local areas in particular specifically requested an exchange of best practice at EU level on the issue of integrating minority groups into the local community.

Health services

Some responses called for European action in the field of **healthcare systems,** particularly in relation to cross border activities. Many contributors noted that their views in relation to this issue were submitted to the Health Services Consultation[8] which was conducted in parallel to this consultation. However, some respondents said that tackling cross-border challenges, while respecting the principle of subsidiary, was a task for the Strategy. The financial sustainability of health systems was highlighted as an important consideration by a number of responses. One contributor suggested that there could be added value in a European analysis looking at the organisation of health systems focusing on primary care or the hospital sector.

Patient safety was clearly identified as one of the key challenges for a new Health Strategy, particularly by Member States. Patient Safety was understood to include work on healthcare-acquired infections as well as the management of clinical risks and quality standards. Safety of products, particularly counterfeit medicines, was also raised by respondents as an issue that the Health Strategy should tackle.

A number of respondents thought the Health Strategy should play a role in supporting health professionals in their continuous professional development, to ensure that their knowledge was adapted to changes in society and medical science, including in specialised fields such as geriatric medicine, patient safety and nutrition. Furthermore,

[8] http://ec.europa.eu/health/ph_overview/co_operation/mobility/community_framework_en.htm

representatives of complementary and alternative medicines organisations called for the recognition of their qualifications and practices.

Health promotion and health determinants

Promotion of healthy lifestyles and addressing key health determinants was highlighted as a key issue for the Health Strategy. A large number of respondents supported the proposal in the discussion document for further development of healthy lifestyle policies in the fields of nutrition, physical activity, alcohol and tobacco. Drugs and sexual health were also highlighted by some respondents as major challenges. Some contributors also emphasised the importance of targeting prevention campaigns towards particular groups such as children and young people, the elderly, people from minority groups, or people suffering from chronic diseases. Other respondents called for campaigns that would support the early detection of diseases. In terms of other tools to use for the promotion of healthy lifestyles, many contributors said that identifying best practice was key, and that the value of actions could be maximised through sharing experiences. Some NGOs stressed that their own concrete experience and capacity for effectively disseminating information should be used in the development of prevention strategies.

A third of the contributors highlighted the importance of combining different approaches to tackling health issues, and specifically health promotion. Using life-cycle and key settings approaches was widely favoured. A number of contributors suggested focusing on health education to children through schools, information to adults through workplaces and information to the elderly through targeted tools. Some recommended annual medical check-ups at work or at school as effective mechanisms to encourage preventive medicine, and proposed an analysis of current practice in this area. The media, including both television and new media such as the internet and online video, was also presented as possible settings for health promotion.

Some respondents, particularly from national or regional organisations, pointed out the value of pooling ideas and sharing experiences of national initiatives and of projects financed by European programmes. They emphasised the need for evidence-based and cost-effective approaches.

Information on health

Improving information on health was a major concern underlined by about 20% of the respondents. This should cover information from the EU, using tools such as the Health Portal, as some respondents recommended. Others suggested also focusing on introducing information and education on health into settings such as schools and workplaces, to increase the 'health literacy' of the population. Other contributors highlighted that the Strategy should ensure that patients and professionals are aware of their rights in relation to mobility between EU Member States, including in relation to services offered, health insurance, and costs. More generally, some contributors stressed the need for patients to assume more responsibility for their health and be more involved in health and healthcare decisions, with the help of reliable and user-friendly information.

Some contributors recommended extending the use of the current Health Portal to disseminate information and exchange of good practice to health professionals and among national and local authorities. This would complement information available elsewhere, for example on WHO's website. There was a large consensus in favour of the development of an information system with mandatory collection and exchange of information, which would be accessible to all.

In addition, most contributors, including 9 Member States, called for the development or setting up of a health information mechanism which could provide comparable data to benchmark initiatives that have been carried out at regional or national level and help to identify successful projects. While some contributors wanted a mechanism that would monitor specific fields such as treatment, chronic disease or vaccines, other respondents called for one which would cover health systems extensively, advising on the definition gathering, monitoring, and comparison of data and the identification of effective interventions at various levels.

Innovation and research

Innovation in the field of health, including new technologies such as personalised medicines and e-Health, was highlighted as an important issue by 10% of the contributors. These contributors saw an EU role in relation to managing innovation for sustainable healthcare systems, and also in terms of promoting innovative research to support health needs. Some contributors, including from the public health sector, called for more support for research in the field of health and proposed that the EU's work undertaken to support the development of orphan medicinal products should be extended to geriatric medicines or neglected diseases. In addition, some respondents called for further development in the field of health technology assessment.

