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**REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE
COUNCIL, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE
COMMITTEE OF THE REGIONS**

Ex-post Evaluation of the 2nd Health Programme 2008-2013

Decision No 1350/2007/EC
establishing a second programme of Community action in the field of health (2008-13)

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1. INTRODUCTION

1.1. Purpose of the evaluation

This staff working document accompanies the Commission report and the external evaluation report that the Commission is transmitting to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions under Article 13(3)(c) of Decision No 1350/2007/EC.¹

The external and independent *ex post* evaluation of the 2nd Health Programme was conducted in 2014-2015. Its purpose was primarily to assess the performance of the Programme management implementation, including follow-up to the recommendations in past health programme evaluations. The evaluation contributes to a better understanding of the strengths and weaknesses of Programme implementation and management and provides conclusions that can be used as a basis for improving the implementation of the current 3rd Health Programme.

1.2. Scope of the evaluation

This evaluation follows on from previous evaluations of the 1st Public Health Programme and the 2nd Health Programme, building on the results, in particular of the mid-term evaluation of the latter, without repeating earlier evaluation work carried out to inform the design of the 3rd Health Programme.

Consequently, it focuses on specific aspects of the Programme, such as programme management, dissemination of results and synergies with other programmes, seeking to complement the previous evaluations. While addressing the functioning of the entire Programme, the contractors concentrated on issues that were insufficiently explored in past exercises and provided conclusions that can form a basis for changes to improve the effectiveness and efficiency of the 3rd Health Programme.

2. BACKGROUND TO THE INITIATIVE

2.1. Description of the initiative and its objectives

According to the Treaty on the Functioning of the European Union (TFEU), a high level of health protection shall be ensured in the definition and implementation of all Union policies (Article 168 (1) TFEU). Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health.

The 2nd Health Programme was the main instrument for implementing the EU's 2008-2013 health strategy *Together for health*;² from 2011, it was aligned with the priorities of the Europe 2020 strategy.³

The Programme's overall aim was to **complement, support and add value to Member States' policies and to contribute to increased solidarity and prosperity in the EU by protecting and promoting human health and safety and improving public health**. Health is a prerequisite for economic recovery and 'inclusive growth', and the health sector attracts interest for innovation and 'smart' investment.

The Programme financed pan-European actions geared to achieving three **main objectives**:

- i. ***improving citizens' health security*** and protecting them from health threats and emergencies, such as pandemics and natural disasters;
- ii. ***promoting health and reducing health inequalities*** across Europe, whether relating to lifestyle, such as access to opportunities for physical activity, to health care, such as access to the necessary medical intervention; and
- iii. ***generating health information and health knowledge and disseminating it*** to relevant parties, from the general public to policymakers and health professionals.

¹ Decision No 1350/2007/EC of the European Parliament and of the Council of 23 October 2007 establishing a second programme of Community action in the field of health (2008-13) (OJ L 301, 20.11.2007, p. 3–13).

² COM(2007) 630 final, 23.10.2007; http://ec.europa.eu/health-eu/doc/whitepaper_en.pdf.

³ COM(2010) 2020, 3.3.2010; http://ec.europa.eu/europe2020/index_en.htm.

Three broad thematic areas corresponding to these objectives were identified, with priorities and sub-priorities (see Figure 1).

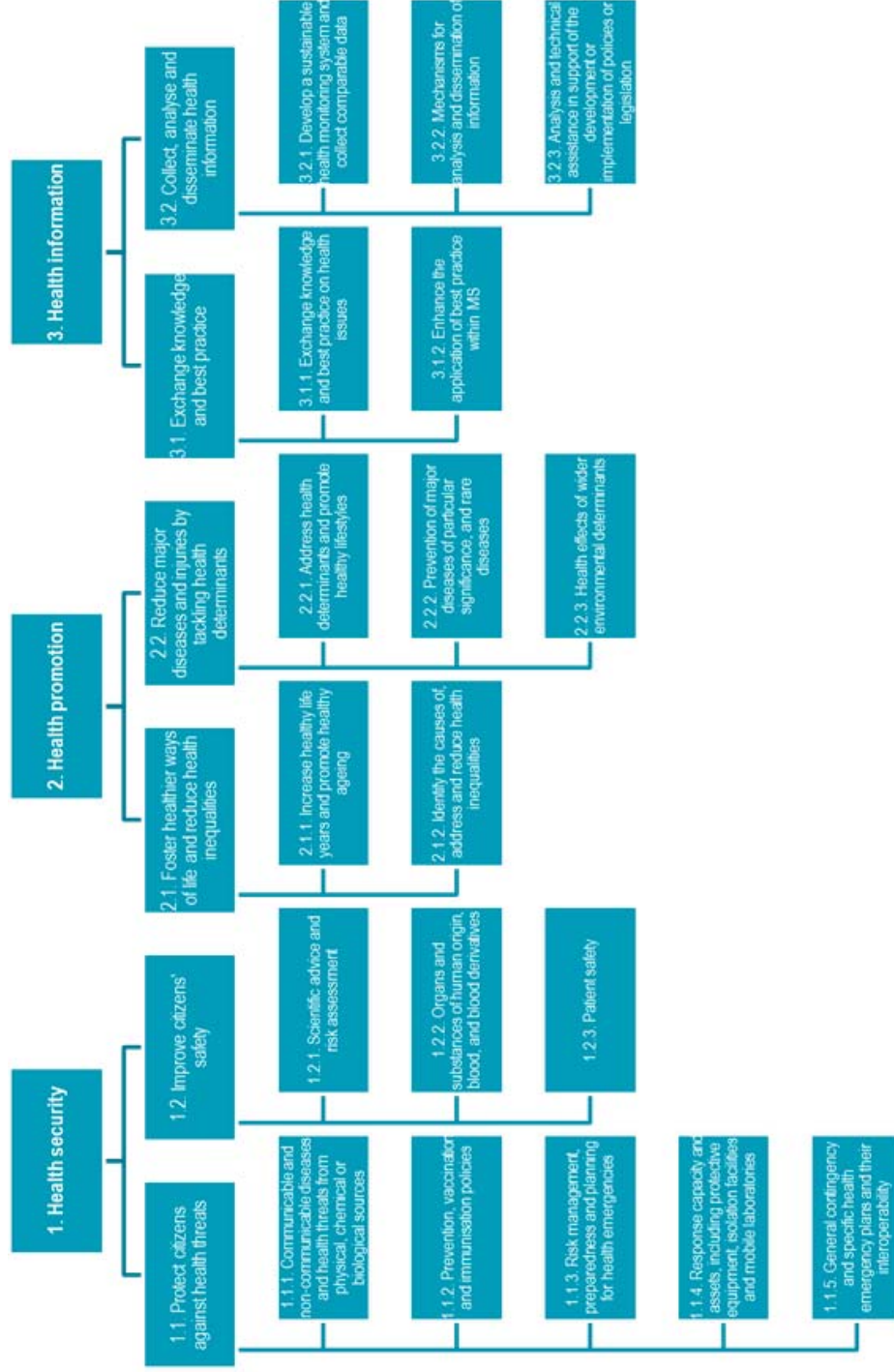
2.2. What outputs were expected from the Programme?

Under Article 168 TFEU, the Union shall encourage cooperation between the Member States, and support their action, including through the establishment of guidelines and indicators, the organisation of exchange of best practice and support for monitoring and evaluation. Member States' responsibilities for the definition of their health policy and for the organisation and delivery of health services and medical care should be respected.

The Programme was expected to support and add value to Member States' policies and hence contribute to protecting the health and safety of citizens through actions in the field of public health. Accordingly, the Programme financed a large number of actions with a good coverage of all the priorities and sub-priorities established in Decision No 1350/2007/EC, the outputs of which can be broken down as follows:

- **knowledge- and evidence-building** through studies and/or surveys (e.g. Eurobarometer), including evaluations and impact assessments that are beneficial on a number of levels, e.g. providing a basis for informed policymaking and reporting;
- **tools and/or methodologies** that help to secure advantages for both the public-health communities (e.g. integrating their work processes) and citizens directly (e.g. with regard to improving diagnostic tests, improving patient care, etc.);
- **communication, awareness-raising and networking** (e.g. co-funding pan-EU conferences and networks *inter alia* in the field of rare diseases);
- **comparable data** across the EU, providing information for policymaking purposes, e.g. European core health indicators (ECHIs);
- **training, educational material and guidance** with a positive impact on the public-health community (e.g. by providing guidelines on patient care, diagnostics, social inclusion of vulnerable groups, etc.) and on citizens who might benefit from treatment by better-educated healthcare professionals;
- **best practices**, helping to achieve and maintain high standards in all health-related areas (research, prevention, access, care, treatment, etc.); and
- **capacity-building** in the public-health community at different levels (e.g. increasing the capacity of healthcare systems to deal with diseases through an exchange of knowledge with healthcare institutions in other Member States).

Figure 1: 2nd Health Programme – thematic areas, priorities and sub-priorities



2.3. What results and impacts were expected from the Programme?

Many health-related challenges, such as cross-border health threats, cannot be addressed at country level; hence there is a clear need for EU action to complement Member States' efforts. However, any action at EU level should demonstrate EU added value⁴ and actions co-funded by the Programme were expected to result in one or more of the following:

- a contribution to the development and/or implementation of EU legislation;
- money saved and duplication of efforts avoided by cooperation across national health systems for the improvement of health in the EU;
- identification and application of best practice in all participating countries, e.g. procedures, approaches, methods or tools that could be applied by healthcare professionals or others;
- evidence-based decision-making facilitated, e.g. by providing scientific information, real-time data for comparison and/or indicators that can inform decision-making at a higher political/policy level;
- risks reduced and consequences of cross-border health threats mitigated by the establishing of relevant structures for coordination;
- increase in the movement of patients and healthcare personnel between Member States, thereby contributing to a better match between supply and demand;
- sustained networking activities among stakeholders, contributing to knowledge-sharing and health capacity-building in the EU; and
- support for the deployment of innovative solutions for healthcare provision, in terms of both products and services.

The results overall are expected to impact on public health in Europe in order to achieve the main objective of the Programme, i.e. to complement, support and add value to Member States' policies and to contribute to increased solidarity and prosperity in the EU by protecting and promoting human health and safety and improving public health.

2.4. Baseline

The 1st Public Health Programme (2003-2007) grew out of a small number of isolated, empirically managed activities in response to calls from the Council and the European Parliament, such as action on HIV/AIDS, health information, etc. The number of priorities increased gradually around the three main objectives of health promotion, health security and health information, in order to optimise impact and meet new expectations through an integrated approach. The Programme was operated exclusively through grants for projects and a small number of tenders. The Member States that joined the Union in May 2004 became involved progressively and were underrepresented in the actions financed. The Programme was managed by the Commission, except for a small part which was transferred to the Public Health Executive Agency, which became the Executive Agency for Health and Consumers (EAHC) and later the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA), after its establishment and operational launch in 2006.

The evaluation of the 1st Public Health Programme recognised its strong potential contribution to preparing, developing and implementing EU public-health policies, despite the broad spectrum of health priorities it covered, and called for more focus and rationalisation. The dissemination of the results was seen as an important area for improvement: the outcomes of the actions targeting health policymaking at EU, national or regional levels were neither sufficiently known nor widely used by stakeholders and policymakers. Disseminating results was seen as essential to ensuring their sustainability and helping to monitor the impact of the actions.

The design of the 2nd Health Programme was similar to that of its predecessor, but involved new financial mechanisms, in addition to grants for projects and conferences, in order to respond better to stakeholders' needs: operating grants for non-governmental organisations, direct grants for boosting cooperation with international

⁴ Following the Commission's Communication *Reforming budget, changing Europe* in the context of the 2008/2009 budget review (COM(2007) 1118), 'EU added value' was introduced as an award criterion in the evaluation of proposals. On the basis of its experience and expertise, the Executive Agency for Health and Consumers, which the Commission entrusted with implementation of the Programme, identified ways in which EU added value is created and methods for assessing it. See also section 7.1 (Relevance and EU added value).

health organisations, joint actions with Member States and tenders to cover specific needs related to the support of EU health policies.

3. EVALUATION QUESTIONS

The evaluation is based on a set of 14 questions divided into four main areas:

- (a) management tools;
- (b) dissemination practices;
- (c) Programme impact; and
- (d) synergies with other services and programmes.

The questions do not follow the classical approach to programme evaluation (focusing on relevance, effectiveness, efficiency, coherence and utility) but, following the results and recommendations of the mid-term evaluation, target specific areas of concern in programme implementation.

As regards *programme design and management*, the mid-term evaluation resulted in recommendations to:

- define more tangible and focused objectives and establish progress indicators;
- prepare strategic multi-annual planning to determine appropriate priority actions and select the corresponding financial mechanisms;
- provide technical assistance to potential applicants for preparing appropriate proposals;
- create a nomenclature for explaining EU added value and integrate it in the application process through specific criteria;
- provide further explanations on the scientific evidence required in proposals and how to share it;
- share other information with Programme stakeholders and potential beneficiaries;
- develop a regular reporting system for the actions and their results;
- communicate/disseminate project results better and more systematically and improve communication with Programme stakeholders; and
- make full use of consistencies and complementarities between Programme actions and other actions at international, European and national level, including sharing of data among Commission services, Member State authorities and international organisations.

These recommendations underlay the first four evaluation questions, which were designed to measure the progress made on the *effectiveness* of the Programme management:

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

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

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

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

As regards *dissemination practices*, the mid-term evaluation recommended fostering the dissemination of results and organising an exchange of information on results between the Agency, Commission officials, policymakers in Member States and other stakeholders.

The evaluation questions relating to dissemination were:

- EQ 5: (a) To what extent have the actions/outcomes/results of the 2nd Health Programme been published? To what extent are they (made) accessible to the international scientific and health community, to health policymakers, civil society and to the wider public in the EU?
(b) Are the results published and disseminated in a sustainable way?
(c) How useful is the EAHC database in this context? How can it be improved?
(d) Which other tools would be useful in this context?
- EQ 6: What is the relation between the publications/activity reporting and Member State participation in the 2nd Health Programme, the number of health scientists, public-health specialists and physicians per Member State? Are patterns identifiable? Have dissemination activities been undertaken in a way to overcome possible geographical imbalances in certain actions?
- EQ 7: To what extent do stakeholders other than Member State governments (sub-national regional organisations, civil society, social partners, etc.) promote Programme outcomes and results, and via which channels? This should consider both organisations funded by the Programme, and others.
- EQ 8: How could the current dissemination practices be improved to increase return on investment?

Since the negotiations with the Council and European Parliament on the 3rd Health Programme confirmed the important role dissemination plays in maximising programme impact, Article 13(4) of Regulation (EU) No 282/2014 explicitly requires wide dissemination of the results.⁵ Accordingly, these questions and the subsequent answers were intended to contribute to improving dissemination further.

Given the difficulty of **assessing the impact** of a small programme against the scale of health needs in Europe, the relevant evaluation questions focused first on the relevance of the Programme actions *vis-à-vis* the Union mandate on health and secondly on the *short- and medium-term progress achieved in specific areas*. With a view to the next programming period, the questions also seek to elicit elements for a better understanding of how the Programme could impact on health policies in the Member States.

- EQ 9: How and to what extent has the 2nd Health Programme supported Member States' health policy and actions (in relation to the provisions on support, cooperation and coordination in Article 168 of the Treaty)?
- EQ 10: Which are the main health policy areas in which progress has been achieved due to the support of the Health Programme, and what constitutes this progress?
- EQ 11: What are reasonable assumptions on the way to measure the impact of the programme in terms of (a) short-term, (b) middle-term, (c) long-term timelines and (d) in relation to average project trajectories?
- EQ 12: Which factors/reasons may intervene and positively or negatively influence the impact of the Programme?
- EQ 13: What are the main lessons than can be drawn to ensure an overall successful transition from the 2nd to the 3rd Health Programme?

The success of the Programme also depends on **synergies with other programmes** in the area of health. Thus, the last evaluation question refers to *coherence and consistency* and focuses on the two other major programmes (under the FP7 research programme and the Structural Funds) with substantial EU funding and interest for Member States. However, other synergies with smaller programmes are also covered, since the question concerns the **Commission's general objectives for economic growth and social inclusion**.

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

⁵ 'The Commission shall make the results of actions undertaken pursuant to this Regulation publicly available and shall ensure that they are widely disseminated in order to contribute to improving health in the Union'; Article 13(4) of Regulation (EU) No 282/2014 of the European Parliament and of the Council of 11 March 2014 on the establishment of a third Programme for the Union's action in the field of health (2014-2020) and repealing Decision No 1350/2007/EC (OJ L 86, 21.3.2014, p. 1–13).

