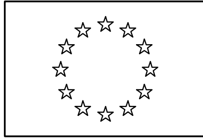

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Together for Health:
A Strategic Approach for the EU 2008-2013

Impact Assessment

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EXECUTIVE SUMMARY

This Impact Assessment considers the need for and potential impact of a new European Community Health Strategy. The strategy would aim to take a new approach to key health challenges by putting in place a strategic framework with clear objectives, setting the direction of travel for the coming years.

The EU has a clear role to play in health. Working towards the EU's fundamental mission, to enable free movement of people, goods and services, and to cooperate on cross-border issues, requires the consideration of health issues. From common standards for health-related products to ensuring healthcare for travellers, the EU has a role to play, while at the same time respecting the subsidiarity principle. In some cases, such as coordination for pandemic preparedness, the EU's role is clearly indispensable. In other cases, the EU is able to add value to actions at national level by means such as facilitating the sharing of best practice, developing networks, and funding projects. Much valuable work has been done in the field of health at EU level, not only in the health sector but in many other sectors such as research, regional policy, enterprise, employment and environment. However, there are growing calls for more health action at EU level. As the Union has enlarged since 2004, health gaps have widened. Threats from communicable and non-communicable disease continue, alongside globalisation and increasing concern about the future sustainability of health systems, particularly given the predicted ageing of the population. A new strategic approach to EU health policy is needed to address these challenges.

This IA does not examine a list of specific actions to take on health. Rather, it looks at options for a strategic framework that will set the direction of travel for work on health across the European Community for the next ten years. The objectives comprise both governance and health objectives. In terms of governance, the strategy aims to develop and put in place strategic objectives, increase Health In All Policies cooperation and improve the visibility of work on health at EU level. In terms of health objectives, four key areas are identified, fostering healthy lifestyles and reducing inequities in health, tackling threats to health, supporting sustainable health systems and strengthening the EU's voice in global health. These broad objectives will be achieved through the continuation of current action and through new actions at EU, national and local level, supported by an appropriate implementation mechanism to drive real change.

The policy options considered were firstly to continue as present, without a new Health Strategy. Options 2-4 consider different methods for putting a strategy in place. These options set out cumulative levels of action in relation to such a Strategy. Option 2 describes a Strategy with increased intersectoral action at the EU level only, Option 3 adds to this Structured Cooperation with Member States and Stakeholders, and Option 4 adds legislation for Binding Targets.

Option 3 was identified as the preferred option because it allows for ownership and engagement on the Strategy by Member States and Stakeholders, but is a proportionate approach. Through a Structured Cooperation mechanism, Member States would agree indicators through which to measure the broad objectives set out in the Strategy. These indicators would be expected to be taken from the existing indicators used at EU level to prevent imposing an additional burden on Member States. The Structured Cooperation mechanism would then lead work towards the achievement of the objectives alongside a renewed focus on health across all sectors and working with all partners.

1. PROCEDURAL ISSUES AND CONSULTATION OF INTERESTED PARTIES

1.1. Organisation and Timing

A White Paper on Health Strategy was included as a strategic initiative in the Commission's Legislative Work Programme for 2007[1], with DG SANCO as the lead Directorate General. Work on the Impact Assessment began after the completion of the Roadmap in late October 2006, and was finished ahead of Interservice Consultation in **July 2007**.

The Impact Assessment Board was consulted on 16 May 2007. The Board's recommendations reflected the challenges of producing an Impact Assessment for a broad, overarching strategy spanning multiple different elements, where the impact of each individual action cannot be analysed. The main recommendations of the Board were that the internal logic of the IA should be clarified, that the added value of action at EU level should be more clearly brought out, that the analysis of options section should focus more clearly on economic, social and environmental impacts, and that justification for the 10 year time-span of the strategy should be included. Following the recommendations of the Board, a structure based on the set of seven 'health' and 'governance' objectives of the IA was developed, to run throughout the document, simplifying the presentation of the issue and clarifying the areas where added value was achievable. The analysis of environmental, social and economic impacts was more clearly defined in the analysis section, and a paragraph was added more clearly explaining the reasoning behind the 10 year timescale. The second opinion of the Board recognised the improvements made. Suggestions to further enhance the IA included a stronger focus on the shortcomings of current activities and more detailed objectives. As, in most areas, the Strategy aims to build on effective current work, only minor changes were made in relation to the first point. In relation to the second point, the aim is that the Commission and Member States should work together to develop precise objectives, so they will not be fully defined at this stage. However, some priorities in the areas of demographic change, climate change, and new technologies have been suggested in the text.

An Interservice steering group was set up for the Strategy and met on 17 November 2006, 31 January 2007, and 27 March 2007. DGs participating were AGRI, AIDCO, COMP, DEV, EAC, ECFIN, ECHO, ELARG, EMPL, ENTR, ENVI, EUROSTAT, INFSO, JLS, JRC, MARKT, REGIO, RELEX, RTD, SG, SJ, TAXUD, and TRADE. As well as offering input into the development of this Impact Assessment, the group members contributed to a mapping exercise on their work on health, which will be included as an Annex to the White Paper.

1.2. Consultation Processes

In late 2004, the Commission consulted stakeholders on what future action the EU should take in the field of health through the initiative ‘Enabling Good Health for All – A Reflection Process for a new EU Health Strategy’. The reflection process generated a broad debate amongst stakeholders, national and regional authorities, NGOs, universities, individual citizens and the private sector[2].

On 11 December 2006 a Discussion Document was released to enable stakeholders to comment further on plans for a new Health Strategy, this time with a focus on objective-setting and implementation mechanisms. This process ended on 12 February 2007.

[1] COM(2006) 629, item 11, p. 15.

[2] http://ec.europa.eu/health/ph_overview/strategy/reflection_process_en.htm

Members of the High Level Committee on Public Health (all Member States) also received a supplementary questionnaire requesting their views on objective-setting and implementation mechanisms in relation to developing a new Health Strategy. Responses were received from 12 of the 27 Member States.

Comments from all consultation processes have been reflected in this Impact Assessment. Regarding the consultation process, the requirements of the Commission's minimum standards for consultation have been respected[3].

1.3. Consultation Meetings

Alongside the two processes described above, consultation took place through a wide range of meetings. Annex 1 sets out a list of consultation meetings that took place between October 2006 and March 2007. This list includes consultation with Member States, in particular at the biannual High Level Committee on Public Health in October 2006, and also with regional groups. It includes consultation with other Commission services, including 3 meetings of the Interservice Steering Group (see above), as well as bilaterals with services with a particular interest in health, including INFSO, EMPL, ENTR, RTD, REGIO, MARKT and EUROSTAT. Meetings were held with NGOs, in particular the Health Policy Forum which meets regularly and has a membership of 49 health-related NGOs. Meetings were also held with a wide range of experts and other stakeholders, including industry representatives and three meetings with a small discussion group of health strategy experts.

1.4. Consultation Results

193 responses were received to the 2004 reflection process, including 12 Member States. Key outcomes[4] were that stakeholders want a comprehensive approach to health that mainstreams health concerns into all Community policies; that they see a need to bridge inequalities in health across the EU; that the EU should take a much stronger role in global health; that the EU should focus on health promotion; that it should tackle key issues such as mental health and cross-border matters, and that the EU, its Member States and stakeholders should work together to deliver concrete results. This input has formed the basis of the proposed Strategy as set out in section 2.

156 responses were received for the 2006-2007 consultation process, including 16 Member States. Key outcomes[5] were general support for a new overarching, strategic and coherent framework for health policy in the coming decade. The vast majority supported the three broad priorities proposed by the Commission: working on core issues, ensuring health considerations in all policies and engaging global considerations. The respondents advised that policy coherence should be ensured through an enhanced use of health Impact Assessment and that European as well as national administrations should ensure internal coordination in their activities impacting on health.

There was broad support for enhancing European cooperation in a number of fields including health threats, reducing inequalities in health, health information and promotion of healthy

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[3] COM(2004) 704 - http://ec.europa.eu/civil_society/consultation_standards/index_en.htm

[4] See http://ec.europa.eu/health/ph_overview/strategy/reflection_process_en.htm for full text of responses and consultation report.

[5] See http://s-sanco-wcm/health/ph_overview/strategy/results_consultation_en.htm for full text of responses and consultation report.

lifestyles. Respondents from all level stressed the need for the development of a European health information system with an open access to comparable data.

In terms of implementation mechanisms, there was broad support for the establishment of a Structured Cooperation mechanism, similar to the Open Method of Coordination which was developed to measure the progress towards Lisbon goals. In parallel, alternative approaches were proposed, including development of legislation or enhancement of existing structures with centralised expertise. Finally, it was highlighted that the success of the strategy would also be linked to the sense of ownership at local, regional and national level. To that end, action plans at European and National level were recommended by respondents with the establishment of a regular reporting system and a mid term review.

Key outcomes of the consultation meetings have also been fed into this paper[6].

2. PROBLEM DEFINITION

INTRODUCTION

This document is an assessment of the potential impact of the proposed White Paper 'Together for Health: A Strategic Approach for the EU 2008-17', a new Community Strategy which aims to bring together all sectors in working towards common health objectives. Developing a useful Impact Assessment for something as broad as an overarching Strategy is a challenge. It is not possible to evaluate the impact of individual actions, and the link between strategic actions and concrete results is very difficult to quantify. This Impact Assessment therefore sets out a broad-ranging 'problem definition' section (Section 1) looking at current health challenges, good governance challenges, and conducting a subsidiarity test. The 'policy options' and 'analysis of impacts' sections (Section 3 and 4) estimate, in broad terms, the impact of a number of different methods of putting in place a Community strategic framework for health.

Health is important for individuals and for society. People expect to be protected against illness and disease. They want to bring up their children in a healthy environment, and demand that their workplace is safe and hygienic. They need access to reliable and high-quality health services. At the same time, improving the health and well-being of European citizens is also important for the European Union. The EU's core aims to enable free movement of people, goods and services, and cooperation on cross-border issues, means that work at EU level has always had, and will continue to have a health dimension, at the same time as the subsidiarity principle is respected. From the movement of health products to providing a safe environment, from ensuring the production and processing of safe and nutritious food, to responding to people's need for healthcare when travelling, it is impossible to avoid health in policy at the EU level. The importance of health for the EU has been reaffirmed by the agreement at the European Council meeting of 21-22 June 2007 on the framework for a Reform Treaty, which proposes to reinforce health as a major focus of the EU's work.

[6] In the text, 'Consultation' refers to the 2006-7 consultation, while 'reflection process consultation' refers to the earlier 2004 consultation

The achievement of the Commission's strategic objectives of Prosperity, Solidarity, Security and Europe in the World is clearly linked to health. In terms of **security**, EU action on cross-border health threats from communicable diseases such as avian flu, and on bioterrorism continues to be vital. In relation to **solidarity**, reducing inequities across the enlarged EU in terms of life expectancy, health status and provision of high-quality health services is part of achieving the goal of a more cohesive Europe. In relation to **prosperity**, population health is a key factor for productivity and growth, and this is reflected in the inclusion of the Healthy Life Years indicator as a Lisbon agenda indicator[7] and in relation to **Europe in the world,** the EU has an important role in international health governance as well as in terms of trade in health products and responses to humanitarian crises and development aid.

Table 1: Key Health Challenges and Objectives linked to current Commission Objectives

Key Health Challenges	Key Health Objectives	Commission Objectives
Communicable disease e.g. Pandemic, bioterrorism	Increase Capacity to Tackle Health Threats	Security
Enlarged EU with 27 Member States – Wider Health Gaps	Promote Health and Reduce Health Inequities	Solidarity
Population Ageing, Rise of new Technologies	Increase Sustainability of Health Systems	Prosperity
Consequences of Globalisation	Improve EU Effectiveness on the Global Stage	Europe in the World

Much has been achieved in health policy at the EU level in a range of areas, based on different parts of the Treaty, for example in health and safety at work, pharmaceuticals, public health, food safety, research and environment. Following the introduction of specific public health provisions into the EU Treaty[8], in the 1990s the EU worked on several 'sectoral' health programmes, looking at individual issues such as cancer, communicable diseases, rare diseases and health promotion. In 2000 the Commission adopted a first public health strategy[9] which gave rise to the Public Health Programme (2003-2008), setting out a framework for action on health determinants, health threats, information and monitoring within the health sector at EU level.

However, the EU is now facing **new challenges**, which require a new approach. Europe is changing as globalisation continues and innovative technologies are developed every day. The ageing population is changing disease patterns and putting pressure on health systems, new disease threats such as avian flu and the risk of bioterrorist attacks are emerging. Lifestyle-related illness, particularly linked to obesity and smoking, are a major part of the disease

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7 See Annex 4 for further information about the relationship of health to the economy.

8 Initially in Article 129 of the Maastricht Treaty and then in a strengthened form in Article 152 of the Treaty of Amsterdam.

9 Proposal for a Decision of the European Parliament and of the Council adopting a Programme of Community Action in the Field of Public Health (2001-2006) - COM(2000) 285.

burden. Table 1 shows some of the key health challenges facing the EU, linked the Commission's overarching objectives, and to key health objectives. A new strategy will aim to maximise the EU's ability to tackle these health challenges, while supporting the Commission's broader objectives.

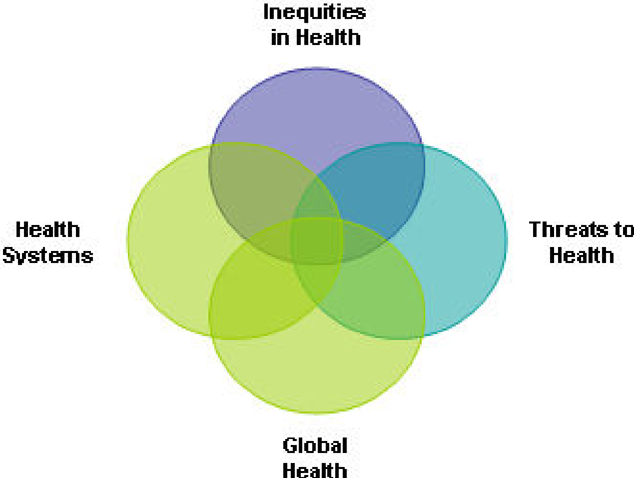
In order to address these increasing health challenges, the Strategy aims to advance good governance methods, by putting an overarching strategic framework in place with effective objectives and an implementation mechanism, building Health In All Policies cooperation, and increasing visibility and understanding about health at EU level.

The proposed Strategy would set out a first stage to 2013, the end of the current financial perspectives, when an evaluation will take place to support the definition of further work towards strategic objectives.

2.1. Changing Health Challenges

The EU is currently facing new challenges. Four key health challenges for the EU, which relate to the Commission's objectives of prosperity, security, solidarity and Europe in the world, are the increased health inequities caused by EU enlargement, current and emerging threats to health, the challenge of supporting sustainable health systems, and the opportunity to increase EU activity in the field of global health. Within the scope of this document it is impossible to describe all the actions that are currently undertaken or will be undertaken in the future. Therefore a short introduction to key concerns is included, describing the added value of current and future EU action in that area. The overall subsidiarity test addressing the necessity and added-value of EU policies in the area of health is then summarized in section 2.3.

These four areas are not discrete but overlap with one another. For example, tackling *inequities* means reducing inequities in access to *health systems* and in treatment of disease. Increasing the focus on *global health* means recognising the global element in all areas of health, e.g. the employment of health professionals, which is an issue for sustainable *health systems*, and tackling *health threats* like communicable disease. Setting objectives in these areas would therefore provide a dynamic and inclusive framework for focusing on protecting and improving health across the EU.



(1) Enlarged EU with Greater Inequities in Health

Although most Europeans today enjoy the prospect of a longer and healthier life than previous generations, major inequities still exist. Health inequities are inequalities in health (differences in health status, and differences in access to treatment and care) that are avoidable and unfair.

A major reason for inequity comes from conditions related to socio-economic factors, lifestyle and environmental conditions. Poverty, low levels of education, differences in gender, membership of some minority ethnic groups, and disability are some of the factors that are associated with poorer health. Inequalities will always exist within and between countries. The EU has a role to address areas where change can be made and where added value is achievable, for example by facilitating the sharing of best practice and taking action where issues have a cross border impact.

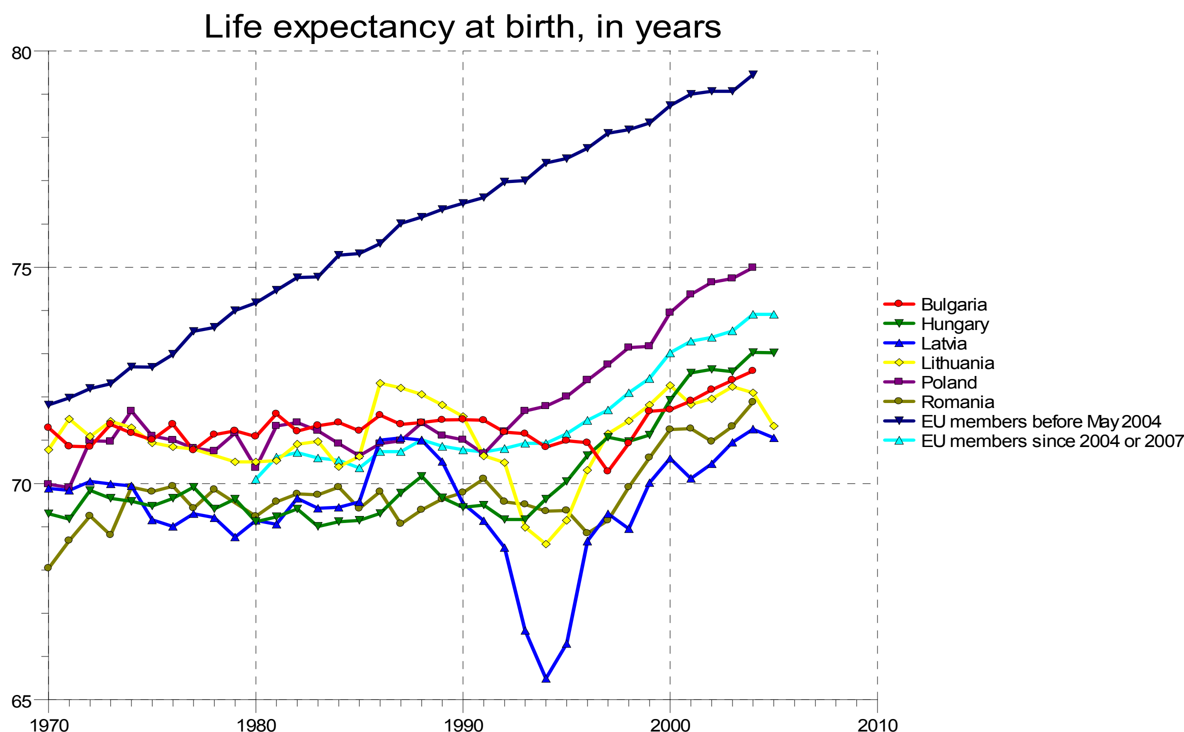
Key Facts

The difference in life expectancy at birth between people living in different countries within the EU is more than 7 years for females and 12 years for males. A baby is more than 6 times more likely to die before their first birthday in Romania than in Sweden.[10] Graph 1 shows the differences in **life expectancy** including the clear gap between EU-15 and EU-12 Member States. In the majority of EU Member States life expectancy has improved consistently over the last 50 years but this general trend masks major differences between countries. Some Member States experienced a decline in life expectancy during the mid 1990s and in Latvia and Lithuania life expectancy at birth has dropped significantly in the latest figures (2005)[11].

Graph 1: Life Expectancy at Birth (1970 to 2005) in EU Members before 1 May 2004, EU Members after 2004, and selected countries

[10] European Community Health Status Indicators 2005, infant mortality per 1000 live births, Romania 15.0, Sweden 2.4.

[11] Source: Eurostat.



The Healthy Life Years indicator, an indicator of the Lisbon agenda, is used to measure how much time people are spending in good health. This varies widely across the EU. In 2003 Healthy Life Years ranged from 71 years in Italy to 53 in Hungary for men, and 74 in Italy to 57 in Finland for women.