2.2. Mainstreaming health

A quarter of the contributors underlined that the inclusion of health in all policies was a priority for the Health Strategy, most stressing the value of ensuring coherence in policy making in the field of health. Respondents said that health in all policies could have positive effects in terms of, for example, disease prevention. In addition to the support for ensuring better consideration of health in the development and implementation of polices at the European level, some respondents called for actions to support similar approaches at national, regional and local level. It was stressed that a focus on health in all policies should not only target specific policy areas, but should also impact on structures and institutional requirements for increasing cross-sectoral work.

Some contributors recommended various tools for the methodology and the application of health in all policies, from the mainstreaming of the use of 'health impact assessment', to the development of new structures within the EU Institutions. Moreover, one respondent suggested that the concept of mainstreaming health needed to be extended to a greater focus on *future impacts*.

2.3. Global health

A number of contributors stressed the importance of identifying common European values to guide actions on global health. They underlined that the approach to global health should be built on the EU's experience and achievements in protecting and improving health within the EU, in addition to the international agreements relating to global health such as the Millennium Development Goals and the Global Fund to fight AIDS, Tuberculosis and Malaria. A key message from a number of contributors was the importance of shifting the emphasis in global health actions from international cooperation based on development aid to partnerships based on solidarity and guided by the needs of the beneficiary countries.

Most people who responded on this issue suggested that in addition to strengthening the coherence and coordination between different policy areas within the Commission, it should put an emphasis on working closely with international organisations such as the WHO, the Council of Europe, the OECD, the World Bank and the WTO. Some

contributors recommended prioritising cooperation with the European Neighbourhood and with Africa.

Some contributors proposed specific activities on global health that the Strategy should cover. These included the implementation of the International Health Regulations and the WHO Framework Convention on Tobacco Control (FCTC), and work to support the adoption of an international code on commercial promotion of unhealthy foods and beverages. In addition to the importance of working on these international regulatory areas, contributors recommended political engagement at the global level on challenges such as tackling the severe shortage of health professionals, improving access to medicines including research and development of new medicines and health technologies, and working on broader issues such as the identification of the health consequences of climate change with a commitment towards both prevention and mitigation. For many respondents, action on global health should include both communicable and non-communicable diseases. Nevertheless a number considered that HIV/AIDS was an issue which requires special attention.

3. Objectives

Setting objectives was considered to be of major importance for the Health Strategy, and a number of proposals were made for short term and long term objectives. Contributors stressed that objectives would need to be achievable and realistic.

In terms of setting objectives in the short and in the long term, respondents had various approaches to their possible nature. Most of those who responded on this point stressed that if objectives are to be set, they should be achievable and realistic. Some regional organisations said that regional objectives could be defined among a number of broad areas commonly agreed. It was also suggested that objectives should be set in cooperation with other international organisations.

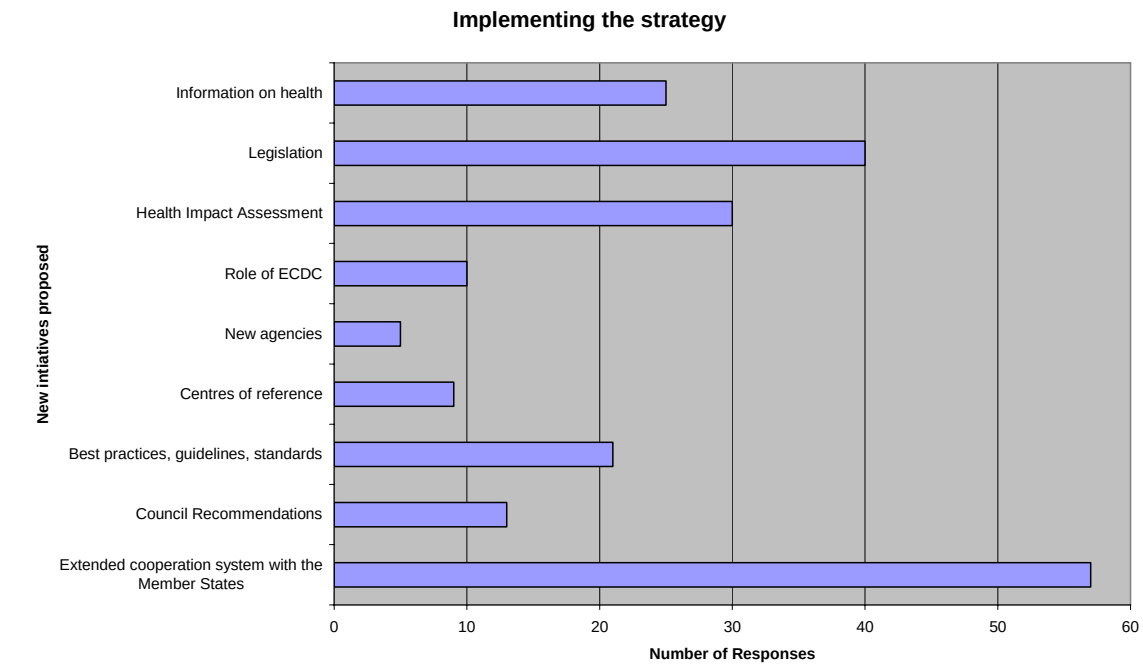
For the short term, some respondents recommended setting resource and infrastructure objectives, including putting in place mechanisms that would have a longer term impact. Objectives for the next five years could include developing a health information system (see above), facilitating exchange of good practice, setting guidelines, developing monitoring arrangements for systems already in place, and ensuring the use of health in all policies concepts through health impact assessment. Responses also emphasised the importance of focussing on preparedness for health threats to ensure health security. Some respondents stressed the desirability of finding ways whereby Member States could agree on policy goals and methods to tackle health determinants and inequalities where short term objectives could, for instance, be a reduction of alcohol and tobacco consumption.