4. METHOD

4.1. Process and methods used

The external evaluation study started in May 2014 and the final report was delivered in July 2015. An interservice steering group established in December 2013 discussed and validated the evaluation mandate and agreed on the evaluation questions and the terms of reference⁶ for the specific contract. The group met four times to discuss in addition to the above, the inception, interim and draft final reports and provided comments on the methods and organisation of the evaluation. It was composed of representatives from DG SANTE, RTD, AGRI, JRC, EMPL, REGIO, EAC and CONNECT, the Secretariat-General and CHAFEA. In addition, the European Hospital and Healthcare Federation (HOPE), the European Health Management Association (EHMA) and the European Public Health Association (EPHA) were represented in order to feed in the views of health-policy stakeholders. In the spirit of a collaborative and transparent approach, the findings and main conclusions were presented to the national focal points on 12 January and 22 May 2015 and to the Programme Committee members on 6 March 2015 and 4 February 2016 and they were asked for their comments and opinions.

The evaluation involved a variety of quantitative and qualitative data collection and review methods and analytical tools to respond to specific information needs and requirements respecting the principle of triangulation. Annex I contains a matrix showing the various tools used to make assessments on the basis of agreed judgment criteria and answer each of the evaluation questions. The contractors used desk research, direct observations, a survey of the national focal points and interviews with Commission officials, CHAFEA project officers, Programme Committee members, beneficiaries and project leaders, and the assistants of two Members of the European Parliament to generate data for analysis. Also, they carried out **an analysis of 80 actions** selected proportionally from across the main Programme areas, priorities and financial mechanisms to assess EU added value and to review the type of actions (research, development and implementation), the type of partner organisations, the partnerships' geographical spread, cross-sectoral cooperation and dissemination practices.

To assess how co-funded actions contributed to the Programme objectives and identify factors that could strategically maximise the potential impact of the Programme, the evaluators selected **13 case studies** (five projects, five joint actions and three tenders) from the 80 actions in order to delve deeper into specific aspects, such as the design of actions, implementation, results and their dissemination, and added value.

They also conducted a **bibliometric analysis** of the Programme's visibility in scientific journals and, to some extent, **an assessment of Member States' public-health capacity** in relation to their capacity to participate in the Programme and make use of the funding.

Finally, on the basis that it is critical for the Programme's success to ensure that all key stakeholders are effectively engaged in and/or informed of the Programme and its results, the contractors undertook **an analysis of the Programme stakeholders**. This sought to explore the power, position and interests that different stakeholder groups brought to the Programme and to identify how they could be involved further.

When carrying out the work, the contractors defined conditions and features on the basis of which to assess Programme actions and verified their validity, in particular through the case studies:

- essential conditions, common to all actions, that influence effectiveness and thus could influence the probability of the action having an impact in the longer term (Table 1); and
- specific key features per funding instrument, as each instrument is meant to respond to different needs and produce certain outputs/results, e.g. tenders to obtain studies and respond to specific Commission needs, joint actions to boost Member States' cooperation on common health issues, calls for proposals for projects on health issues with a wider scope and to incentivise innovation, and operating grants to support NGOs and specific networks.

⁶ The terms of reference are set out in section 1 of the annexes to the evaluation report.

Table 1: Essential conditions for actions' effectiveness

Condition	Description
The actions address a relevant problem	To contribute to HP objectives, actions need to address a specific problem that fits into one of the priorities and where the EU added value of action is high.
The actions are based on concrete and SMART objectives.	In order to implement a service efficiently, you need to develop concrete objectives, operationalised in a SMART way, i.e. your objectives should be specific, measurable, achievable, realistic and time-dependent.
The actions are evidence-based.	Overall and SMART objectives are more likely to be achieved when projects are designed on an evidence-based understanding of how the activities they implement are related to what they actually want to achieve. This includes building on existing knowledge.
The actions have clear target groups.	Efficient organisations are often characterised by a relevant and explicit definition of their target groups.
The actions have developed adequate implementation strategies	The goals of the HP are far-reaching and require dedicated effort over a long period. This means that the chances of achieving long-term effects improve if the project activities are sustainable and are implemented by the participating actors.
The actions are characterised by a high degree of target achievement.	If the above conditions are met and actions achieve what they set out to do, this is likely to generate impacts that contribute to the wider HP objectives.
The actions have effective strategies for disseminating results.	Dissemination of results is key to facilitating their take-up beyond the participants themselves.

The contractors sought to take an innovative approach to assessing on-going efforts (in line with the recommendations of the final evaluation of the 1st Public Health Programme and the mid-term evaluation of the 2nd Health Programme) to involve low-GDP/GNI⁷ Member States. This meant measuring not only increased participation in calls, but also initiatives for the transfer of knowledge to these countries (evaluation questions 3 and 6). The contractors suggested approaching participation by countries that joined the EU from 2004 onwards not only from an economic angle, i.e. participation rates of low- *versus* high-GDP/GNI countries, but also assessing the relationship between countries' participation and their 'public-health capacity'.

4.2. Limitations – robustness of findings

The evaluation is not based on a theory-change approach⁸, as it was considered too difficult to construct *a posteriori* an overall intervention logic for a programme with very broad objectives and multiple priorities grounded in the EU's supporting competence in public health, as laid down in the Treaty on the Functioning of the European Union. It was also too early to assess results as outputs of the actions were just being delivered.

For this reason, the contractors based their work on **explicit expectations and assumptions** (see the essential conditions and specific key features above) as to what the Programme and the various financial mechanisms were to achieve. They followed a purpose-driven approach to sampling (for the in-depth review, case studies, bibliometric analysis, stakeholder analysis, etc.), focusing on those actions and facets of the Programme that promised to be of most value and interest for the analysis, given the specific evaluation purpose and questions. The Commission services gave their agreement to the choices made.

It was also decided to limit the breadth of the evaluation, since the 3rd Health Programme had already been launched and certain aspects became more pertinent than others, depending on their continued relevance for the new Programme (see point 2.2 on the scope of this evaluation). As a result, while certain key features of the 2nd Programme (in particular the very broad scope and resulting lack of focus, including operational and specific objectives) would normally have been addressed in more depth in a final evaluation, they were not given much prominence here. Relevant recommendations (e.g. as regards the need for more specific objectives and indicators) had already been made in the mid-term evaluation and addressed in the design of the 3rd Health Programme.

As mentioned above, the contractors went beyond distinguishing participation between high- and low-GNI Member States to explore the statistical relationship between Member States' 'public-health capacity' and their

⁷ Gross domestic product (GDP); gross national income (GNI).

⁸ A theory of change is a tool for developing solutions to complex social problems. A basic theory of change explains how a group of early and intermediate accomplishments sets the stage for producing long-range results.

participation rates (taking as a proxy variable the amount of funding that organisations from a given country were able to obtain). This approach proved to have significant methodological limitations, mainly due to the lack of a commonly agreed definition of ‘public-health capacity’. Consequently, the analysis was limited to some indicators relating to wealth (GDP/GNI), health research spending, health expenditure, health publications, healthcare resources, health outcomes and healthcare performance. Moreover, data quality and availability for some of these were not always ideal for the correlations that the evaluators were examining.

The weaknesses in the design of the Programme objectives resulting in the lack of indicators for systematic monitoring as already found in the mid-term evaluation posed another limitation to assess the effectiveness of the programme.

Given these limitations, the findings and conclusions are representative only for the actions investigated and cannot necessarily be extrapolated to all actions under the Programme, as the results of individual actions cannot simply be aggregated to assess overall impact.

Also, given the broad Programme objectives, limited dissemination efforts, dependence on the willingness of Member State authorities to take up the results and integrate them in national health policies, and the time taken for health indicators to change, the evaluation can at this stage assess outputs from individual actions only and not the impact of the whole Programme.

4.3. Quality assessment of the study

By and large, we agree with the contractors’ findings, the answers to the evaluation questions and its conclusions within the limitations described above⁹. In the contractors’ discussions with interservice steering group members, it became clear that, for four questions¹⁰ more information would have been appreciated.

In relation to the effectiveness of changes concerning the specific funding mechanisms (i.e. use of joint actions, balance between calls for proposals and calls for tender) in delivering policy-related outputs the contractors’ approach is more theoretical and explains how it was expected that the Programme would support Member States’ health policies, but it was not possible to show, on the basis of outputs to date, the extent to which it has achieved its goal.

In relation to the identification of patterns between Member States participation in the 2nd Health Programme and its public health capacity the limited quality and availability of data on Member States’ public-health capacity did not allow for a robust analysis.

Suggestions for improvement on dissemination practices were limited to better targeting audiences but did not look into return on investment as required in the Terms of Reference. We accepted the contractor’s explanation that it will not be feasible to measure the ‘return on dissemination investment’ in terms of health outcomes, since this would require complex models to assess evidence-based policy-making, which are outside of the scope of the assignment.

In the absence of explicit specific objectives and indicators already from the design of the 2nd Health Programme, it was not possible for the contractor to clearly indicate the extent to which the Programme supported Member States’ health policies. The Programme is a series of successful individual actions but it is impossible for numerous reasons to draw concrete links from individual actions or the Programme as a whole to the high-level indicators (i.e. Healthy Live Years) relating to health outcomes, when these are sometimes available. Also the actions’ desired outcomes, even in the best circumstances, take years to materialise and are largely highly specific to the actions in question.

⁹ The quality assessment of the *ex post* evaluation is provided in Annex IV of this document.

¹⁰ EQ 2, where the contractors’ approach is more theoretical and explains how it was expected that the Programme would support Member States’ health policies, but that it is not possible to show, on the basis of outputs to date, the extent to which it has achieved its goal;

EQ 6, where the limited quality and availability of data on Member States’ public-health capacity undermined the patterns identified;

EQ 8, where suggestions were made to tailor dissemination to specific target audiences taking into consideration the stakeholder analysis, but without looking into return on investment, a question raised specifically in relation to the likely costs of dissemination; and

EQ 9, where the contractors do not indicate clearly the extent to which the Programme supported Member States’ policies and actions.

5. IMPLEMENTATION OF THE PROGRAMME

The Commission prepares every year, in close consultation with Member States health authorities serving on the Programme Committee the Annual Work Programme and adopts it through "Comitology" procedure. The Work Programme defines the most relevant actions to address Member States health needs and create added value at EU level. These actions should have high public health relevance and pertinent geographical coverage.

The CHAFEA¹¹ was entrusted with implementing most of the Programme through competitive calls for grants and tenders. The Commission implemented only specific, highly policy-relevant service contracts and cross-cutting actions, such as IT services, itself.

6.1. Budget distribution per financial mechanism

Various financial mechanisms were used to implement the Programme:

- **Projects** are used to explore a wide range of subject areas and delivery mechanisms, and take forward health policy initiatives in an innovative way, almost as ‘pilots’. They absorbed most of the available budget and provided significant scope for innovation. Their use declined in the second half of the Programme, mainly in favour of joint actions and tenders, in an effort to concentrate the Programme on a series of a few major actions aligned with the Europe 2020 strategy;
- **Tenders:** calls for service provision are used to cover specific Commission needs with regard to studies, evaluations, surveys and technical assistance. This includes IT- and communication-related services required to develop and update EU health legislation or to fulfil the Commission’s obligations under EU health legislation. A good example is the development of reference tools for the design and use of a single European coding system for tissues and cells.¹² Service contracts are also used where the scope and objectives are very concrete and under Commission control, e.g. in the development and conduct of training courses and exercises with Member States to build capacity to deal with emergency situations;
- **Joint actions** are a new financial mechanism introduced in the 2nd Health Programme to cover specific health-policy needs and aimed at supporting EU cooperation with as many partners as possible from all countries participating in the Programme, to generate momentum for wider impact. The number of joint actions called for increased from 2011 onwards in order to enhance the Programme’s policy relevance and make it more compatible with the Europe 2020 objectives of smart and inclusive growth.

Joint actions are often started, after several years of cooperation between relevant stakeholders from (or designated by) Member State authorities, in a bid to secure political endorsement and optimise policy coordination. They typically develop/share/refine/test tools, methods and approaches for specific issues or activities and involve a degree of capacity-building. . The gain for the Member States involved is expected to be substantial in terms of knowledge and experience exchanged and should also lead to tangible cost savings. For this reason, the Programme sought to ensure that joint actions attract the widest possible participation from all Member States;
- **Operating grants** are also a new instrument in the 2nd Health Programme. They support the running costs of pan-European NGOs and specific networks that focus on priority health issues and contribute to furthering health policy in the EU;
- **Conference grants:** while support for pan-EU conferences on important health topics was not really new as a type of action, their selection through an annual competitive call, separate from the call for projects, was introduced under the 2nd Health Programme to avoid competition with proposals for larger health projects. Grants for (twice-yearly) central conferences on health were awarded directly to the Member State holding the Presidency, which also selected the conference topic and took care of the organisation; and
- **Direct grants to international organisations,** such as the World Health Organisation (WHO) and the Organisation for Economic Cooperation and Development (OECD), were provided to continue international cooperation on major health issues (mainly the collection and analysis of health data).

¹¹ Previously EAHC (Executive Agency for Health and Consumers)

¹² http://ec.europa.eu/chafea/health/tenders_H03_2011.html;
http://ec.europa.eu/health/blood_tissues_organs/docs/tissues_single_european_code_en.pdf.

In total, 788 actions were financed: 147 projects, 30 joint actions, 420 service contracts, 84 operating grants, 36 direct grants with international health organisations and 71 conferences. The overall budget distribution per funding mechanism is shown in Table 2.

Table 2: Programme spending by funding mechanism

Funding mechanism	Total	%
Projects	€106 293 671.24	36 %
Service contracts (tenders)	€72 053 873.45	25 %
Joint actions	€63 962 704.38	22 %
Operating grants	€20 825 185.85	7 %
Direct grant agreements	€13 805 987.00	5 %
Grants for conferences	€5 268 308.14	2 %
Other ¹³	€11 693 227.81	4 %
Total	€293 902 957.87	100 % ¹⁴

Source: CHAFEA database and DG SANTE

The financial instruments used most were projects, service contracts and joint actions; together, these accounted for more than 80 % of the budget.

6.2. Budget distribution per thematic area

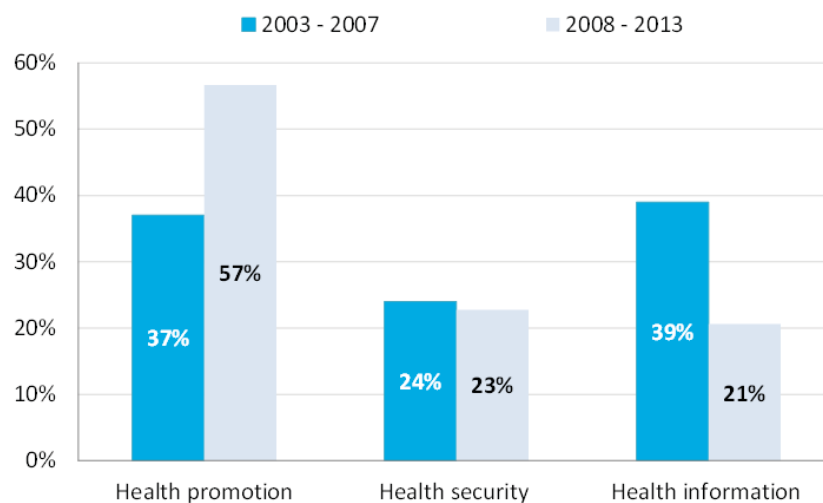
In pursuit of its objectives, the Programme supported actions in three thematic areas: health security, health promotion and health information. Actions supporting the objective of health promotion were at the heart of the Programme, accounting for 57 % of total funds allocated, while the areas of health security and health information received 23 % and 21 % respectively.¹⁵

¹³ 'Other' includes actions signed and committed to by DG SANTE and CHAFEA, such as special indemnities to experts for their participation in and work for EU scientific committees, an administrative agreement with the Joint Research Centre, publications and various communication initiatives to promote the 2nd Health Programme, sub delegations to Eurostat, etc.

¹⁴ Figures do not add up to 100 % due to rounding.

¹⁵ Due to rounding, these percentages do not add up to 100 %. Operating grants are included in this attribution of funds per strand.