Inequities in health are closely linked to the economic prosperity of a country. Increasing economic prosperity through initiatives like the Lisbon agenda will therefore support improvements in health. However, specific health interventions are also effective. Promoting health, addressing health determinants, improving health literacy and health information, increasing the availability of healthy choices and improving the efficiency and responsiveness of health services can help to narrow the health gaps.

The predicted trend of population **ageing**, resulting from low birth rates, increasing longevity, and the ageing of the 'baby boom' generation is now well established on political agendas across Europe. The additional health expenditure that this will entail, and other consequences, such as the likely shortage of healthcare professionals, will clearly pose a major challenge to the sustainability of health systems. By 2050 the number of people in the EU aged 65+ will increase by 70% and the 80+ age group will increase by 170% in the same period. DG ECFIN projections have estimated that if healthy life expectancy evolves broadly in line with change in age-specific life expectancy, then the projected increase in spending on healthcare due to ageing would be halved. [12] A healthy, active ageing population can be supported through effective health policy across the lifecycle, in particular in relation to offering more healthy choices and tackling non-communicable disease.

[12] The impact of ageing on public expenditure: projections for the EU-25 Member States on pensions, healthcare, long term care, education and unemployment transfers (2004-2050) DG ECFIN 2006, p. 133.

Non-communicable diseases contribute to a substantial part of the burden of disease in the EU. Modern patterns of living are having a complex effect on risk factors for health. Physical activity is in decline due to reductions in the physical requirements for work, increased motorised transport and more passive leisure activities. There is clear evidence that overweight and obesity are rapidly increasing. Patterns of smoking and harmful alcohol consumption are also increasing in some groups, particularly amongst young people. Chart 1 shows that tobacco use, high blood pressure, nutritional factors such as obesity and high cholesterol, alcohol abuse, low levels of physical activity, illicit drugs and unsafe sex are some of the most important risk factors for poor health in Europe. Many of these causes or 'determinants' of ill-health are preventable by means of ensuring that healthy choices are available to citizens. Annex 3 sets out more information on key determinants of health.

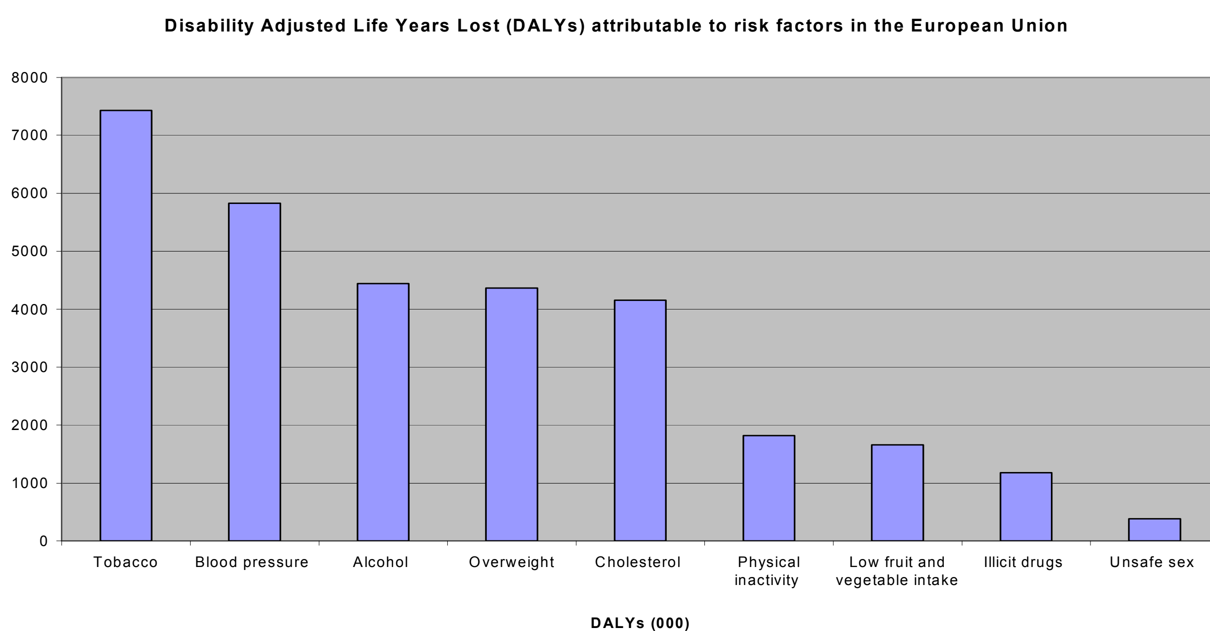


Chart 1: Source WHO[13]

Current Actions

Much work has been done to tackle inequities in health. In its Resolution of 29 June 2000 on health determinants, the Council considered that the increasing differences in health status and health outcomes between and within Member States called for renewed and coordinated efforts at national and Community level.[14] Additional attention on the link between social inequalities and health inequalities has arisen since the establishment by the World Health Organisation in 2004 of a Commission on Social Determinants and there is increasing appreciation as part of the review of the Lisbon process, that reducing the social impact on health can lead to improved health of the population with corresponding increases in human capital, reductions in social payments and economic growth. In particular, the use of Structural Funds for health through EU regional policy can lead to concrete improvements, as demonstrated in the broad-ranging Portuguese 'Saúde' project.[15] DG EMPL's Open Method of

[13] World Health Organization Burden of Disease Report 2002 – Annex 3. Data are for European Countries classified as very low child and very low adult mortality.

[14] OJ C 218, 31.7.2000, p. 8.

[15] http://ec.europa.eu/regional_policy/country/prordn/details.cfm?gv_PAY=PT&gv_reg=ALL&gv_PGM=1999PT161PO005&LAN=5

Coordination on Social Protection and Social Inclusion is a key policy tackling social and health inequalities.

In the area of non-communicable disease, strategies have been developed in the areas of alcohol, mental health and nutrition and physical activity. Further information is included in Annex 3. Policies with an impact on the determinants of health include agriculture, including the promotion of healthy foods, and decoupling of subsidies for unhealthy products such as tobacco. Close links also exist in the tobacco area between health objectives and taxation policies. There are synergies with JLS in terms of illegal drugs, including work on indicators for drugs along with Eurostat and expert agency EMCDDA. Synergies are also found in relation to health promotion in workplace and schools settings with EMPL and EAC. As with all areas, research projects support better understanding of the issues.

Added Value of a New Strategic Approach at EU level

As described above, EU is already actively involved in tackling inequities in health. However, there is clearly scope for further work in this area. Added value would be found in particular in a new focus towards raising awareness at Member State level in relation to the potential for Regional Policy to contribute to the health sector, both through health-related investments and through systematic sharing of the successful experiences of some Member States and regions with others. This would be particularly beneficial for new Member States and regions. EU added value would be found in measures (such as facilitating the sharing of best practice) to support Member States to improve health literacy, to enable people to have better access to information and services, to make more healthy choices available, and to support 'lifecycle' approaches to health focusing on the need for effective health promotion and interventions from childhood through to old age. The experience of some Member States has shown that effective low-cost preventative measures, such as cancer screening can have a real impact on health outcomes for a population. Studies have shown that screening people aged over 50 for breast cancer and colon cancer can reduce mortality by 35% and 16% respectively[16]. Therefore clear EU added value could be found in a renewed approach to disseminating best practice in these areas, thus helping to narrow the health gaps within and between EU-27 countries. A new strategic approach would also mean enhanced networks to encourage communication between Member States, experts, and stakeholders on the issues.

Reducing inequities in health was considered by many consultation respondents from all backgrounds as an important objective of the strategy. In a questionnaire to the High Level Committee on Public Health[17], several Member States identified mental illness, cancer and cardiovascular disease as key issues on which the EU should focus, and named physical activity, smoking and alcohol/drugs as top priority risk factors to tackle. They also identified the workplace and schools as key settings to promote health.

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[16] Figures from European Code Against Cancer, 2003 – www.cancercode.org

[17] An informal advisory body of senior Member State officials to the Commission, which meets 2/3 times per year and operates with a number of working groups on specific issues.

(2) Current and Emerging Threats to Health

Key Facts

Communicable disease remains an important health threat to European citizens. Parts of Europe have the fastest rate of new HIV/AIDS cases in the world. In 2005, 77,553 newly diagnosed cases of HIV infection (104 per million population) were reported in the European Region of the World Health Organization,[18] while rates of Tuberculosis (TB) increased by 8% in Sweden and 5% in the UK, with new more resistant strains of TB a growing concern[19]. In recent years threats from SARS and avian influenza, and the increased risks of a bioterrorist attack since September 11th have shown the need for good coordination between Member States on surveillance, preparedness and response.

Climate change is also a looming threat with the potential for a severe impact on health. In recent years, extreme weather conditions have proved harmful and fatal particularly among the elderly and other vulnerable groups. France suffered an estimated 15,000 deaths due to an August heat-wave in 2003. Climate change may also change the areas affected by communicable diseases, such as malaria and tick-bourne diseases, reduce the predictability of communicable disease threats such as pandemics, and worsen the consequences of these.

Threats to health also occur in healthcare settings and **patient safety** is an important area of concern. Studies have shown that 10% of patients admitted to a hospital in the UK encounter an adverse effect[20]. These range from healthcare acquired infections to prescribing errors and unsafe devices. In the Netherlands, research has shown that around 800,000 Dutch people over the age of 18 have been subject, in their own perception, to errors based on the inadequate transfer of medical information[21]. It is likely that this problem exists at a similar scale in other EU Member States.

Current Actions

In terms of communicable disease, work on this area by the EU has included actions to improve preparedness and response to epidemics or deliberate acts of threat such as bioterrorism, to support Member States in addressing communicable disease threats such as HIV/AIDS and TB, anti-microbial resistance, patient safety issues, pharmaceuticals and medical devices safety, and the quality and safety of blood, tissues and cells. Many communicable disease threats require close EU-level cooperation and coordination between Member States and international actors. The European Centre for Disease Control was set up in 2004-2005 in response to the need for a more coordinated approach to communicable disease, and its mandate will be reviewed in 2008 to reflect what has been learned in the first years of the Centre, and to ensure that the system for responding to threats is as effective as possible in the light of current and emerging challenges, with the optimum use of resources. The existing legal instruments for communicable disease surveillance and reporting will also be reviewed. The introduction and implementation of the International Health Regulations is

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[18] HIV/AIDS Surveillance in Europe: End-year report 2005 No 73.

[19] EuroTB annual report 2005.

[20] This translates to ca. 850 000 adverse effects a year. Source: UK Department of Health Expert Group. An organisation with a memory: report of an expert group on learning from adverse events in NHS. Chairman: Chief Medical Officer London: The Stationery Office, 2000.

[21] For relevant information, see http://www.npcf.nl/ Similar information is also available from WINAP and from the Dutch Association of Pharmacists.

currently a major priority, aiming to make alert and information systems at the EU level and through WHO more compatible and coherent.

In the area of patient safety a working group of the High Level Group on Health Services and Medical Care has developed a recommendation to describing the areas of patient safety where action could be taken at Member State level and/or at the EU level. These include developing the knowledge base, establishing reporting mechanisms, instituting training for staff, and developing a culture of safe care in healthcare management and leadership. Based on these recommendations, action on patient safety at the EU level is planned for 2008.

Other sectors involved in protecting citizens from a wide range of health threats include the employment sector, in the area of health and safety at work and coordination in relation to social security schemes, the enterprise sector in the regulation of pharmaceuticals, medical devices, chemicals, cosmetics etc, the EC Research Framework Programmes on health, food, environment and other health-related areas, Consumer Safety, Food Safety, Animal Health, Environmental issues such as air quality, water quality, noise, climate change, industrial emissions, and chemicals, and Transport in relation to accidents, in particular road safety. The Joint Research Centre currently supports a range of research from the migration of chemicals into food products to detecting genetically-modified organisms in imported food, which support policy responses.

Added Value of a New Strategic Approach at EU level

Although much work has been done, the growing challenges presented by health threats to EU citizens mean that a new focus is needed. There is a risk, given the seriousness of emerging health threats that the usual pace of evolution of mechanisms, institutions and programmes may prove insufficient to respond to these challenges in an effective and timely manner. Experience in recent years with health threats such as avian influenza and SARS has demonstrated that a priority area for development is improving surveillance and alert systems across the EU and international lines of communication, as well as making links with existing surveillance and alert systems for events which may have a public health impact, such as pharmaceutical or nuclear safety systems. In addition, further information is needed on how to address the consequences of climate change on health and health systems. Issues of vaccination are another major area needing increased attention, including vaccinations for pandemic and seasonal influenza, but also childhood vaccinations. For example, the EU can add value to the issue of the introduction of HPV vaccination for cervical cancer by providing opportunities for Member States to exchange best practice and experience.

Renewed support for these efforts led by a new strategic approach could add value by driving forward improvements, as well as implementing new initiatives building on cross-sectoral synergies, such as virtual mapping of disease, increased cooperation on organ donation and transplantation, and the potential health risks of climate change. In addition, health threats, including the need to ensure preparedness and protection of European citizens through cooperation among Member States were identified as one of the main priority areas for the Health Strategy by many consultation respondents. Patient safety, including work on hospital acquired infection and epidemiology safety, was clearly identified as a key challenge, especially by the Member States.

(3) Sustainable Health Systems

The sustainability of health systems in the future is a challenge where the EU can add value due to cross border issues such as patient and health professional mobility, and in facilitating exchange of knowledge and good practice on issues such as demographic change and the increase in new technologies[22].

Key Facts

The impact of the single market on health, with the increasing mobility of patients, services and health professionals, coupled with more general issues that confront national health systems such as the growing pressures from new technology, demographic change and popular expectations, call for adequate Community responses in the field of health services and co-operation between health systems at European level. Current economic projections show that the future cost of healthcare between now and 2050 will depend crucially on efficiency in provision; this will be as significant a factor as population ageing itself. Ensuring sufficient capacity in the field of healthcare and public health is an issue needing consideration, in particular in the new Member States.

Innovation and the development of new technologies are key issues that affect EU health systems. For example, e-health (which has been identified as one of the 6 most promising markets in the EU by the Lead Market Initiative) through electronic health records, personal health devices for the elderly, the chronically sick, and disabled, and as a means to reduce medical errors through recording adverse incidents, and biotechnologies which combine disciplines such as genetics, molecular biology, biochemistry and cell biology, show great potential to contribute to improved healthcare.

Furthermore, the growing use of life sciences and biotechnology, for the development of drugs, vaccines and innovative therapies, as well as the applications of "nanomedicine", represent huge potential for innovation and growth[23]. The health sector must take advantage of innovation and technology where this will lead to greater efficiency and health improvements. A balance must, however, be struck in terms of cost-effectiveness. Developing means for Health Technology Assessment (HTA) is one area where the EU can add value by enabling the exchange of knowledge and best practice, and this was supported in the consultation.

Current Actions

To aid investment towards modernised and efficient health systems and better healthcare, health has already been integrated into instruments aimed at enhancing growth and employment in Europe: the Lisbon Strategy, Regional Policy and the EC Research Framework Programmes. The complexities around cross-border healthcare have been demonstrated in a number of judgments by the European Court of Justice concerning the right of patients to benefit from medical treatment in another Member State. An initiative on health services to help clarify these and other health services issues is therefore under development

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[22] It is expected that a new Reform Treaty will include a reference to encouraging cooperation on health services at the EU level.

[23] Communication from the Commission on the mid term review of the Strategy on Life Sciences and Biotechnology - COM(2007) 175.

at EU level. Since 2004, the High Level Group on Health Services and Medical Care has brought experts together to discuss issues such as cross border care, the training and mobility of health professionals, health and health systems Impact Assessment, patient safety, networks of centres of reference, health technology assessment, and e-health.

Sectors with clear links to health services at European Commission level include DG MARKT, who lead on infringement issues including relating to health professional mobility, pharmacy restrictions, etc, DG TRADE who facilitates cross border trade with health services and access for health professionals in and from third countries, and DG REGIO who, in cooperation with Member States, regions and regional partners, implement Regional Policy, including health-related aspects. DG EMPL's Open Method of Coordination on Social Protection and Social Inclusion relates to health and long term care systems, and DG EMPL also work on coordination in relation to social security schemes in relation to patient mobility[24] and on demographic change issues. Further examples are DG ENTR who lead on pharmaceuticals, DG COMP who support competition between healthcare products and services, DG INFSO who work with technologies in relation to health and healthcare, and DG RTD who support health research on issues affecting health systems under the 7th Framework Programme for Research. DG ECFIN has put a particular focus on ageing in recent reports, given its huge potential impact on public finances. [25]

Added Value of a New Strategic Approach at EU level

The planned **Community framework for safe and efficient health services** would be put in place as an element of the overarching Health Strategy, with the aim of responding to current inefficiencies that could undermine Europe’s potential to maintain sustainable health systems in future years, in particular with regard to population ageing. Facing these challenges and in particular their cross-border dimension calls for adequate support to national systems at European level, while respecting the subsidiarity principle. Individual Member States are already tackling these issues although some are doing more than others. As cross-border economic activities within the EU continue to increase, there are rising numbers of patients seeking treatment and health professionals working abroad. An EU approach is needed to support closer cooperation at EU-level to ensure a coherent approach to these cross-border issues, and this is where the added-value of a new strategy can be the most significant. Similarly, EU level work on healthcare systems, especially in relation to cross-border activities, was considered to be an important area of work in the consultation responses. Some contributors stressed that the Strategy should ensure that patients and professionals are aware of their rights in relation to mobility between EU Member States, including in relation to services offered, health insurance, and costs. The consultation on the health services itself showed general consensus in favour of a clear Community framework on health systems[26].

Added value can also be found in **boosting the health capacity of the regions**, which are primary actors in delivering healthcare, which would be supported by a coherent new EU level health strategy with a strong implementation mechanism at Member State level. A more focused approach through a new health strategy could lead to better **cooperation between healthcare systems**, particularly benefiting border regions or places where there are capacity

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24 Cf Regulation 1408/71 which provides for access to healthcare for people moving within the EU and its successor Regulation (EC) No 883/2004.

25 More information on the work of different Directorate Generals on health can be found in Annex 2 and at www.europa .eu.

26 http://ec.europa.eu/health/ph_overview/co_operation/mobility/results_open_consultation_en.htm

constraints or the need for particular concentrations of resources or expertise. Current variations across the EU in terms of techniques, resources and outcomes show that there is enormous scope to improve the results obtained from existing resources by bringing healthcare across the Union towards the standard of the best. For example, for bladder cancer, although survival rates are improving in general, there are substantial differences in survival among countries in Europe, with five-year survival rates ranging from highs of 78% in Austria to 47% in Poland and Estonia.[27]

(4) Globalisation and Health

In today's globalised world it is increasingly difficult to separate national or EU wide actions from global policy. Decisions affecting EU citizens directly are often made at global level, and EU's internal policy can have consequences outside the EU borders. The EU can therefore add value through showing leadership in global aspects of health policy. This is essential both for the protection of the European population and for the respect of people living outside the EU. The EU has a Treaty obligation in article 152 to, *'foster cooperation with third countries and the competent international organisations in the sphere of public health,'* and it is likely that a new Reform Treaty will also include a new objective for the EU, in its relations with the wider world, to uphold and promote the Union's values and interests and contribute to the protection of its citizens.

Key Facts

The 57th World Health Assembly on May 2005, called Member States *to work towards universal coverage of basic healthcare, and attaining internationally agreed development goals including those contained in the United Nations Millennium Declaration*. Public financing for basic health services is essential, especially for pro-poor fair financing[28]. Specific preventive and treatment interventions can reduce the burden of disease in the short and middle term, alongside longer term measures to support the wide economy and improve socioeconomic conditions. It has been estimated that a comprehensive package of essential services[29] costs € 20-30 per capita and year[30]. Developing countries face a gap in public financing for health. If countries were to allocate 15% of their government's budgets to health (Abuja target, OECD average), then the additional public funding from domestic sources would be over € 25 billion.

