Council of the
European Union

Brussels, 4 April 2017
(OR. en)

7993/17

SAN 138

COVER NOTE

From:	Secretary-General of the European Commission, signed by Mr Jordi AYET PUIGARNAU, Director
date of receipt:	3 April 2017
To:	Mr Jeppe TRANHOLM-MIKKELSEN, Secretary-General of the Council of the European Union
No. Cion doc.:	COM(2017) 149 final
Subject:	REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL Implementation of the third Programme of Community action in the field of health in 2014

Delegations will find attached document COM(2017) 149 final.

Encl.: COM(2017) 149 final

EUROPEAN
COMMISSION

Brussels, 3.4.2017
COM(2017) 149 final

REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL

Implementation of the third Programme of Community action in the field of health in 2014

{SWD(2017) 119 final}

Table of contents

INTRODUCTION

This report presents the implementation of the Third Health Programme in 2014. This was the first year of the implementation of the Third Health Programme established by Regulation (EU) No 282/2014 of the European Parliament and of the Council of 11 March 2014.[1] This Regulation applies from 1 January 2014 for a Programme lasting seven years until 31 December 2020. Under Article 13 of the Regulation, the Commission must report to the Health Programme Committee on the implementation of all actions funded through the Programme, and keep the European Parliament and the Council informed. This report meets that requirement. It provides detailed information on the 2014 budget and how it was spent.

The accompanying Staff Working Document in Annex 1 presents a set of examples of the key multi-annual actions co-funded under the Second Health Programme[2] for which final results became available in 2014. It also describes examples of action funded under the 2014 work programme in ancillary fields such as evaluation and dissemination. Overview tables detailing all activities co-funded and contracts provided can be found in Annexes 2-10.

The Third Health Programme has a total budget of EUR 449 400 000. It has four specific objectives:

1. to promote health, prevent diseases and foster supportive environments for **healthy lifestyles** taking into account the 'health in all policies' principle;
2. to protect Union citizens from serious **cross-border health threats**;
3. to contribute to innovative, efficient and sustainable **health systems**;
4. to facilitate access to **better and safer healthcare** for Union citizens.

The Programme defines progress indicators for each objective. To reach these objectives, the Programme can be implemented using a wide range of funding instruments. These are:

- action co-financed with Member State authorities ('joint actions');
- projects and operating grants to specifically support non-governmental organisations and networks;
- direct agreements with international organisations, public procurement; and
- other actions.

In line with the multi-annual plan drawn up in 2013, the 2014 annual work programme focused on chronic diseases. Hence, several actions to tackle chronic diseases were co-funded in 2014; one is highlighted in this report. The Programme also co-funds initiatives that help implement EU law. This report provides two examples of how the Programme was successful in this area in 2014.

Looking ahead…

[1] OJ L 86, 21.3.2014, p. 1.

[2] OJ L 301, 20.11.2007, p. 3.

In this first year of the Third Health Programme a number of important initiatives, including eight joint actions, were supported and started thanks to Programme co-funding. In line with the conclusions from the ex post evaluation of the Second Health Programme, the Commission ensures that the implementation of the Third Health Programme is closely monitored and that results are publicised more widely. The Commission further continues to encourage and foster the participation of all Member States and countries participating in the Programme and seek synergies with other EU funding programmes.

ACTION OF THE YEAR — THEMATIC FOCUS OF 2014: CHRONIC DISEASES

The priority health topic for the 2014 annual work programme was chronic diseases. Overall, three calls for proposals for projects on different aspects of chronic disease prevention and management were launched, resulting in five co-funded projects. A joint action on nutrition and physical activity and another one on dementia were concluded, as were six projects in the area of active and healthy ageing. The PATHWAYS project described below is a good example. It addresses the important issue of the participation of chronic disease patients in the work force. This is fully in line with the Commission's agenda on jobs and growth.

1.1 PATHWAYS Project — Participation to healthy workplaces and inclusive strategies in the work sector

1.1.1 Background

PATHWAYS — Participation to healthy workplaces and inclusive strategies in the work sector was one of the projects co-funded in 2014 as part of the focus that year on chronic diseases. PATHWAYS started in summer 2015, will run for 36 months and will receive up to EUR 969 379.00 in co-funding. It involves 12 partners from 10 different European countries (Austria, Belgium, the Czech Republic, Germany, Greece, Italy, Norway, Poland, Slovenia and Spain), all of whom have vast expertise in the area of chronic and mental conditions and employment.