Figure 2: 1st Public Health Programme and 2nd Health Programme spending by thematic area



Source: CHAFEA database and DG SANTE

Health promotion gained in prominence as compared with the 1st Public Health Programme (see Figure 2), underlining the importance the 2nd Health Programme placed on addressing health determinants and tackling health inequalities. Meanwhile, actions focusing on the generation and dissemination of health information declined. The relative importance ascribed to the health security objective remained virtually unchanged, although the epidemiological surveillance networks were transferred at the end of the 1st Public Health Programme to the European Centre for Disease Prevention and Control (ECDC).

Overall, the contractors found that five priorities and sub-priorities accounted collectively for about three quarters of Programme spending:

- **health determinants and healthy lifestyles:** 24 % of the overall Programme budget was aimed at tackling key health determinants such as nutrition, alcohol, tobacco and drugs, and other determinants more related to social and environmental factors;
- **prevention of major and rare diseases:** 16 % of the overall spending related to major diseases (e.g. cardiovascular disease, cancer and HIV/AIDS prevention) and rare diseases (including support for developing recognised expert reference groups, assistance to Member States in developing and taking forward rare-disease strategies, and contributing to WHO international classifications of rare diseases);
- **health monitoring and data:** 11 % of the budget was spent on forming an effective and sustainable network for health technology assessment (HTA) across Europe to help develop reliable, timely, transparent and transferable information to contribute to HTAs in European countries. It also supported work relating to ECHIs to facilitate monitoring and comparison between EU countries, thereby serving as a basis for policymaking;
- **health threats:** 13 % for actions *inter alia* to facilitate collaboration between laboratories and develop common testing methods, with the aim of developing strategies and mechanisms to respond to health threats and emergencies;
- **safety:** 10 % to fund a variety of actions relating to issues such as organ donation and transplantation, and patient safety, some of which facilitated the exchange of organs donated in Member States; assessing data on manufactured nanomaterials and seeking to establish a European framework for the evaluation of organ transplant results.

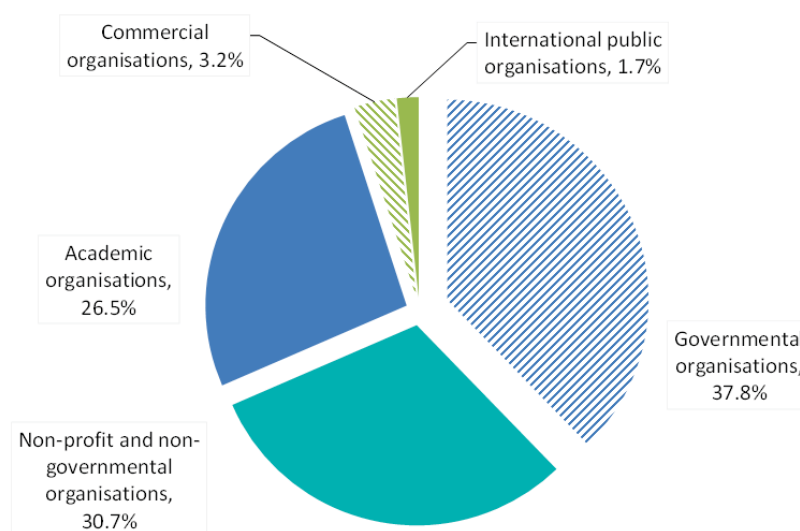
The reports and deliverables produced by the actions co-funded under the Programme are available on CHAFEA's website. A database¹⁶ provides open access to the results, with the exception of service contracts and direct agreements with international organisations.

6.3. Participation by type of stakeholder group

A wide and diverse range of stakeholders participated in and benefited from the grants provided by the Programme. Figure 3 provides a breakdown by group of grant beneficiaries.¹⁷ More specifically, the groups are as follows:

- **governmental organisations:** these represent the largest group (37.8 %) of stakeholders that participated in the Programme. They include health policymakers, regulators, general or specialised governmental public-health organisations and institutions, and healthcare providers. They were chiefly interested in participating in joint actions, particularly those relating to health security and health information;
- **non-profit and non-governmental organisations:** these make up a second rank of participating organisations (30.7 %). They mainly received operating grants, but also participated in projects and joint actions;
- **academic and research organisations:** with a share of 26.5 %, these were involved mainly in projects (to the same approximate extent across all three thematic areas);
- **commercial organisations:** their participation accounts for 3.2 % (significantly more if we take into consideration their participation in tenders which are in the most of the cases addressed to them); and
- **international organisations:** their cooperation with the Commission, mainly under the health information objective (collecting and analysing health data), accounted for 1.7 % of the total.

Figure 3: Participation of stakeholder groups receiving grants under the 2nd Health Programme



Source: CHAFEA database and DG SANTE

6.4. Participation by geographical area

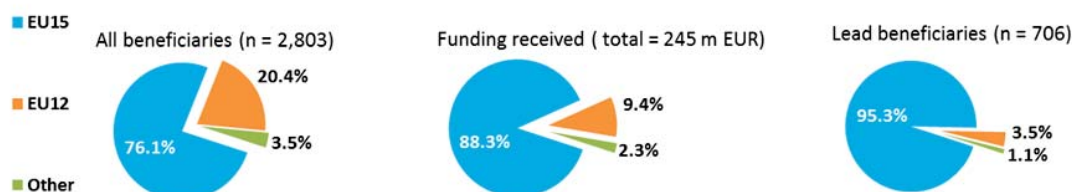
All Member States and the three EEA EFTA countries (Iceland, Liechtenstein and Norway) participated in the Programme. As the Programme was open to candidate countries, Croatia was involved for the entire period (as a Member State from 1 July 2014). In line with recommendations in the final evaluation of the 1st Public Health Programme, efforts were made, especially through the joint actions, to involve more actors from the 'EU-12' Member States that joined the Union in and after 2004.

¹⁶ <http://ec.europa.eu/chafea/projects/database.html>.

¹⁷ This figure covers all funding except tenders.

In terms of number of beneficiaries, participation in the Programme reflected relative population sizes.¹⁸ Just over three quarters (76.1 %) of beneficiaries were based in the ‘EU-15’, while the EU-12 accounted for 20.4 %. There is a disparity in terms of the allocation of funding, with 88.3 % going to organisations from the EU-15 and 9.4 % to those based in the EU-12. This is probably due in part to differences in wages and labour costs. However, the difference between EU-15 and EU-12 is far more pronounced when one considers the spread of lead beneficiaries, of which an overwhelming 95 % were based in the EU-15, with only 4 % based in the EU-12. This was especially visible in service contracts, projects and operating grants, for which nearly all lead partners were based in the EU-15. However, 15 % of lead partners for grants for conferences (11 of 71) and 10 % for joint actions (3 of 30) were based in the EU-12. This breakdown is presented in Figure 4.

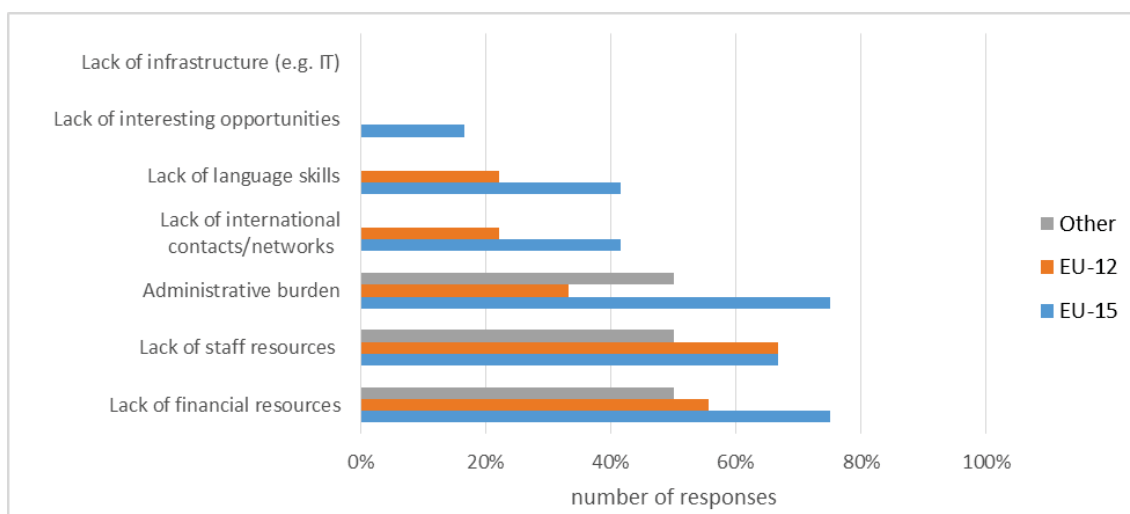
Figure 4: Proportion of (total and lead) beneficiaries and funding received (EU-15, EU-12 and other participating countries)



Source: CHAFEA database and DG SANTE

The mid-term evaluation mentioned that administrative and cultural barriers, in addition to financial constraints, could act as obstacles to the participation of low-GDP countries. The final evaluation (following a survey of national focal points) reported that the EU-15 faced more (or at least cited more often) a lack of human and financial resources and administrative burden (see Figure 5).

Figure 5: Main barriers to the participation of EU-12 and EU-15 organisations



Source: Survey of national focal points in the framework of the *ex post* evaluation

¹⁸ According to Eurostat data, in 2011 the total EU population was 501 million, of whom 404 million (81 %) lived in the EU-15 and 97 million (19 %) in the EU-12.

6. FINDINGS OF THE EVALUATION

7.1. Programme management

The relevance of the Programme was extensively assessed by the mid-term evaluation, but the *ex post* evaluation provided a second opportunity to examine the relevance of a series of co-funded actions. This was done on the basis of the 13 case studies, which led to positive conclusions.

The mid-term evaluation concluded that the Health Programme is focusing on relevant priority areas addressing the main public health issues in Europe; however the Programme's broad objectives were not helpful to prioritise actions as most health-related issues could fit under them under any circumstances.

However, the ex-post evaluation also found that during its second half, the Health Programme increased the policy relevance of funded actions. Through an increased involvement of DG SANTE's management in the annual planning a greater level of coherence with the Europe 2020 targets was achieved. Through making use of joint actions to a greater extent buy-in from national governments and participation of key stakeholders from nearly all Member States was secured. However, the lack of appropriate indicators at Programme level and the absence of a systematic monitoring to link the available data at action level with higher level health indicators made it difficult to fully understand whether and how the Programme impacts on national health policies.

Selecting actions on the basis of their EU added value

The 2nd Health Programme aims at complementing, supporting and adding value to Member States' policies thus providing 'EU added value'. As Decision No 1350/2007/EC establishing the 2nd Health Programme did not define 'EU added value', the EAHC/CHAFEA developed seven criteria to determine whether proposed actions have the potential to generate EU added value. These criteria were tested and validated in the course of the mid-term evaluation in 2011. The Commission added an eighth criterion concerning potential for innovation in the area of health and integrated all eight criteria in Regulation (EU) No 282/2014 (recital 6) establishing the 3rd Health Programme and in the subsequent awarding procedures for actions to be co-funded. The eight criteria used are the following:

- 1) *implementing EU legislation*: to ensure that actions contribute to the development and/or implementation of EU legislation;
- 2) *economies of scale*: to save money and provide a better service to citizens by avoiding duplication of effort and cooperating across national health systems;
- 3) *promotion of best practice*: to apply best practice in all participating Member States, e.g. by identifying procedures, approaches, methods or tools that could be applied by healthcare professionals or others;
- 4) *benchmarking for decision-making*: to facilitate evidence-based decision-making, e.g. by providing scientific information, real-time data for comparison and/or indicators that can impact decision-making at a higher political/policy level;
- 5) *cross-border threats*: to reduce risks and mitigate the consequences of cross-border health threats by establishing relevant coordination structures;
- 6) *free movement of persons*: to increase the movement of patients and healthcare personnel between Member States, thereby contributing to a better match between supply and demand;
- 7) *networking*: to ensure that networking activities among stakeholders, which contribute to knowledge-sharing and building health capacity in the EU, are supported and sustained; and
- 8) *unlocking the potential of innovation*: to support the deployment of innovative solutions for healthcare provision, in terms of both products and services.

In the ex-post evaluation 80 actions were scored by an expert panel for potential to deliver EU added value and under which added value criteria (validation of the selection process). For 13 actions outputs and results were assessed for delivering EU added value. This served as a basis for analysing which type of actions have the greatest potential to deliver EU added value and on which criteria added value is being delivered.

The evaluation found that use of the criteria is effective and that actions co-funded through the Programme, particularly the joint actions, scored high on the EU added value. Much of the demonstrable EU added value

relates to the identification of best practices, the scientific evidence to be used for benchmarking for decision-making and networking activities (see figure 6 and 7). However, these three criteria are not sufficiently linked to tangible and concrete benefits. Further guidance on these criteria would be necessary to enable applicants to propose more suitable actions that not only identify good practices, for instance, but also address barriers to implementing them across the EU. Actions received medium scoring for innovation, EU health legislation and economics of scale while the criteria of cross-border health threats and free movement of persons were under-represented.

Figure 6: Average scores by EU added value criteria, all actions¹⁹

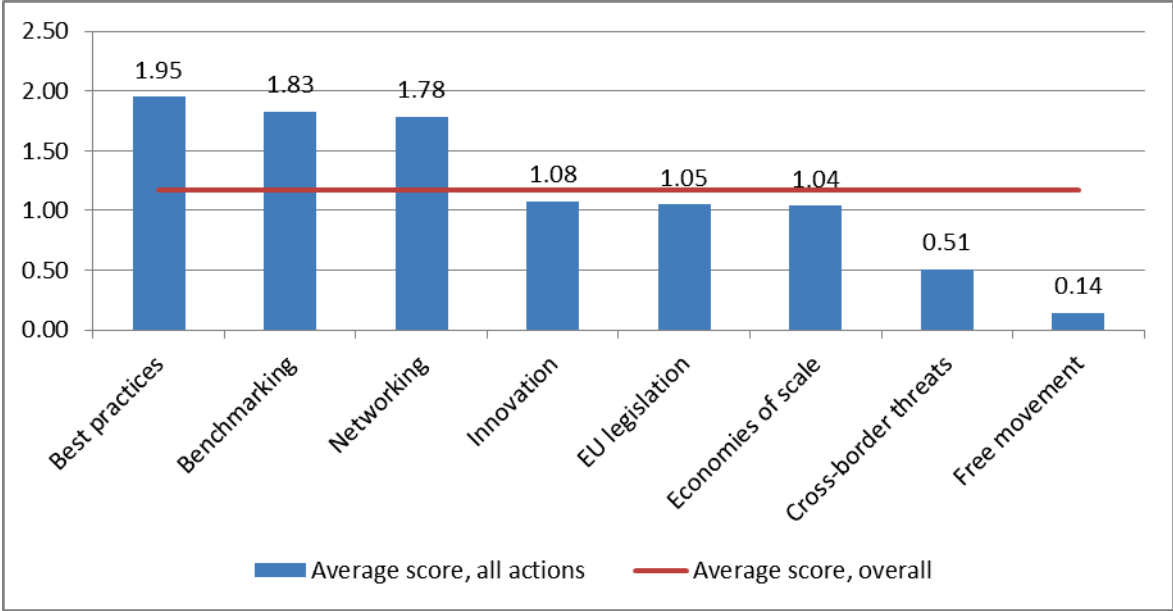
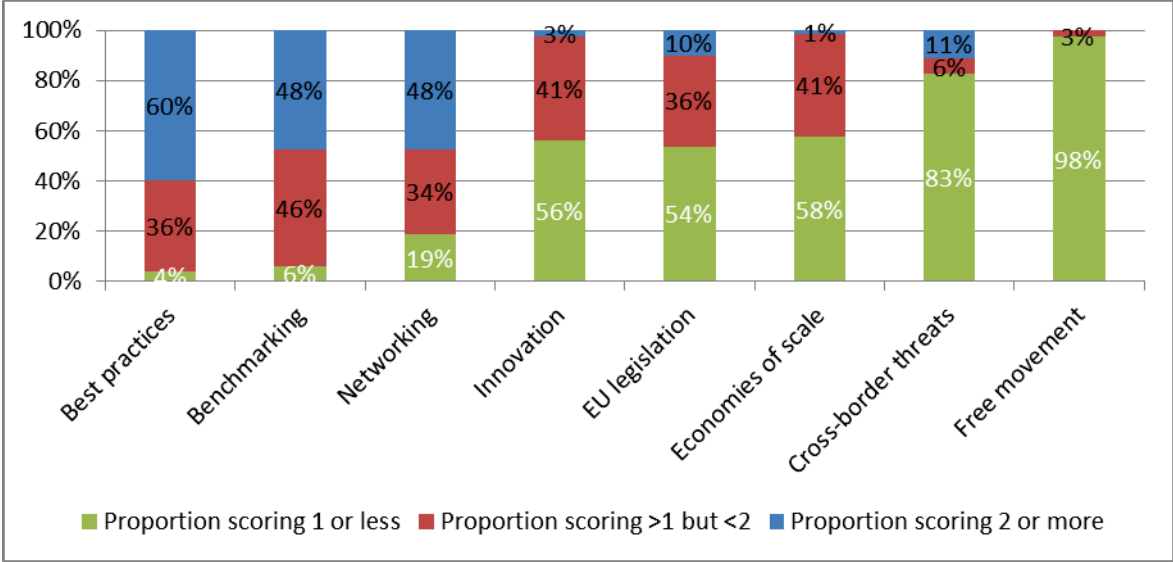


Figure 7: Proportion of actions averaging scores of 2.0 or more and 1.0 or less, by EU added value criteria



This way, the evaluation made clear that the robustness and completeness of the three first highly scored criteria is not optimal and lack the necessary discrimination power to avoid that the large majority of the actions fit broadly under these ones.