Although investment in health is expected to increase in countries experiencing economic growth, the need for more investment is also expected to rise, particularly in high-HIV prevalence countries. The commitments of the EU at Monterrey and Barcelona to gradually increase the level of aid, together with the adherence to the Paris principles of alignment and coordination, provide the EU with a historic opportunity to champion the global right to health, through supporting equitable access to basic healthcare. EU action in this field can help to tackle major ongoing problems, including over 20 million preventable premature deaths, the global threats of pandemics, resistant strains of micro-organisms, emerging and re-

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27 EUROCARE 3 - survival of cancer patients in Europe; see http://www.eurocare.it/

28 The concept of pro-poor financing of healthcare systems (e.g. based on healthcare insurance rather than out-of-pocket payments) aims to ensure equitable access to healthcare, even for the poorest population groups.

29 Services to address priorities through cost-effective interventions (costing less than € 50 per Disability Adjusted Life Year; including HIV/AIDS).

30 Investing in Health", WB WDR 1993; "Attacking Poverty", WB WDR 2000/01, "Macroeconomics and Health" 2002 : http://www.cmhealth.org/cmh_desc.htm.

emerging diseases and growing levels of insecurity, unrest and massive migration flows. Global HIV/AIDS deaths are projected to rise from 2.8 million in 2002 to 6.5 million in 2030[31] The global proportion of deaths due to non-communicable diseases is projected to rise from 59% in 2002 to 69% in 2030 and total tobacco-attributable deaths are foreseen to rise from 5.4 million in 2005 to 8.3 million in 2030. [32]

New actors are emerging on the global health arena and new forms of interactions are taking place. For instance, new public-private-partnerships have multiplied to over 100 and gained importance and foundations are playing a significant role in financing of global health[33]. At the same time, the Paris principles call for greater respect to ownership in the recipient countries and more predictable budget support so as to allow countries to set their national strategies, including universal access to basic healthcare and education.

Globalisation has increased cross-border flows of people and products. A key global health threat is the severe **shortage of health professionals,** particularly in developing countries. This is a problem of cross-border nature requiring actions at the global level, as a major contributing factor is the migration of health workers to wealthier countries, causing "brain drain" in many developing countries. The global shortage of health workers is estimated to be 4.3 million workers and the situation is most critical in developing countries. In Sub-Saharan Africa the average ratio of physicians and nurses per 100 000 people is 15.5 and 73.4 respectively, compared to a ratio of 311 and 737.5 in developed countries.[34] This is likely to get worse as demographic changes in developed counties mean that more health workers are needed and less are available.

<u>Current Actions</u>

The EU as a whole is the world's largest development and humanitarian aid donor, and health is an important component in the EU's assistance to world-wide efforts to save and preserve lives, to combat poverty and to work towards the Millennium Development Goals. The EU has also played a key role in negotiations on the WHO Framework Convention on Tobacco Control, on the International Health Regulations and on G8 discussions on health. The WHO is a main player in global health, but the EU is also working with other UN and international organisations active in health as well as with other bilateral and regional partners and civil society. Close cooperation with other international actors, for example the partnership between the EU and the Global Fund to fight AIDS, Tuberculosis and Malaria, and other public-private-partnerships[35] dedicated to global health issues, is also a vital part of EU's work on global health.

Global health is linked to work by the RELEX 'family' of DGs of which DG DEV and AIDCO work towards health elements of the Millenium Development Goals. DG ECHO responds to health threats in third countries and towards saving and preserving lives in emergency and immediate post-emergency situations. DG RELEX deals with relations to third countries, including European Neighbourhood policy and DG ENLARG with candidate and potential candidate countries. Global health policy is also part of the work of DG TRADE

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[31] Mathers CD, Loncar D (2006) Projections of global mortality and burden of disease from 2002-2030.

[32] ibid

[33] Some examples are the Global Fund to tackle AIDS, Tuberculosis and Malaria; the International Initiative for Aids Vaccination (IAVI); the Global Alliance for Vaccines and Immunisation (GAVI), and the Bill and Melinda Gates Foundation.

[34] World Health Organization, World Health Report 2006: Working Together for Health.

[35] e.g. the European and Developing Countries Clinical Trials Partnership (EDCTP).

in terms of international trade with health goods and services and JLS on the issue of migration. Amongst many other sectors with links to global health issues, food safety is a key area with a clear global dimension, as food is imported into the EU from over 200 countries, and ensuring the safety of these imports is an ongoing challenge.

Added Value of a New Strategic Approach at EU level

As described above, the EU is active on the international health stage. However, this activity could be strengthened to give the EU a stronger voice to represent Member States on health issues. The increased globalisation of health is presenting challenges in **governance**. A large number of bilateral and international organisations and public-private partnerships are active in global health. To avoid conflicting messages and duplication of work, and to clearly define the roles of actors on the global health stage, close collaboration between these organisations is crucial. Effective coordination and a coherent intersectoral approach are necessary components of global health governance, and a new strategic focus on global health issues would add value by supporting this more fully.

The EU is committed to take a leading role in the fight against poverty, hunger and disease in the world.[36] This has not yet been fully exploited. The EU can add value in its contributions to global health by sharing its common European **values** as well as its experience in implementing health policy that reduces health inequalities, strengthens health systems and promotes access to basic healthcare, and improves health indicators.

Engaging more strongly in global health policy would aim to make health a key issue on the agenda in the EU's **relations with third countries** – bilaterally, regionally and globally. A key message from the new development consensus and the Paris principles is the importance of shifting from international cooperation based on development aid to partnerships based on solidarity and guided by the needs of the beneficiary countries.

Two additional key issues where EU added value was foreseen by a number of consultation respondents were addressing the severe shortage of health professionals globally, and improving access to medicines including research and development of new medicines and health technologies, especially for neglected diseases.

2.2. Advancing Good Governance

A new governance approach is needed to better support effective work at EU level given the changes taking place in the EU. These include setting clear objectives for work on health at the EU level; achieving greater inter-sectoral cooperation on health, (also known as mainstreaming, or Health in all Policies); and achieving greater transparency and visibility of work on health at the EU level.

(5) Creating a Coherent Framework

Currently no overarching strategic framework for health exists at the EU level. Health is clearly an important element in many areas of work; within the health sector itself the Public Health Programme provides a framework for health spending, while the European Environment and Health Action Plan[37], ongoing E-health initiatives[38] and the health themes

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[36] See Declaration on the occasion of the 50th anniversary of the signature of the Treaties of Rome, and European Development Consensus 2006.

[37] COM(2006) 625.

under the EC Research Framework Programme[39] are three examples in other sectors. The expansion of the EU and emerging health challenges as set out in the previous section mean that it is now time to build on these successful initiatives with a more inclusive framework to set the direction of travel for health policy for the coming decade. The need for a strategic approach, setting measurable objectives, is supported by past evaluations of the Public Health Programme (see Box 1.)

Box 1: Evaluations of Previous Health Programmes

Evaluations of previous health programmes support a more coherent approach to EU health policy, including setting clear and well-defined objectives and goals.

In the evaluation of the eight separate programmes run in the field of health from 1996-2002 (health promotion, information, education and training, rare diseases, pollution-related diseases, AIDS and communicable diseases, cancer, drug prevention, injury prevention, and health monitoring), one comment was that 'the implementation of the programmes seems to have been rather compartmentalised. There were few bridges between programmes'. It recommends

'the development of a complete and coherent theory of action for the general public health framework, identifying the levels of (quantified) objectives, the target groups, and possible monitoring indicators. This strategic thinking should be accompanied by a long-term perspective of where the Commission wants to go in the field of public health in the 15 or 20 coming years'.[40]

The evaluation of the Public Health Programme 2003-2008 (PHP) recommends development of,

'more quantitative intermediary outcome measures to support milestones which could chart progress towards more general public health measures (e.g. comparable health indicators such as the Healthy Life Years indicator).'[41]

It notes that measuring the effectiveness of the PHP faced considerable barriers due in part to a lack of measurable performance indicators,[42] stating,

'we recommend making the objectives and success indicators of the PHP more explicit and ensure the dissemination of these to stakeholders…monitoring progress against these and communicating progress transparently.

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38 ec.europa.eu/information_society/activities/health

39 http://ec.europa.eu/research/fp7/index_en.cfm?pg=health

40 Deloitte report of 2004 : "Final Evaluation of the eight Community Action Programmes on Public Health (1996-2002) – web link: http://europa.eu.int/comm/health/ph_programme/evaluation_en.htm.

41 Interim Evaluation of the Public Health Programme 2003-2008, Final Report 12 January 2007, Rand Europe, p. 5.

42 Ibid, p. 3

Added Value of a Coherent Framework at EU level

A coherent framework for health policy would encompass the broad range of work on health across the European Community. Setting objectives to which all sectors agree, which build upon the aims of existing sectoral strategies and programmes and serve to bring them together and underpin them, can act as a 'beacon' to encourage progress towards key health objectives. If those objectives are supported by measurable indicators, this provides a means for monitoring of progress and a **driver for achieving the objectives**.

A new framework would also add value in terms of **rationalising and simplifying,** where appropriate, groups and initiatives currently ongoing in the health field at EU level. An implementation mechanism for the Strategy could replace a number of current groups where energies could be channelled towards achieving the Strategy's objectives.

While the Strategy's broad aims are expected to be compatible with national health strategies in those Member States which have a broad health strategy in place, they should also support the development of health strategies in all Member States and more generally **support strengthened health action at national, regional and local level**. This is supported by responses to the consultation in which some Member States, regional and local administrations saw the Strategy as a potential guide for their own activities. Member States including regions and local areas would be responsible for delivering progress towards the objectives, and a small number of broad objectives set by the Commission as part of a new health strategy would therefore be supported by more specific objectives developed with Member States. Member States would also agree on indicators to measure progress against the objectives. Other stakeholders, including health professionals, academic bodies, non-governmental organisations, industry and others should also be aware of the Strategy's objectives and support them through their own activities.

Objectives set by the European Community on health would complement other international goals and objectives for health including the WHO Europe's Health 21[43] and the Millennium Development Goals[44] to which EU Member States have already committed themselves, as well as EU objectives (see section 3). The goals set by international bodies are focused on tackling similar health challenges, but the EU has a unique role to play in health and added value is found in the definition of a framework **to guide the use of EU policies, programmes, instruments and actions** in tackling these health challenges as well as other areas where the EU can add value.

(6) Increasing 'Health In All Policies' Cooperation

Health in all Policies (HIAP) is a concept that underpins work on health at the European Level. Under article 152 of the Treaty, the EU is required to make sure that a high level of health protection is ensured in ‘the definition and implementation of all Community Policies and Activities’. Many sectors take actions that have an impact on health, for example regional development, environment, research, economic policy, social policy, etc. Policy partnerships are ongoing, for example in the fields of pharmaceuticals; demographic change and ageing; Regional policy health-related actions (infrastructure, research, training), health research in the RTD Framework Programmes, and health in the information society. Annex 2 contains a list of health-related actions across many different sectors at the European level. It is

[43] WHO Europe (1999) *Health 21 - Health for All in the 21st Century* Copenhagen: WHO.
[44] http://www.un.org/milleniumgoals/

necessary not only to acknowledge this fact but to encourage active coordination between sectors to develop long-term strategic approaches to health problems.

Significant work to increase HIAP cooperation has been undertaken at EU level in recent years; methodologies have been developed for Health Impact Assessment (HIA) and Health Systems Impact Assessment (HSIA), a number of projects have been funded[45]. An interservice group meets several times each year to share information on health-related initiatives. Council Conclusions on Health In All Policies were agreed under the Finnish Presidency on 30 November 2006, which, inter alia, invited the Commission to set out a plan for work in Health in All Policies with a specific emphasis on equity in health and to consider including such activities in its new Health Strategy. A recent evaluation found that use of the key Healthy Life Years indicator 'is not (yet) widespread, especially within Commission Services and by National and Regional Non-Health Ministries'. It recommends improving dissemination activities, supporting HIAP aims within the proposed new health strategy, and developing further coordinated action plans linking health with other policy areas.[46]

There is therefore potential to strengthen the current approach by putting in place a mechanism that links actions across all sectors to the achievement of strategic health objectives. A cross sectoral approach is a vital element of the proposed new strategic framework, as work in the health sector alone would limit the possible achievements. Increasing HIAP cooperation at EU level in relation to the strategic health objectives will mean that the value of action on health in other policy areas is fully recognised and that possibilities for partnerships to share knowledge and expertise are fully exploited, and this will be reflected within Member States.

Added Value of a Renewed Health in All Policies Approach (HIAP)

While some countries are active in working towards HIAP, in many Member States health policy is not linked up to other sectors. Building on current achievements in HIAP at EU level will support the **development of a cross-sectoral approach for more effective health policy at national, regional and local level**. For example, enhanced HIAP cooperation to support the objective to reduce inequities in health could lead to better understanding of the links between health and economics and an increase of the use of the full scope of Regional Policy for health-related actions by Member States and regions. Similarly, an enhanced cooperation between health, employment and education sectors to promote health in the workplace and schools would encourage Member States to make similar cross-sectoral links and achieve related health gains.

Increasingly, real change is being made by **involving partners outside the health sector** in achieving health improvements. The Platform for Action on Diet, Nutrition and Physical Activity has successfully engaged the food and broadcasting industry on issues relating to improving population health. This can be replicated in other sectors, and a similar platform is being developed in relation to alcohol misuse. A new strategy would build on this approach, expanding it to other areas and encouraging similar approaches at national, regional and local levels to achieve health gains in key areas.

By setting a governance objective on HIAP the Strategy can also add value through a more focused **dissemination of practical information and tools** in relation to HIAP, for example

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[45] For example, http://ec.europa.eu/health/ph_projects/2001/monitoring/monitoring_project_2001_full_en.htm#11 and http://ec.europa.eu/health/ph_projects/2004/action1/action1_2004_20_en.htm

[46] Rand Europe, Evaluating the Uptake of the Healthy Life Years Indicator, December 2006.

in relation to Health Impact Assessment and Health Systems Impact Assessment for new initiatives. Added value could also be found in improved coordination in working between the different sets of health indicators managed for different policies, including ECHI indicators, Social Protection indicators, and Sustainable Development indicators in relation to health.

Consultation responses in both the 2004 reflection process and the 2006-2007 process were strongly in favour of strengthening HIAP, including at national, regional and local level. There was also a large consensus on the importance of ensuring the application of Health Impact Assessment at all policy levels and in all sectors.

(7) Improving Visibility and Transparency

The rejection of the EU Constitution in 2005 by referenda in two Member States has led to the EU reflecting on how it can better connect with its citizens. The Commission's White Paper on European Governance[47] stresses the need for greater attention to five key principles of governance, 'openness, participation, accountability, effectiveness and coherence'. An overall health strategy can support these five aims.

The evaluation of the Public Health Programme 2003-2008 recommended giving 'sharper definition'[48] to the Programme to build on its visibility within the health community, and recommended better coordination and effective information across the European Community to avoid overlaps and improve synergies between EC programmes and policies.[49]

Added Value of Greater Visibility and Transparency of EU Health Action

A new health strategy can support openness and accountability by **clarifying the role of the EU in health** to Member States and stakeholders, and therefore decrease the chance of the EU being misunderstood and undervalued in this field. A health strategy will help to define the role of the EU, Member States and other stakeholders in improving and protecting health, and encouraging participation. A health strategy will offer a coherent, transparent vision of what the EU's aims are in terms of health, and what actions it may take, leading to greater effectiveness through a focus on key areas where added value is achievable. Developing an EU health strategy will, in itself, send a strong political message about the important role of the EU in health to all stakeholders including European citizens and international organizations, and lead to greater understanding of the rationale for and legitimacy of action on health at the EU level. This clarification of the EU's role may lead to more effective partnerships with Member States and other stakeholders who may be more willing to work closely with the EU on those issues where EU added value is demonstrated.

As great social and technological change has taken place in recent years, citizens are seeking to understand and take greater control of their own healthcare. Although Member States have a clear role to advise citizens on health issues, citizens also have the right to information on what is happening at EU level. The Commission has a role in offering information directly to citizens, for example through the Health Portal, which aims to provide European citizens with easy access to comprehensive information on Public Health initiatives and programmes at EU level, and to promote the improvement of public health in the EU.[50] Added value can be

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[47] COM(2001) 428.
[48] Ibid, p. 4
[49] Ibid, p. 8
[50] www.health.europa.eu

found in building on this approach to **make EU health policy more accessible to citizens** including through the communication of a coherent, strategic EU approach to health.

The EU's ability to collect comparable data and information to provide an overview across Member States is invaluable for policymakers at the national level, and can also be useful for hospital managers, health professionals, health research centres, universities and others. This can range from information on best practice and techniques, to data on the prevalence of diseases, to information on cross-border issues relating to the mobility of patients and health professionals. Providing this information helps to share knowledge across the EU while at the same time respecting the Member States' prerogative on the establishment and organisation of their health systems. One example of a successful information tool supported by the European Commission is the Orphanet website which offers free information on rare diseases for patients, families, industry, health professionals and researchers.[51] A new strategy would build on the success of current practices by offering **accessible and coherent comparable data on progress towards the strategic health objectives that can act as benchmarks across the EU** and drive improvements towards the level of the best performers. At the same time, the visibility and accessibility of health information in general will be enhanced at both EU and national levels through, for example, sharing best practice in promoting health in a wide range of settings such as schools and workplaces, exploiting new media to communicate health messages, and clarifying rights for patients and professionals when crossing borders for treatment or employment.

2.3. Subsidiarity Test

The subsidiarity test asks whether EU action is really necessary (the 'necessity test'), or whether action by Member States is sufficient to solve the problem. It asks whether action at EU level add value to the work done by Member States (the 'added value test'), and it asks if the measures chosen are proportionate to the objectives (the 'boundary test'). This section looks at the first two tests. The subsidiarity test, in particular the boundary test, is also applied to options under Section 4. This section also draws from the analysis of the added value of a new strategic approach presented within the description of each of seven challenges in Sections 2.1 and 2.2.

EU **Member States have the prime responsibility** for protecting and improving the health of their citizens. As part of that responsibility, it is for them to decide on the organisation and delivery of health services and medical care. However, the fundamental aims of the EU in terms of free movement of goods and services, and working together on cross-border issues, necessarily have a health dimension. It is recognised that there are many areas relating to health where, to be effective, action needs to involve cooperation and coordination between countries. The prevention of the major health scourges and issues with a cross-border or international impact, such as pandemic preparedness or movement of patients or health professionals within the single market, where Member States cannot act alone effectively, are areas where cooperative **action at EU level is indispensable.** In addition, applying the single market and striving for EU integration must include health issues because health is affected by many different policy areas, and is provided for in many areas of the Treaty (see below).

There are also a wide range of health issues where the EU has a key role in undertaking actions which **add value** to and complement the work done by Member States in making European Citizens healthier and safer. In recent years the EU, in partnership with Member

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[51] www.orpha.net

States, has made important progress in improving and protecting health. Important achievements have included, for example, legislation on tobacco advertising and on blood products, and the launch of the European Centre for Disease Control (ECDC). Through the EU Public Health Programme and other funding mechanisms, work has been developed on a EU health information and knowledge system including the creation of a comparable system of indicators to monitor health statuts of Europeans, the European Health Indicators (ECHI) system, a comparable system of tools to collect health information (health interview surveys, health examination surveys, hospital information system, etc) in cooperation with the EU Statistical Programme, and a series of health reports. Policy initiatives have been launched on mental health, and accidents and injuries. Networks have been developed in the rare diseases, major and chronic diseases, lifestyle, health and environment and health systems areas.

The EU can add value through a wide range of activities. These may include working to reach critical mass or obtain **economies of scale**, for example sharing information on rare diseases where only a small number people are affected in each Member State. It may mean working with Member States to enlarge the **internal market** and increasing the **international competitiveness** of health services. Added value can be found in health promotion **campaigns** (such as the 'Help' tobacco campaign[52]), in devising **common standards** such as food labelling, in the support of pharmaceutical research, in e-health development and deployment, and in **research** in a wide range of areas. **Sharing best practice and benchmarking** activities in many areas can play a major role for the efficient and effective use of scarce resources and therefore the European coordination of MS action can prove particularly important in terms of future financial sustainability.