For the long term, overall health improvements in society, reduction of health inequalities, and improvement of lifestyle indicators were objectives put forward. It was also suggested by some respondents that the development of activities at the international level would have to be foreseen as a long term objective. Finally, some respondents said that work on health systems and on health promotion would require long term objectives.

4. Implementation

Respondents put forward a wide range of suggestions for implementation mechanisms to support progress towards the objectives of the Strategy. These include proposals for new legislative developments, a mechanism to involve the Member States, increased use of Health Impact Assessment in the development of new policies, broadening the mandate of some existing European agencies, the creation of new agencies, extending the use of centres of reference, European guidelines, Council Recommendations and European events related to health .

A variety of proposals was put forward by the respondents for the implementation of the Strategy, including legislative tools, the extension of the use of centres of reference and the development of a mechanism involving Member States using methods developed in the Open Method of Coordination. Among the 153 responses, two thirds contained proposals for actions for the implementation of the Strategy, very many favouring ways of reinforcing collaboration in the implementation phase of the Strategy with Member States, NGOs and international organisations.



Initiatives proposed by the respondents for the implementation of the Strategy

4.1. Legislation

Developing new legislation was for many respondents, including half of the Member States who responded, a possible solution for some of the challenges identified. Other respondents, however, wanted to underline the importance of prior assessment of the need for legislation. Of those who favoured new legislation, the great majority suggested its development in three specific fields: alcohol, tobacco and food labelling and advertisement. Two contributors urged the Commission to develop legislation for new technologies such as telemedicine or informatics products. Five contributors called for a

clear legislative framework for cross-border health services, while others referred to their contributions on this to the parallel consultation on the health services initiative.

4.2. Health Impact Assessment

Many of the contributors said that the Strategy should support the application of Health Impact Assessment (HIA) in all policy sectors. Some contributors urged the Commission to promote and to ensure the application of this method both at European and at national level. To that end, respondents emphasised the need to develop methodologies, to promote the use of HIA at all levels and to ensure the existence and availability of professional resources to support its application. A number of respondents suggested the development of toolkits of impact assessment techniques, while other recommended the establishment of a unit dedicated to health impact assessment within DG SANCO. Furthermore, it was noted that expertise from health professionals may be required when conducting HIAs.

4.3. Other mechanisms proposed

Several further potential tools for the implementation of the Strategy were identified.

Some contributors supported the use of **agencies** for implementation of specific elements of the Strategy. A number of respondents wanted to use the planned review of the remit of the **European Centre for Disease Prevention** (ECDC) to strengthen and develop its actions as a response to European and global challenges related to communicable diseases and also potentially others. Equally, a small number of contributors proposed extending the activities of the **European Monitoring Centre for Drugs and Drug Addiction** (EMCDDA), suggesting that abuse of tobacco and alcohol could be considered as addictions and therefore could potentially be monitored by the agency.

Some respondents recommended the **creation of new dedicated agencies.** These could play a variety of roles: either as a regulator, for example a European regulatory agency on tobacco and nicotine products; or engage in monitoring activities, for example an agency dedicated to workforce mobility; or be involved in the collection and analysis of information on a specific topic, such as rare diseases, where an agency could act as a clearing house for information in patient registries, quality assessment, clinical trials, or bio banks.

A number of respondents highlighted the potential value of **centres of reference**, where healthcare services could be provided to patients who have conditions requiring a particular concentration of resources or expertise in order to provide high quality and cost-effective care. These could also be focal points for medical training, research, information dissemination and evaluation[9]. One response proposed the implementation of new centres dedicated to rare diseases.