¹⁹ The scoring scale ranged from 0-3 as follows: 0 indicated ‘no EU added value foreseen’; 1 indicated ‘EU added value possible’; 2 indicated ‘EU added value likely’ and 3 indicated EU added value almost certain.

Effectiveness and efficiency of the Programme management

The effectiveness of the Programme management was assessed by the contractors, including the programme's increased focus, on priority areas, while addressing Member States' needs and encouraging their participation. Consideration was given to how implementation was monitored and how results were disseminated. Relevant findings will be used to inform implementation of the current 3rd Health Programme on the basis of the findings of the contractor, the following conclusions can be drawn.

The Programme management improved significantly in the second half of the period. Substantial efforts were made to implement recommendations from the mid-term evaluation, relating *inter alia* to more strategic programming²⁰, the systematic use of EU-added-value criteria in grant applications and evaluation²¹, providing clearer guidance to applicants and having better contact with applicants and beneficiaries²². Annex II presents the measures taken to implement these recommendations and the remaining issues looked into in the evaluation with a view to suggesting further improvements.

The changes in the management of the Programme increased its potential to serve Member States' needs and to complement and support their health policies. More directive planning methods and increased use of joint actions and tenders resulted in a greater focus on specific health policies in order to meet specific needs.

While the 1st Public Health Programme was implemented mainly via projects and a small number of tenders, the 2nd Health Programme relied increasingly on joint actions. These aim to involve a significant number of Member States working jointly on key health policies in the expectation that the outputs will be more policy-related (as compared with outputs from projects). A total of 30 joint actions were co-funded during the 2nd Health Programme, for almost €64 million. A full list of joint actions and overall achievements is provided in Annex III.

Although joint actions attracted participation from all Member States and other participating countries, the Programme does not seem geographically balanced in terms of budget distribution and Member States' participation (total number of beneficiaries and beneficiaries in leading positions), as shown in Figure 4. While joint actions were a financing mechanism used increasingly in the second half of the Programme and attracted relatively more participants from the EU-12 countries (which accounted for 13 % of the overall budget spent on joint actions),²³ the intensive use of calls for tender over the Programme period attracted interest chiefly from entities in a limited number of EU-15 Member States, with Belgium in the lead. This offsets the relatively higher EU-12 participation in joint actions.

This evaluation takes a significant step forward in starting to reflect on Member States' public health capacity and how this affected their participation in the Programme. The previous evaluations have only mentioned the financial barriers some Member States could face for their participation in the Health Programme, and the distinction was made between high and low GDP/GNI Member States. The ex-post evaluation even under the methodological limitations imposed by the fact that there is no common agreed definition at EU level for "public-health capacity", gave a relatively interesting insight using only some indicators relating to wealth (GDP/GNI), health research spending, health expenditure, health publications, healthcare resources, health outcomes and healthcare performance. It permitted the linkage of the low participation of Member States (in the most of the cases these are low GNI countries) with what public-health capacity meant for the Health Programme. Building public health capacity was not an objective under the Programme, but findings suggest *a posteriori* that it may have been a means or even a prerequisite for successful participation: the Member States that participated more actively were those with solid public-health capacity, while the 'weaker' countries had lower participation rates and received less funding.

²⁰ Annual Work Programmes of 2011 and onwards have streamlined the number of priorities and proposed actions in coherence with the Europe 2020 Strategy (see below, table 3)

²¹ EU added value criteria were put to systematic use during the second half of the HP, in particular being built into the application and assessment process for actions. Definitions of EU added value criteria were provided in the FAQ for the final year of calls for proposals for the 2nd HP (2013). For the 3rd HP, EU added value criteria are enshrined in the Programme Regulation 282/2014/EC, included in the 2014 AWP and references included in guides for applicants.

²² See annex II, "Recommendations applied" and more specifically in p. 39 where it is mentioned that a guidance document for actions developed by CHAFEA and guide available for each funding mechanism together are available each year with the call for proposals; Positive feedback from survey of applicants to calls for proposals 2008 – 2013 regarding both the guidance documents and helpdesk services but still room for improvement (for example Frequently Asked Questions section should contain more technical answers rather than mainly general ones).

²³ For projects, the EU-12 share of the budget was 11 %.

The evaluations repeatedly point to the challenge of monitoring Programme implementation. Monitoring output and outcome from a programme with so many actions, diverse in terms of form and content, is not always easy, especially when it comes to making links to higher-level public-health indicators. However, CHAFEA collects comprehensive monitoring data at input and activity levels. However the data are not organised systematically; which hampers their aggregation and use in real time to inform strategic planning so as alignment with priorities and objectives cannot sufficiently be ensured and deficiencies persist in the monitoring of the Programme performance. Given the architecture of the Programme, the evaluation was unable to shed more light on this issue or provide a common set of indicators for all actions or objectives. It does, however, underline the importance of suitable indicators for good monitoring and reporting for the improved dissemination of action outputs.

Dissemination activities

The increased dissemination efforts are recognised as contributing to the success of the Programme. Failure to share outputs and results with those who need them to build health policies and other initiatives based on scientific knowledge tested in real settings constitutes a real obstacle to assessing the Programme's impact.

The contractors carried out an extensive analysis of the means used for dissemination, either by the beneficiaries in the framework of the co-funded actions or by CHAFEA, on a more aggregated level. Previous evaluations showed that Programme outputs and results should be disseminated at three levels:

- 1) at the level of the co-funded actions; every action has its own dissemination strategy and plan, which in some instances is very effective and in others less so, mainly due to a lack of clarity and focus as to the most relevant target audiences and how best to reach them;
- 2) dissemination activities organised and means produced by CHAFEA, such as brochures,²⁴ 'cluster meetings',²⁵ project database,²⁶ etc.; and
- 3) dissemination by the Commission, e.g. a high-level conference on EU health programmes organised in Brussels on 3 May 2012,²⁷ DG SANTE's bi-monthly electronic newsletter²⁸ and information for policymakers, Programme Committee members, the European Parliament and the Council through annual programme implementation reports.²⁹

The contractors assessed these levels and the means applied in more detail. For example, beneficiaries are encouraged to publish their results in scientific journals. The bibliometric analysis showed that numerous published articles (more than expected) referred to 2nd Health Programme actions, but the visibility of the Programme is not always sufficient, as it was not always acknowledged as the source of the funding, even though this is required under the grant agreements.

As the most appropriate audiences for the dissemination of results vary, so do the most effective tools and channels for reaching these audiences. Some actions and their results are relevant for specialists only; others have wider relevance also for patients and healthcare service users. Overall, however, the evaluation research suggests that the most frequently targeted audiences are governmental organisations, healthcare professionals, and academia and researchers (in this order). These can sometimes be reached via publications in scientific journals (which result from some actions funded under the Health Programme), but it is important to note that research is not the main focus of the Health Programme, and scientific publications, although they present an interesting channel for disseminating information, are not always the most effective way of reaching directly those stakeholders responsible for implementing changes in the area of health.

The contractors also assessed the utility of CHAFEA's project database, which provides public access to the abstracts and deliverables of co-funded actions (with the exception of tenders and direct grants to international organisations). The database is quite static and not always up-to-date. The deliverables, e.g. extensive final project reports, are not always user-friendly and additional interactive functions are lacking that could make the database a useful tool providing a real service to stakeholders.

²⁴ http://ec.europa.eu/chafea/publications/publications_for_health_programme.html.

²⁵ Meetings organised in cooperation with competent Member State authorities to provide journalists and other interested audiences with an opportunity to learn about EU health policy and a portfolio of relevant Health Programme actions in a given topic area.

²⁶ <http://ec.europa.eu/chafea/projects/database.html>.

²⁷ http://ec.europa.eu/health/programme/events/ev_20120503_en.htm.

²⁸ http://ec.europa.eu/health/newsletter/newsletter_en.htm.

²⁹ http://ec.europa.eu/health/programme/policy/index_en.htm.

The 'cluster meetings' organised by CHAFEA in cooperation with competent Member State authorities are assessed positively as attracting good attendance and decent press coverage. Three cluster meetings were held under the 2nd Health Programme, on rare diseases, organ transplantation and vaccination. The 60 – 120 participants were experts in the relevant field as well as journalists from different EU countries, invited by Chafea. The number of journalists was about 20, covering an equal number of Member States. The average number of articles that appeared after the meeting in the general and specialized press is about 25 covering about half of the Member States. Efforts are needed to promote that articles triggered by such meetings mention the Programme and the EU explicitly and to widen press coverage beyond the Member State in which the meeting takes place.

While the contractors could not assess the extent to which the various dissemination actions reached the various stakeholders, they recognise that dissemination had improved over the course of the Programme and that this contributed to its efficiency. They point out that no dissemination activities were undertaken specifically to overcome geographical imbalances. They also remark that most publications, guidance documents, etc. are available only in English.

The smooth functioning of programme management and the growing responsibility of CHAFEA across all administrative functions meant that certain tasks could be streamlined and made more efficient.

7.2. The Programme's effectiveness and factors that are influencing it

Previous evaluations sought to measure the impact of the Programme, but this proved difficult for reasons inherent in its design, the multiplicity of its actions and its broad objectives, which interact with many other external factors, such as the long timescale over which effects on health materialise.

The majority of actions in the framework of this evaluation were assessed as successful in terms of their implementation, but it is not possible to 'add up' their outputs or to follow through on their individual impacts to produce a composite Programme impact (see limitations referred to in section 5.2).

The merit of the evaluation is that it highlights numerous factors on which the Programme's impact depends and which influence it positively (or negatively if absent). The case studies, which assessed the outcome of 13 actions, showed that it is of vital importance that actions:

- have clear links to existing policy initiatives (*to demonstrate how they further existing policy initiatives and policies; this corresponds to the 'policy relevance' award criterion for selecting the most relevant actions for co-funding*);
- have prepared plans for sustained follow-up efforts (*in order to avoid co-funding actions that will not continue once the EU co-funding is stopped*);
- work to propose feasible policy changes (considering the context) in the medium term (*this will help beneficiaries to concentrate their work on actions that can bring tangible and pragmatic results by addressing not only what has to be done, but also the challenges to be overcome and prepare the field for changes in the health sector*);
- have a well-delineated scope and clearly defined objectives (*the absence of which may result in partners taking disparate action without working towards a common goal*);
- have a plausible 'intervention logic' (*to guide the partners throughout implementation*);
- involve all relevant partners (*the absence of a strong and complementary partnership can hamper implementation*);
- have strong project management (*leadership is important if actions are to be implemented according to the plan and achieve high-quality results*);
- involve constructive engagement from DG SANTE/CHAFEA; and
- are implemented through the most suitable financial mechanism.

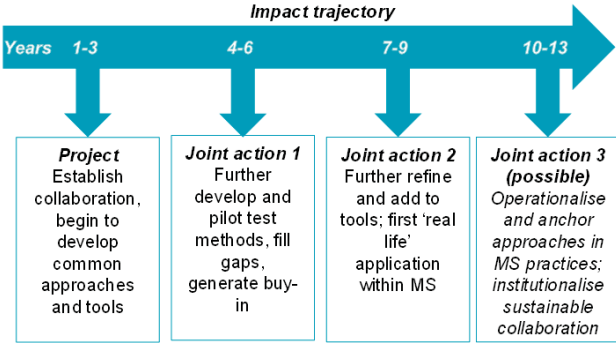
Since ultimate responsibility for public health is (mostly) left to other organisations (in particular national health authorities), the success of the Programme derives from its ability to help make those other organisations (which range from international organisations and national health ministries to universities and NGOs) do their jobs better and more effectively.

Actions were more successful when they addressed identifiable policy needs, had a well-delineated scope and produced results that could be readily applied in practice. While joint actions and service contracts met these criteria to a greater extent than projects, there were a few examples among all action types where this was not the case.

With the increased use of joint actions in the second half of the period, the Programme selected specific areas in which it especially sought to directly involve Member States authorities and the relevant bodies responsible for implementing health policies who have an interest in applying the Programme's outcomes, and thus maximised the chances of impacts materialising in the years to come. Significant achievements resulted from the majority of Member State health authorities being involved and cooperating very closely at the appropriate level on major health issues of common interest (see Annex III).

Joint actions often are the culmination of long years of cooperation and build on previous achievements made possible through project grants started sometimes 10 or more years ago. Figure 8 illustrates by way of example the impact trajectory of the EUnetHTA joint action on HTA.

Figure 8: Impact trajectory of the EUnetHTA joint action



The challenge for the 2nd Health Programme, given its modest budget, was guaranteeing the sustainability of actions and results of which the impact is demonstrated only if they are taken up and used by Member State authorities and/or other actors. This is why 'reiterations' of actions (possibly leading from a project to a joint action) are observed for some priority health issues and no follow-up for negative priorities that were not supported further.

While funding of recurrent actions was included as an option under the Programme in order to meet this challenge, there are two risks:

- if funding for priorities is suspended after a certain period of time, the achievements could be lost; and
- if the Programme spends too much on multiple iterations of a few priority actions, it could fail to identify meaningful new initiatives and miss opportunities to invest in new areas in rapidly changing contexts.

Each funding mechanism has its strengths and weaknesses. Joint actions, projects and service contracts were all shown to be highly appropriate conditions that played to the relative strengths described in the table below. By contrast, opting for the wrong funding mechanism in given circumstances (e.g. using a project when DG SANTE's needs and desired product are well defined, which is better suited to service contracts) severely undermined actions' potential effectiveness (and cost-effectiveness).

Table 3: Conditions of success for given funding mechanisms

Funding mechanism	Ideal circumstances	Risks / challenges
Joint actions	<ul style="list-style-type: none"> Clearly established case for pan-European collaboration at a technical (and not only political) level Buy-in from key stakeholders in (nearly) all Member States Feasibility of desired results already confirmed from previous work Political momentum sufficient for results to be applied in practice 	<ul style="list-style-type: none"> Due to their size and the number of partners typically involved, joint actions are costly to implement and can be difficult to manage If established prematurely, joint actions can be too unwieldy to provide a forum for exploring new ideas and experimenting The chances of results being taken up is reduced if a critical mass of Member States is not secured
Projects	<ul style="list-style-type: none"> Highly relevant topic but case for pan-European collaboration not fully established, particularly regarding practical solutions Need for a ‘pilot’ to ascertain level of interest and feasibility of changing status quo Availability of strong leadership and established interest from a smaller group of committed partners to pursue a focused set of objectives 	<ul style="list-style-type: none"> Value of collaboration beyond the level of the partners themselves needs to be established If the primary focus is on networking and sharing best practices, the need to create more tangible results can be lost Projects often struggle with national differences in data availability / comparability Overly ambitious / diverse objectives can reduce effectiveness If policy links are absent, it is difficult to overcome barriers for EU-wide implementation of results
Service contracts	<ul style="list-style-type: none"> Existence of specific and clearly defined DG SANTE needs / ideas Narrow set of objectives and limited scope Clear link to specific policy process or initiative 	<ul style="list-style-type: none"> Level of ambition needs to be aligned with typical budgets (€100-250k). Clear need for action should be established beyond interest of specific DG SANTE units. Excessive reliance on service contracts would be detrimental to HP inclusiveness (in terms of types and geographic spread of beneficiaries)

7.4. Coherence and consistency with other European policies and programmes

There are important synergies between the 2nd Health Programme and the Seventh Framework Programme (FP7): actions under the former build on and use FP7-funded research (e.g. on health threats from

nanomaterials³⁰) and the latter is a vehicle for the further investigation of issues and knowledge gaps that arise as a result of Programme actions (e.g. on specific HTA methodologies and application areas³¹).