Importantly, the Community as a whole has a major role to play in creating the conditions which support and maintain health, such as employment, health and safety at work, sustainable economic growth, technology, high quality environment, effective energy and transport infrastructure, and safe products. Many "non-health" sectors have a major, direct role in improving and protecting health, for example, in the field of environmental health, health and safety at work, pharmaceuticals, and research. This role is recognised in the Treaty (see Box 2) which situates what has become known as **'Health in All Policies'** (HIAP) at the heart of work on health at the EU level.

The EU therefore clearly adds value in a wide range of areas relating to health. Given the need to tackle current and emerging health challenges in the most effective manner and to advance good governance in health at the EU level, there is also an important added value resulting from taking a new strategic approach in relation to the seven challenges identified. As set out in Sections 2.1 and 2.2, clear added value examples can be identified in the seven areas:

- 1) Enlarged EU with Greater Inequities in Health

Added value of a new strategic EU approach is found in, e.g. utilising the potential of Regional Policy for health-related actions; a renewed focus on making healthy choices available and enabling more access to information on health

- 2) Current and Emerging Threats to Health

[52] http://ec.europa.eu/health/ph_determinants/life_style/Tobacco/help_en.htm

Added value of a new strategic EU approach is found in, e.g. improving surveillance and alert systems; increasing cooperation on issues such as vaccination, organ donation, and climate change

- 3) Sustainable Health Systems

Added value of a new strategic EU approach is found in, e.g. taking forward a new Community framework for health services; greater support for improving health capacity in the regions; supporting greater cooperation between health systems

- 4) Globalisation and Health

Added value of a new strategic EU approach is found in, e.g. a stronger voice for the EU in global health governance; raising health on the agenda of work with third countries; an increased global perspective for all health issues (e.g. communicable disease threats, etc.)

- 5) Creating a Coherent Framework

Added value of a new strategic EU framework for health is to drive forward positive change; rationalise current mechanisms; support strategic action on health at national level; strengthen cooperation between Member States at EU level

- 6) Increasing Health In All Policies Cooperation

Added value of increasing HIAP cooperation at EU level is to ensure optimal policy approaches to protecting and improving health; to support multisectoral approaches at national and international levels; involve more partners leading to more effective initiatives; development and dissemination of tools for HIAP

- 7) Improving Visibility and Transparency of EU Health Action

Added value of improving visibility of EU Health Action is to clarify the role of the EU in health to all stakeholders, to make EU health policy more accessible to citizens, and to improve availability of comparable data and information to support progress towards objectives.

Box 2: Health in the Treaty Establishing the European Community

The Treaty clearly states that the activities of the Community shall include '*a contribution to the attainment of a high level of health protection*' Article 3 (1) (p)

EU action on health is also explicitly provided for in Treaty Article 152[53], which states that '*a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities'.*

Article 152 also states that

"The Community shall encourage cooperation between the Member States in the areas referred to in this Article, and if necessary, lend support to their action. Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes………The Commission may, in close contact with Member States, take any initiative to promote such coordination", bearing

[53] European Union Consolidated Versions on the Treaty of the European Union and of the Treaty Establishing the European Community (OJ C 325, 24.12.2002).

in mind that, *"Community action in the field of public health shall fully respect the responsibilities of the Member States for the organization and delivery of health services and medical care."*

However, health is also mentioned in other articles throughout the Treaty. For example,

Article 95 (3), (6) and (8) concerning health in relation to the **internal market**

Article 133 (6) concerning **common commercial policy**, stating that health services *"...shall fall within the shared competence of the Community and its Member States…".*

Article 137 (1) (a) *"1.'The Community shall support and complement the activities of the Member States in the following fields: a) improvement in particular of the working environment to protect **workers' health and safety**"*

Article 153 *"The Community shall contribute to protecting the **health, safety and economic interests of consumers**"*

Article 174 (1) *"Community policy on the **environment** shall contribute to pursuit of the following objectives: (...)- protecting human health.*

Articles 18(1), 39(3), 46(1) and 55 concerning the right to **limit free movement of persons** if necessary on the grounds of public health

Article 163 concerning the objective to promote *'all the **research activities** deemed necessary by virtue of other chapters of this Treaty'.*

Following agreement at the European Council meeting of 21-22 June, it is likely that a new Reform Treaty will introduce amendments strengthening scope for EU action in the field of health.

In response to the consultation, many Member States acknowledged the substantial achievements of the Commission in the field of health over the recent years including the aspects of health promotion and prevention, management of health threats and combating communicable disease. Many also highlighted the importance of designing a strategy that would respond to the actual challenges while respecting the principle of subsidiarity, by focusing on issues that had cross-border aspects or European added-value. Some respondents also called for more clarity on the respective competencies and responsibilities of Member States and the EU in the field of health.

The EU's legal right and obligation to take action on cross-border health issues, and its demonstration of success in taking relevant and effective action on health, while respecting Member States' prerogative, is clear. The ability of the EU to add value to work done by Member States in the field of health is also demonstrated. As a new health strategy will cover the broad range of work on health at EU level, providing a more coherent framework for this work, we can assume that the necessity test and added value test have been passed. (The subsidiarity test, in particular the boundary test, will also be applied under section 4 in relation to each option).

CONCLUSION

In conclusion, therefore, this Problem Definition section of the Impact Assessment has argued that new **health challenges** facing the EU action in four key areas of inequities in health, current and emerging threats to health, the need to support the sustainability of health systems, and the need to better address global health issues, require a new focus at EU level. The EU can provide important added value in all these areas, which can be maximised through employing a new overarching EU health strategy.

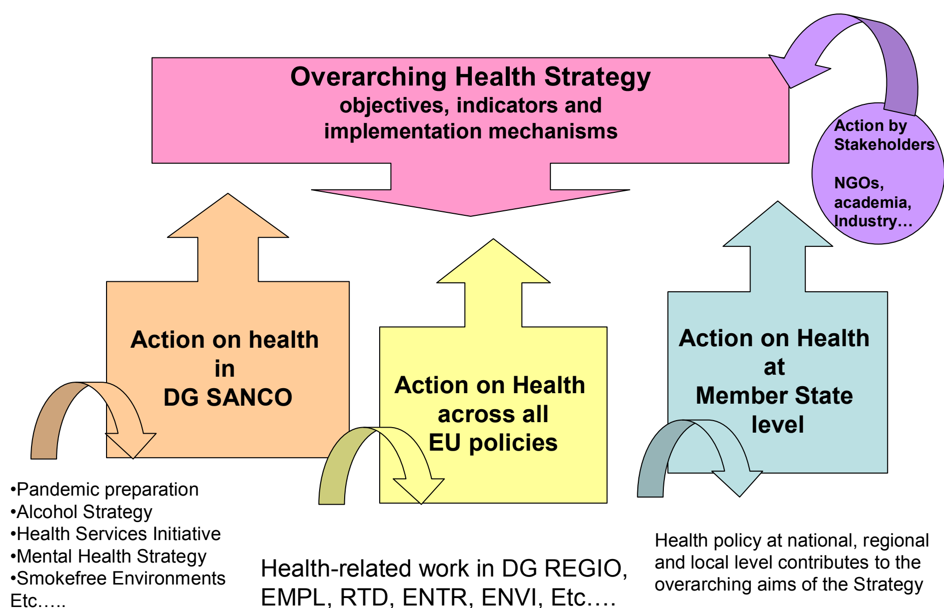
It was also argued that to ensure the effectiveness of a new Strategy, three **governance challenges** need to be addressed: a coherent overarching framework including strategic objectives should be put in place, Health In All Policies cooperation should be reinforced, and visibility of the EU approach should be increased. A focused approach reflecting these three elements will produce clear added value.

The **subsidiarity test** concluded that the EU has a clear mandate for action and can add value in many areas in the field of health, including playing a role in addressing key existing and emerging health challenges in the EU. Member States are responsible for national health services, but the EU has a wide range of roles to play, and the EU's potential for helping to address health challenges in the EU should be optimised through the development of a new strategic framework.

3. OBJECTIVES

The objectives for the Health Strategy relate to the problems defined in section 2.1 and 2.2.

It is not possible in the context of this Impact Assessment to cover the detailed content of the proposed Health Strategy. This will contain multiple actions, many of which are already ongoing both in DG SANCO and other services, which will address a range of challenges. The Strategy does not aim to replace actions currently undertaken on health at EU level, but to put in place a new overarching strategic framework to focus on key challenges and guide current and future actions in all sectors (see diagram below).



Health Objectives:

Four broad health objectives are defined, relating to the Changing Health Challenges identified in Section 2.1. These general objectives will be supported by specific and operational objectives which will be defined in cooperation with Member States in the initial phase of the implementation process. Some of these individual actions would require a specific Impact Assessment and monitoring process. These areas will need to remain flexible enough to cover work in relation to existing challenges and to avoid excluding any new challenges that may not have been foreseen.

These four objectives relate closely to the Commission's existing objectives of Solidarity, Security, Prosperity, and Europe in the World, as well as with key European strategies. Objective 1 relates to the solidarity objective, in assisting all Member States to achieve the health standards of the best, and it also relates to the Open Method of Coordination on Social Protection and Social Exclusion. Objective 2 relates to security and the protection of citizens from heath threats. Objective 3 relates particularly to prosperity and the Sustainable Development Strategy, as sustainable and cost-effective health systems support a health population and therefore a strong economy. Objective 4 relates to the objective of Europe in the World. All four objectives are in line with the Lisbon Strategy, as all aim for better health and healthcare which is clearly linked to economic prosperity.

The four health objectives are as follows:

- **Objective 1 – To Foster Healthier Lifestyles and Reduce Inequities In Health Across The EU – particularly in relation to supporting healthy ageing**

- **Objective 2 – To Protect Citizens and Patients from Known and Unknown Threats to Health**

- **Objective 3 – To Increase The Sustainability Of Health Systems with a focus on New Technologies**

- **Objective 4 – Strengthening the EU's Voice in Global Health**

Good Governance Objectives:

Three good governance objectives are defined, relating to the issues identified in Section 2.2 These will be supported by operational objectives that are linked to the implementation of an effective strategy.

- **Objective 5 – to set a Strategic Framework with objectives and measurable indicators**

The Strategy would identify clear objectives measurable by indicators for progress at EU level in the field of health over the coming 10 year period. This will enable a focused approach to tackling health objectives 1-4. Further specific and operational objectives would be developed with Member States and would need to be in line with the Lisbon Strategy, the Sustainable Development Strategy, the Open Method of Coordination on Social Protection and Social Exclusion and other key EU policies.

- **Objective 6 – To Achieve Greater Health In All Policies Cooperation**

Health is affected, and has the potential to be affected in both positive and negative ways, by a wide range of non-health policies. This general objective is central to supporting health objectives 1-4 as health policy alone will not fulfil potential for positive change without partnerships in other sectors.

- **Objective 7 – To Achieve Greater Visibility for work on health at European level**

A key objective for the Health Strategy, which will be a clear measure of its success, is that it creates greater visibility and understanding of work done on health at the EU level, and supports the enhanced communication of health information.

4. POLICY OPTIONS

It is not the function of this Impact Assessment to set out in detail the lists of actions that will support the health objectives. Many actions are already ongoing, and new actions will have their own Impact Assessment where necessary. The purpose of the strategy is rather to put in place a new framework to set the direction of travel. The options therefore look at different ways of putting such a framework in place.

	Overview of Options
Option 1	Status Quo: No new Health Strategy
Option 2	Health Strategy with Enhanced Intersectoral Action at EU level
Option 3	Health Strategy with Enhanced Intersectoral Action and Structured Cooperation with Member States and Other Stakeholders
Option 4	Health Strategy with Enhanced Intersectoral Action, Structured Cooperation with Member States and Other Stakeholders, and Binding Targets

Option 1: Status Quo: No new Health Strategy

Continue with existing and planned work without setting overarching objectives or developing a coherent, strategic approach for key actions in the health sector, cross sectoral actions and global issues.

Instruments: continue as present using a range of tools as appropriate.

Option 2: Health Strategy with Enhanced Intersectoral Action at EU level

This would include:

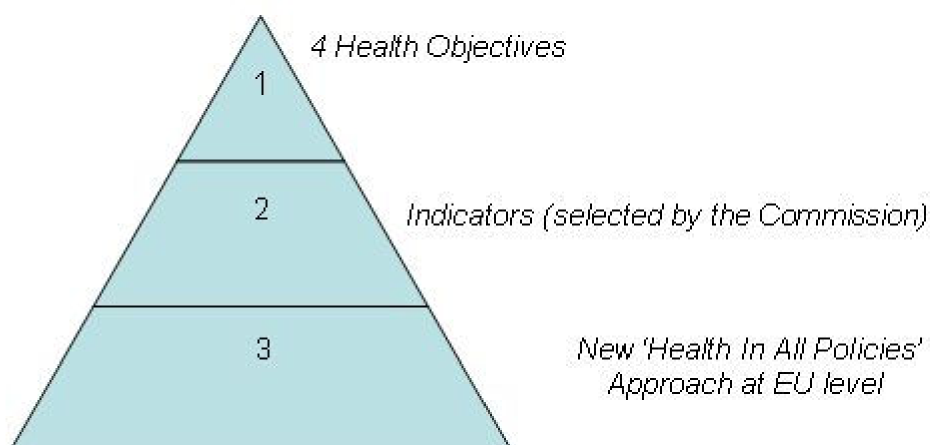
a) Setting 4 health **objectives** to guide future actions, supported by specific and operational objectives, and observing the 3 good governance objectives.

b) Selecting quantitative **indicators** to measure progress against these objectives where appropriate. These might be, for example, increase cancer screening, increase numbers of networks of centres of reference, or increase numbers of Member States with e-medical records. Under Option 2, these indicators would be selected by the Commission.

c) Development of an **enhanced 'Health in all Policies' Intersectoral Approach** to support action to achieve the objectives of the Strategy alongside other sectors and specialised EU agencies, for example in relation to the Lisbon Agenda and competitiveness, technology and innovation, young people’s health, health prevention/life-long learning, ageing and health, health and the world of work, health and regional development.

Instruments: White Paper Communication, Commission interservice monitoring mechanism

Diagram: Option 2



Option 3: Health Strategy with Enhanced Intersectoral Action and Structured Cooperation with Member States and Other Stakeholders

In addition to Option 2, Option 3 would include:

a) Setting up a new **consensus mechanism of 'Structured Cooperation'** with Member States. The new mechanism would use methods that have been tried and tested under the Open Method of Coordination which is used for work towards the Lisbon goals, and would involve agreeing indicators in relation to the objectives of the Strategy, developing specific and operational objectives to support the achievement of the 4 health objectives, sharing information to support national, regional and local policy development to support the objectives, mutual learning processes, and other relevant activities. This new structured cooperation would also establish a process for monitoring the Strategy. [54]

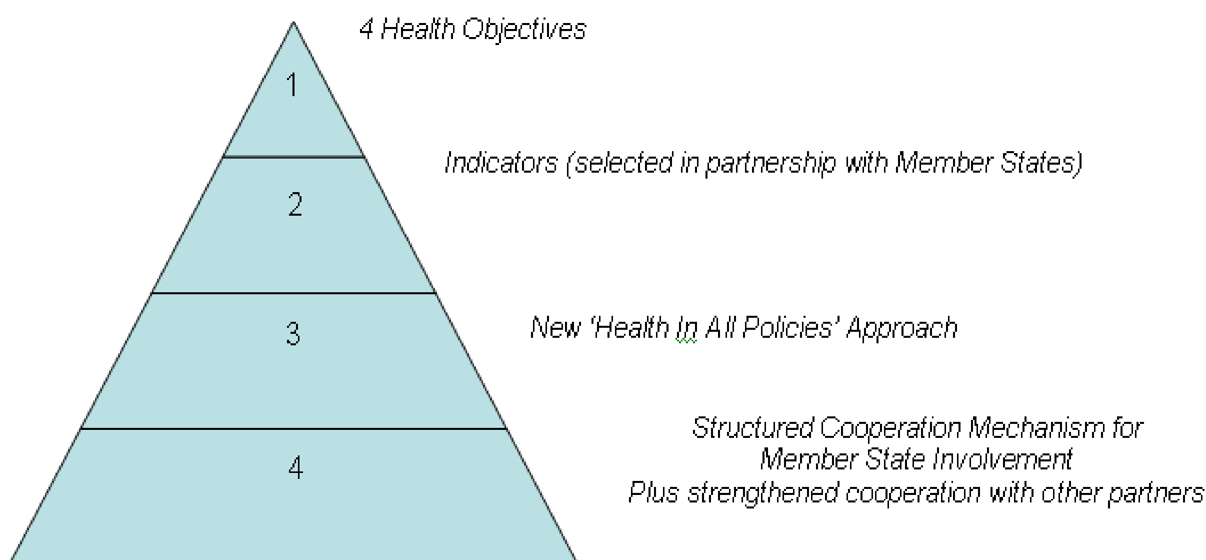
b) A Health In All Policies approach which goes beyond EU level to support greater intersectoral cooperation at national, regional and local levels.

c) Building closer links with regions through, for example, greater cooperation with the Committee of the Regions and through the Structural Funds mechanism.

d) Strengthening existing mechanisms of dialogue and cooperation with health partners, with a particular focus on civil society, through a new advisory board or forum.

Instruments: White Paper Communication, Commission interservice monitoring mechanism, coordination and partnership mechanisms

Diagram: Option 3

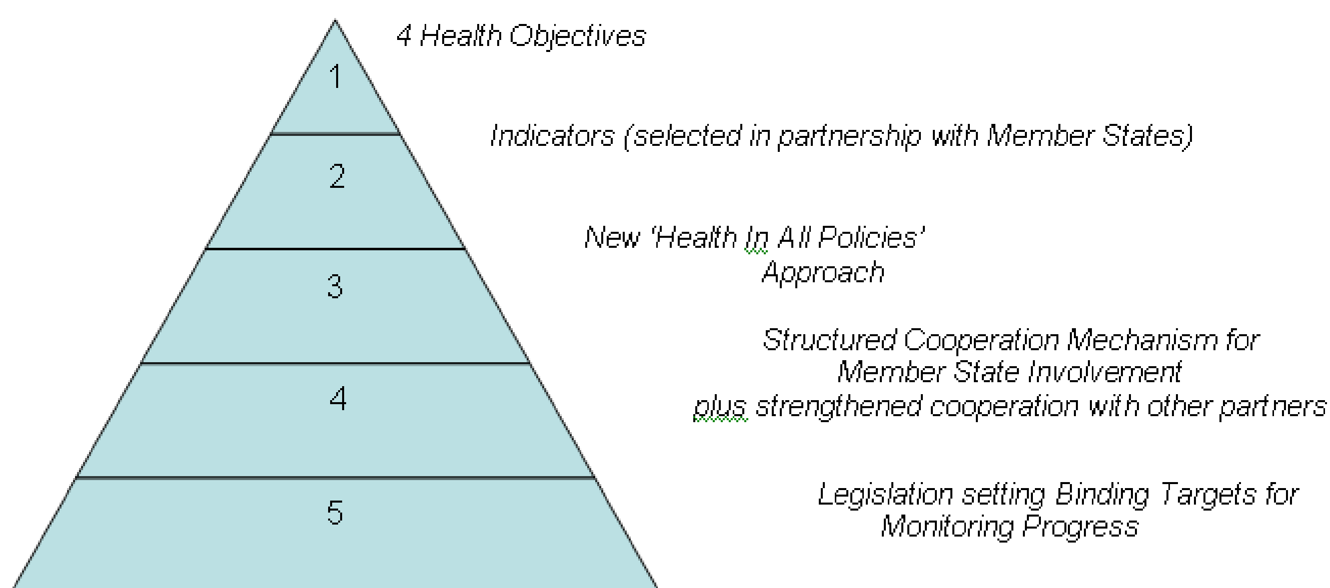


[54] Fostering cooperation and coordination with the Member States has its basis in Article 152, and it is likely that a new provision to strengthen cooperation on health will be included in a new Reform Treaty, following the European Council meeting of 21-22 June 2007.