10% of the contributors highlighted the importance of the development of **guidelines,** and the sharing of **best practice** with the possible establishment of standards in a number of health fields. A number of examples for potential European guidelines were proposed, including guidelines on health professionals' role in prevention, and for implementation of national policies for specific diseases.

[9] Report from the High Level Group to the Employment, Social Affairs, Health and Consumer Protection Council on 6-7 December 2004 (HLG/2004/21 FINAL), http://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/highlevel_2004_026_en.pdf

Relating to policy coherence and mainstreaming health - a priority supported by a broad consensus- some contributors proposed the development of a political mechanism to support cross-sectoral work. One suggestion was for creating a group of Commissioners to focus on health, with similar approaches to be taken at national level. Another proposal, from a Member State, was that each new Presidency should focus on the impact on health of one non-health policy.

A number of the contributors proposed, **as an alternative to legislative options**, the adoption of **Council Recommendations**. They stressed the major political impact Council Recommendations could have as a first step for coordination among Member States. Various proposals were made for the Recommendations, including the fields of prevention of major diseases, comparable information, health promotion and education on healthy lifestyles.

In addition, in relation to supporting work on healthy lifestyles, one respondent proposed a **European Year of Health and Well Being,** while another proposed a week on similar issues.

A number of contributors stressed the need to make more use of **existing Community financial mechanisms** for the implementation of the Strategy, including using the Structural Funds for health professional development and the Seventh Framework Programme for health research.

5. Involvement of Member States

Respondents saw Member States as key actors for achieving the objectives of the Health Strategy, and coordination between Member States and with the Commission was seen as vital for its implementation. Various solutions were put forward, and broad support was expressed for a new mechanism of structured cooperation using methods tried and tested under the Open Method of Cooperation.

A number of respondents underlined that the Strategy's success will depend on its added value to the Member States, including regional and local authorities.

Seven Member States emphasised the importance of interconnection and clear coordination between European and national levels, and two stressed that green papers, Council recommendations and clearly defined objectives at the EU level can assist in the definition of their own national strategies in the field of health.

Respondents highlighted the need for effective arrangements or mechanisms to ensure this linkage. For instance, a number of respondents suggested that national plans to support the Strategy should be established.

Structured cooperation system with the Member States

Many contributors stressed that a new mechanism of structured cooperation using methods developed under the Open Method of Cooperation would be the right means for achieving the objective of coordinated implementation. This proposal was supported by eight Member States. Three other Member States favoured establishing closer

coordination and enhanced exchange between the administrations, but did not comment specifically about the kind of mechanism to be employed.

Many stakeholders mentioned the utility of the existing Open Method of Coordination on Social Protection and Social Exclusion. Establishing a new mechanism for Health Strategy using similar tools and methods was seen by many to be an effective way to foster the exchange of experiences and good practice, and as a means of providing general orientation and key messages without developing obligations or mandatory guidelines. It was also seen as a way to facilitate consensus and ownership among representatives at national, regional and local level. Some responses suggested specific fields of action for such a mechanism, including information, health in the workplace, stroke care, health technology assessment as the next step to the existing network, EUnetHTA, health information and data collection, and preparedness for health threats.

On the other hand, two Member States were hesitant about using this kind of structured mechanism and considered that there had to be prior consideration of the potential added value it could provide for different areas of work, and of its mandate, before any such mechanism was developed. Some other respondents also stressed that clear delimitation of responsibilities would have to be defined under such a mechanism.

In addition to a structured cooperation mechanism, several further proposals were made to strengthen the complementarily of European-level and national work. Most Member States wanted the Strategy to support the exchange of good practice and to develop guidelines for policy which could be used in Member States.

Finally, the need to ensure ownership of the Strategy at the Member State level was also stressed. This required that sufficient inducement and a reasonable timeframe for actions were provided. One Member State proposed that the Strategy should be subject to a regular progress report to Council to promote the engagement of the Member States.

Finally, two contributors suggested that an approach similar to that taken in the field of education through the **Bologna Process**[10], could be adopted with the development of a Declaration for Health Ministers aiming at the establishment of a European Area for Health.

6. Involvement of other stakeholders

Respondents strongly supported the use of platforms or working groups involving stakeholders. Some suggested reorganising some of the current groups by, for example, undertaking a mapping exercise, clarifying membership and putting in place mission statements. Respondents stressed the value of involving stakeholders throughout initiatives from the consultation process through to the implementation.

Many respondents welcomed the proposals in the discussion document to involve a broad range of health stakeholders in the Strategy.