Synergy effects with the Structural Funds are less obvious, as the main results produced by the 2nd Health Programme actions such as networking or joint solutions (good practice methods or approaches) do not lend themselves to implementation using co-funding from the European Regional Development Fund, the Cohesion Fund or the European Social Fund. However, almost €5 million from the Programme budget was spent to promote the use of Structural Funds for health. These actions provided guidance and awareness-raising that should enable those responsible for operational programmes to address health-related issues more effectively³².

From 2011, the Programme placed more emphasis on the Europe 2020 goals for smart and inclusive growth, by prioritising:

- actions relating to the European Innovation Partnership in the field of active and healthy ageing, which was set up as an Innovation Union flagship initiative;
- actions to address health determinants such as nutrition, smoking and alcohol abuse, which underlie many age-related chronic diseases;
- work on cancer and rare diseases;
- EU cooperation on HTA;
- work on the safety of blood, tissues, cells and organs (which contributes to improving health across the lifecycle, thereby contributing to healthy ageing);
- measures that apply information and communication technologies in the area of health; and
- actions aimed at bridging health inequalities to ensure better health for all and better access to healthcare systems.

Comparing spending on such actions under the most relevant priorities in the first and second halves of the Programme (i.e. before and after Europe 2020 was adopted), the budget for actions on active and health ageing increased by 485 % and for those on health inequalities by 307 %, while for those on smart growth-related priorities it saw a modest increase or even slight decrease. In contrast, funding for actions addressing health determinants and promoting healthy lifestyles and those aiming to develop a health monitoring system/collect comparable data decreased by 17 % and 21 % respectively (Table 3).

Table 3: Funding for key priorities relating to Europe 2020 objectives

Europe 2020 objective	Priority	HP funding 2008-2010 (€)	HP funding 2011-2013 (€)	Change
Smart growth	Organs and substances of human origin, blood and blood derivatives (1.2.2)	4 213 499	5 239 964	+24 %
	Increase healthy life years and promote healthy ageing (2.1.1)	2 887 184	16 893 162	+485 %

³⁰ A series of relevant projects were funded by FP6 and FP7 which included, for example, investigations into methods for testing toxicity and eco-toxicity and risk assessment, and helped lay the foundation for the NANOGENOTOX Joint Action on “Safety evaluation of manufactured nanomaterials by characterisation of their potential genotoxic hazard”, launched under the HP in 2009. In turn, the FP7 project NANOREG that began in 2013 builds on NANOGENOTOX with a specific focus on regulation.

³¹ Based on needs expressed by the resulting EUnetHTA network, the projects ADHOPHTA, ADVANCE-HTA, INTEGRATE-HTA, and MEDTECHTA have been launched under FP7 on specific HTA methodologies and application areas, and there are annual coordination meetings between these and EUnetHTA.

³² Euregio III: Health investments in Structural Funds 2000-2006: learning lessons to inform regions in the 2007-2013 period (project, 2009-2011). This project evolved significantly over its lifetime to respond to emerging issues and needs, and ended up generating evidence from existing SF projects that can show how to improve the effectiveness, efficiency and sustainability of direct health system investments using SF in the next cycle (2014-2020). The results have been relatively widely used, inter alia for training sessions and a guide for desk officers in or with DGs REGIO and EMPL, and as input for the discussions of subgroup 2 of the Council reflection process on health systems.

	Address health determinants and promote healthy lifestyles (2.2.1)	32 897 669	27 221 835	-17 %
	Prevention of major diseases of particular significance, and rare diseases (2.2.2)	19 103 140	19 920 192	+4 %
	Develop a sustainable health monitoring system and collect comparable data (3.2.1)	15 719 845	12 490 561	-21 %
Inclusive growth	Identify the causes of, address and reduce health inequalities (2.1.2)	3 552 153	14 440 968	+307 %

Source: CHAFAE database and DG SANTE

7. CONCLUSIONS

The main conclusions that can be supported based on the evaluation can be summarised as follows:

- **The management of the 2nd Health Programme improved** compared with the 1st Public Health Programme as a result of being entrusted to the Executive Agency and of the introduction of different financial mechanisms, such as joint actions, operating grants and direct grants with international organisations, which better serve stakeholders' needs and respond to their expectations.

By following up many recommendations from the mid-term evaluation, implementation improved further in the second half of the Programme, through **the use of more strategic programming, the systematic use of EU-added-value criteria in grant applications and selection, clearer guidance for applicants and better contact with applicants and beneficiaries**. However, there are still concerns around monitoring, dissemination of results and administrative burden for applicants and beneficiaries. Good monitoring is crucial, also for communicating Programme results, and increased systematic efforts are needed to ensure dissemination with clear strategic objectives, targeting stakeholders with the most influence and power.

- The Programme was **highly coherent with the Europe 2020 strategy** for smart and inclusive growth. Since 2011, its policy relevance was enhanced by the use of more joint actions and tenders, and more funding for actions that focus on promoting healthy and active ageing and reducing health inequalities. However, every case of relevant need does not necessarily imply a strong case for EU involvement. **To maximise the impact of the Programme, the relevant actions should demonstrate clearly their EU added value**. This is why criteria for EU added value were established in the course of the Programme and applied in the assessment of proposals. For the 3rd Health Programme, the Commission went a step further by proposing that Regulation (EU) No 282/2014 contained an explicit reference to these criteria, which continue to be integrated in the evaluation process for awarding funding to ensure that all co-funded actions deliver EU added value.

In comparison with other financial mechanisms, **joint actions often generate substantial added value, in some cases leading to tangible cost savings in addition to providing useful lessons for the Member States involved**. They deal with priorities determined through a comprehensive appraisal of public-health needs in Europe, with input from Member States and other interested parties, e.g. expert committees. They often support a policy process in a specific field of health³³ and encourage Member States to cooperate in the implementation of an existing legal framework.³⁴ Some joint actions address emerging health problems in the global health environment; pathogens do not respect borders and can affect several Member States, so common action is often required.³⁵ Joint actions can also arise in response to 'horizon-scanning' work by EU expert committees to identify emerging health problems in Europe which could become a priority for action at European level.³⁶

The 'project' funding mechanism, as used for the majority of actions aimed at health promotion and accounting for 57 % of the total funding awarded, responds to EU-added-value criteria relating mainly to **best practices, benchmarking for better decision-making and networking**. These criteria have weak links to tangible policy benefits and need to be more clearly defined and communicated so as to help applicants to submit proposals and ensure that actions deliver more tangible and concrete benefits. Therefore, the evaluators' suggestion for **re-working these three criteria seems to make sense**. This could

³³ e.g. the EJA joint action; <http://ec.europa.eu/chafea/projects/database.html?prjno=20112201>.

³⁴ e.g. the FOEDUS joint action; <http://ec.europa.eu/chafea/projects/database.html?prjno=20122101>.

³⁵ e.g. the QUANDHIP joint action; <http://ec.europa.eu/chafea/projects/database.html?prjno=20102102>.

³⁶ e.g. the EQUITY ACTION and ECHIM joint actions; <http://ec.europa.eu/chafea/projects/database.html?prjno=20102203> and <http://ec.europa.eu/chafea/projects/database.html?prjno=20082391>.

be very useful for credibly demonstrating how such actions lead to more concrete benefits over the longer term.

- **The Programme finances actions** with the potential to influence health policies positively at national and EU level, taking into account certain conditions, including **long-term financing for secured sustainability of activities and outcomes**. Nevertheless, the contractors found it difficult to assess the impact of the Programme as a whole, given its broad objectives, the multiplicity of priorities and the absence of indicators for measuring progress (an issue raised in earlier evaluations). Recommendations from the mid-term evaluation calling for a focus on a restricted number of actions with defined progress indicators linked to the corresponding Programme objectives have been implemented in the design of the 3rd Health Programme and will be assessed in its mid-term evaluation in 2016-2017.
- Regarding the low participation of EU 12 Member States in the Health Programme, the evaluation findings confirm that efforts should be continued to encourage greater participation from underrepresented Member States, *inter alia* by targeting key governmental institutions and drawing attention to the opportunities on offer. If it continues, the low participation of some Member States may hamper the success of the 3rd Health Programme.

Going forward, and given that public-health capacity-building is explicitly included in the legal basis of the 3rd Health Programme, it would seem necessary for the concept to be clearly defined, agreed, factored into clear Programme priority-setting and the conducive design of individual actions (including possible specific mechanisms to support ‘weaker’ Member States), and further elaborated in monitoring arrangements and future evaluations.

Also, wider dissemination of outputs and results can provide good examples and convincing arguments for more involvement and leadership for all Member States/participating countries interested in the Programme.

ANNEX I – EVALUATION MATRIX

Evaluation questions	Judgment criteria	Preliminary indicators	Data sources
Evaluation bloc (a) Programme management tools			
i. To what extent have the recommendations of the mid-term evaluation concerning the management and the design of the Programme been implemented?	<ul style="list-style-type: none"> ✓ Extent to which a strategic multi-annual planning with long-term targets was developed. ✓ Extent to which the Programme continues to employ the current system of different and diversified financial mechanisms. ✓ Extent to which clear guidelines are provided to potential applicants and applicants. 	<ul style="list-style-type: none"> ✓ More tangible and focussed objectives (SMART) developed ✓ Evidence of long-term planning ✓ Targets set in consultation with national health experts ✓ Indicators developed 	<ul style="list-style-type: none"> ✓ Desk research (including statistical review and analysis)
	<ul style="list-style-type: none"> ✓ Extent to which the Programme continues to employ the current system of different and diversified financial mechanisms. 	<ul style="list-style-type: none"> ✓ Number of actions funded (2008-13) and budget allocated by financial mechanisms ✓ Officials' and stakeholders' views on the balance of funding mechanisms 	<ul style="list-style-type: none"> ✓ NFP survey
	<ul style="list-style-type: none"> ✓ Extent to which clear guidelines are provided to potential applicants and applicants. 	<ul style="list-style-type: none"> ✓ Evidence of clear guidelines provided to potential applicants and applicants (e.g. on intervention logics, ToCs, SMART objectives, indicators, definitions of certain terms etc.)_ ✓ Evidence of retention of requirement for proposals to outline compliance with AWP priority areas and HP objectives ✓ Stakeholders' perceptions on whether clear / simple guidelines are provided 	<ul style="list-style-type: none"> ✓ Interviews with: <ul style="list-style-type: none"> - DG SANTE and CHAFAEA officials - Programme Committee members and National Focal Points - External stakeholders
	<ul style="list-style-type: none"> ✓ Extent to which EU added value is being emphasised, particularly at the proposal stage. 	<ul style="list-style-type: none"> ✓ Existence and level of dissemination of a nomenclature for explaining EU added value etc. ✓ Level of utilisation of this nomenclature in proposals and actions 	
	<ul style="list-style-type: none"> ✓ Extent to which Programme application procedures have been simplified and rationalised. 	<ul style="list-style-type: none"> ✓ Evidence of simplified and rationalised Programme application procedures (including "lighter" application process, use of framework contracts to reduce repetitive and burdensome tendering procedures) ✓ Officials' and stakeholders' perceptions on whether Programme application procedures have been simplified and rationalised and what more could be done 	
	<ul style="list-style-type: none"> ✓ Extent to which monitoring has been enhanced 	<ul style="list-style-type: none"> ✓ Evidence that applicant satisfaction surveys are still being undertaken ✓ Evidence of the monitoring of types of organisations applying for funding ✓ Evidence of more in depth assessments of samples of actions 	

Evaluation questions	Judgment criteria	Preliminary indicators	Data sources
	<ul style="list-style-type: none"> ✓ Extent to which actions and their results have been better disseminated 	<ul style="list-style-type: none"> ✓ Evidence of dedicated budgets for dissemination at action level ✓ Evidence of clearer guidelines on target groups, dissemination plans ✓ Evidence of increased dissemination activities from DG SANCO / action leaders to stakeholders (e.g. Programme Committee, EP, Council, CoR, wider audiences) 	
<p>ii. How effective have recent changes in the emphasis on and use of specific funding mechanisms (i.e. use of Joint Actions, balance between calls for proposals and calls for tender) been in delivering policy-related outputs, and what was the impact on the geographical distribution of beneficiaries?</p>	<ul style="list-style-type: none"> ✓ Extent to which better use has been made of synergies at national, European and international levels ✓ Extent to which changes in the emphasis on and use of specific funding mechanisms have contributed to policy-related outputs ✓ Extent to which changes in the emphasis on and use of specific funding mechanisms has had any impact on the geographical distribution of beneficiaries 	<ul style="list-style-type: none"> ✓ Evidence of (increased) collaboration with relevant interested parties/organisations, e.g. through meetings and conferences ✓ Evidence of increased data sharing between HP actions and similar activities at national, European, international levels ✓ Evidence and examples of policy-related outputs ✓ Evidence demonstrating links between the emphasis / use of specific funding mechanisms and policy-related outputs ✓ Officials' and stakeholders' perceptions on whether changes in the emphasis on and use of specific funding mechanisms have contributed to policy-related outputs ✓ Evidence and examples of changes in the geographical distribution of beneficiaries ✓ Evidence / examples demonstrating links between the emphasis / use of specific funding mechanisms and changes in the geographical distribution of beneficiaries ✓ Officials' and stakeholders' perceptions on whether changes in the emphasis on and use of specific funding mechanisms have contributed to changes in the geographical distribution of beneficiaries 	<ul style="list-style-type: none"> ✓ Desk research (including statistical review and analysis) ✓ Interviews with: <ul style="list-style-type: none"> - DG SANTE and CHAFAEA officials - Programme Committee members and National Focal Points - External stakeholders
<p>iii. To what extent did the implementation of previous recommendations influence the Programme's other operations, including the recruitment of beneficiaries and the level of participation of all Member States in Programme actions (including the facilitation of participation from low GNI countries)?</p>	<ul style="list-style-type: none"> ✓ Extent to which the implementation of previous recommendations has impacted on the recruitment of beneficiaries ✓ Extent to which the implementation of previous recommendations has impacted on the level of participation of all Member States, and in particular has facilitated participation from low GNI countries 	<ul style="list-style-type: none"> ✓ Quantity of proposals received per year under the different funding mechanisms ✓ Evolution of the profile of applicants (by Member State and by partner-type) ✓ Officials' and stakeholders' perceptions on whether and in which ways the implementation of previous recommendations has impacted on the recruitment of beneficiaries ✓ Evolution of the level of participation of Member States ✓ Officials' and stakeholders' perceptions on whether and in which ways the implementation of previous recommendations has impacted on the level of participation of all Member States 	<ul style="list-style-type: none"> ✓ Desk research (including statistical review and analysis) ✓ Interviews with: <ul style="list-style-type: none"> - DG SANTE and CHAFAEA officials - Programme Committee members and National Focal Points