Option 4: Health Strategy with Enhanced Intersectoral Action, Structured Cooperation with Member States and Other Stakeholders, and Binding Targets

Option 4 would be a strengthened version of Option 3. As in Options 2 and 3, a set of indicators would be agreed. However, this option would include **legislation** to set **binding targets** to drive forward work towards the objectives by close scrutiny of progress across Member States. Other stakeholders could report in line with Member State reporting, on a voluntary basis.

Instruments: White Paper Communication, Commission interservice monitoring mechanism, other coordination and partnership mechanisms, legislation for binding targets



5. ANALYSIS OF IMPACTS

This section looks at the possible impacts of each of the four policy options set out in the last section. Given the broad nature of the Strategy, it is not possible to provide detailed and quantifiable estimates of the impact of the options. Instead, general estimates of the impact of each approach have been made.

Before analysing Options 1-4, it is worth briefly considering the negative impacts of not having any EU-level work on health. Under 1.2 above, the justification for EU action on health is set out; some issues are of a cross border nature, and EU action is indispensable. For other issues, the EU can clearly add value. Box 4 sets out some concrete examples of the 'impact' of no action on health at EU level. This acts as a baseline for the consideration of Options 1-4.

Box 4 – Negative Consequences of No Health Action at EU level

- No coordination of pandemic influenza planning; lines of communication would be confused, and mutual agreements between Member States bilateral or fragmented.
- No projects within the Health Programme; many projects on key health issues are funded each year, with 353.77 million euros available for projects between 2003 – 2008.
- Without EU mutual recognition of qualifications, movement of health professionals between countries would be much more difficult.
- No transnational health research in Framework Programmes to improve understanding of health issues while increasing EU competitiveness and innovative capacity.
- No ban on tobacco advertising across the EU, leading to the continued promotion of a product which causes more than 79,000 deaths per year in the EU[55].
- No advice from EU health-related scientific committees on issues like nanotechnologies or exposure to electromagnetic radiation or environmental pollutants.
- No European Health Insurance Card, covering EU citizens for necessary medical care when travelling within the European Economic Area.
- Less interchange of knowledge, ideas, and best practice in the field of health between national health administrations and experts from across the EU.

Option 1: Status Quo: No new Health Strategy

Introduction

Current work on health at EU level is valuable and will lead to positive benefits in terms of Economic, Social and Environmental aspects. Although these are too complex and numerous to mention in detail, this section sets out some examples and analysis, with a particular focus

[55] Lifting the Smokescreen, 10 reasons for a smoke free Europe, Smoke Free Partnership 2006.

on the relationship between health and economic prosperity. The aim of a new Health Strategy is not necessarily to do more (although some new actions will be identified) but to give health policy at EU level more focus, coherence, direction, and prioritisation and thus enable it to be more effective and efficient. Continuing as at present would mean that potential benefits of this approach will not be realised.

Economic Impact of Option 1

There is a clear link between health and economic prosperity, both in terms of costs of health systems and of illness to the economy, and in terms of the facts that effective investment in health can support future sustainability particularly given the demographic ageing of the population, and that the health market is a key sector for growth and innovation. Annex 3 contains a more detailed analysis of the relationship between health and the economy. It is becoming more widely accepted that work done at EU level on health contributes to economic prosperity and sustainability. This is recognised in the inclusion of the Healthy Life Years indicator (a measure of the number of years that a person can expect to live in good health) in the Lisbon agenda, and in the fact that Structural Funds can be broadly used for improving health infrastructure and workforce and supporting actions on health prevention and promotion so that they contribute to the overall cohesion and economic development of the EU's regions. However, continuing with the Status Quo option makes it likely that the full potential for supporting the economy through health is not achieved, particularly in relation to **Objective 3, to increase the sustainability of health systems with a focus on New Technologies**, because the lack of a visible, strategic framework means that the link between health and the economy is not fully taken into account in all areas, and this may lead to a less sustainable economic future for Europe.

Social Impact of Option 1

As health itself falls into the category of social impacts, it is clear that a broad range of positive impacts can be expected from the 'no new action' option, which cannot be enumerated here, but include current initiatives to protect citizens including pandemic preparedness planning, work to prevent ill-health such as the Commission's initiative on smoke-free environments, mental health and the adopted EU strategy to reduce alcohol related harm[56], work in the area of health services including the proposed new initiative on health services, and the Pharmaceutical Forum which brings together industry, Member States and stakeholders, work to increase knowledge on health issues including using DG Research framework programme projects, and many other actions including those done in non-health policy areas.

There are, however, limitations in continuing as present as there is potential for better cooperation, coherence and objective setting. As set out in the problem definition section of this Impact Assessment, new challenges to health mean that the EU needs to refocus on key priorities where added value is achievable, building on current actions. Continuing with the Status Quo would mean that the benefits of a renewed focus on the **four health objectives, (1 -to foster healthier lifestyles and reduce inequities in health across the EU, 2 - to protect citizens and patients from known and unknown threats to health, 3 - to increase the sustainability of health systems with a focus on New Technologies and 4 - to stenghten the EU's voice in global health),** would be lost.

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[56] Commission Communication on an EU strategy to support Member States in reducing alcohol related harm - COM(2006) 625.

Similarly, positive social impacts in relation to the **three governance objectives (5 - to set a strategic framework with objectives and measurable indicators, 6 - to achieve greater Health In All Policies cooperation, and 7 - to achieve greater visibility for work on health at European level)** would be lost. No clear direction of travel would be set for the EU in terms of a strategic framework, leading to less focus on key areas. Synergies between sectors at all levels may not be exploited fully leading to a limited impact of health initiatives, and citizens and stakeholders would not have improved clarity on, and participation in, the EU's work on health.

Environmental Impact of Option 1

In terms of environmental impacts, ongoing positive work will take place on environment and health under the European Environment and Health Action Plan 2004-2010[57], which aims to reduce the disease burden caused by environmental factors in the EU, to identify and prevent new health threats caused by environmental factors and to strengthen EU capacity for policymaking in this area. Positive impact on health is also expected by the ongoing work done in the sectoral health related environmental policies such as REACH[58] legislation for chemicals, the thematic Strategy on the Sustainable Use of Pesticides[59], the 2005[60] strategy on Mercury, Thematic Strategy on Air Pollution[61], policy on water quality[62], noise[63], etc. However, more visibility of environment and health actions could be achieved **Objective 7 to achieve greater visibility for work on health at European level.** Further, integration across the EU in line with **Objective 6 to achieve greater Health In All Policies cooperation** could lead to the development of actions in other areas where synergies between health and environment are to be found. For example, environmental problems have often a global dimension where only initiatives coordinated at local, national and international level can ensure that the actions taken are effective and will deliver expected health and environmental benefits (e.g. greenhouse gas emissions and climate change which are key concerns for the coming years) and there is potential for these to be further developed (see Annex 3d).

Conclusion

Although positive impacts will be achieved by continuing with current work on health at the EU level, choosing Option 1 would not, however, refocus on significant new challenges within and beyond the EU and would therefore not address these challenges in the optimum way. Options 2-4 refer to the introduction of a new Health Strategy which sets clear objectives, identifies priorities and gives a clear sense of direction.

Option 2: Health Strategy with Enhanced Intersectoral Action at EU level

Option 2 aims to draw together the work done on health at EU level in all sectors. The Health Strategy will not be a 'DG SANCO' strategy but a Community-wide Strategy. The achievement of common objectives by all sectors working in partnership will require a new

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57 COM(2006) 625.
58 Registration, Evaluation and Authorisation of Chemicals.
59 COM(2006) 327.
60 Communication from the Commission to the Council and the European Parliament on a Community Strategy Concerning Mercury - COM(2005) 20, SEC(2005) 101.
61 COM(2005) 446.
62 E.g. Drinking Water Directive 98/93/EC, Bathing Water Quality Directive 76/160/EEC, and Directive 91/271/EEC on urban waste water treatment.
63 See Green Paper - COM(96) 540 -, Directive 2002/49/EC, etc.

cross-sectoral 'Health in all Policies' approach including an improved mechanism for monitoring progress.

Economic Impact of Option 2

Under Option 2, the relationship between health and economic growth and prosperity could be more fully exploited than under Option 1 through more focused development of cross-sectoral synergies in a wide range of fields, building on the significant progress being made in relation to, for example, the impact of a healthy population on the labour force, innovation in the field of health, e-health technology, taxation policy on products such as tobacco, supporting efficient health systems to ensure effective public spending, and health in regional policy and the Structural Funds, many of these contributing in particular to **Objective 3 - to increase the sustainability of health systems with a focus on New Technologies**. This is turn may help to stimulate greater understanding EU-wide of the importance of investments in health and health systems. However, without the full engagement of Member States and other stakeholders as foreseen in Options 3 and 4, the impact on economic prosperity would be limited, and beyond the use of European Funding mechanisms there might be little change at national level.

Social Impact of Option 2

In terms of social impact, Option 2 would build on existing cross-sectoral synergies, particularly in the fields of employment and education, which are increasingly recognised as settings for health promotion and prevention of disease and ill-health, supporting the achievement in particular of **Objective 1 - to foster healthier lifestyles and reduce inequities in health across the EU**. One benefit would be strengthened health links with the Open Method of Coordination for social protection and social inclusion, which already works with Member States on key issues affecting Lisbon agenda goals. In comparison with Option 1, therefore, Option 2 could lead to improved clarification of key health issues at the EU level which could lead to some health gains. Enhanced HIAP cooperation at EU level might also stimulate greater HIAP cooperation at national, regional and local levels, supporting **Objective 6 - to achieve greater Health In All Policies cooperation**. However, without the full engagement of Member States and other stakeholders as foreseen in Options 3 and 4, changes in health status and other positive social impacts would be unlikely to be significant. In particular, the fact that indicators to measure progress against the health objectives would be selected at Commission level would mean that the 'buy-in' required to drive changes in health policy and therefore changes in outcomes at national, regional and local level would be unlikely to be achieved. Other stakeholders such as NGOs representing a wide range of health groups, as well as academia and industry may benefit from the clarity given by the EU health strategy but as no new mechanism is set up under Option 2, the possibilities for their involvement and therefore their contribution to positive social and economic impacts may not be maximised.

Environmental Impact of Option 2

In terms of environmental impact, Option 2 would build on existing work in relation to the European Environment and Health Action Plan as under Option 1. Cross-sectoral work could be further developed in fields like the health impact of climate change, health impacts within the built environment, etc, in order to work towards positive environmental health outcomes. Option 2 may offer a slightly greater positive impact on environmental health than Option 1, but without full engagement of Member States, the ultimate outcomes are unlikely to be significantly different.

Enhanced Intersectoral Action - Boundary Test

Under Option 2, a means of measuring progress by all sectors against the common objectives would be implemented, alongside a package of measures to support better cross-sectoral working on health. It is likely that this Option would achieve a generally positive impact on health policy due to more coherent cross-sectoral work and better understanding across sectors. It would not place any new burden on Member States and so would respect the boundary test and subsidiarity principle. However, the value of a new, more coherent strategy will be limited unless Member States and stakeholders are closely involved in development of strategic objectives and the implementation of the objectives of the Strategy at national level. Option 3 and 4 go further than Option 2 in looking at a coherent strategy paired with new, stronger coordination and cooperation mechanisms outside the Commission.

Option 3: Health Strategy with Enhanced Intersectoral Action and Structured Cooperation with Member States and Other Stakeholders

Option 3 aims to build on Option 2 by adding a new mechanism of structured cooperation between MS and other stakeholders, aiming for recognition and 'ownership' by all players in the strategy through setting new mechanisms for stronger cooperation and coordination.

Economic Impact of Option 3

Option 3 is expected to have a stronger positive economic impact than Options 1 and 2. As Member States are responsible for public spending, facing the need to ensure future economic sustainability, and planning the use of convergence funding, their 'buy-in' to a new Strategy will support economic benefits. At the same time, the structured cooperation mechanism will support sharing of knowledge on economic issues between Member States. A new strategy, developing both intersectoral work and relationships with actors and partners could help to support a 'culture change' towards a better understanding across all sectors and at all levels that health is an important economic factor and that effective investment in health, including in health promotion and prevention, is vital in terms of future sustainability of health systems. More specifically, engagement with Member States and other stakeholders to tackle broad health objectives could support economic gains in relation to the four health objectives; for example, reducing health inequity and improving population health status go hand in hand with economic prosperity supporting **Objective 1**, more efficient health systems are more cost effective for public spending, supporting **Objective 3,** and a stronger EU presence in global health governance could lead to economic benefits in terms of, for example, trade and sustainability of supply of health professionals, supporting **Objective 4.**

Social Impact of Option 3

The social benefits of Option 3 would be found in the more directed approach by all partners to **all four health objectives**. Gains would be expected in health status through improvement at all levels in a broad range of disease measures and operational processes, in greater understanding of how to run health systems efficiently to ensure future financial sustainability in the fact of pressures such as the ageing population, and in an enhanced engagement in global governance. This engagement with Member States could be expected to achieve a significantly greater health and social outcomes than Options 1 and 2. Some successful examples of EU implementation mechanisms in partnership with Member States are shown in Box 3.

Box 3 - Examples of EU-Member State Implementation Mechanisms

Example 1: The Open Method of Coordination

The Open Method of Coordination (OMC) was introduced by the European Council of Lisbon in March 2000 as a method of helping member states progress jointly in the reforms they needed to undertake in order to reach the Lisbon goals. Since then it has been applied in the European employment strategy, social inclusion, pensions, immigration, education and culture and asylum.

OMC is the soft governance tool, agreed between Member States in Lisbon, to ensure satisfactory progress in policy areas which are primarily of Member State competence. OMC involves:

"- fixing guidelines for the Union combined with specific timetables for achieving the goals

which they set in the short, medium and long terms;

- establishing, where appropriate, quantitative and qualitative indicators and benchmarks

against the best in the world and tailored to the needs of different Member States and sectors

as a means of comparing best practice;

- translating these European guidelines into national and regional policies by setting specific

targets and adopting measures, taking into account national and regional differences;

- periodic monitoring, evaluation and peer review organised as mutual learning processes".

(Lisbon Strategy)

An external evaluation of OMC activities in DG Enterprise and Industry found that in the area of Small and Medium sized Enterprises where it had mainly been used, the OMC work was successful. It recommended that there was strong potential to developed OMC in other areas.[64]

Example 2: CREST

[64] Evaluation of the Open Method of Coordination activities coordinated by DG Enterprise and Industry, GHK/Technopolis, Sept 2006, p. 9.

Under the broader OMC, DG Research set up CREST (Committee de la Recherche Scientifique et Technique) as an advisory body to the European Council. This created five expert groups on different areas to address key actions, identify good practice and suggest policy recommendations to Member States in relation to achieving the goals of the OMC. In the first OMC cycle they used reports from the five groups to produce an overall report with 30 recommendations for the second OMC Cycle. The second cycle then went on to concentrate on more focused topics.[65] CREST found that in the first cycle the OMC,

'resulted in a number of concrete benefits' in the field of research including the establishment of networks of national policymakers, the collection, collation and exchange of information on national policies, the identification through peer review of good practices, and the identification of key issues and, in some instances, specific recommendations for the future.'[66]

Example 3: The Bologna Declaration

This example of an international implementation system is being used in the area of education. It is a pledge by 29 countries, in 1999, to reform the structures of their higher educations systems in a convergent way, with 40 countries now participating. By aiming for convergence, the process preserves the fundamental principles of autonomy and diversity. The process includes a single common goal, a deadline of 2010 and a set of specified objectives, e.g. 'the adoption of a common framework of readable and comparable degrees'. It is followed by a consultative group of all countries, as well as a smaller follow-up group.

In 2005 a further meeting in Bergen noted that progress had been made: convergent reforms are already in place in several European countries, signalling a move towards shorter studies, 2-tier degree structures, external evaluation, and other changes. [67]

Setting up the structured cooperation mechanism would mean that existing EU-level committees in the public health sector may need to be rationalised or streamlined to better support a new Health Strategy. This would achieve a positive social impact as work would be more efficiently focused towards well-defined health objectives in a smaller number of groups, and work with other sectors such as social protection policy could also be strengthened. The mechanism would also compliment and support the work of existing mechanisms including the OMC on Social Protection and Social Exclusion. This simplified structure would support **Objective 7** in making EU health policy more accessible, visible and transparent.

Alongside a mechanism for Structured Cooperation between Member States, Option 3 also provides for new means of Structured Cooperation with stakeholders, including EU citizens. Health experts have advocated a 'network governance' approach for policy to focus on the determinants of health, asserting that the most successful policymaking engages a wide range of players from all sectors, complemented by 'policy commitments at different levels of government and in the private and non-governmental sector'.[68] These partners have an important role in delivering health policy. This approach is a step further than Option 2,

[65] http://ec.europa.eu/invest-in-research/coordination/coordination01_en.htm

[66] http://ec.europa.eu/invest-in-research/pdf/download_en/crest_report_barcelona_research_investment_objective.pdf, p. 10.

[67] http://ec.europa.eu/education/policies/educ/bologna/bologna_en.html

[68] Kickbusch I. Innovation in health policy: responding to the health society. Gac Sanit 2007;21 (in press).

which allows for enhanced intersectoral work at the European level only. Option 3 would aim for enhanced intersectoral and multi-partner work at all levels, therefore enabling many more opportunities for work to achieve positive health and social impacts, and supporting **Objective 6 to achieve greater HIAP cooperation** more strongly than Options 1 and 2.

Positive outcomes of innovative work with stakeholders also include the Platform for Action on Diet Nutrition and Physical Activity, and the Pharmaceutical Form (see Box 4). This supports the likelihood of a positive impact through new stakeholder mechanisms developed under the Health Strategy, as well as though a new strategic view of the work of the existing platforms.

Box 4 – Examples of Multi-Stakeholder Activities in Health-Related Areas

The Platform for Action on Diet, Nutrition and Physical Activity is an example of an implementation mechanism which has had positive outcomes. The Commission set up the EU Platform on Diet, Physical Activity and Health in March 2005 as a voluntary forum for diverse stakeholders operating at European level to contribute to tackling growing levels of obesity. Members include organisations representing industry, research organisations and public health civil society. Platform members have committed to taking steps to reduce obesity within their areas of work, and a clear and reliable system of monitoring the commitments to demonstrate progress has been developed.

The Pharmaceutical Forum is another example of successful cooperation between partners. The Pharmaceutical Forum is a high-level political platform for discussion supported by a Steering Committee and three expert Working Groups. The aim is to enhance the competitiveness of the pharmaceutical industry in terms of its contribution to social and public health objectives. The Forum brings together Ministers from all European Union Member States, representatives of the European Parliament, patients, the pharmaceutical industry, healthcare professionals, and insurance funds.

Environmental Impact of Option 3

Under Option 3, greater improvement in the field of environmental health could be expected than in Options 1 and 2. Building on ongoing work, Option 3 would allow for increased opportunities to share knowledge and experience on environmental health issues between Member States and with other Stakeholders. Emerging issues such as tackling climate change could be better addressed within the new mechanisms, particularly in relation to the global stage, supporting **Objective 4, to strengthen the EU's voice in global health.**

A 'Structured Cooperation' Approach – Subsidiarity and Boundary Test

The Open Method of Coordination (OMC) is a Member State-led approach, set up by the Council of Lisbon in March 2000. Its benefits are that it is a robust procedure which binds Member States to working towards its goals, and is therefore likely to have greater outputs and outcomes than less binding procedures. The Structured Cooperation suggested by Option 3 would take lessons from the methods of the OMC. On the other hand, the requirements placed on Member States by OMC-style approaches to meet, gather data and report on a regular basis could be seen as burdensome. Member States and other stakeholders were therefore consulted about implementation mechanisms to test whether there would be support for a formal system of structured cooperation for the Strategy.