1.1.2 Brief description

People with chronic diseases and mental disorders often experience work-related problems, such as unemployment, absenteeism, reduced productivity and stigmatisation in the workplace. The rising prevalence of chronic diseases and mental disorders against budget austerity requires innovative strategies to help these people participate in the labour market.

However, we lack knowledge about available strategies and whether they are effective. We must also clarify the employment-related needs of people with chronic diseases and mental disorders. Hence, in response, PATHWAYS will identify integration and reintegration strategies that are available in Europe and beyond and determine their effectiveness. It will further assess the specific employment-related needs of people with chronic diseases and mental disorders. Lastly, it will develop guidelines to support the implementation of effective professional integration and reintegration strategies. Stakeholder consultations will be one method used.

1.1.3 Expected results

PATHWAYS will provide a series of reports, including:

- one comparing the available strategies based on the five categories of social welfare and healthcare models in Europe; and
- one on unmet employment needs in people with chronic diseases, including recommendations on how to tackle them.

A database will compile the available evidence on the effectiveness of existing integration and reintegration into work strategies for people with chronic conditions, and the evidence will be described in a scoping paper.

Lastly, PATHWAYS will conclude with policy recommendations to implement inclusive strategies towards a more inclusive labour market in which people with chronic diseases and mental disorders can participate meaningfully.

INITIATIVES THAT DIRECTLY CONTRIBUTE TO IMPLEMENTING EU LAW

The Health Programme funds services provided by external contractors that support the Commission in implementing decisions and directives in the field of health. Below one example of such services that were carried out in 2014.

1.2 Request for service — implementation of the Cross-border Healthcare Directive 2011/24/EU

1.2.1 Background description

This study considered the effects of the Cross-border Healthcare Directive 2011/24/EU[3]. Its overall objective was to report on Member States' implementation of the Directive, as required under Article 20(1), and identify gaps and potential for improvement. The study drew on the situation on the ground and other valuable external sources. These services were provided through a service contract with KPMG Advisory N.V., Technopolis Group and Empirica GmbH, under the framework contract SANCO/2012/02/011 — Lot 1. The contract ran from 21 July 2014 to 21 March 2015 at a cost of EUR 179 026.

1.2.2 Brief description

In addition to desk research and a literature review, a detailed website review and widely used participatory research methods were used. Building on previous research efforts, all the websites of the 32 national contact points for cross-border healthcare (NCPs) were analysed (32 countries or territories as Scotland, Wales, England, Northern Ireland and Gibraltar were included separately for the UK).

[3] OJ L 88, 4.4.2011, p.45

The ‘pseudo-patient’ research method was used to take account of the ‘end-user’ perspective. The evaluators approached NCPs in 12 Member States (Austria, Belgium, France, Germany, Hungary, Italy, Lithuania, Malta, the Netherlands, Slovenia, Spain and Sweden) by both email and telephone using three different pre-designed scenarios.

Subjective, opinion-based data were also collected in the focus countries and at European level via 59 stakeholder interviews and an online survey addressed to the NCPs in the focus countries. Some 50 % of stakeholders contacted agreed to be interviewed over the four-week period. They represented a range of health insurance providers, healthcare providers, patient ombudsmen, national and regional authorities, patient groups, audit bodies, trade unions and frontline healthcare prescriber organisations. All NCPs completed at least a part of the online survey. A Strength-Weakness-Opportunities-Threats (SWOT) analysis focusing on the services provided to the patients complements the conclusions of the study.

1.3.3 Specific results

This study is part of ongoing work to build a zero baseline as a starting point for measuring and assessing cross-border healthcare in the Union. As a general finding, all the stakeholders involved confirmed that the number of patients having made use of cross-border healthcare under the Directive is low.

This study delivers a meaningful, albeit qualitative contribution to the baseline assessment and to future evaluation efforts, in line with the ‘evaluate first’ principle. The study findings were published in May 2015 on the European Commission’s website and were presented at the NCPs’ meeting organised by the European Commission on 2 December 2015, where they were met with great interest. It is hoped that the methodological avenues of the study will be explored further by interested stakeholders and by the wider research community.