Evaluation questions	Judgment criteria	Preliminary indicators	Data sources
<p>iv. What are the state of the art tools in terms of monitoring project outputs that could be applied to the Programme, what are the expected benefits against costs and how could they be implemented?</p>	<p>✓ Extent to which there are relevant state of the art tools for monitoring project outputs that could be applied to the Programme</p> <p>✓ Benefits against costs of applying tools for monitoring project outputs</p> <p>✓ Ways in which these tools could be implemented to the Programme, including associated risks</p>	<p>✓ Inventory of state of the art tools for monitoring project outputs</p> <p>✓ Examples from national and EU Programmes</p> <p>✓ SWOT analysis of identified tools / monitoring systems</p> <p>✓ Officials' and stakeholders' perceptions on benefits and costs of applying identified tools for monitoring project outputs</p> <p>✓ Officials' and stakeholders' perceptions on ways in which these tools could be implemented to the Programme, and associated risks</p>	<p>✓ Desk research</p> <p>✓ NFP survey</p> <p>✓ Interviews with: - DG SANTE and CHAFAEA officials - Programme Committee members and National Focal Points - Representatives of other programmes and initiatives (e.g. National Institutes of Health, National Institute for Health Research)</p>
Evaluation bloc (b) Programme dissemination practices			
<p>v.</p> <p>a) To what extent have the actions/ outcomes/ results of the Second Health Programme been published? To what extent are they (made) accessible to the international scientific and health community, to health policy makers, civil society, and to the wider public in the EU?</p> <p>b) Are the results published and disseminated in a sustainable way?</p> <p>c) How useful is the EAHC database in this context? How can it be improved?</p> <p>d) Which other tools would be useful in this context?</p> <p>(for part d) of the question, see question viii. below)</p>	<p>✓ Extent to which individual HP actions develop dissemination strategies</p> <p>✓ Extent to which relevant stakeholder groups are targeted (as recipients or multipliers of information)</p> <p>✓ Extent to which dissemination strategies for action results are implemented effectively</p>	<p>✓ % of actions that developed explicit dissemination plans</p> <p>✓ Breakdown of stakeholders targeted</p> <p>✓ Funds budgeted / spent on dissemination (as a share of total action budget)</p> <p>✓ Access (no. of hits) to selected actions' websites</p> <p>✓ No. of copies of final report sent / distributed (electronic and hard copies)</p> <p>✓ No. of dissemination events organised (conferences etc.) to present results</p> <p>✓ Use of other dissemination tools (e.g. newsletters)</p> <p>✓ Evidence of uptake / implementation of results, depending on dissemination strategies pursued</p> <p>✓ Effectiveness of dissemination strategies / tools / activities / target audiences as perceived by stakeholders</p> <p>✓ Number of articles published in peer-reviewed journals</p> <p>✓ Number of citations of such articles</p> <p>✓ Journal impact factor of HP2-related publications</p> <p>✓ H-index (citation index) of HP2-related publications</p>	<p>✓ Review of database / documentation on 90 actions</p> <p>✓ Case studies</p> <p>✓ Stakeholder analysis</p> <p>✓ Stakeholder interviews</p>
<p>Quantity of scientific output stemming from Programme actions</p> <p>Quality of scientific output stemming from Programme actions</p>	<p>✓ Quantity of scientific output stemming from Programme actions</p> <p>✓ Quality of scientific output stemming from Programme actions</p>		<p>✓ Bibliometric analysis of selected actions</p>

Evaluation questions	Judgment criteria	Preliminary indicators	Data sources
	<ul style="list-style-type: none"> ✓ Sustainability of dissemination efforts 	<ul style="list-style-type: none"> ✓ Extent to which further dissemination is foreseen / carried out after the end of HP2 funding ✓ Extent to which relevant websites remain live / updated following action completion ✓ Extent to which scientific output remains accessible / is cited (see above) 	<ul style="list-style-type: none"> ✓ Review of database / documentation on 90 actions ✓ Case studies
	<ul style="list-style-type: none"> ✓ Usefulness of EU (DG SANTE / CHAFAEA) dissemination activities and tools, in particular the database 	<ul style="list-style-type: none"> ✓ No. of visits to CHAFAEA database ✓ Usefulness of database as perceived by stakeholders ✓ Stakeholder views and perceptions of other tools (events, publications, etc.) by DG SANTE / CHAFAEA 	<ul style="list-style-type: none"> ✓ Review of database and other tools / activities ✓ Stakeholder interviews ✓ NFP survey
<p>vi. What is the relation between the publications/activity reporting and the Member State participation in the Second Health Programme, the number of health scientists, public health specialists and physicians per Member States? Are patterns identifiable? Have dissemination activities been undertaken in way to overcome possible geographical imbalances in certain actions?</p>	<ul style="list-style-type: none"> ✓ Extent to which participation / publication rates by MS reflect the relative public health capacity of MS 	<ul style="list-style-type: none"> ✓ Participation of organisations from different MS in actions (as coordinator or collaborator), per year ✓ No. of scientific publications related to HP actions, by MS ✓ Measures of public health capacity: (1) health resources (financial / human), (2) health research (GERD, publications, clinical trials) ✓ Relationship between the above, patterns and trends over time 	<ul style="list-style-type: none"> ✓ HP action 'portfolio' review ✓ Data review from other sources (ECHI, other sources)
	<ul style="list-style-type: none"> ✓ Extent to which dissemination has contributed to reducing imbalances 	<ul style="list-style-type: none"> ✓ No. and type of measures adopted to overcome imbalances ✓ Extent of change that can be attributed to such measures ✓ No. of dissemination activities undertaken to redress geographical imbalances in selected actions ✓ Geographical differences in the level of satisfaction of stakeholders of selected projects with the dissemination efforts made 	<ul style="list-style-type: none"> ✓ Stakeholder interviews ✓ NFP survey ✓ Case studies
<p>vii. To what extent do stakeholders other than Member State governments (subnational regional organisations, civil society, social partners etc.) promote Programme outcomes and results, and via which channels? This should consider both organisations funded by the programme, and others.</p>	<ul style="list-style-type: none"> ✓ Extent and outreach of promotion activities carried out by the various non-State actors ✓ Extent of recourse to the different communication channels (web, other media, conference /meetings etc.) ✓ Tangible effects on health policy / strategy at the various level related to dissemination 	<ul style="list-style-type: none"> ✓ % of actions with non-State actors promoting outcomes/results spontaneously (broken down by type) ✓ Frequency of utilisation of the various communication channels for the above activities ✓ Level of outreach of the above dissemination actions (for selected projects) 	<ul style="list-style-type: none"> ✓ Review of database / documentation on 90 actions ✓ Online questionnaire with National Focal Points ✓ Interviews with non-governmental promoters / disseminators

Evaluation questions	Judgment criteria	Preliminary indicators	Data sources
<p>viii. How could the current dissemination practices be improved to increase return on investment?</p>	<p>✓ Room for improvement of current dissemination practices ✓ Cost-effectiveness of other dissemination tools / approaches that could be used</p>	<p>✓ No. of reported cases of tangible effects (and type) on policy / strategy from the above activities (selected actions) ✓ Overview of other relevant possible dissemination tools (to be identified) ✓ Estimated costs of alternative approaches ✓ Likely benefits</p>	<p>✓ Case studies (focused on dissemination) ✓ Ideas gleaned from interviews / surveys / other sources ✓ Cost-benefit / cost-effectiveness analysis</p>
Evaluation bloc (c) Impact of the programme			
<p>ix: How and to what extent has the Second Health Programme supported Member States' health policy and actions (in relation to the provisions on support, cooperation and coordination in Article 168 of the Treaty)?</p>	<p>✓ Extent to which the Programme has supported Member States' health policy and actions ✓ Ways in which the Programme has supported Member States' health policy and actions</p>	<p>✓ Evidence and examples of ways in which the Programme has supported Member States' health policy and actions ✓ Extent to which the Programme meets the essential criteria for maximising its potential impact ✓ Stakeholders' perceptions on ways in which the Programme has supported Member States' health policy and actions ✓ Stakeholders' perceptions on (i) whether Programme activities are additional to what MS would have done anyway, and (ii) what might have happened in the absence of the Programme</p>	<p>✓ Desk research - screening exercise and in-depth review ✓ Case studies ✓ NFP survey ✓ Interviews with: - DG SANTE and CHAFAEA officials - Programme Committee members and National Focal Points - External stakeholders</p>
<p>x: Which are the main health policy areas in which progress has been achieved due to the support of the Health Programme, and what constitutes this progress?</p>	<p>✓ Identification of the main health policy areas in which progress has been achieved as a result of Programme support ✓ Identification of actions / results illustrating the progress achieved</p>	<p>✓ Evolution over time in the main health policy areas where actions have been funded ✓ Evidence and examples of health policy areas where significant progress has been achieved due to the support of the Programme based on an assessment in relation to the 7 added value criteria ✓ Stakeholders' views on the health policy areas where the Programme has had the greatest impact and where it should be providing more support ✓ Stakeholders' perceptions on (i) whether Programme activities are additional to what MS would have done anyway, and (ii) what might have happened in the absence of the Programme ✓ Degree to which given actions are sustainable, i.e. would continue with a reduction in / in the absence of EU funding ✓ Extent to which given actions meet the pre-defined</p>	<p>✓ Desk research - screening exercise, in-depth review and added value analysis ✓ Case studies ✓ NFP survey ✓ Interviews with: - DG SANTE and CHAFAEA officials - Programme Committee members and National Focal Points - External stakeholders</p>

Evaluation questions	Judgment criteria	Preliminary indicators	Data sources
<p>xi: What are reasonable assumptions on the way to measure the impact of the programme in terms of timelines a) short-term, b) middle-term, c) long-term and d) in relation to average project trajectories?</p>	<p>✓ Identification of assumptions to measure the impact of the programme in terms of timelines a) short-term, b) middle-term, c) long-term and d) in relation to average project trajectories</p>	<p>essential conditions for actions (i.e. the action has defined SMART objectives and targets; the action has defined a clear target group; the action has developed clear implementation and dissemination strategies; the action has delivered its main deliverables to a sufficient standard; the action has covered its stated target group; the action has met its stated targets; the action has disseminated its outputs / results to plan)</p> <p>✓ Stakeholders' perceptions on the actions / results illustrating the progress achieved</p> <p>✓ In-depth review of Programme impact for a selection of actions and analysis of when this can be measured</p> <p>✓ Stakeholders' perceptions on time-adapted ways in which to measure the Programme's impact</p>	<p>✓ Case studies</p> <p>✓ NFP survey</p> <p>✓ Interviews with: - DG SANTE and CHAFAE officials - Programme Committee members and National Focal Points</p>
<p>xii: Which factors/reasons may intervene and influence positively or negatively the impact of the Programme?</p>	<p>✓ Identification of factors/ reasons that can positively or negatively influence the impact of the Programme</p>	<p>✓ Identification of examples of factors / reasons that can positively or negatively influence the impact of the Programme</p> <p>✓ Stakeholders' perceptions on factors / reasons that can positively or negatively influence the Programme</p>	<p>✓ Case studies</p> <p>✓ NFP survey</p> <p>✓ Interviews with: - DG SANTE and CHAFAE officials - Programme Committee members and National Focal Points - External stakeholders</p>
<p>xiii: What are the main lessons than can be drawn to ensure an overall successful transition from the second to the third Health Programme?</p>	<p>✓ Identification of lessons to ensure an overall successful transition from the second to the third Health Programme</p>	<p>✓ Evidence and examples of lessons to ensure an overall successful transition from the second to the third Health Programme</p> <p>✓ Stakeholders' perceptions on lessons to ensure an overall successful transition from the second to the third Health Programme</p>	<p>✓ Desk research - Desk review and analysis of relevant documentation</p> <p>✓ Desk research - screening exercise, in-depth review and added value analysis</p> <p>✓ Case studies</p> <p>✓ NFP survey</p>

Evaluation questions	Judgment criteria	Preliminary indicators	Data sources
			✓ Interviews with: - DG SANTE and CHAFAE officials - Programme Committee members and National Focal Points - External stakeholders
Evaluation bloc (d) Synergies with other policies and programmes			
<p>xiv. What synergies are there with other policies and programmes of the Commission such as the European Structural and Cohesion Funds, the programmes managed by DG RTD, other DGs (in particular EMPL, CONNECT) and to what extent did the Health Programme underpin the Commission's general objectives - focus on Europe 2020 and their objectives related to social policy (e.g. the renewed Social Agenda) and economic growth (research and innovation, competitiveness)?</p>	<ul style="list-style-type: none"> ✓ Extent to which health interventions funded under the HP and key other programmes have potential synergies (theoretical analysis) ✓ Extent of actual synergies (illustrated by examples) ✓ Level of coordination at planning and implementation level (delivery) 	<ul style="list-style-type: none"> ✓ Comparison of health-related funding (HP, FP7, ERDF, ESF) ✓ Specific examples of synergy effects (if any) ✓ Existence of EU-level mechanisms for coordination of priorities, exchange of results and/or cross-fertilisation ✓ Satisfaction of key staff with the degree of synergies / complementarity 	<ul style="list-style-type: none"> ✓ Desk research (including value chain analysis) ✓ Interviews with officials representing other services and programmes
	<ul style="list-style-type: none"> ✓ Coherence of HP with main EU policy objectives (Europe 2020) 	<ul style="list-style-type: none"> ✓ No. of HP2 projects consistent with Europe 2020 objectives ✓ Effects of HP2 actions on smart / inclusive growth 	<ul style="list-style-type: none"> ✓ Desk research

ANNEX II – RECOMMENDATIONS APPLIED

Recommendation(s) of the mid-term evaluation of the HP 2008-2013	Intended effect(s)	Preliminary assessment of implementation	Issues tested further during the ex-post final evaluation of the HP 2008-2013
CONCEPTION			
<p>More tangible and focussed objectives (SMART³⁷); better defined strategic framework for the HP and the development of indicators</p>	<p>To ensure the programme is focussed on certain public health issues (especially those that are difficult for MS to reach individually) and for targets / indicators to be developed to measure the extent to which these objectives / priority areas are achieved as well as greater transparency in how priorities are reached in Annual Work Programmes</p> <p>(also see "Design" Recommendation – to give EU added value greater prominence in proposal stage)</p>	<p>2nd HP:</p> <p>2012 and 2013 AWP's focused on Europe 2020 relevance</p> <p>Evidence of shift from 'bottom up' development process to 'strategic' prioritisation (based on increased input from DG SANTE senior leaders)</p>	<p>To what extent were indicators developed at a strategic level (rather than action level) under the 2nd HP to show progress / achievements relative to the stated objectives?</p>
		<p>3rd HP:</p> <p>Objectives re-defined for the 3rd HP³⁸ with the result that they are much more focused on supporting EU priorities and therefore the pursuit of EU added value</p> <p>Progress indicators have been introduced for 3rd HP³⁹ (however there is no reference to them in official documents consulted to date, e.g. the AWP 2014)</p>	

³⁷

Specific, Measurable, Attainable, Relevant, Time-bound = SMART

³⁸

Promote health, prevent diseases and foster supportive environments for **healthy lifestyles** taking into account the 'health in all policies' principle; Protect Union citizens from serious **cross-border health threats**; Contribute to innovative, efficient and sustainable **health systems**; Facilitate access to **better and safer healthcare** for Union citizens (see Programme Regulation 282/2014/EC. URL: <http://eur-lex.europa.eu/legal-content/EN/TEXT/PDF/?uri=CELEX:32014R0282&from=EN>)

³⁹

See presentation of the third health programme (see http://ec.europa.eu/health/programme/docs/ev_20141104_co01_en.pdf)

Recommendation(s) of the mid-term evaluation of the HP 2008-2013	Intended effect(s)	Preliminary assessment of implementation	Issues tested further during the ex-post final evaluation of the HP 2008-2013
<p>Develop long-term planning and targets in consultation with national health experts</p>	<p>To facilitate:</p> <ul style="list-style-type: none"> Setting appropriate priority actions vis-à-vis health needs and objectives in individual Member States Selecting financing mechanisms <p>To ensure an appropriate spread among the objectives and priorities.</p>	<p>Greater share of funding allocated to joint actions, service contracts and operating grants (cf. smaller share to presidential conferences, projects) from 2011 – 2013 cf. 2008-2010.</p> <p>More emphasis (both in terms of number of actions and budget spent) on "Health Promotion" cf. "Health Security" and "Health Information".</p> <p>According to our preliminary assessment, the Annual Work Plans do not provide a clear rationale / justification behind varying levels of funding for each objective</p> <p>All countries (with the exception of Luxembourg) received more funding for Health Promotion than Health Security or Health Information⁴⁰, although there were some exceptions⁴¹</p>	<p>Assess in greater detail whether DG SANTE explain and document this process clearly and whether the AWP's provide sufficient rationale / justification behind varying levels of funding for each objective</p> <p>Has value for money improved through greater use of JAS?</p> <p>It remains to be seen (through survey analysis and interviews) whether divergences in the focus of funding by strand can be attributed to differing health needs in each country</p>
DESIGN			
<p>Retain current funding mechanisms and consultation of action leaders on their experience with new funding mechanisms</p>	<p>To continue to provide insight into the pros and cons of each funding mechanism, what aspects they would change / improve at the end of each action</p>	<p>All funding mechanisms continue to be used but as described above, the relative proportion of budget allocated to each funding mechanism shifted following on from the Mid-term evaluation</p>	<p>Look into degree of consultation with action leaders once an action has come to a close</p>

⁴⁰ Note that country-level data is only available for CHAFEA managed actions, and not for DG-SANTE managed actions.

⁴¹ All countries (with the exception of Luxembourg) received more funding for Health Promotion than Health Security or Health Information. The proportion ranged from 29% of funds received (Luxembourg) to 90% (Iceland). For Health Information and Health Promotion the lower range was sometimes very low: for example 5% or less of funds went to Health Information in Iceland, Cyprus, Bulgaria and Romania, while 10% or less of funds went to Health Security in Iceland and Finland.