In the response to the consultation, there was a general consensus in favour of developing a Structured Cooperation mechanism. In a separate questionnaire to the High Level Committee on Public Health, support for an OMC-style approach was also expressed by a number of respondents. Many respondents referred to positive impressions of the existing Open Method of Coordination on Social Protection and Social Exclusion, and those responsible for leading on that work within the Commission noted that Member States preferred to work within a mechanism which gave them ownership over the setting of indicators. Some respondents said that an OMC-style approach would have the correct set of tools for exchange of experiences and good practice, and as a way of providing general orientation and key messages without developing obligations or mandatory guidelines. The method was also seen as a way to facilitate consensus and ownership among representatives at national, regional and local level.

A Structured Cooperation mechanism would **support the Subsidiarity Principle**, which states that the EU should only take on tasks which cannot be performed effectively at a more immediate or local level. The EU is in the position to agree cross-cutting objectives with all players, but a Structured Cooperation mechanism would place ownership in the hands of Member States. In general, therefore, support from many Member States and stakeholders as well as positive past experience of similar implementation mechanisms suggests that a new mechanism of structured cooperation would have a broadly positive impact towards improving and protecting health in the EU, while being proportional in terms of burden placed on Member States and respecting the Subsidiarity Principle and Boundary Test.

Administrative Burden

Although it is difficult to evaluate, it is likely that a new mechanism of Structured Cooperation would not carry a significant administrative burden for Member States or for other stakeholders. The potential burden of developing new indicators will be avoided, as the Strategy will focus on bringing together existing indicators to more fully exploit data for a better overall view of the situation, to inform the policy response, and to measure progress against the objectives. The Structured Cooperation mechanism would offer advantages in terms of opportunities for a more streamlined approach to EU level discussion on key issues. However, future actions under the Strategy (particularly any legislative actions) may carry a burden which would be evaluated for each initiative.

Conclusion

Structured Cooperation under Option 3 would mean greater visibility and transparency of EU health policy. It would contribute to more structured and strategic cooperation with all partners and a more coherent and well coordinated approach to promote health within the EU and globally. It would mean streamlining of existing mechanisms at EU level to ensure efficiency of work towards the objectives. It is likely that this approach would have a generally positive impact on improving and protecting health in the EU, and would be stronger than Option 2 without imposing an unreasonable burden on Member States and other partners.

Option 4: Health Strategy with Enhanced Intersectoral Action, Structured Cooperation with Member States and Other Stakeholders, and Binding Targets

Option 4 goes a step further than Option 3. It recommends using legislation to set binding, obligatory targets for the Member States to achieve, rather than agreeing, through negotiation within the Structured Cooperation mechanism, on specific objectives to support the 4 health

objectives. This would be a strong and definitive step towards achieving health goals. On the other hand, it could be seen as too heavy-handed.

Economic Impact of Option 4

In terms of economic impacts, these would be expected to be similar to those described under Option 3. Given the nature of binding legislation, it could be expected that the positive impact described may be stronger. However, this would be offset against the concern that setting legislative targets may be burdensome and problematic for Member States, with the potential to reduce the flexibility available to tailor national, regional and local policies to particular needs.

Social Impact of Option 4

Option 4 could be expected to achieve greater positive social impacts than Options 1 to 3. Targets are likely to produce positive results. Binding health targets in a high profile EU strategy are likely to attract media attention, which can in turn act as a lever to achieving the targets. However, there is a risk that a target oversimplifies the ultimate aim, for example reducing the mortality rates relating to a disease ignores the non-fatal consequences of that disease. At the EU level, targets must be agreed by all Member States, who are likely to be starting from very different baselines. This can lead to a 'lowest common denominator' being set, which fails to be a challenge to the majority of Member States, so that even though setting binding targets may be effective, it will only be effective for a few Member States.

Targets are 'resource-intensive' at all levels and require administrative time in setting up mechanisms to capture, input, collect and return data and then to run those mechanisms. They need some level of policing, or checking, that data is accurate and being collected correctly. This investment can be justified when there is a specific issue that needs timely attention, for example targets for reducing emissions. An overarching EU Health Strategy, however, covers a huge number of issues. Either a large number of targets would need to be set, leading to a substantial administrative burden, or targets would have to be focused on a small number of very specific issues, with the risk of excluding important issues. Setting binding targets for health would therefore be likely to have some localised positive social outcomes but not in all Member States, and not across all key areas. Other stakeholders would not be bound by the targets and may be less engaged with them than with a system of objectives in which they have more opportunity for discussion and engagement on how to proceed. Binding targets may not be as effective in terms of the balance of resources needed to run them as a broader, direction setting approach in cooperation with Member States and other Stakeholders, as in Option 3.

Environmental Impact of Option 4

The environmental impact of Option 4 is likely to be similar to that of Option 3. If a specific binding target or targets was set on environmental health, this could support significant positive outcomes. However, as the European Environment and Health Action Plan and other initiatives are ongoing under the Status Quo, this could be seen as an unnecessary and confusing move, whereas under Option 3 a more open approach allowing for discussion and knowledge sharing between partners on a range of issues could be seen as contributing more to a positive environmental impact.

Option 4: Subsidiarity and Boundary Test

Binding Targets could be set at EU level by means of legislation, supporting the requirement to attain a high level of health protection as set out in Article 3 (1)(p). Broadly, it could be expected that setting targets would ultimately have a positive impact on health in the EU. In terms of subsidiarity, if binding targets on health issues at national level were found to be ineffective for some cross-border issues, it could be argued that Option 4 would respect the subsidiarity principle. However, in terms of proportionality, the objectives of the strategy could be met by less stringent action by the EU than this Option and the boundary test is therefore not respected by Option 4.

Conclusion

Option 4 would be the strongest option in terms of requiring action by Member States. It could be expected to achieve positive outcomes, particularly in the health and social fields. However, the limitations of setting binding legislative targets as opposed to agreeing operational objectives within a structured cooperation system are that this may unnecessarily divert resources at national, regional and local level to administering the targets, that the targets may only be meaningful for some Member States, and that targets would either be too numerous or too reductive. Crucially, binding targets appear to be a disproportionate measure for achieving the objectives of the health strategy and may not respect the subsidiarity principle.

6. COMPARING THE OPTIONS

Objective	Option 1: Status Quo	Option 2: Health Strategy with Enhanced Intersectoral Action	Option 3: Health Strategy with Enhanced Intersectoral Action and Structured Cooperation with Stakeholders	Option 4: Health Strategy with Enhanced Intersectoral Action, Structured Cooperation with Stakeholders and Binding Targets
Health Objectives				
1. To Foster Healthier Lifestyles and Reduce Inequities In Health Across The EU	Option 1 would lead to benefits based on the continuing knowledge and information sharing between Member States, and, in particular, the use of the Structural Funds for health. However, given the enlargement to 27 Member States from 15 since 2004, continuing as present may not support the changing needs of the larger EU.	Option 2 could lead to a stronger focus on reducing inequities and healthy lifestyles through increased work to develop synergies across the EU, through bringing together in a more strategic way the many varied actions across the EU that impact on health and health determinants. However, without full engagement by Member States the added value and actual outcomes would be limited.	Option 3 would engage all Member States to focus attention on the objective of reducing inequities and supporting healthy lifestyles. In particular, this may support Member States performing at the lower end of the spectrum on particular issues to learn from the experience of others. This option would be likely to have a positive outcome.	Option 4, like Option 3, would be likely to have a positive outcome in reducing inequities and supporting healthy lifestyles. The impact might be greater than in Option 3 due to the imposing of binding legislative targets. However, this may be seen as disproportionately burdensome to Member States.
2. To Protect Citizens and Patients from Known and Unknown Threats to Health	Option 1 would lead to benefits based on continuing action to protect people's health. However, the lack of a coherent strategic direction may mean that potential for improvement would not be fully exploited.	Option 2 could lead to benefits in protecting people's health, particularly through a new focus on exploiting synergies between sectors e.g. the applications of e-health to address risk management. However, without the full engagement of Member	Option 3 would be likely to lead to positive impacts on protecting people's health, due to the definition of indicators by Member States to measure progress against this objective.	Option 4 could be expected to have a slightly stronger positive impact than Option 3 due to the imposing of binding legislative targets. However, this may be seen as disproportionately burdensome to Member

		States, the impact would be limited.		States and may reduce their flexibility in addressing problems at national level.
3. To Increase The Sustainability Of Health Systems with a focus on New Technologies	Option 1 would lead to continued exchange of knowledge and good practice. However, this may not achieve the EU's full potential for action and could lead to the loss of economic benefits that may arise from a more targeted approach to health systems issues.	Although enhanced dialogue across sectors at EU level on issues around health systems could lead to further clarification of issues and action needed, Option 2 would be unlikely to lead to great added value in relation to the Status Quo as Member States have the right to control national health systems, and would need to be fully engaged in any work in this area at EU level.	Option 3 would be likely to have a positive impact by engaging Member States and directing activity towards sustainability issues. This Option would support the proposed Health Services Initiative which would address some issues.	Option 4 could be expected to have a slightly stronger positive impact than Option 3 due to the imposing of binding legislative targets. However, this may be seen as disproportionately burdensome to Member States particularly given their right to manage national health systems independently.
4. To Strengthen the EU's Voice in Global Health	Option 1 would mean continuing collaboration on health with key international bodies, and ongoing work particularly in the Relex family of DGs in relation to development aid. However, this would not provide a new focus on global health issues that is necessary given the increasing challenges of globalisation.	In Option 2, enhanced dialogue across sectors at EU level on global health issues could be valuable but without full engagement of Member States, this may not lead to real change towards a more global approach to health policy in the EU.	Option 3 would be likely to have a positive impact through putting in place a clear focus on key issues at EU level which would then be communicated at the global level. This Option would also support the consideration of global issues in health policy at all levels.	Option 4 would be likely to have a stronger impact than Option 3, particularly through requiring Member States to include global health considerations in their national health policies. However, this may be seen as a disproportionate approach.

Good Governance Objectives				
5. Setting Strategic Objectives	Option 1 would not set strategic objectives, so a new, coherent framework would not be put in place. Although effective work would continue, a clear, strategic vision for the future would not be achieved, and there would not be a focus on addressing key new challenges.	Option 2 would set strategic objectives which would help to strengthen synergies across sectors by offering a clear, strategic framework and direction of travel. However, as this approach would be essentially confined to the European Commission, it is likely that the objectives would not become widely recognised by Member States and other stakeholders, and that progress towards the objectives would therefore be limited.	Option 3 would put in place strategic objectives as well as a 'structured cooperation' implementation system with Member States and stakeholders to support work towards these objectives. It would be likely to be more effective than Options 1 and 2.	Option 4, like Option 3, is likely to be an effective option in relation to objective setting. It is likely to be slightly more effective than Option 3 as it enforces Member States to work toward the objectives through binding targets, rather than relying on the cooperation process alone. This Option, however, could be seen as disproportionately burdensome to Member States.
6. Increasing Health In All Policies (HIAP) Cooperation	Option 1 would continue with existing HIAP cooperation, with effective partnerships and synergies relating to health continuing across a range of policy areas. There would, however, be no strategic overview of work across all policy areas, with the risks of duplication of work, of not fully exploiting synergies, and not engaging Member States as strongly as possible on the issue of HIAP.	Option 2 would boost HIAP cooperation at the European level, building on partnerships that are already well established. However, without the full engagement of Member States, opportunities to achieve a 'culture change' similar to that achieved in the environment sector (i.e. recognition that health is an issue that requires cooperation between all policy areas) would be limited, and gains at EU level may not be reflected at national level.	Option 3 would build on Option 2 by not only enhancing HIAP cooperation at European level, but due to the structured cooperation mechanism, would be likely to contribute to a move towards greater recognition of the importance of intersectoral working at national, regional and local levels across the EU, and greater involvement of non-traditional stakeholders as partners to achieve health aims.	Option 4 would be as effective as Option 3 in increasing HIAP cooperation.

7. Improving Visibility	Option 1 would not adequately meet the objective of improving visibility and understanding of work on health at the EU level. Without a well defined Strategy, presenting a clear direction of travel that stakeholders and citizens can engage with would be difficult.	Option 2 would be unlikely to adequately fulfil the objective of greater visibility, understanding and transparency of work on health at EU level. Putting in place a strategic framework without the full engagement of Member States and stakeholders will limit the extent to which that framework is recognised and used.	Option 3 would be more likely than Options 1 and 2 to fulfil the objective of improved visibility of work on health at EU level, as Member States and Stakeholders would be fully involved in supporting the strategic objectives set by the Strategy, and the structured cooperation process will open up new opportunities for sharing knowledge and information at all levels.	Option 4 could be slightly more effective than Option 3 in improving visibility of work done at the EU level, as setting binding targets may mean that more policymakers at national, regional and local levels are required to consider EU health objectives. However, this Option, could be seen as disproportionately burdensome to Member States.

Preferred Option

Option 3 uses the powers given to the EU in the Treaty to go a step further than Option 2, by putting in place a new implementation system. This Option would ensure that the new strategy is not just a paper exercise, but that it drives real change. At the same time it does not go too far in placing a burden on Member States and respects the subsidiarity and proportionality principles. This Option is therefore the preferred Option which is expected to have the greatest positive impact for EU citizens balanced against a reasonable level of additional input from EU Member States.

7. MONITORING AND EVALUATION

Monitoring and evaluation will be on the basis of measurement against the seven objectives set out in section 3.

Good Governance Objectives

The three 'good governance' objectives can be measured by the following indicators:

- Process indicator – that a framework with objectives has been put in place (objective 5)
- Quantitative indicator – awareness of the new strategy among policymakers, professionals, academia and the public
- Qualitative indicator – that HIAP is more common practice at all levels

Health Objectives

Setting the parameters for monitoring and evaluation of the four health objectives of the Strategy are outside the scope of the White Paper and **will need to be decided by and with EU Member States following adoption of the Strategy**. The recommendation to take forward Option 3 means that a new implementation mechanism of Structured Cooperation will be agreed and set up by and with Member States. One of the first tasks of this new Cooperation process will be to set indicators for monitoring the Strategy, target values for those indicators, how the data will be disaggregated, and how frequently data will be collected.

It is expected that the Strategy will set a small number of broad, overarching objectives in the field of health, based on the three objectives set out in Section 2, to which all players can agree. These objectives will in turn be supported by indicators. The EU already collects a substantial number of indicators in the field of health and **it is expected that the Strategy can be monitored by means of existing indicators from various sources (e.g. see Box 5), thus placing no further burden on Member States in terms of collecting new data.**

To set appropriate indicators, the following questions will need to be considered:

– What have Member States done to implement a particular policy?

– What have other stakeholders done to implement a particular policy?

– What changes of behaviour need to be measured for the policy to succeed?

– What information do citizens need for the policy to be successfully implemented?

– What are the health outcomes resulting from the policy in question?

– What are the health in all policies aspects of the policy?

In terms of evaluation, the Strategy will have a mid-term evaluation to determine whether adequate progress is being made and to make any necessary changes, and a final evaluation. The Strategy will cover a period of 10 years.

In the consultation, many respondents acknowledged the importance of setting indicators. In some contributions it was stressed that Member States should have the responsibilities for collecting data while the European Commission should be responsible for the comparison of the results, setting milestones, and identifying best practice. Many respondents advised setting indicators that could precisely measure the economic or clinical benefits of specific action or reforms. Respondents called for coherence in the development of indicators, and many advised the use of indicators already defined within SANCO such as ECHI, measurements developed using the Eurobarometer survey or the use of specific measures such as mortality and morbidity rate, blood pressure or cholesterol level. The use of the Healthy Life Years (HLY) indicator, on of the Lisbon Process indicators was supported by most of the contributors, although some respondents stressed its limitations due to the fact that the self-assessment element can lead to problems of comparability between cultures, and some would prefer the use of the similar DALY or QALY measures. It was noted that process indicators for Health In All Policies could be developed. Some suggested that qualitative targets appropriate to each country could be defined.

The vast majority of the contributors suggested setting up a system of surveillance and reporting on the Health Strategy at the European level based on comparable data. Many suggested that high level objectives and specific indicators together with milestones should be subjected to annual monitoring, contributing to an annual health report.

Many respondents, including Member States, proposed that the list of the indictors should be agreed and established as a second step, once the broader objectives of the strategy were in place. Some contributors recommended producing, in addition to the Strategy document, a more detailed action plan where information on actors and responsibilities, timeline, tools, milestones would be defined in cooperation with Member States and with the involvement of stakeholders. The mid-term review of the strategy was seen important for reviewing progress.

Box 5 - Examples of existing indicators that, among others, could be used to monitor the Health Strategy:

- % difference in life expectancy between women and men within the EU (Eurostat mortality data)
- Infant mortality, under 18 mortality (Eurostat mortality data)
- Proportion of population aged 18-65 years reporting not working due to own illness or disability (EU Labour Force Survey)
- Loss of life expectancy (LLE) – used for air quality in relation to particulate matter (RAINS model)
- Healthy Life Years Indicator (Lisbon Structural Indicators)
- Smoking prevalence (ECHI)
- Obesity in adults (Health interview surveys, health examination surveys)

The ECHI-1 and ECHI-2 projects under the Health Monitoring Programme have developed a comprehensive list of indicators in close cooperation with Member States[69]. The first list of 40 indicators on the ECHI list could be used in the monitoring of the Strategy (see Annex 4). Further developments on comparable instruments for collection of data should permit the expansion of the ECHI list to around 400 indicators in the coming years.

[69] http://ec.europa.eu/health/ph_information/dissemination/dissemination_en.htm

ANNEXES

Annex 1: Health Strategy Consultation Meetings

Commission – **blue** Member States, Regions and Neighbourhood Countries - **yellow**

NGOs – **orange** Other Stakeholders/Experts/multiple stakeholders – **pink**

EVENT	DATE	DESCRIPTION
European Health Forum Gastein	4 October 2006	200 policymakers, NGOs and experts from across the EU
Interservice Group on Health	10 October 2006	An interservice group which meets regularly to share information on work in the health field. Services are to nominate colleagues to attend the Strategy Interservice Steering Group ISSG)
Stockholm Region	20 October 2006	8 visitors from Swedish Stockholm Region
High Level Committee on Public Health	25 October 2006	A biannual meeting of high level civil servants from National Health Ministries
Conference Bleue	27 October 2006	Industry group with a focus on pharmaceuticals
UK Deputy Chief Medical Officer in charge of Public Health	8-9 November 2006	Visit by high level UK delegation
Bilateral with EUROSTAT	10 November 2006	Interservice Bilateral
Meeting with Graham Lister and SANCO Unit O2	13 November 2006	Discussion with expert on strategic planning
Interservice Steering Group on the Health Strategy	17 November 2006	First meeting of ISSG
North West England Region EUBO meeting	20 November 2006	Meeting with 150 members of regional offices in Brussels
Health Policy Forum	22 November 2006	Annual meeting of health-related NGOs (49 member organisations)

South East Europe group	23-25 November 2006	Health Strategy presented to 9 South East Europe countries including Accession and Candidate Countries.
Meeting with Mark Suhrcke and Svetla Tsolova, WHO European Office	4 December 2006	Discussion with experts on Health Economics
Meeting with European Free Trade Association	5 December 2006	Presentation to Iceland, Norway, Switzerland and Liechtenstein
Meeting with Welsh National Assembly	7 December 2006	Presentation to 2 representatives from the Wales Brussels Office
Meeting with English public health and strategy experts in London	12-13 December 2006	Discussions on strategic planning and objective setting
Taskforce on Health Expectancies, Luxembourg	12 December 2006	Presentation to Expert Taskforce
Bilateral with INFSO	12 December 2006	Interservice Bilateral
Taskforce on Major and Chronic Diseases, Luxembourg	13 December 2006	Presentation to Expert Taskforce
European Public Health Alliance meeting	13 December 2006	Presentation to a network of 80 NGOs
Trilateral with INFSO and EUROSTAT	18 December 2006	Interservice Trilateral
Health Attachés	18 December 2006	Presentation to Member State Health Attachés group
Agence Spatiale Europeen	9 January 2007	Discussion meeting
Bilateral with EMPL	10 January 2007	Interservice Bilateral
Meeting with ENTR	11 January 2007	Interservice Discussion
Meeting with REGIO	11 January 2007	Interservice Discussion
Meeting with World Health Organisation	16 January 2007	Discussion meeting
SANCO International Affairs Committee	17 January 2007	Presentation to Commission Services with an interest in international aspects of health
Meeting with UNICE, Union of	17 January 2007	Discussion with Industry

Industrial and Employers Confederations in Europe		Stakeholders
Bilateral with RTD	18 January 2007	Interservice Bilateral
Meeting of Expert Panel[70]	25 January 2007	Discussion meeting with 5 experts in the field of health
Second Interservice Steering Group on the Health Strategy	31 January 2007	Second ISSG
EU-Ukrainian Coordination Committee	31 January 2007	Presentation
EU-Jordan Subcommittee	2 February 2007	Presentation
Meeting with English operational research analysts	6 February 2007	Discussion Meeting
Meeting with World Bank European representative	7 February 2007	Discussion Meeting
Meeting with Martin McKee London School of Hygiene and Tropical Medicine	7 February 2007	Expert meeting
Meeting with European Public Health Alliance	14 February 2007	Discussion meeting with EPHA management
Meeting with European Patients Forum, Nicola Bedlington and Anders Olauson	14 February 2007	Discussion meeting with stakeholders
Meeting with Assembly of the Regions	14 February 2007	Discussion meeting with secretariat
Meeting with DG SANCO Directorates E (Willem Daelman) and D (Eric Marin)	15 February 2007	Intra-SANCO meeting with animal health and food safety Directorates
Meeting with UK Treasury	15 February 2007	Discussion meeting
Meeting with DG SANCO Dir B	20 February 2007	Intra-SANCO meeting with consumer protection Directorate

[70] A selection of experts on a range of health policy issues, including Ilona Kickbusch, expert on health governance, health promotion and public health, Nick Boyd, expert on EU health policy from a Member State perspective, Philip Berman, expert on health organisations, Josep Figueras, expert on European health systems and policies, Adam Kozierkiewicz, expert on health policy from a Member State perspective.