This study is, however, not a formal evaluation. Complaints, infringements and transposition measures were not part of its remit. Given the recent adoption of the Directive and the scarcity of readily available data on patient mobility, a formal evaluation of the Directive would have been premature.

BUDGET IMPLEMENTATION

1.3 Budget

The budget for the Third Health Programme 2014-2020 is EUR 449.4 million. This includes EUR 33.48 million for the functioning of the Consumer, Health, Food and Agriculture Executive Agency (Chafea) which the Commission has asked to manage the Health Programme 2014-2020. Chafea has been providing the Commission with technical, scientific and administrative assistance in implementing the Health Programme since 2005.[4] It

[4] Decision 2004/858/EC of 15 December 2004 (OJ L 369, 16.12.2004, p. 73) amended by Decision 2008/544/EC of 20 June 2008 (OJ L 173, 3.7.2008, p. 27).

organises annual calls for proposals, coordinates the evaluation of submissions, and negotiates, signs and manages related grant agreements. It is also responsible for many procurement procedures.

The budget set out in the work plan for 2014[5] was EUR 58 579 000, broken down as follows:

- operational expenditure: EUR 52 870 000, corresponding to budget line 17 03 01 *Encouraging innovation in healthcare and increasing the sustainability of health systems, improving the health of the Union citizens and protecting them from cross-border health threats*;
- administrative expenditure: EUR 1 500 000 — corresponding to budget line 17 01 04 02 — support expenditure for Health for Growth programme.[6]

The total operational budget – including in addition EFTA/EEA credits and recovery credits from previous budget years - was EUR 54 856 308.05 and the total administrative budget was EUR 1 547 747.69.

In 2014, Chafea managed EUR 44 541 244.83 of this budget, while the Commission managed EUR 9 409 832.88 covering procurement, direct grants and other measures.

1.4 Priorities for 2014 and financing mechanisms

The priorities for 2014 were set out in Commission Implementing Decision C (2014) 3383 of 26 May 2014 concerning the adoption of the 2014 work programme and related criteria.[7]

Several financing mechanisms were used to implement the work plan for 2014. These are described in detail below.

Competitive selection and award procedures were used to select initiatives for funding. Competitive selection and award procedures are not used for joint actions, direct grant agreements and conferences organised by Council presidencies because in those cases competitive procedures are either not allowed under the specific rules or are not used in practice, for example due to a monopoly situation.

Administrative credits covered expenditure such as studies, meetings of experts, information and publication costs, and technical and administrative assistance for IT systems.

[5] Commission Decision C(2014) 3383 of 26.5.2014, http://ec.europa.eu/health/programme/events/adoption_workplan_2014_en.htm.

[6] The name originally proposed for the Third Health Programme was 'Health for Growth' Programme: hence, the name of the budget line. As this name was not retained, the budget line has been re-named for the work programme 2016.

[7] http://ec.europa.eu/health/programme/events/adoption_workplan_2014_en.htm.

1.5 Implementation of the operational budget by financing mechanism

Type of financing mechanism	Implementation (EUR)	Share of mechanism in total executed budget
Calls for proposals	**17 393 292.88**	**31.7**
Project grants	12 677 193.08	23.1
Operating grants	4 716 099.80	8.
Grants for joint actions	**18 506 972.39**	**33.7**
Conference grants to the Member States holding the presidency of the EU	**157 901.00**	**0.**
Direct grant agreements	**3 849 825.96**	
Managed by CHAFEA	**2 700 000.00**	
Managed by DG SANTE	**1 149 825.96**	
Procurement (service contracts)	**12 769 292.44**	**23.3**
Managed by CHAFEA	5 283 078.56	9.
Managed by DG SANTE	7 486 213.88	13.6
Other actions	**1 273 793.04**	**2.**
Managed by CHAFEA	500 000.00	
Managed by DG SANTE	773 793.04	
Budget spent in 2014	**53 951 077.71**	
Total available budget	**54 856 307.05**	
Credits not used[8]		
by CHAFEA	711 310.68	
by DG SANTE	193 918.66	
Budget spent	**98.3 %**	

By way of comparison, the table below shows the percentage of the available budget spent per financial mechanism on average in the Second Health Programme and in 2014. While a lower

[8] Pre-accession credits not yet used, differences between amounts in the award decision and amounts actually contracted.

proportion was spent on projects in 2014, more was spent on joint actions. The percentages are similar for other financial tools.