Recommendation(s) of the mid-term evaluation of the HP 2008-2013	Intended effect(s)	Preliminary assessment of implementation	Issues tested further during the ex-post final evaluation of the HP 2008-2013
<p>Retain requirement for proposals to outline compliance with AWP priority areas and HP objectives</p>	<p>DG SANTE continue assessing proposals according to their policy relevance</p> <p>External evaluators continue rating proposals according to their evidence base⁴²</p>	<p>Guides include information on awarding criteria which make reference to policy and contextual relevance of action as well as reference to evidence base</p>	
<p>Emphasise and clarify EU added value particularly in the proposal/application process stage</p>	<p>The promotion of clearer EU AV allows the programme to better achieve its objective</p>	<p>All EU AV criteria are still not altogether clear</p> <p>Poster on EU added value produced for High Level Conference on Health Programmes⁴³</p> <p>EU Added Value is included in the application guides but the information has not evolved since the mid-term evaluation / does not make reference to clear guidelines on EU added value</p> <p>Meaning of EU added value is outlined in FAQ for Health Programme calls for proposals 2013 on the CHAFEA website (not clear when this was first included)⁴⁴</p> <hr/> <p>3rd HP:</p> <p>EU AV criteria are detailed in Programme Regulation 282/2014/EC (6)⁴⁵</p>	<p>Clarity /applicability of EU AV (in general and for applicants)?</p>

⁴² For example, the 2011 Guide for Operating Grants asks for information on the “evidence base (citing data, studies, etc.) for the general activities and overall objective of the organization / network.”

⁴³ http://ec.europa.eu/health/programme/docs/ev_20120503_eu_added_value_en.pdf

⁴⁴ <http://ec.europa.eu/chafea/health/faq.html>

⁴⁵ “The Programme should be a means of promoting actions in areas where there is a Union added value that can be demonstrated on the basis of the following: exchanging good practices between Member States; supporting networks for knowledge sharing or mutual learning; addressing cross-border threats to reduce their risks and mitigate their consequences; addressing certain issues relating to the internal market where

Recommendation(s) of the mid-term evaluation of the HP 2008-2013	Intended effect(s)	Preliminary assessment of implementation	Issues tested further during the ex-post final evaluation of the HP 2008-2013
		<p>Reference is made to EU AV in the (annexes to) AWP 2014⁴⁶</p> <p>Calls for proposals for actions make reference to EU AV⁴⁷ and factsheet on EU AV to be distributed along with calls for proposal from 2014 onwards as well as a reference included in the guides for applicants⁴⁸</p> <p>Info days for potential applicants organised on 11 April and 11 June 2014</p>	
MANAGEMENT			
<p>Monitor the organisations applying for funding and carry out a more in depth assessment of sample of actions</p>	<p>To ensure there is equal access for all applicants to receive funding</p> <p>To provide insight into the actions funded but also to have data available to disseminate to interested parties</p>	<p>Annual consensus reports produced for given projects that have ended by CHAFAE following evaluations by three experts. Focus placed in particular on projects where problems have been identified.</p> <p>Overall, government organisations make up the largest proportion of beneficiaries, followed by non-profit organisations and academic organisations. A very small</p>	<p>Explore the make-up of <i>main and associated beneficiaries</i> across the EU by action type and strand</p>

the Union has substantial legitimacy to ensure high-quality solutions across Member States; unlocking the potential of innovation in health; actions that could lead to a system for benchmarking to allow informed decision-making at Union level; improving efficiency by avoiding a waste of resources due to duplication and optimising the use of financial resources.”

⁴⁶ http://ec.europa.eu/health/programme/events/adoption_workplan_2014_en.htm

⁴⁷ See for example, the factsheet for Project grants: http://ec.europa.eu/chafea/documents/health/factsheets_hp_pg_en.pdf

⁴⁸ See for example the 2014 guide for Project applicants: http://ec.europa.eu/research/participants/data/ref/other_eu_prog/hp-call-guide-app-pj_en.pdf and EU factsheets via: <http://ec.europa.eu/chafea/health/index.html> ; project factsheets: <http://ec.europa.eu/chafea/health/projects.html>; operating grant factsheet: <http://ec.europa.eu/chafea/health/grants.html>; joint action factsheet: <http://ec.europa.eu/chafea/health/actions.html>

Recommendation(s) of the mid-term evaluation of the HP 2008-2013	Intended effect(s)	Preliminary assessment of implementation	Issues tested further during the ex-post final evaluation of the HP 2008-2013
		<p>proportion of partners are classified as commercial organisations, while the proportion of non-governmental organisations and international public organisations and private individuals is negligible.</p> <p>The in-depth review provided more detailed information on sub-groups of beneficiaries, for example, more or less a quarter of government organisations are “policy makers and regulators” (28%), “general public health organisations/institutions” (28%), “Specialised health organisations and institutes” (23%) while the remaining share were divided between “Healthcare providers and commissioners” (14%) and “other” (i.e. non-health) government bodies (7%).</p>	
Provide better guidance for proposals and simplification of application processes	More, better applications leading to actions with more relevant, tangible results	<p>2nd HP:</p> <p>Guidance document for actions developed by CHAFFEA and guide available for each funding mechanism together with call for proposals</p> <p>Positive feedback from survey of applicants to calls for proposals 2008 – 2013 regarding both the guidance documents and helpdesk services but still room for improvement (for example Frequently Asked Questions section should</p>	<p>Identify ways to manage and implement on-going improvements (e.g. simplifying technical and financial parts of application forms) using survey results and feedback</p> <p>Look into benefits of NFPs</p> <p>Test sub-recommendations outlined in the Mid Term Evaluation which relate to improving guidance for</p>

Recommendation(s) of the mid-term evaluation of the HP 2008-2013	Intended effect(s)	Preliminary assessment of implementation	Issues tested further during the ex-post final evaluation of the HP 2008-2013
		<p>contain more technical answers rather than mainly general ones)</p> <p>From evaluators point of view, the administrative side of applications could be improved and simplified (suggestions include move to electronic submissions, improvements to the structure of information provided)</p> <p>3rd HP:</p> <p>Simplification measures introduced, including the electronic submission of proposals via the Electronic Exchange System of the EC Participant Portal⁴⁹, new procedures for granting Joint Actions (i.e. without the need for a call for proposal) and operating grants, among others.</p>	<p>applicants:</p> <ul style="list-style-type: none"> • intervention logics and theories of change to participants⁵⁰, • setting indicators that could provide an insight into the extent to which the outcomes are being / have been achieved. Without these it is difficult to determine how effective an action has been and the extent of its impact at the point of assessment; • how to set SMART objectives in order to effectively measure progress; • definitions of what is required in certain sections of the application form, i.e. "evidence base", given that applicants might have different understandings of certain terms used (without interfering in the peer review process and without encroaching on the capacity of the applicants to formulate the evidence base); • assessing potential "EU added value" along clear and quantifiable criteria • defining target groups / dissemination plans / evaluation plans.

⁴⁹ <http://ec.europa.eu/cha/cha/news/news327.html>

⁵⁰ definitions and very clear examples of Inputs, Outputs, Results, Outcomes and Impacts of an action

Recommendation(s) of the mid-term evaluation of the HP 2008-2013	Intended effect(s)	Preliminary assessment of implementation	Issues tested further during the ex-post final evaluation of the HP 2008-2013
<p>Ensure better dissemination of actions and their results, including dedicated budgets, by DG SANTE / action leaders to stakeholders (e.g. Programme Committee, EP, Council, CoR, wider audiences)</p>	<p>The better and more systematic the dissemination, the wider the reach of the programme</p>	<p>DG SANTE: Increased focus on dissemination of results by DG SANTE (e.g. brochures, covering broad range of actions, grouped under thematic areas)</p> <p>The Mid-term evaluation mentioned a planned conference (High Level Conference on EU Health Programmes: results and future perspectives⁵¹) in particular as having significant potential to support dissemination efforts⁵¹</p> <p>CHAFEA: Improvements made to CHAFEA database of actions</p>	<p>Where is there still room for improvement in terms of dissemination, e.g. on the website/newsletters, production of short summaries for national policy makers? The interviews and case studies will inform this.</p> <p>Which dissemination methods are most effective (level of dissemination / dissemination method)? Further research to be carried out on this as part of the analysis of the results of the in-depth review.</p> <p>Use the case studies to assess: Whether target audiences identified? Are target audiences identified sufficiently specific? Do actions have clear dissemination plans? Do they allocate a budget to dissemination in their proposals?</p> <p>Has communication between DG SANTE, CHAFEA and the Programme Committee improved (for example so that the latter are more aware of dissemination efforts)? To be explored during the interviews.</p>
<p>Make use of synergies</p>	<p>Multiplying the impact of the HP through disseminating results and collaborating with relevant interested</p>	<p>2nd HP: Roadmap for dissemination is currently being designed and is in draft format.</p>	<p>To what extent were synergies capitalised on under the 2nd HP? (One of the research questions for the case studies – that related to EU added value - will be used to hone in on the extent to which</p>

⁵¹ http://ec.europa.eu/health/programme/events/ev_20120503_en.htm

Recommendation(s) of the mid-term evaluation of the HP 2008-2013	Intended effect(s)	Preliminary assessment of implementation	Issues tested further during the ex-post final evaluation of the HP 2008-2013
	parties/organisations	<p>The activities (including a specific framework contract) will disseminate the outputs and outcomes of the finished actions funded under the 2nd Health Programme.</p> <p>The in-depth review shows that the extent of linkages between actions funded through the Health Programme and other EU programmes is limited. The review process was able to ascertain linkages in 19% of actions and show that in 35% there were none; but in nearly half (46%) “don’t know” was selected.</p> <p>3rd HP:</p> <p>Explicit reference to supporting complementary funding programmes as per thematic priorities in annex 1 of the Commission Decision for 3rd HP</p>	<p>potential synergies and linkages were capitalised on during the 2nd HP)</p>

ANNEX III – JOINT ACTIONS ACHIEVEMENTS 2008 – 2013

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JOINT ACTIONS ACHIEVEMENTS 2008 – 2013	
2008	
NAME OF JOINT ACTION	ACHIEVEMENTS OF JOINT ACTION
<i>Joint Action to support the Rare Diseases Task Force Scientific Secretariat and contribute to the revision of the International Classification of Diseases in the field of rare diseases (RDTF Scientific support)</i>	Effective scientific and technical support was provided to the RDTF/EUCERD and an important contribution to revising the ICD in order to make rare diseases more visible. The JA raised awareness of rare diseases and contributed to shaping national and EU policies, especially with its three Annual Reports on the State of the Art of Rare Disease Activities in Europe.
<i>Joint Action for European Community Health Indicators and Monitoring (ECHIM JA)</i>	The main result is the 2012 version of the ECHI shortlist of 88 indicators, each now with a fully updated documentation list that defines its method of calculation and best available data source, taking into account methodological quality, availability of data, the burden for Member States if new or altered data collection is needed, and the political importance of the indicator. The ECHIM JA also compiled information on the status of implementation in most European countries, and analysed health indicators not published in international databases.
2009	
NAME OF JOINT ACTION	ACHIEVEMENTS OF JOINT ACTION
<i>Safety evaluation of manufactured nanomaterials by characterisation of their potential genotoxic hazard (NANOGENOTOX)</i>	The main outcome was a set of standard operating procedures for the rapid characterisation of different types of manufactured nanomaterials in terms of their potential genotoxicity, a dispersion method for producing suitable media for exposure to these nanomaterials, and datasets of the physico-chemical properties of the tested nanomaterials. The JA also generated in vitro genotoxicity data on the tested nanomaterials that can be used for risk assessment of nanomaterials in a variety of applications, including medicinal and consumer products.
<i>European Health Examination Survey Pilot Joint Action (EHES JA)</i>	The main outcomes from the EHES JA were national plans for the Health Examination Survey (HES) and reports of the national pilot surveys. Germany, Italy, Netherlands and England carried out full-size national HES in parallel with the JA. Slovakia conducted its full-scale HES in 2011, and Finland in 2012. The Czech Republic, Greece, Malta, Poland and Portugal completed theirs in 2013-14. Two countries that were not partners of the JA conducted national surveys using the EHES procedures: Luxembourg (2012) and France (2014).
<i>European network for Health Technology Assessment (HTA) Joint Action (EUnetHTA)</i>	The JA developed a background review and an HTA Core Model for rapid "Relative Effectiveness Assessment" of pharmaceuticals, together with a report on national HTA strategies. The report on training needs was followed by a training workshop on EUnetHTA tools. The JA also collaborated with the European Medicines Agency (EMA) to improve the European Public Assessment Reports (EPARs), which are the full scientific assessment report published by EMA for every medicine, granted a central marketing authorisation.
2010	
NAME OF JOINT ACTION	ACHIEVEMENTS OF JOINT ACTION
<i>Mutual Organ Donation and Transplantation Exchanges: Improving and developing cadaveric organ donation and transplantation programmes (MODE)</i>	MODE's main achievement was better knowledge of the quality and effectiveness of the systems for organ donation and transplantation in participating countries. The participants gained in-depth knowledge of the training given to healthcare personnel of individual countries, in order to meet their specific needs.
	QUANDHIP's main achievement was to create an effective laboratory network able to respond to outbreaks of highly infectious pathogens. This was achieved by developing guidance outlining the activation and response processes undertaken by established expertise within

<p><i>Quality Assurance Exercises and Networking on the Detection of Highly Infectious Pathogens (QUANDHIP)</i></p>	<p>the laboratory network. Through this guidance, the European laboratories network is expected to manage possible future natural and deliberate outbreaks of high-risk pathogens. The JA's diagnostic tools are also expected to boost the capacity of global health security systems, and to address the laboratory core capacities required by the WHO International Health Regulations.</p>
<p><i>Alzheimer's Cooperative Valuation in Europe (ALCOVE)</i></p>	<p>As a result of its investigations, ALCOVE found that the number of people living with dementia in the EU was about 22.1% lower than had been suggested by other earlier estimations. Based on this work, the Joint Action identified a set of recommendations for future data collections. In addition, ALCOVE produced detailed recommendations in other areas, namely: timely diagnosis of dementia and interventions to provide support systems, including ambulatory ones, for the management of the behavioural and psychological symptoms of dementia.</p>
<p><i>European Partnership for Action Against Cancer (EPAAC)</i></p>	<p>The main result of the JA was the 'European Guide for Quality National Cancer Control Programmes', which provides an outline for policy-makers on the basic tenets of cancer control policy. EPAAC also provided a set of selected indicators that enable efficient monitoring of the roll-out of such programmes. The production of a guideline for developing a National Cancer Plan in all Member States was another major achievement. Results related to screening and early diagnosis included the creation of the "European School for Screening Management, preparation of a report on inequalities in cancer screening programmes; development of quality criteria for health checks and organisation of regional workshops on population-based screening programmes. Activities under the JA also led to the development of many European networks in cancer care. EPAAC explored ways that networks can innovatively and efficiently help patients at regional, national and EU levels. The JA also designed the structure of a future European cancer information system (ECIS) and took the first step towards this (harmonisation of incidence and survival data) in order to update European cancer data and construct a common database computing incidence, survival and prevalence data.</p>
<p><i>Joint Action on Health Inequalities (Equity Action)</i></p>	<p>The main outcome was increased action and mutual learning about socio-economic and area-based inequalities in health, and increased commitment to improving the situation in Europe. More specifically, the action led several countries to significantly improve their capacity to take action to address health inequalities, and reached a greater consensus on which approaches really work, plus knowledge and awareness of tools/methods that help to promote a cross-government approach to health equity.</p>
<p><i>European Surveillance of Congenital Anomalies (EUROCAT)</i></p>	<p>The EUROCAT JA supported epidemiological surveillance through the EUROCAT network of population-based congenital anomaly registers. It was one of several JAs in the area of rare diseases, and aimed to establish a sustainable, high-quality and easily accessible information system on CA for almost one third of the European birth population.</p>
<p><i>Joint Action on Monitoring Injuries in Europe (JAMIE)</i></p>	<p>One of the JA's main outputs was the IDB-JAMIE manual, designed to support national injury surveillance and reporting systems across the EU. The manual was fine-tuned through meetings and the training of partners in applying the publication's rules and guidelines in local practice.</p>
<p><i>Development of the European portal of rare diseases and orphan drugs (ORPHANET Europe)</i></p>	<p>In this JA participants collaborated to make the "Orphanet" portal the main reference source of information on rare diseases for all European citizens. Orphanet now offers information on well over 3 000 rare diseases, in English, Dutch, French, German, Italian, Portuguese and Spanish.</p>
<p><i>European Health and Life Expectancy Information System (EHLEIS)</i></p>	<p>The main outcome of the JA was a consolidated information system allowing online calculation of health indicators (prevalence, life and health expectancies including healthy life years (HLY), with health information drawn from European surveys. The partners also modified the system's general architecture to allow its future extension to national and sub-national use by the Member States. The JA produced four series of country reports on health expectancy, which were published in the partners' national</p>