Meeting of Expert Panel	20 February 2007	Discussion meeting with 3 experts in the field of health
Meeting with EuropaBio	26 March 2007	Meeting with industry stakeholder
Third Interservice Steering Group on Health Strategy	27 March 2007	Third ISSG
Commission-WHO-European Health Observatory TAIEX seminar on health in all policies to the attention of European Neighbourhood Policy partners	25-26 June 2007	Discussion meeting

Annex 2: Health Activities Across the European Community

This list is not exhaustive but gives an indication of the wide range of ongoing activities on health across the European Community. These have been grouped in relation to the four health objectives described in the Impact Assessment. Activities planned for the coming years have not been included.

A list of health-related EU agencies and funding mechanisms is also included.

Further information on these initiatives can be found at www.ec.europa.eu

1. Foster Healthier Lifestyles and Reduce Inequities in Health Across the EU
• European Territorial Cooperation, cross border cooperation, convergence Regions - REGIO • Evaluation of the budgetary impact of changes in the demographic and health status - ECFIN • Evaluation of the available policy measures to control growth of the Healthcare costs - ECFIN • Non life Insurance Directive - MARKT • Minimum rate for tobacco taxation- TAXUD • EU action plan on Drugs 2005-2008 – JLS/SANCO • Council Regulation on Promotion for EU agricultural products on the Internal Market-AGRI • Recognition of health professional qualifications – MARKT • Infringement action on cases relating to restrictions on pharmacies and biomedical laboratories - MARKT • Open Method of Coordination on social protection and social inclusion – EMPL • Protection of social security rights of migrant people - Regulation 1408/71 on coordination of social security schemes – EMPL • electronic European Health Insurance Card (eHIC) – EMPL • Infringement action on cases relating to refusal to reimburse medical costs of patients treated abroad - MARKT • EU Disability Action Plan 2005 – EMPL • Council resolution on common objective for a greater understanding and knowledge of youth: implementing measures include health style – EAC • Communication about equity and efficiency in European education and training style – EAC • Framework Programme 6 and Framework Programme 7 including Health, Scientific support to policies and Food quality and safety as research themes – RTD • European Social Funds - EMPL • “Common Basic Principles” including on healthcare developed in the "common agenda for integration" - JLS • Regulation on the access to healthcare in the MS by 3rd country nationals – JLS

2. Protect Citizens and Patients from Known and Unknown Threats to Health
• Health and safety at work - EMPL • Pharmaceutical Legislation, its revision in application since Nov. 2005, Specific Regulation for Orphan Medicinal Products, for medicinal products of paediatric use – ENTR • New Approach for Medical Devices: legal framework with a set of directives – ENTR • Cosmetics legal framework – ENTR/JRC • Consumer products safety – JRC • Chemicals: Directive REACH – ENTR/ENVI/JRC • Electronical and medical equipment legal framework - ENTR • Assessment on counterfeit medicines situations in terms of legislation, enforcement, communication, public awareness – ENTR • Fight against counterfeit -TAXUD/JRC • Health and Environment action plan 2004-2010 – ENVI • Policies in impacting environment on air quality, water quality, noise – ENVI/JRC • Framework Programme 6 and Framework Programme 7 including Health, Scientific support to policies and Food quality and safety as research themes – RTD/JRC
3. Increase the Sustainability of Health Systems with a focus on New Technologies
• Green paper on demographic future of Europe, from challenge to opportunity – EMPL • OMC on healthcare and long term care-EMPL • Communication on elder abuse planned for Oct 2007 - EMPL • Pharmaceutical Forum established in 2005 – ENTR/SANCO • Strategy on Life Science and Biotechnology - ENTR • Framework Programme 6 and Framework Programme 7 including Health, Scientific support to policies and Food quality and safety as research themes – RTD • Implementation state aid competition rules in health markets – COMP • Competitions rules on mergers - COMP • eHealth research projects, e-Health Action Plan - INFSO
4. Strengthening the EU's voice in global health
• Promotion of health policies in the framework of various types of agreement or political dialogue with partner countries. RELEX * European Neighbourhood Policy (ENP): On the basis of the health sections in all ENP action plans, dialogue and cooperation is being stepped up. Health cooperation projects are ongoing and planned through the European Neighbourhood and

Partnership Instrument. The Commission is increasingly involving ENP partners in EU meetings and networks (e.g. Think Tank HIV/Aids, network of Competent health authorities, TAIEX funded seminar on Health in all policies)

* Country Strategies (2007-2013) for Asia includes health sector

* Development Cooperation Instrument for Asia and Latin America allows cooperation in field of health to strengthen health systems

- Multilateral trade negotiations: Doha Development Agenda launched in 2000. EC policy is that services considered as public utilities may be subject to government monopolies or to exclusive rights granted to private operator – TRADE
- Bilateral and regional negotiations: including inter alia health and social services, and services of Health professionals - TRADE
- Communication and Programme for action on health workforce crisis - DEV
- Model Guidelines on Mainstreaming HIV/AIDS; – ECHO
- Review of Quality Assurance Mechanisms for Medicines and Medical Supplies in Humanitarian Aid - ECHO
- Thematic programs against main poverty diseases to support achievement of the Millennium Development Goals- AIDCO
- Specific health actions for populations affected by humanitarian crisis (natural or man-made): primary healthcare, secondary healthcare, temporary health infrastructures, specific horizontal issues - ECHO
- IPR and better access to medicines in developing countries, Regulation on compulsory licensing of patents for pharmaceuticals for exports to developing countries adopted in 2006 – MARKT
- Framework Programme 6 and Framework Programme 7 including Health, Scientific support to policies and Food quality and safety as research themes – RTD
- Envelop to fight new health treats/ emerging disease in animal and human health as fight against and prevention of Avian and Pandemic Influenza plus coordination to wards the external response. RELEX
- Regulation on the right of MS to refuse residence permits for reasons related to public health -JLS

Agencies in the field of Health

- European Centre for Disease Prevention and Control (ECDC)
- European Foundation for the Improvement of Living and Working Conditions (EUROFOUND)
- European Environment Agency (EEA)
- European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)
- European Medicines Agency (EMEA)
- European Agency for Fundamental Rights (FRA)
- European Agency for Health and Safety at Work
- European Food Safety Authority (EFSA)
- European Chemicals Agency (ECHA)
- European Space Agency (ESA)

Funding Mechanisms
• Public Health Programme • Framework Programme 6/ Framework Programme 7 • European Regional Development Funds • European Social Funds

Annex 3: Key Health Determinants

This Annex provides additional data and information on key health determinants which supports the discussion of changing health challenges in section 2.1, and the objectives of the Strategy described in section 3. More information on EU policies can be found at the Health Portal, www.health.europa.eu.

a) Obesity, Diet and Nutrition

b) Alcohol

c) Smoking

d) Environmental Health

e) Mental Health

f) Drugs

A number of these topics are included in the FP7 Call for Proposals of the thematic focus "Health" under pillar 3: "Optimising the delivery of healthcare to European citizens"[71].

a) Obesity, Diet and Nutrition

Around 30% of school children in the EU are estimated to be overweight or obese (EU 25). The obesity phenomenon is responsible for a number of very serious physical and mental health problems, ranging from diabetes to cancer, heart disease, infertility and psychological disorders. It is estimated that obesity accounts for up to 7% of healthcare costs in the EU, in addition to the wider costs to the economy due to lower productivity and premature death. Nutritional habits have changed significantly over the last decades, and unhealthy food is often cheap to buy. Being overweight is the most important risk factor for Type II Diabetes, while direct costs for diabetes in the EU vary between 2 and 7% of total health expenditure. Progress has been made on raising awareness of the dangers of high fat, salt and sugar diets. Some industry players have responded to the change in public opinion. Pepsico has reduced saturated fats in Walkers crisps by 70%, and salt by 25% in the UK.[72] Increased economic growth also appears to have a beneficial effect on cardiovascular disease.[73] Further research is needed to explore potential genetic susceptibility of obesity.

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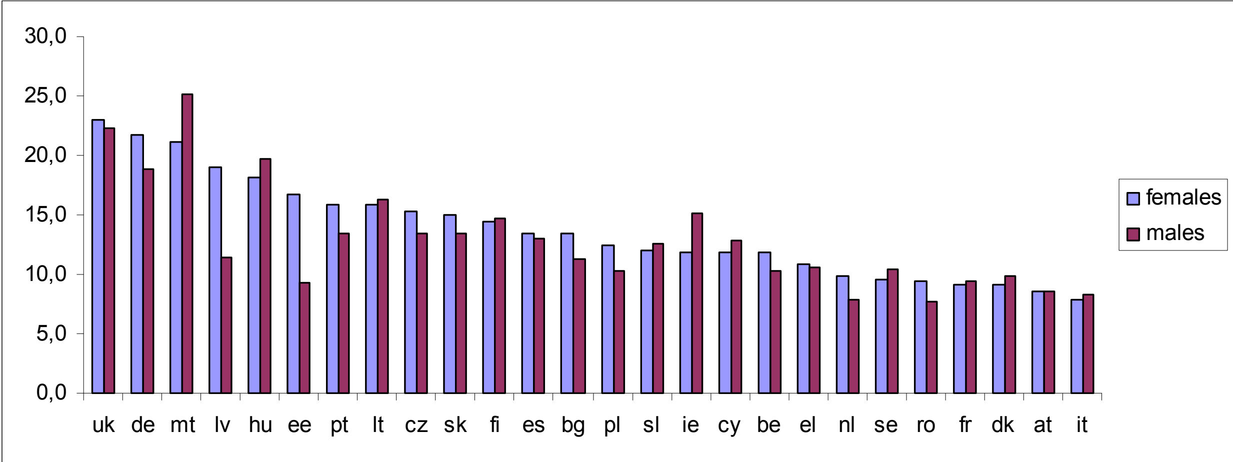
[71] http://cordis.europa.eu/fp7/dc/index.cfm?fuseaction=UserSite.CooperationDetailsCallPage&call_id=63

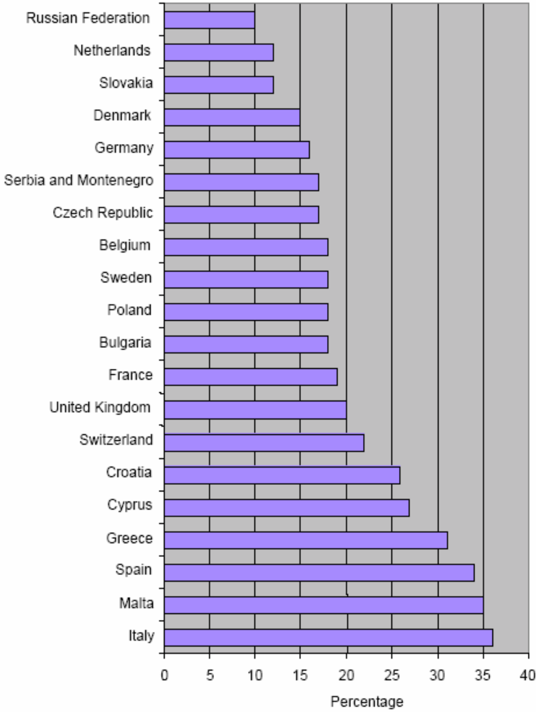
[72] http://www.pepsicowiderworld.co.uk/health.php

[73] Suhrke and Urban, Are Cardiovascular Diseases Bad for Economic Growth? CESifo Working Paper No. 1845, November 2006.

Obesity in European adults % (BMI>30)[74]



Percentage of overweight and obese children aged 7-11 in selected countries in the World Health Organisation European Region[75]



The Commission adopted a White Paper on a Strategy for Europe on Nutrition, Overweight and Obesity related health issues on 30 May 2007. This sets out the Community policies relevant to tackling these conditions, and how the Community can support Member States in their efforts. Relevant and on-going actions include the body of Community food law and regulation on labelling and health claims which contributes to creating a supportive information environment for consumers. Other community actions include a proposed scheme

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[74] Source: Eurostat.

[75] *World Health Organisation: The challenge of obesity in the WHO region, Fact sheet (EURO/13/05), September 2005.*

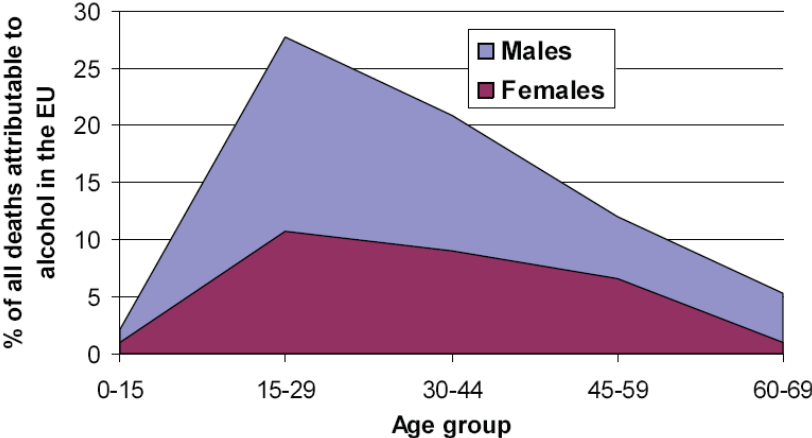
to distribute Fruit and Vegetables to school children (through the common agricultural policy) and therefore improve availability of these foods to a key vulnerable group, as well as cohesion and transport policy for which fund are available that can be used by Member States to improve their physical environment (such as in the development of urban planning and transport systems that encourage walking and cycling.)

Approaches to tackling obesity and overweight are therefore highly intersectoral and a key public health challenge is to engage other policies areas at all levels from Community to local level. Successful approaches necessitate the involvement of a wide range of stakeholders (such as the food industry, advertising and media sector, schools, clinicians and the NGO community). For this reason, the Commission set up the EU Platform for action on Diet, Physical Activity and Health (see page 38). A new, high profile strategic framework would be valuable to improve the buy-in from the range of stakeholders involved (both in governments and among private stakeholders such as the major food companies) by clarifying the strategic environment for public health, leading to greater transparency of our motives, goals and objectives and thereby promoting greater trust between partners. A new Strategy may also support the development of new multi-stakeholder forums in other areas, building on the success of the Platform.

b) Alcohol

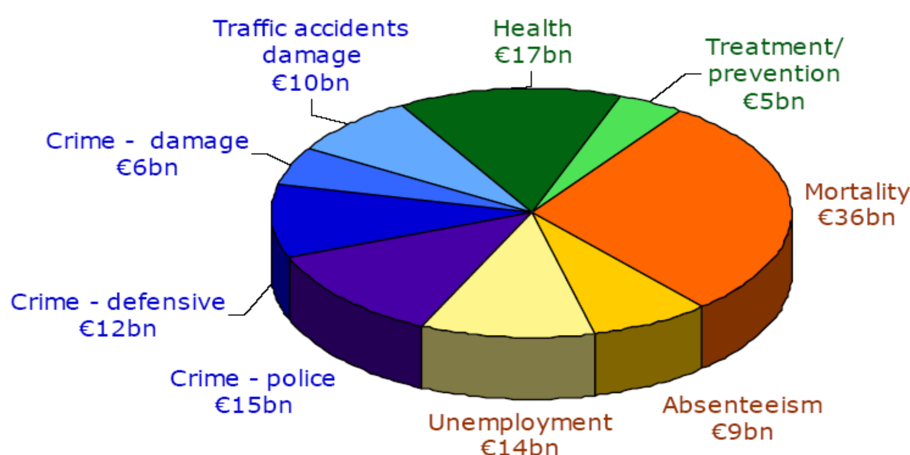
Harmful and hazardous use of alcohol can cause 60 different types of diseases and conditions[76]. estimated to be responsible for about 195 000 deaths each year in the EU[77] The young shoulder a disproportionate amount of this burden with over 10% of youth female mortality and around 25% of youth male mortality due to alcohol (15 000 deaths/year). Alcohol related deaths peak in the age group 15 – 29. Harmful use of alcohol has effects not only on the drinker but also on the society as a whole. Alcohol is estimated to be a causal factor in 16% of child abuse and neglect[78] and one out of four fatalities on EU roads is caused by drink-driving (more than 10,000 per year).

Percentage of deaths attributable to alcohol among EU citizens under 70 (2000)



[76] Gutjahr et. Al. 2001; English et. Al. 1995: Ridolfo and Stevenson 2001; Room et. al. 2005.
[77] Anderson, P and Baumberg B (2006) Alcohol and Europe, London Institute of Alcohol Studies.
[78] English et al.

The cost of alcohol related harm to the EU's economy has been estimated at €125 billion for 2003, equivalent to 1.3% of GDP. This estimate includes losses due to underperformance at work, work absenteeism, premature death etc[79]



In October 2006 the Commission adopted the EU alcohol Strategy[80]. The adoption was the starting point of a long-term work to reduce alcohol harm in the EU. This strategy will be put into practice through; a Committee on National Policy and Action and a European Alcohol and Health Forum with economic operators and non-governmental organisations willing to step up actions aimed at reducing alcohol harm.

c) Smoking

In the EU, one in four people aged between 15 and 24 are daily smokers,[81] while studies have shown that the majority of smokers want to stop smoking.[82] Smoking has been proven to have a causal relationship with many serious and life-threatening diseases. Current cigarette smokers have over twice the risk of dying from all cancers combined than people who have never smoked. For heavy smokers the risk is three-fold compared with never-smokers[83]. It is estimated that in 2006 there were almost 335000 deaths for lung cancer in Europe[84]. Mortality from chronic obstructive pulmonary disease (COPD) is 14-times higher in cigarette smokers than in never-smokers.[85] Smoking also increases a person's risk of cardiovascular disease. The risk of mortality from any cardiovascular disease in all cigarette smokers is greater than 1.6

79 Anderson, P and Baumberg B (2006) Alcohol and Europe, London Institute of Alcohol Studies.

80 COM(2006) 625.

81 Eurostat, Health Interview Surveys 2004 (NewCronos Database).

82 Fong et al, The near-universal experience of regret among smokers in four countries: findings from the International Tobacco Control Policy Evaluation Survey. Nicotine Tob Res. 2004 Dec;6 Suppl 3:S341-51.