Type of financing mechanism	**Share of mechanism in total executed budget in 2014**	**Share of mechanism in total executed budget in Second Health Programme**
Project grants	23.1 %	36 %
Operating grants	8.5 %	7 %
Grants for joint actions	33.7 %	22 %
Direct grant agreements	4.9 %	7 %
Procurement (service contracts)	23.0 %	25 %
Other actions	2.3 %	4 %

Calls for proposals

Calls for proposals — for projects and operating grants actions —were launched on 6 June 2014 on the Participant Portal of the Horizon 2020 Programme,[9] the public health website on EUROPA[10] and on Chafea's website.[11] Most applications were received from main partners in EU-15 Member States, who accounted for 86 % of project applications, 100 % of operating grant applications, and 100 % of joint action applications. 41 % of all partners in the joint actions are from EU-13 countries, as are 16 % of the project partners.

Chafea organised a joint action workshop in October 2014 and a joint action quality assurance workshop in February 2015. The National Focal Points for the Health Programme also organised national information days in BG, HR, CZ, EL, HU, IE, IT, LT, NL, NO, PL, PT, RO, SK, ES and UK. Guidelines for applicants were made available on the Participant Portal. The Chafea helpdesk also provided assistance and practical help.

Altogether, 50 proposals for projects and 40 operating grant proposals were received for an amount totalling EUR 42 887 771. Applications were evaluated in accordance with the rules and criteria set out in Commission Implementing Decision C (2014) 3383 and the calls for proposals. 37 external experts from 18 countries took part in the evaluation process. The

9

http://ec.europa.eu/research/participants/portal/desktop/en/opportunities/3hp/index.html#c,calls=hasForthcomingTopics/t/true/0/1/0&hasOpenTopics/t/true/0/1/0&allClosedTopics/t/true/1/1/0&+PublicationDate/desc

10 http://ec.europa.eu/health/programme/policy/index_en.html.

11 http://ec.europa.eu/chafea/health/index.html.

experts were drawn from a list established following a call for expressions of interest entitled 'call for expressions of interest in the area of public health'.[12]

The evaluation process took place in two stages.

In the **first stage**, three external evaluators reviewed each proposal. A consolidated evaluation report for each proposal was drawn up at a meeting organised by Chafea.

In the **second stage**, the evaluation committee checked that the evaluators had complied with the relevant rules and criteria. It then drew up final lists of proposals recommended for funding, together with reserve lists. The evaluation committee comprised representatives from the Directorate-General for Health and Food Safety (DG SANTE), the Directorate-General for Research and Innovation and from Chafea. The award decision for projects[13] and operating grants[14] were taken by Chafea.

1.5.1 Project grants

Project grants were awarded to actions involving several partners, usually public health bodies and non-governmental organisations. The maximum EU contribution is 60 % of eligible costs. However, the EU contribution may go up to 80 % if a proposal meets the criteria for exceptional utility. In 2014, two projects qualified for exceptional utility.

In all, 50 proposals were submitted in response to the call for proposals for projects. Six proposals were excluded in the screening phase. Out of the remaining 44 proposals 12 were recommended for funding and four were placed on a reserve list. In the end, 13 projects were funded for a total of EUR 11 567 617. Their distribution among the programme objectives was as follows:

1. health promotion: EUR 3 535 947 (5 projects);
2. health threats: no projects funded;
3. health systems: EUR 8 031 670 (7 projects);
4. better and safer healthcare: no projects funded.

The annex lists all projects funded.

[12] OJ S 040-065407, 26.2. 2014 and http://ec.europa.eu/chafea/ami/.

[13] http://ec.europa.eu/chafea/documents/health/list-projects-2014_en.pdf.

[14] http://ec.europa.eu/chafea/documents/health/award-fpa-agreements-2014_en.pdf and http://ec.europa.eu/chafea/documents/health/specific-grant-agreements-2014_en.pdf.