[10] The Lisbon Strategy encompasses the Commission's contribution to the intergovernmental Bologna Process, aiming to establish a European Higher Education Area which is intended to facilitate mobility of people, transparency and recognition of qualifications, the quality and European dimension in higher education, as well as the attractiveness of European institutions for third country students. http://ec.europa.eu/education/policies/educ/bologna/bologna.pdf

Some respondents called for a clear mapping of all the existing platforms, groups, and networks existing at EU level. Some said that, for the various groups involving stakeholders, there needed to be greater transparency in the nomination and involvement of participants and a balance in the representation of the stakeholders and interest groups. Contributors also called for the definition of commitments and tasks for the participants, the development of, new working methods, including greater use of the internet. Some contributors suggested the introduction of Mission statements and terms of reference for platforms which did not yet have them.

Some contributors shared their positive impressions about some existing interaction mechanisms between the Commission and health stakeholders. The Platform for Action on Nutrition and Physical Activity and the 'Healthy Democracy' peer review process[11] were regarded as good examples of such mechanisms. Moreover, NGOs expressed broad support for the continuation of the Health Policy Forum and Open Forum and called for more regular meetings.

Some professional organisations described positive experiences with other services where stakeholders were involved as partners in European Commission activities. To reinforce the possibilities for involving stakeholders, the pilot project of DG Internal Market on collaboration with pharmacists in the field of mobility of health professionals was given as a good example[12].

Concerning the contributions of stakeholders to policy making, it was stressed by a number of respondents, including two Member States, that in addition to open public consultations, the Commission should ensure that stakeholders, including patients and civil society were involved in the entire process, from the formation of policy proposals to their implementation and review.

Some respondents, including one Member State, supported the use of Public Private Partnerships in the health field. However, some respondents thought that there was a need to clarify their role and participation before they could be widely used.

Finally, a sizeable number of contributors, particularly public health NGOs, patient groups and industry called upon the Commission to find solutions to the problem of lack of adequate funding of patients' groups and health NGOs.

7. Ensuring progress

Respondents called for outcome and process indicators to monitor progress towards the objectives of the Health Strategy. These should be defined in cooperation with Member States. Member States would be responsible for providing data, while the Commission would provide a mechanism for monitoring and evaluating progress. The Health Strategy should have a mid-term review.

Nearly one third of the respondents stressed the importance of setting indicators for the Strategy and of monitoring progress. Many respondents advised that indicators should be linked to specific actions. Some respondents, including two Member States,

[11] http://ec.europa.eu/consumers/reports/peer_review_report_2006_en.pdf

[12] Internal Market Information System Project

proposed setting up a list of the indictors as a second step, once the broad objectives of the strategy were agreed.

In terms of the selection of indicators for the strategy, half of the respondents who contributed on this point, including six Member States, supported the use of the Health Life Years (HLY), indicator which measures years spent in good health. The fact that HLY is already one of the indicators of the Lisbon process was one reason given for this choice. Nevertheless, two contributors stressed that the HLY indicator had limitations as it is partly measured through self-assessment. It may therefore be less easy to use for comparisons between Member States owing to cultural differences. These contributors said that the commitment of the Member States would be necessary to ensure the quality of the results if the HLY indicator was to be used.

Coherence in the development of indicators was called for by some contributors, to ensure comparable data. Some advised the use of indicators that are already defined such as the European Community Health Indicators (ECHI), European Public Health Information, Knowledge & Data Management System Indicators (EUPHIX), indicators developed by Eurobarometers, mortality and morbidity rates, Disability Adjusted Life Years (DALYs), Quality Adjusted Life Years (QALYs) and the distribution of risk factors. Some favoured a few specific measures of individuals' health, such as blood pressure or cholesterol level. Other contributors suggested broader outcome indictors, as for instance, indicators related to lifestyle (percentage of smokers or the change in market share of cigarette trade) or to health inequality (life expectancy by gender, health of socially excluded communities).

In addition to outcome indicators, respondents also stressed the importance of developing process indicators to monitor the progress of the Strategy. A number of proposals were made for process indicators, for example the number of established networks, the number of developed guidelines, regulatory development, or policy development in different fields. These could be evaluated by concrete initiatives; one Member State suggested drinking and driving as an example.

A step-wise approach in terms of implementation and ensuring progress on the Strategy was supported by a number of respondents. Several proposed, as part of this process, that a detailed action plan for the Strategy should be drawn up where information on actors and responsibilities, timelines, tools, and milestones would be defined. Such a plan should be developed in cooperation with Member States and with the involvement of stakeholders. Some respondents also emphasised the need for national and regional action plans to complement an EU action plan.