	languages. It also produced the proceedings of the EHLEIS annual meetings, to encourage Member States to use health expectancies, including HLY, in their social policies. The JA developed new statistical tools for attribution and decomposition analyses, and health impact assessment. It also produced technical reports and scientific analyses exploring gender variations in HLY within Europe, trends over time, social differentials in GALI (Global Activity Limitation Indicator) between Member States, and various validation studies of the GALI.
<i>Joint Action e-Health Governance Initiative (JA-EHGov)</i>	JA-EHGov successfully contributed to establishing a dedicated mechanism for eHealth at EU level, thus bridging the gaps between governance, strategy and the operational level in this field. The JA focused on informing policy and healthcare decision-makers in the EU countries represented in the eHealth Network. In addition, the JA-EHGov created an archive of EU eHealth work in the field of electronic-ID, legal, semantic and technical interoperability
2011	
NAME OF JOINT ACTION	ACHIEVEMENTS OF JOINT ACTION
<i>European Union Network for Patient Safety and Quality of Care (PaSQ)</i>	The JA has collected around 500 good practices (Patient Safety Practices and Good Organisational Practices). These are now accessible to healthcare professionals and the public through a mutual learning web platform: www.PaSQ.eu . The JA has also organised some 35 exchange events, involving experts from 20 Member States. These events enable experts and stakeholders to discuss and share selected clinical and organisational good practices that they have selected on the learning platform. This led to identification of the most important priorities: patient involvement/empowerment reporting and learning, rapid exchange systems, quality improvement systems, and implementation of good clinical practices.
<i>Achieving Comprehensive Coordination in Organ Donation throughout the European Union (ACCORD)</i>	ACCORD has investigated EU countries' experience of living donation and Living Donor Registries (LDRs). It has also come up with recommendations for LDRs and a Pan-European Registry of LDRs (data set/dictionary if technical, organisational and governance issues) and produced a web-based platform for piloting its recommendations for international data sharing. The pilot phases showed that data collection is possible, according to the methodology proposed and taking into account different types of situations (file upload for countries with pre-existing register(s) and direct entry for countries without a register). In addition, the JA has produced a preliminary description of end-of-life practices applied to brain-injured patients, after a study of 67 hospitals across 15 EU countries; trained professionals from participating countries on the Plan-Do-Study-Act (PDSA) methodology; and identified areas for improvement at participating hospitals (and sometimes at higher level), whilst designing and implementing plans for improvement.
<i>EUCERD Joint Action: working for rare diseases (EJA)</i>	The key outcome of the EJA is a set of recommendations and opinions on critical questions arising from the implementation of policies on rare disease both at the EU and Member State levels. Based on exchange of experience between Member States' health authorities, as well as from the contribution of stakeholders, these recommendations are then endorsed by the EUCERD/Expert Group and communicated to national and European policymakers, patient organisations and professional associations.
<i>European Network for Health Technology Assessment (HTA) Joint Action 2 (EUnetHTA JA2)</i>	Overall, EUnetHTA 2 JA has developed and endorsed its recommendations on a sustainable EU cooperation on HTA. It has continued to influence and play an important role in the HTA Network, and as a result national adaptation of EUnetHTA outputs is gaining momentum. Partners in this JA have also further developed processes for handling HTA conflict of interest and confidentiality. Lastly, this JA organised a successful 'HTA 2.0 Europe – Teaming Up for Value' conference in Rome, Italy in October 2014, attracting 450

	participants from all over the world.
<i>Cross-Border Patient Registries Initiative (PARENT)</i>	<p>Besides a comprehensive overview of the current situation in the EU/Member States regarding patient registries, the JA has developed a coordination mechanism ("the Associated Projects Group") to exploit synergies between PARENT and related EU Joint Actions and projects on patient registries. This Group coordinates work to ensure that parallel activities are not duplicating or diverging in terms of methodology, semantics, or policy. It will actively encourage decision-makers from associated projects to align their activities and exploit results, whilst sharing and exchanging resources with PARENT. In 2013, the JA launched the Prototype and Pilot for</p> <p>a EU-level relevant source of information for national patient registries, known as the PARENT Registry of Registries (parent-RoR.eu).</p>
2012⁵²	
NAME OF JOINT ACTION	ACHIEVEMENTS OF JOINT ACTION
<i>European Health Workforce Planning & Forecasting (EUHWforce)</i>	The main outcome will be the consolidation of a permanent network for Health Workforce (HWF) planning and forecasting. This will support the EU and the Member States as they work towards a stronger and more effective European HWF. As a result, HWF planners will be better prepared for future challenges in the field, supported by a better prepared educational and health system. Further expected outcomes of this JA include increased capacity in HWF planning and forecasting, data collection and analysis; improved data collection, notably for HWF mobility in the EU; and better insight into international benchmarks on HWF.
<i>Facilitating exchange of organs donated in EU Member States (FOEDUS)</i>	FOEDUS is expected to develop an EU-wide common approach to organ exchange, plus a better knowledge of existing barriers (financial, logistic, and legal) that are hindering this practice. By developing better practice (e.g. recommendations for international organ exchange) and easier exchange of organs donated in EU countries, the JA is working towards increasing bilateral agreements among EU countries. This aims to increase the number of available organs donated and transplanted across Europe.
<i>Mental Health and Well-being (MH-WB)</i>	MH-WB has already created new – and promoted existing – networks of relevant stakeholders in participating countries. In those countries, it has analysed the fields of prevention of depression and suicide, development of community-based approaches, mental health at the workplace, mental health in schools, and integration of mental health in all policies. The JA has also gathered good practices in MH-WB policy. It is now developing recommendations for action that will be widely discussed with all relevant stakeholders in Europe.
<i>Improving Quality in HIV Prevention (Quality Action)</i>	The expected results of Quality Action are: recognition of Quality Assurance/Quality Improvement (QA/QI) in strategic documents and forums; a commitment to integrate QA/QI at all levels; transferable, evidence-based, pilot-tested, practical QA/QI tools and training; capacity to use QA/QI at the programme and project levels; a sustainable network of organisations and trained experts experienced in QA/QI; guidance on effective HIV prevention based on a Charter for Quality, and a policy kit.
<i>The impact on maritime transport of health threats due to biological, chemical and radiobiological agents,</i>	EU SHIPSAN ACT has already produced a State of the Art report, with a literature review on infectious diseases, surveys on practices of EU authorities on chemical, biological, radiological and nuclear (CBRN) incidents in maritime transport, hygiene inspection on fishing and inland vessels, and training needs on core capacities at points of entry. The action produced a ship inspection plan including competencies, roles and responsibilities and code of conduct. The outlines of inspection were revised and used during 98 full inspections and two re-inspections on board of 87 cruise ships and 11 ferries by the trained inspection teams. The inspections revealed

⁵² The Joint Actions starting in 2012 and 2013 have not been finalized. Hence, no final results are available.

<p><i>including communicable diseases (SHIPSAN ACT)</i></p>	<p>554 deficiencies, including 90 non-compliances with EU legislation and 414 non-compliances with European Manual for Hygiene Standards and Communicable Diseases Surveillance recommended standards. Guidelines will be produced to allow consistent preparedness planning in the EU based on shared and common standards, facilitating International Health Regulation implementation.</p>
2013	
NAME OF JOINT ACTION	ACHIEVEMENTS OF JOINT ACTION
<p><i>Assisted Reproductive Technologies and Haematopoietic stem cells Improvements for Quality and Safety throughout Europe (ARTHIQS)</i></p>	<p>ARTHIQS is making good progress towards all goals: creating capacity at national level in all 28 EU Member States for assisted reproductive technologies and on haematopoietic stem cells (HSC) partners exchanged their HSC donor follow-up procedures, and discussed topics to be covered by the guideline for Cordon-Blood-Banks (CBB) authorisation.</p>
<p><i>European Guide on Quality Improvement in Comprehensive Cancer Control (CANCON)</i></p>	<p>The JA builds on the EPAAC Joint Action and its first aim is to improve overall cancer control through quality-based cancer screening programmes, better integration of cancer care, community-based care approaches and by providing concerted efforts in all aspects of survivorship, including palliative care. These key elements will be combined with other relevant aspects of cancer control to develop a European Guide on Quality Improvement in Comprehensive Cancer Control. The second main aim is to discuss key cancer control topics through the Member State Platform, leading to position papers that all EU countries can use when developing their own cancer-control policies.</p>
<p><i>Chronic Diseases and Promoting Healthy Ageing across the Life Cycle (JA-CHRODIS)</i></p>	<p>Once completed, JA-CHRODIS is expected to deliver a mechanism for the collection, validation, scaling up and transfer of good practices on chronic care. It will have paid particular attention to health promotion and the prevention of chronic conditions, multi-morbidity and diabetes. Concrete outputs will include a platform for knowledge exchange, including a help desk and a clearinghouse, a training programme for health professionals to address multi-morbidity, a set of best practices on primary prevention, early detection, secondary prevention and management of diabetes, including patient empowerment programmes and a review of existing national programmes on diabetes.</p>
<p><i>Joint Action on Reducing Alcohol-related Harm (JA RARHA)</i></p>	<p>The JA contributes to capacity building among partners and in the wider public health community. It strengthens capacity in alcohol survey methodology and provides a common instrument for monitoring progress in reducing alcohol related harm. In addition it clarifies the scientific basis and practical implications of drinking guidelines as a public health measure. It increases consensus on key messages about harmful drinking to the population and health professionals. It also enhances access to well described, likely transferable interventions on which some evidence of effectiveness in influencing attitudes or behaviour and cost estimates are available. The tools developed in the JA help plan public health policies that in the longer term contribute to reducing alcohol related harm, the risk of chronic diseases and the burden for health systems.</p>
<p><i>Strengthening Collaborations for Operating Pharmacovigilance in Europe (SCOPE)</i></p>	<p>SCOPE is expected to provide benchmarking of different EU systems through audit and survey work to identify best practices and weaknesses in the national pharmacovigilance systems. It will also create a network among Member States to share and document best practice through fora under different topics. In addition, it will develop tools and guidance to support best practice. These will help Member States to identify and manage efficient use of resources for operation of their quality system, whilst helping them to plan capacity for future pharmacovigilance assessment work.</p>

QUALITY ASSESSMENT FORM⁵³

The present quality assessment is a synthesis of assessments carried out by the Steering Group members such as the Sec Gen, the DG SANTE evaluation function, other DG SANTE units and external health stakeholders

Date of the Quality Assessment 21/07/2015

<u>(1) RELEVANCE</u>					
<i>Does the evaluation respond to information needs, in particular as expressed in the terms of references?</i>					
SCORING	Poor	Satisfactory	Good	Very Good	Excellent
				X	
Arguments for scoring: The evaluation corresponds to the needs as expressed in the Terms of Reference though a number of issues have not been fully addressed. Limitations in scope are discussed and justified.					
If relevant: Contextual (such as deficient terms of references) and contractual constraints (such as lack of time, insufficient resources)					

⁵³ Refer to the 'Guide on Scoring the Criteria' for how to assess each criterion

(2) APPROPRIATE DESIGN

Is the design of the evaluation adequate for obtaining the results needed to answer the evaluation questions?

SCORING	Poor	Satisfactory	Good	Very Good	Excellent
				X	

Arguments for scoring: The applied methodology follows the approach set out in the Terms of Reference, and in some cases was more ambitious, even if at the end some of these ambitions were not totally satisfied (public health capacity of MS). The indicators were defined after discussion with all Steering Group members.

If relevant: **Contextual** (unexpected issues) and **contractual constraints** (such as lack of time and resources)

(3) RELIABLE DATA

Are data collected adequate for their intended use and have their reliability been ascertained?

SCORING	Poor	Satisfactory	Good	Very Good	Excellent
			X		

Arguments for scoring: There were a lot of interviews but also data collected via open sources. Tools and data collection limitations are discussed and explained. The combination of qualitative and quantitative data is adequate to strengthening the evaluation. The quality was controlled internally and by the Steering Group.

If relevant: **Contextual** (such as lack of data or access to data base) and **contractual constraints** (such as lack of time and resources)

(4) SOUND ANALYSIS

Are data systematically analysed to answer evaluation questions and cover other information needs in a valid manner?

SCORING	Poor	Satisfactory	Good	Very Good	Excellent
			X		

Arguments for scoring: The analysis uses appropriate quantitative and qualitative techniques suitable to the evaluation context. Cross checking of findings has taken place. The policy context is well taken into account in the analysis and the report reflects an appropriate range of stakeholders consulted. However, the correlation analysis is not in all aspects adequate for the type of data available.

If relevant: **Contextual and contractual constraints** (such as lack of resources and time)

(5) CREDIBLE FINDINGS

Do findings follow logically from and are justified by, the data/information analysis and interpretations based on pre-established criteria and rational?

SCORING	Poor	Satisfactory	Good	Very Good	Excellent
			X		

Arguments for scoring: The evaluation presents a correct sequence. Findings are supported by evidence originating from sound analysis. Generalisations or extrapolations when made are justified. Limitations on validity are pointed out and results of the analysis reflect an acceptable compromise of the perceptions of stakeholders and those described by figures and facts observed and estimated.

If relevant: **Contextual and contractual constraints**

(6) VALID CONCLUSIONS

Are conclusions non-biased and fully based on findings?

SCORING	Poor	Satisfactory	Good	Very Good	Excellent
				X	

Arguments for scoring: The experience of the contractors and their previous work in earlier evaluations of the Strategy and the Health Programme helped the evaluators direct their research and product valid conclusions. Conclusions are coherently and logically substantiated by evaluation findings. They are orderly presented and related. Controversial issues are presented in a fair and balanced manner.

If relevant: **Contextual and contractual constraints**

(7) HELPFUL RECOMENDATIONS

Do areas need improvements identified in coherence with the conclusions? Are the suggested options realistic and impartial?

SCORING	Poor	Satisfactory	Good	Very Good	Excellent
				X	

Arguments for scoring: Recommendations stem logically from conclusions. They are quite clear and focus on improvement very practically and not just theoretically. A certain number of them reiterate earlier ones not yet fully implemented and for this reason judged ex-ante as difficult to put into practice.

If relevant: Contextual and contractual constraints

(8) CLARITY

Is the report well structured, balanced and written in an understandable manner?

SCORING	Poor	Satisfactory	Good	Very Good	Excellent
			X		

Arguments for scoring: The report is professionally written and easy to follow. It is based on the four main blocs of the Programme implementation which are a) the management of the Programme, b) the dissemination practices, c) the impact and d) the synergies with other Programmes and Strategies. All evaluation questions have been answered with various level of satisfaction and the evaluation aspects of relevance, effectiveness, efficiency, Eu added value, etc. have not been neglected.

If relevant: Contextual and contractual constraints

OVERALL ASSESSMENT OF THE FINAL EVALUATION REPORT

Is the overall quality of the report adequate, in particular:

- Does the evaluation fulfil contractual conditions? **YES**
- Are the findings and conclusions of the report reliable, and are there any specific limitations to their validity and completeness? **YES, the specific limitations are explicitly presented in the final report. and discussed with the Steering Group Members.**
- Is the information in the report potentially useful for designing intervention, setting priorities, allocating resources or improving interventions? **YES**

Given the contextual and contractual constraints encountered:

- What lessons can be learned from the evaluation process?

It appears to have been correct to have focused the evaluation on specific issues of the programme instead of applying the traditional questions across the board.

Such a more focused evaluation should have been conducted already at mid-term. This would have helped DG SANTE to make explicit the objectives of the Programme and implement them in a more concrete way using the various financial mechanisms more consciously.

This evaluation should at least be taken into account in implementing the 3rd Health programme and its subsequent calls. It will be available on the web and communicated further in order to make easy to understand and improve all the process when participating in a call from all European partners.

In the meanwhile, an action plan is being elaborated and will strive to put in practice the options for change.