1.5.2 Operating grants

Operating grants were awarded to non-profit organisations or networks that are:

- non-governmental;
- non-profit-making and independent of industry, commercial and business or other conflicting interests;
- working in the public health area;
- play an effective role in civil dialogue processes at Union level;
- pursue at least one of the specific objectives of the Programme;
- active at Union level and in at least half of the Member States; and
- have a balanced geographical coverage of the Union.

The maximum EU contribution is 60 % of their annual operating costs. However, the EU contribution may increase to 80 % if a proposal meets the criteria for exceptional utility. In 2014, only four operating grants qualified for exceptional utility.

With the start of the Third Health Programme, Chafea introduced the call for multi-annual 'framework partnership' instrument. The holders of three-year framework partnership agreements can then apply for annual co-funding. A total of 40 proposals were submitted in response to the call for proposals for operating grants. Of these, 14 were awarded a framework partnership agreement (35 % of the proposals received). All of them received an annual operating grant for 2015. The total co-funded was EUR 4 716 099.80

The annex lists all operating grants funded.

1.5.3 Joint actions

Grants for joint actions were awarded to competent authorities or public sector bodies and non-governmental bodies mandated by those competent authorities. The maximum EU contribution is 60 %. However, the EU contribution may go up to 80 % if a proposal meets the criteria for exceptional utility. In 2014, only two joint actions qualified for exceptional utility.

The procedure for joint actions under the Third Health Programme has changed. In order to assure more transparency and inclusiveness, the Member States and countries participating in the Third Health Programme now nominate the competent authorities or other bodies as a first step. Then, those nominated are invited to submit a proposal under the direct grant procedure.

Eight joint actions were co-funded for a total of EUR 18 506 972.39. They were distributed among the programme objectives as follows:

1. health promotion: EUR 5 698 457.39 (three joint actions);
2. health threats: EUR 3 499 873.00 (one joint action);
3. health systems: EUR 2 599 999.00 (two joint actions);

4. better and safer healthcare: EUR 6 708 643.00 (two joint actions).

These joint actions each involved between 10 and 24 Member States and other countries taking part in the programme; involving on average 19 per joint action.

The health topics covered by the joint actions are:

- unbalanced dietary habits and physical inactivity;
- improvement of HIV and co-infection prevention and treatment in priority regions and priority groups in the European Union;
- coordinated action to improve the situation and career of people with dementia;
- highly dangerous and emerging pathogens;
- technical and scientific cooperation on medical devices and in vitro diagnostic medical devices;
- support for the eHealth Network;
- implementation of the Council Recommendation and Commission Communication on Rare Diseases[15]; and
- monitoring and control in the field of blood transfusion and tissue and cell transplantation.

The annex lists all the joint actions funded.

1.6 Direct grant agreements with international organisations

Direct grant agreements with international organisations were awarded to international organisations active in the area of public health. The direct grants also include service-level agreements. The maximum EU contribution is 60 %.

All in all, seven direct grant agreements were signed, for a total of EUR 3 849 825.96 as follows:

Four were signed by Chafea, namely:

1) the contribution agreement with the Council of Europe for the integration of EU legislation on substances of human origin (EUR 500 000);
2) the annual direct grant agreement with the European Pharmacopoeia (EUR 1 100 000);
3) two direct grant agreements with the World Health Organisation:
    - monitoring of the national policies related to nutrition, physical inactivity, overweight and obesity (EUR 600 000); and
    - monitoring of the national policies related to alcohol consumption and harm reduction (EUR 500 000).

[15] http://ec.europa.eu/health/ph_threats/non_com/docs/rare_com_en.pdf

Three were signed by DG SANTE, namely:

1) two direct grants (cross sub-delegation/service-level agreement) to Eurostat regarding morbidity statistics for a total of EUR 1 099 825.96; and
2) one direct grant to the Pharmaceutical Inspection Cooperation Scheme for training in the area of active pharmaceutical ingredients for EUR 50 000.

The annex lists all direct grant agreements that were funded.

1.7 Procurements (service contracts)

Procurement (service contracts) was used to purchase services. The Programme fully covers the cost of procurement.