It was suggested that targets could be defined to drive forward policy developments and to monitor the impact of the policies. Generally, respondents who contributed to this aspect of the consultation favoured developing targets appropriate to each country, similarly to the UN Millennium Development Goals[13]. Indeed, one Member State recommended the development of targets at the national level. In parallel, some respondents called for caution while developing targets where endorsement of Member States would be needed. In their view, setting European targets would be useful only in those cases where it was possible to be clear about who had delivered the results and how, and where comparable data exists.

In order to make best use of the indicators some contributors suggested setting up a system of regular reporting at the European level. A number of contributors proposed

[13] The eight UN Millennium Development Goals – which range from halving extreme poverty to halting the spread of HIV/AIDS and providing universal primary education by the target date of 2015 – form a blueprint agreed to by all the world's countries and the world's leading development institutions. http://www.un.org/millenniumgoals/#

that there should be annual monitoring of defined high level indicators, specific indicators and milestones. National monitoring reports could also be published annually.

In relation to the data underpinning the indicators, there was much emphasis on the need for comparability. Some contributors underlined the point that it was Member States that have the responsibility for collecting data, and the European Commission should not be involved in this. Its role was rather in the comparison of the results, the definition of milestones, and the identification of best practice.

Finally, the value of a mid-term review for the Strategy was highlighted by a number of participants.

8. Conclusion

This report summarises the 153 responses to the Commission's consultation 'Health in Europe: A Strategic Approach - Discussion Document for a Health Strategy. The Commission will take into account the results of this open consultation for the development of the new Health Strategy which is planned to be adopted later in 2007.

ANNEX I – Questions included in the Consultation Document

Within the three broad elements of the Strategy, **addressing core issues**, **mainstreaming health,** and **global health:**

1. How should we prioritise between and within all these areas to focus on those which add real value at the EU level? In which areas is action at the EU level indispensable, and in which is it desirable? For example, is there a means to use the Healthy Life Years indicator or other outcome measurements to give weight to areas on which the EU should concentrate?

2. What should we realistically aim to achieve in practice in these areas of work? What broad objectives should we set for the short term and long term – 5 years and 10 years?

3. Are there issues where legislation would be appropriate? What other non-legislative instruments should be used – for example, a process similar to the Open Method of Coordination? How can we make better use of Impact Assessment?

4. How can different approaches be used and combined, for example approaches to different health determinants, lifecycle approaches, and strategies on key settings (education, the workplace, health care settings)?

In terms of the **implementation** of the Strategy:

5. How can we ensure that progress is made and that objectives are met? For example, should indicators or milestones be used? What measures or indicators could show real short term change, within the early years of the Strategy?

6. How do we ensure that the Strategy adds value to actions at Member State level? How can the responsibility for implementation be shared between the EU and Member States?

7. How could methods for involving stakeholders be improved? How can we create innovative partnerships with stakeholders?

Further comments:

8. Do you have any **further comments**?

ANNEX II – List of the Respondents to the Consultation Document[14]

1. Member States and Third Countries

13	Ministry of Health of Turkey
18	Ministry of Health of Latvia
62	Federal Office of Public Health of Switzerland
81	Ministry of Health and Care Services of Norway
90	Ministry of Health and Consumers of Spain
91	Government of Ireland
104	Ministry of Public Health of Romania
109	Ministry of Health of Cyprus
113	Ministry of Social Affairs and Health of Finland
116	Ministry of Health of Poland
118	Government of Bulgaria
120	Federal Ministry of Health of Germany
126	Ministry of Health and Social Affairs of Sweden
129	Ministry of Health of Hungary
138	Ministry of Social Affairs of Estonia
142	Ministry of Health, Welfare and Sport of the Netherlands
143	Ministry of Health of Belgium
146	Ministry of Health of Italy
149	Department of Health of UK

2. International Organisations

26	Peter Zimmermann	IVVA - International Federation of Anthroposophic Medical Associations
37	Neville Rigby	IASO - International Association for the Study of Obesity
39	Ciara Goldstein	DNDI - Drugs for Neglected Diseases Initiative TB Alliance - Global Alliance for TB Drug Development Institute for One World Health IAVI - International AIDS Vaccine Initiative MMV - Medicines for Malaria Venture
111	Armin H. Fidler	World Bank
139	Anca Toma	IDF- Fédération International du Diabète FEND - Fédération Européenne des Infirmières en Diabète PCDE - Primary Care Diabetes Europe
153	Nata Menabde	World Health Organisation

[14] The participants to the consultation were divided into a number of categories. When some contributors could fit into several categories the attribution has been carried out in the simplest way.