These service contracts cover needs as specified in the work plan for 2014:

- evaluation and monitoring of actions and policies;
- studies;
- advice;
- data and information on health;
- scientific and technical assistance;
- communication;
- dissemination;
- awareness-raising activities; and
- IT applications to support policies.

In 2014, DG SANTE signed several service contracts and specific requests using existing framework contracts. Most of these contracts and requests were for horizontal actions such as communication and IT services for maintenance and functioning of existing IT tools (i.e. the EMP database, EUDAMED, Health Policy Platform, etc.). Procurement contracts also included contracts with experts working for the scientific committees and evaluation and monitoring studies. The overall public procurement budget managed by DG SANTE amounted to EUR 7 486 213.88.

In 2014, Chafea managed 22 new market procedures for the acquisition of services (four contracts under health promotion, four contracts under health threats, six contracts under health systems, five under better and safer health care) and three on horizontal communication for a total of EUR 5 283 078.56.

The amounts per objective and authorising organisation were as follows:

Health Programme objective	Procurement managed by DG SANTE (EUR)	Procurement managed by Chafea (EUR)
Health promotion	1 353 200.72	1 280 967.00
Health threats	0	1 802 209.40
Health systems	1 327 335.79	864 927.50

Better and safer healthcare	733 684.35	1 213 163.00
Horizontal	4 071 993.02	121 811.66
TOTAL	8 260 006.92	5 283 078.56

The annex lists all service contracts signed.

1.8 Other actions

EUR 2 184 000 was earmarked for other actions in 2014. The 'other actions' include experts' fees, for example:

- the expert panel on effective ways of investing in health;
- for experts carrying out system inspection on pharmaceutical ingredients;
- for experts participating in the international conferences on the harmonisation of technical requirements for the registration of pharmaceuticals for human and veterinary uses.

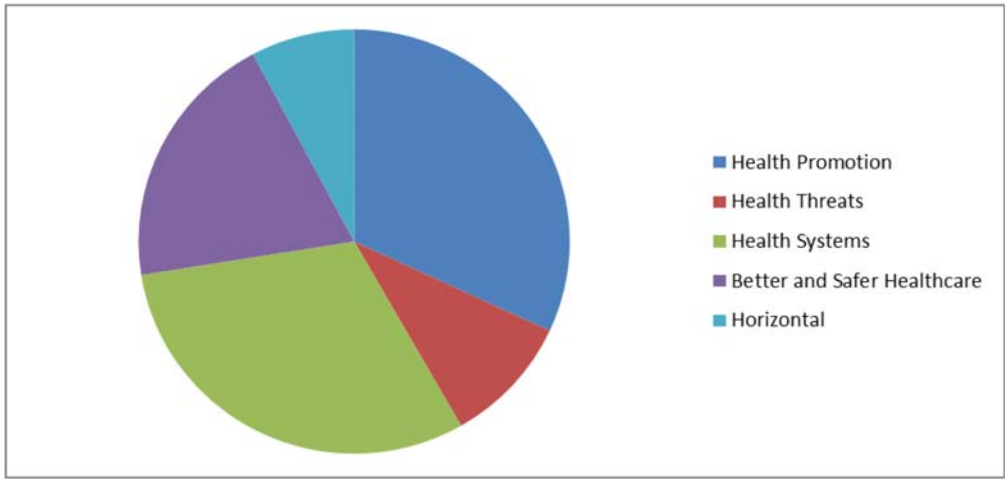
This also includes cost of administrative agreements with the Joint Research Centre and covers the Commission's membership fee to the European Observatory on Health Systems and Policies. For more information on what specific actions fell under the banner 'other actions', please refer to the annex.

1.9 Budget consumption in 2014

All in all, the total operational budget for 2014 was divided among the four specific objectives of the Third Health Programme as follows:

1. health promotion: EUR 16 113 811.99 (30.6 % of the operational budget in 2014);
2. health threats: EUR 5 302 082.40 (10.1 % of the operational budget in 2014);
3. health systems: EUR 16 537 850.33 (31.4 % of the operational budget in 2014);
4. better and safer healthcare: EUR 10 653 702.35 (20.2 % of the operational budget in 2014);
5. horizontal activities (IT, communication): EUR 4 193 804.68 (7.8 % of the operational budget in 2014).

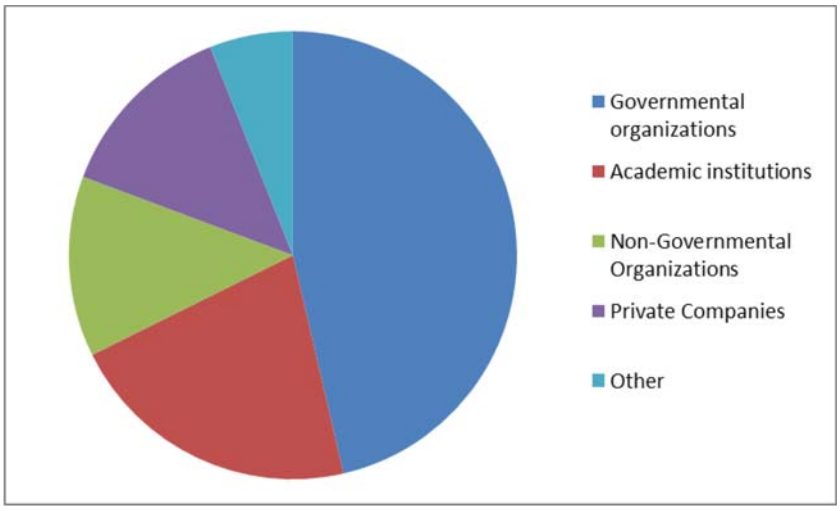
Chart 1 — Operational budget use in 2014 by Third Health Programme objective



1.10 Type of beneficiaries

In 2014, nearly 400[16] different grants and contracts were signed with diverse beneficiaries and service providers ranging from governmental and non-governmental organisations to academic institutions and private companies. The category 'other' includes beneficiaries such as health care providers and international organisations. Chart 2 provides an overview of the different groups of beneficiaries.

Chart 2 — types of beneficiaries of the Third Health Programme in 2014



[16] This excludes contracts made with single experts e.g. those participating in the Scientific Committees.

CONCLUSION

2014 was the first year of the Third Health Programme, which was adopted by European Parliament and Council on 11 March 2014. Consequently, the annual work programme was adopted two months later on 26 May 2014 and thus the whole implementation cycle was also delayed. Thus, most of the grant agreements and several service contracts were signed in the first trimester of 2015. The Third Health Programme Regulation makes some significant improvements compared to the Second Health Programme. These include:

- specific objectives with related indicators;
- a clear definition of 'EU added value'; and
- introducing criteria to define 'exceptional utility' for joint actions.

This meant, for example, that applicants and evaluators were better guided by the definition of 'EU added value' and it was easier for joint action consortia to develop the proposal in such a way that it would qualify for exceptional utility, i.e. 80 % co-funding.

There were also several positive changes as regards the implementation of the Third Health Programme. These included the introduction of online submissions via the Participant Portal; and online evaluation and electronic signature of the grant agreements. The Regulation also introduced simplified administrative procedures and direct grant agreements for joint actions and framework partnership agreements for operating grant holders to enable the recipients of these grants to carry out longer-term planning.

The new procedure for joint actions is also more transparent because as a first step the consortium needs to be established through nominations by Member States/countries participating in the Third Health Programme. However, this means that EU umbrella non-governmental organisations in particular face the challenge of being nominated, whereas during the Second Health Programme they were nominated by the Commission.

The number of participants in joint actions continues to be relatively high, as already seen in the Second Health Programme: on average 25 participants per joint action in 2014 — ranging from 12 to 39. This is a challenge for the overall management and coordination of the joint actions. When looking at the calls for proposal for projects, it can be observed that for two calls no project has been awarded. In one case this was because no applications were received, possibly because the theme was defined rather narrowly and the co-funding proposed relatively low. In the second case several proposal were received, but all were excluded in the evaluation due to insufficient quality.

Following the recommendations of the ex post evaluation, further improvements are due to be implemented in the coming years, including an enhanced electronic monitoring and reporting system, better and more targeted dissemination and continued efforts to increase the participation of organisations and institutions from those countries which, until now, have been under-represented among the beneficiaries.