3. European Organisations

8	Annette Kennedy	EFN - European Federation of Nurses Associations
10	Ivana Silva	PGEU - Pharmaceutical Group of the European Union
12	Christine Marking	EUGMS - European Union Geriatric Medicine Society
14	Christine Marking	Eurocarers - European Association working for carers
15	Wim Rogmans	EuroSafe - the European Association for Injury Prevention and Safety Promotion
16	Antonella Pederiva	CECCM - Confederation of European Community Cigarette Manufacturers
17	Arne Hagen	SAFE - Stroke Alliance for Europe
21	Isabel Mota Borges	AGE - The European Older People's Platform
24	Simona Giampaoli	EUROCISS - European Cardiovascular Indicators Surveillance Set Project
25	Susanne Logstrup	EHN - European Heart Network
28	Brigitte van der Zanden	EPECS - European Patients Empowerment for Customised Solutions
29	Jean-Pierre Baeyens	European Nutrition for Health Alliance
31	Claudia Ritter	Council of European Dentists
32	Finn Børlum Kristensen	EUNetHTA - European Network for Health Technology Assessment
35	Simona Giampaoli	EACPR - European Association for Cardiovascular Prevention and Rehabilitation - Section 'Prevention and Health Policy'
36	Anders Foldspang	ASPHER - Association of Schools of Public Health in the European Region
40	Julia Levy	Alliance for Health and the Future
45	Erick Savoye	EMHF - European Men's Health Forum
47	Flaminia Macchia	EURORDIS - European Organisation for Rare Diseases
52	Spencer Hagard	IUHPE - International Union for Health Promotion and Education – European Regional Committee
56	Christel Gundelach	SABORG
59	Simon Guentner	EUROCITIES
60	Philip Berman	EHMA - European Health Management Association
63	Francis Grogna	ENSP - European Network for Smoking Prevention
65	Ourania Georgoutsakou	AER - Assembly of European Regions
66	Monica Guarinoni	Health & Environment Alliance
68	Lisette Tiddens-Engwirda	CPME - Standing Committee of European Doctors
69	Florence Berteletti	Smoke Free Partnership
70	Christine Dawson	ESIP - European Social Insurance Platform
72	Steven Ward	European Health and Fitness Association
75	Ferdinand de Herdt	ECPM - European Council of Doctors for Pluralism in Medicine IVAA - International Federation of Anthroposophical Medical Associations ECCH - European Council for Classical Homeopathy EFN - European Federation for Naturopathy KAM - Committee for Alternative Medicine NSK - Nordic co-operation Committee for non-conventional Medicine ECHAMP - European Coalition on Homeopathic and Anthroposophic Medicinal Products EFHPA - European Federation of Homeopathic Patients' Associations EFPAM - European Federation of Patients' Associations for

		Anthroposophic Medicine I.A.A.P. - International Association of Anthroposophic Pharmacists
77	Karin Werner	ESCMID - European Society of Clinical Microbiology and Infectious Diseases
79	Martyna Kurcz	ENSA - European Natural Soyfoods Manufacturer Association
80	Gloria Galan	EDMA - European Diagnostic Manufacturers Association
83	Michael Leader	EuropaBio
84	Sophie O'Kelly	ESC - European Society of Cardiology
85	Susanna Palkonen	EFA - European Federation of Allergy and Airways Diseases Patients' Associations
86	Roxana Radulescu	EPF - European Patients' Forum
87	Margarida Silva	ERS - European Respiratory Society
89	Magdalena de Azero	EVM - European Vaccine Manufacturers
93	Daniel Keszthelyi	EMSA - European Medical Students' Association
95	Caroline Costongs	EuroHealthNet
96	Theodoros Koutroubas	CEPLIS - Conseil Européen des Professions Libérales
100	Laurence Ehlers	FEAM - Federation of the European Academies of Medicine
103	Jaka Brumen	EPU - European Pharmaceutical Union
106	Philippe Druart	ECU - European Chiropractors' Union
107	Annette Dumas	Alzheimer Europe
114	Ludvig Hubendick	European Youth Forum Jeunesse
121	Sevdalina Rukanova	EFC-EPGH - European Foundation Centre / European Partnership for Global Health
124	Pascal Garel	HOPE - European Hospital and Healthcare Federation
128	Stephen Gordon	ECCH - European Council for Classical Homeopathy
131	Peggy Maguire	European Institute of Women's Health
140	Lara Garrido-Herrero	EPHA - European Public Health Alliance
145	Ilaria Passarani	BEUC - European Consumers' Organisation
147	Hildrun Sundseth	European Cancer Patient Coalition
148	Christophe De Callatay	EFPIA - European Federation of Pharmaceutical Industries and Associations
151	Peter Schroeder	PHGEN - Public Health Genomics European Network
152	Valery Tzekov	SEE Health Network - South Eastern Europe Health Network

4. National Organisations

6	Vera Simovska	National Organization for the promotion of Health-Enhancing Physical Acitivity HEPA Macedonia	Non EU
23	Hélène Leblanc	Ordre National des Pharmaciens	FR
33	Anneli Vartio	Finnish Institute of Occupational Health	FI
48	Anders Jensen	Norwegian Massage Association	Non EU
53	Vappu Taipale	STAKES	FI
57	Malte Erbrich	Deutsche Sozialversicherung Europavertretung	DE
58	Isabel Vallejo Díaz	FEFE- Federación Empresarial de Farmacéuticos Españoles	ES
61	Tim Marsh	National Heart Forum	UK
67	Peter Carter	Royal College of Nursing	UK
71	Nicola While	British Medical Association	UK
88	Pedro Gonçalves	APHP - Associação Portuguesa de Hospitalização Privada	PT
97	Mika Pyykkö	Finnish Centre for Health Promotion	FI
98	András Nagy	Hungarian Heart Foundation	HU
105	Sven-Olov Carlsson	IOGT-NTO	SV
115	Jopie Nooren	VGN - Vereniging Gehandicaptenzorg Nederland	NL
117	Maura Gillespie	British Heart Foundation	UK
122	Marc Schreiner	German Hospital Federation	DE
127	Rodney Burnham	Royal College of Physicians	UK
130	Thomas Kennedy	Royal College of Psychiatrists	UK
134	Owen Metcalfe	Institute of Public Health in Ireland	IE
135	Maria Nyberg	NHS Confederation	UK
136	Catrin Roberts	RNIB - Royal National Institute of the Blind	UK
144	Jude Williams	Healthcare Commission	UK
150	Elizabeth Cullen	Irish Doctors' Environmental Association	IE

5. Regional and Local Organisations

9	Alan Cunningham	Community Public Health - East Liverpool	UK
22	Chris White	North West of England Public Health Community	UK
30	Sarah Watkins	Welsh Assembly Government	UK
51	Dorthe Nielsen	Greater London Authority	UK
54	Ifeoma Onyia	Sefton Primary Care Trust	UK
64	Craig Titterton	Local Government Association	UK
73	Bjugård Ingvor	Swedish Association of Local Authorities and Regions	SV
76	Jenny-Lee Spencer	NHS London	UK
99	Modi Mwatsama	Heart of Mersey	UK
102	Enrique Granda	Colegio de Farmacéuticos de Valencia	ES

6. Universities and academia

2	Brenda Spencer	Lausanne University Institute of Social and Preventive Medicine	Non EU
4	Dimitrios Sotiriou	University of Athens - School of Medicine	EL
7	Helen Dolk	University of Ulster	UK
34	Michaela Moritz	ÖBIG - Gesundheit Österreich GmbH - Geschäftsbereich	AT
38	Michael Rigby	Centre for Health Planning and Management, Keele University	UK
41	Gabriel Gulis	University of Southern Denmark - Institute of Public Health - Unit of health promotion research	DK
42	Paul Janiaud	Genopole - Groupe d'Intéret Public Recherche en Genomique	FR
50	Tom Kuiper	Universiteit Maastricht - Faculty of Health, Medicine and Life Sciences - BSc European Public Health	NL
55	W. Kirch	Technische Universität Dresden - Medizinische Fakultät Carl Gustav Carus	DE
82	Kim Beazor	Nuffield Trust	UK
125	Laurence Esterle	INSERM U 750, Centre de recherche Médecine, Science, Santé et Société	FR
133	Sarah Woolnough	Cancer Research UK	UK

7. Commercial organisations and companies

74	Scott C. Ratzan	Johnson & Johnson	Non EU
78	Johan Hjertqvist	Health Consumer Powerhouse	EU
92	Brett Ronan	Celesio Pharmacies	EU
101	Véronique Masi	Sanofi-Aventis	Non EU
110	Eric Souêtre	Labco	EU
112	Michael Ryman	EPI (GB) Ltd	UK
132	Stuart Hurst	Pfizer	Non EU
137	Meni Styliadou	Novartis	Non EU
141	Ivo I.J. Struik	GlaxoSmithKline	Non EU

8. Citizens

1	Tuomo Karjalainen	EU
3	Mike Abbott	UK
5	Reinhard Winter	DE
11	Reinhard Fischer	IT
19	Riitta-Maija Hämäläinen	FI
20	Brit Jørgensen	DK
27	André Knottnerus	NL
43	Regine M. Stephan	DE
44	Stephen Clift	UK
46	Lisbeth Bøggild	DK
49	Zammit Richard	MT
94	Francisco Borja Lopez-Jurado	ES
108	Asterios Terpos	EL
119	Andrjez Wojtczak	PL

123	João Vilarinho Santos	PT