83 Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years' observation s on male British doctors. BMJ 2004; 328:1519-1528.

84 Ferlay J, Autier P, Boniol M, Heanue M, Colombet M, Boyle P. Estimates of the cancer incidence and mortality in Europe in 2006. Ann Oncol. 2007 Mar;18(3):581-92.

85 Peto R, Lopez AD, Boreham J,Thun M. Mortality from Smoking in Developed Countries 1950-2010. 2nd Edn. Data updated 23 August 2004. Imperial Cancer Research Fund, World Health Organization. Oxford, Oxford University Press.

times that of never-smokers, with the figure rising to 1.9 times in heavy smokers.[86] Environmental tobacco smoke is associated with serious risks to health. Chronic exposure to second-hand smoke has been established as a cause of many of the same diseases caused by active smoking, including respiratory diseases, lung cancer (20-30% increased risk when living with a smoker[87]), cardiovascular disease (25-30% increased risk of coronary heart disease when living with a smoker), and childhood disease (sudden infant death, pneumonia, bronchitis, asthma and middle ear disease). Exposure in pregnant women can cause lower birth weight, foetal death and preterm delivery.

Recently, the risks of environmental tobacco smoke have been more clearly recognised with several European Member States instituting bans on smoking in the workplace. According to the most recent estimates by the Smoke Free Partnership, more than 79,000 adults die each year as a result of passive smoking in the 25 countries of the EU. There is evidence that passive smoking at work accounted for over 7,000 deaths in the EU in 2002, while exposure at home was responsible for a further 72,000 deaths[88].

Smoking also carries serious financial implications, both on a personal level and to the wider economy. In the EU, for some families up to 10% of total household expenditure goes on tobacco. The direct and indirect costs of smoking in the EU-25 were estimated for 2000 ranging from 97.7 to 130.3 billion Euros in 2000, corresponding between 1.04% and 1.39% of the EU GDP[89].

The tobacco policy of the EU is based on a four stage approach: legislative instruments, support for prevention and cessation activities, mainstream of tobacco control into other Community policies and impact beyond frontiers of the EU. The current tobacco framework consists of two Directives on tobacco advertising and product regulation as well as a recommendation on tobacco control and the WHO Framework Convention on Tobacco Control (FCTC). The Commission adopted recently a Green Paper on smoke-free environment which is now being followed up. A revision of tobacco taxation is on-going as well as discussions about FCTC-protocols on illicit trade and cross-border advertising and the Commission is planning to put forward a comprehensive strategy on tobacco control. Measures aimed particularly at reducing demand for tobacco products by children and adolescents are important. The campaign “Help - for a life without tobacco” targets young people (15-25) as a priority, with a maximum total budget of around €60 million, funded through the Community Tobacco Fund. The Health Strategy provides a useful tool for gathering all these efforts and to link the work to other important health determinants.

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86 Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years' observation s on male British doctors. BMJ 2004; 328:1519-1528.

87 International Agency for Research on Cancer (2002). Monographs on the Evaluation of Carcinogenic Risks to Humans. Tobacco Smoke and Involuntary Smoking. Volume 83, Lyon, IARC, World Health Organization.

88 Lifting the smokescreen. 10 reasons for a smoke free Europe. Smoke Free Partnership. 2006.

89 The ASPECT Consortium. Tobacco or health in the European Union. Past, present and future. European Commission. 2004.

d) Environmental Health

Environmental factors are a major contributor to health and disease. Air, water and soil pollution, and the impact of the built environment via physical exercise, noise, accidents and injuries are major determinants of health in Europe. Climate change may also create health risks that are not yet well understood.

Although the long-term health effects of poor environmental conditions need to be further studied, available estimations suggest that this is a serious health problem. OECD[90] estimates that environmental conditions are responsible for 2 to 6 % of the total burden of diseases in OECD countries mainly due to exposure to outdoor and indoor air pollutants and chemicals in the environment. The same report estimates the possible costs of healthcare expenditure due to environmental condition might be roughly estimated at 0.5 % of GDP in OECD countries. WHO estimates[91] that exposure to fine particulate matter in outdoor air leads to about 100 000 deaths and 725 000 years of life lost each year in Europe. In the last decades there has been a dramatic increase in Europa in asthma and allergies. According to the WHO[92] 11.5% of children suffer from asthmatic symptoms in Europe.

Health effects can also be observed as consequence of climate change. Health effects relate to extreme weather conditions (heat waves, floods, and extreme cold periods) as well as to an increase of human and animal diseases. Other health effects can be observed as a consequence of exposure to ultra violet radiation (cancer and cataracts), water availability, crop production, wildfires etc. A preliminary analysis of the 2003 heat wave in Europe estimated that it caused about 65 000 deaths in Europe. Other health effects are not well estimated for the time being.

Efforts to better understand and prevent such environment related diseases started in the EU at different levels and through a series of activities and projects decades before the adoption of the European Environment and Health Strategy in 2003[93] and the European Environment and Health Action Plan 2004-2010 in 2004[94]. In the framework of this Action Plan considerable progress has been made , with respect to the evaluation of existing environment and health information and monitoring systems[95]. The EU has undertaken a series of actions to improve and better integrate the existing systems already in place EU-wide. Of particular relevance for scope and extent is the cooperation established by the Commission and the WHO to develop a comprehensive information system (Environment and Health Information System – EHIS) to monitor and assess the relations between the environment and human health, and the effectiveness of related policies with a special focus on children's health. This cooperation is carried out in the framework of the ENHIS2 project. Several activities and projects have been undertaken to tackle specific health conditions such as skin cancers, asthma and other respiratory diseases, and other environment-related allergies.

Growing concerns on the effects of Electromagnetic Fields (EMF) on human health have pushed the European Commission to undertake actions aiming at improving knowledge on potential dangerous effects. An updated Opinion on "Possible effects of Electromagnetic

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90 2001 OECD Environmental Outlook.

91 Results from the WHO project "systematic review of health aspects of air pollution in Europe". June 2004.

92 http://www.euro.who.int/eprise/main/who/progs/whd2/20030307_6

93 COM(2003) 338.

94 COM(2004) 416.

95 SEC(2006) 1461.

Fields (EMF) on Human Health" has been recently adopted by the Scientific Committee on Emerging and Newly Identified Health Risks (SCENIHR). An interesting project currently financed by the Commission regards the analysis of any potential impact of EMF on the human ear and in particular any relations between EMF and the development of specific forms of ear cancer.

The Commission is working to ensure that environmental health hazards are identified and addressed through a number of specific initiatives on indoor air quality and an assessment of the health risks of climate change. It has also launched a call for proposals under FP7 to develop a coordinated EU approach to human biomonitoring, .. It will further develop actions being taken within the framework of the Environment and Health Action Plan and through the renewed Sustainable Development Strategy contributing to the goals of the Lisbon Agenda.

e) Mental Health

Positive mental health enables wellbeing and good quality of life, whereas mental health problems and mental disorders have a severe negative impact on people. It is estimated that mental disorders account for 12% of the burden of disease in Europe[96]. Mental health problems are a major cause of work absenteeism and early retirement, thereby causing immense economic losses and social burdens. Suicide is in most cases linked to mental illness and causes the deaths of about 60,000 citizens per year. While the rate of suicide across the EU has fallen over the last 10 years by more than 10%, partly due to improved treatment and prevention policies, the variation between Member States is still very large (see graph below) which suggests that there is still great potential for improvement if those with the worst figures could be improved towards those with the best.

However, mental health does not yet get the attention it deserves. A great proportion of people with mental health problems do not receive appropriate treatment, and funding for mental health remains relatively low in several Member States. The potential for prevention of mental illness and promotion of good mental health, for instance through measures in educational and workplace settings, is not sufficiently exploited.

At present, the Commission is developing a Communication setting out a strategy on mental health, drawing from the conclusions of a Green Paper in 2005[97]. It will establish a framework for cooperation on mental health across Community policies and between Member States, in order to learn from mutual good practice and to strengthen the visibility and implementation of commitments made. A new health strategy would support integration across EU policy in relation to mental health issues, thereby strengthening the credibility and effectiveness of the action.

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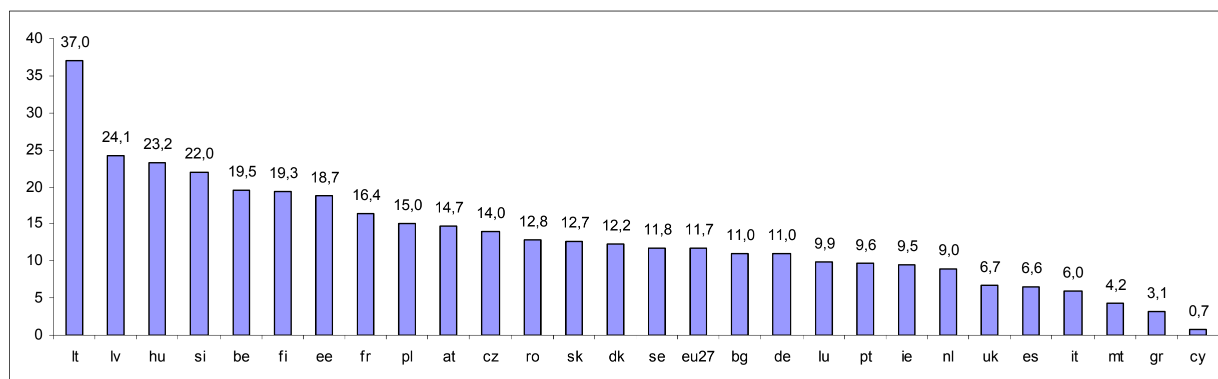
[96] WHO World Health Report 2001.
[97] COM(2005) 484.

Standardised Death Rate for suicide and self-intentional harm per 100 000 people across EU Member States - 2005[98]



f) Drugs[99]

Between 1990 and 2003, between 6500 to over 9000 acute drug deaths (overdoses) were reported each year by EU countries. Drug overdoses are one of the main causes of mortality among young adults in the EU countries, and is linked to alcohol abuse (see b. above). Opiate users (mainly those who inject) have an overall mortality that is up to 20 times higher that the general population of the same age due to overdoses, but also to violence, disease (AIDS and others), etc.

Population mortality rates due to acute drug-related deaths varied widely between European countries, ranging from 0.2 to over 50 deaths per million inhabitants (average of 13). Acute drug-related deaths (overdoses) account for 3% of all deaths among Europeans aged 15 to 39 years in 2003 to 2004, and for more than 7% in Denmark, Estonia, Luxembourg, Malta, Austria, United Kingdom and Norway. The majority of overdose victims are men. Most victims are in their twenties or thirties. Since 2000, many EU countries have reported decreases in the numbers of drug-related deaths, although figures are still high from a longer term perspective. However, among countries reporting data in 2004 (19), there was an overall increase of 3 %, with increases reported in 13 out of the 19 reporting countries (inferences for the whole EU should be made with caution).

The European Action–Plan on Drugs 2005-2008[100], adopted by the Council on 27/06/2005, is based on the framework of the European Drugs Strategy 2005-2012[101], describes specific interventions and actions, focusing on two main strands of action, demand and supply reduction. It also includes a number of cross-cutting themes related to coordination, international relations and information, research and evaluation. On the demand side, this Action-Plan includes the Commission report on the implementation of the 2003 Council Recommendation on the prevention and reduction of health-related harm associated with drug dependence, which was adopted on 18 April 2007[102] and calls for more links to other areas with regard to further initiatives in the field of harm reduction, e.g. drugs and driving, alcohol, HIV/AIDS, mental health, drugs at workplace and civil society. The Action-Plan also

98 Source: Eurostat.
99 Source: EMCCDA Statistical Bulletin 2006.
100 http://eur-lex.europa.eu/LexUriServ/site/en/oj/2005/c_168/c_16820050708en00010018.pdf
101 http://register.consilium.europa.eu/pdf/en/04/st15/st15074.en04.pdf
102 COM(2007)199.

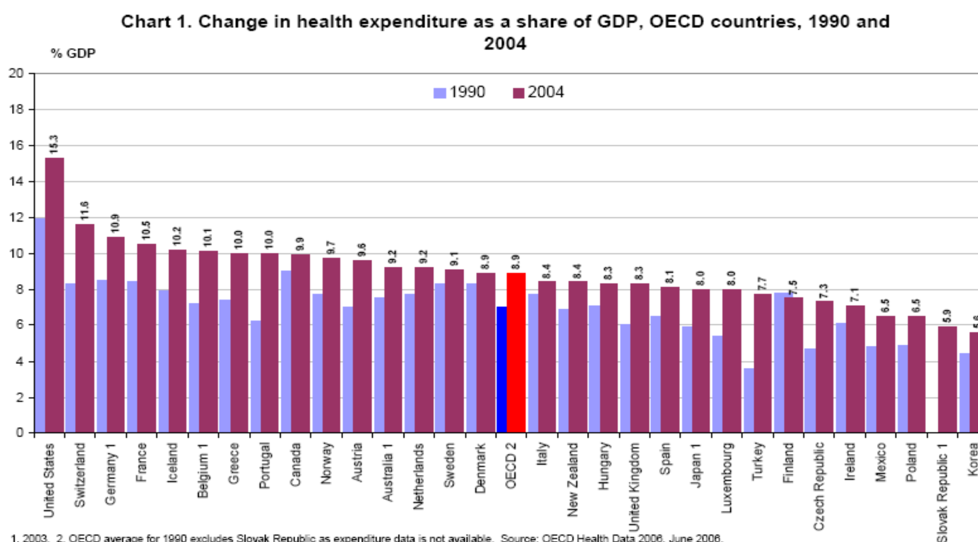
includes a report on drug treatments and good practices across Europe and a proposal for a Council Recommendation on drugs and prisons. A new approach would support more cross sectoral work on the issue at all levels.

Annex 4: Health and its relationship to the Economy

This annex describes some relationships between health and economic prosperity, including looking at public spending and financial sustainability, costs of illness, the health of the labour market, health investment in the prevention of illness, and the economic growth potential of the health sector itself.

Spending in the health sector is an important and rising cost for national administrations. There is mounting pressure for increased growth and efficiency in health sector. This pressure is created by factors such as the development of expensive new technologies, and demographic ageing which, according to analysis by DG ECFIN[103], will pose major economic, budgetary and social challenges which are expected to have a significant impact on growth and lead to considerable pressure to increase public spending, making it difficult for Member States to maintain sound and sustainable public finances in the long-term (see also section 2.3(5)). Healthcare spending around the world generally is rising at a faster rate than economic growth.[104] For example, the USA increased its spending on health as a percentage of GDP by 7% in 2003 (15.2%) compared to 8.8% in 1980, with EU Member States also showing increases. Chart 3 shows rising health spending as a percentage of GDP for OECD countries. Looking ahead, therefore, the EU must consider the financial sustainability of the health sector. The Commission's Sustainable Development Strategy was reviewed in 2006 and recognised the important role health will play in future economic and social sustainability.[105]

Chart 3:



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103 The long-term sustainability of public finances in the EU, DG ECFIN, EUROPEAN ECONOMY. No. 4. 2006, an annex to the Commission's Communication on 'The long-term sustainability of public finances in the EU' - COM(2006) 574, SEC(2006) 1247.

104 Snapshots: Healthcare Spending in the United States and OECD Countries Jan 2007 http://www.kff.org/insurance/snapshot/chcm010307oth.cfm

105 COM(2005) 37 of 9.2.2005: 'The 2005 review of the EU Sustainable Development Strategy: Initial Stocktaking and Future Orientations' and SEC(2005) 161 of 9.2.2005: 'Sustainable Development Indicators to monitor the implementation of the EU Sustainable Development Strategy'.

Alongside the rising costs of running health systems and services and the need for reform, the cost of ill health is in itself a significant burden to the economy. 'Cost of illness' is notoriously difficult to measure, but some estimates are presented in Box 6, taking into account not only costs to the health sector, but to employers. Despite the problems in measuring these costs, it is clear that the impact of illness on the economy is huge. Poor health is an important factor in early retirement and worker absenteeism. Studies have shown that in Germany, the probability of leaving the workforce at the earliest possible age is four times higher for men with disabilities than those without, and in Ireland, the proportion of labour participation is 61% lower for men with chronic diseases.[106] People who continue to work despite health problems are also likely to be less productive than healthy people.[107]

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[106] Suhrke et al, The contribution of health to the economy in the EU, European Commission, 2005.

[107] Ibid, p.20-22.

Box 5. Cost of Illness Estimates

Treating Cardiovascular Disease costs around €74 billion per year in the EU and losses in production of goods and services cost around €106 billion[108]. 80% of all cardiovascular diseases are considered to be preventable by reducing risk factors like smoking and unhealthy diet.

WHO European Region studies show that estimates of direct costs of obesity during the 1990s ranged from 1% of healthcare expenditure in the Netherlands[109] to 1.5% in England and France, and 3.1–4.2% in Germany. A study from Belgium reported estimates of 6%.[110] In England it was estimated that in 1998 obesity accounted for 18 million days of sickness absence and 30,000 premature deaths, equivalent to €715 million per year to treat obesity.[111]

25% of people suffer mental health problems at some point in their lives and in several countries this is shown to be an increasing factor in worker absenteeism. It is estimated that mental disorders cost 3-4% of GDP per year.[112]

It is estimated that alcohol abuse cost the health, welfare, and criminal justice sector in the EU approximately €125 billion in 2003.

The loss to Scottish employers due to decreased productivity, higher rates of absenteeism and fire damage caused by smoking has been calculated at 0.51% - 0.77% of Scottish GDP[113]. Currently asthma affects 30 million people across the continent and costs healthcare services approximately €17.7billion a year.[114]

The SARS epidemic in 2003 was a serious incident which was brought under control by an effective international response. It ultimately killed about 800 people, and despite the well-organised response, led to a total cost for the East and Southeast Asian economies as a whole of about US $18 billion.[115] Without the effective intervention, the cost would have been much higher.

A UK study from 2000 indicated that a 10% reduction in the number of hospital acquired infections could result in a saving of 150 million euros per year[116].

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108 Liu et al, *Heart* 2002;88:597-603.

109 Seidell JC, Deerenberg I. Obesity in Europe: prevalence and consequences for use of medical care. Pharmacoeconomics, 1994; 5: 38–44.

110 Institute Belge de l'Economie de la Santé. Evaluation du coût de l'obesité en Belgique. Briefing 29, June 2000.

111 National Audit Office (England) 2001.

112 Estimation by ILO. http://agency.osha.eu.int/publications/newsletter/8/en/index_23.htm.

113 Parrott S, Godfrey C, Raw M. Costs of Employee Smoking in Scotland. Tobacco Control 2000; 9: 187-192.

114 The European Lung White Book: The First Comprehensive Survey on Respiratory Health in Europe 2003.

115 Assessing the Impact of SARS in Developing Asia, Asian Development Outlook 2003 Update (www.adb.org/documents/books/ado/2003/update/sars.pdf).

116 Plowman R., Graves N., Griffin M., Roberts J.A., Swan A., Cookson B, et al. The socio-economic burden of hospital acquired infection. London: PHLS, 2000.

However, measuring only the costs associated with poor health ignores the fact that good health has a positive effect on the economy. A healthy population supports the workforce and reduces pressure on health services; the health services sector is a major source of jobs, and is a driver of innovation. Health has been shown to be a "robust and sizeable predictor of subsequent economic growth" in many studies looking at differences in growth between poor and rich countries.[117] Health policymakers have long been arguing that 'health means wealth' (see Figure 1); that a healthy population is necessary for economic productivity and prosperity, and that this is a 'virtuous circle', as wealth also leads to better health.

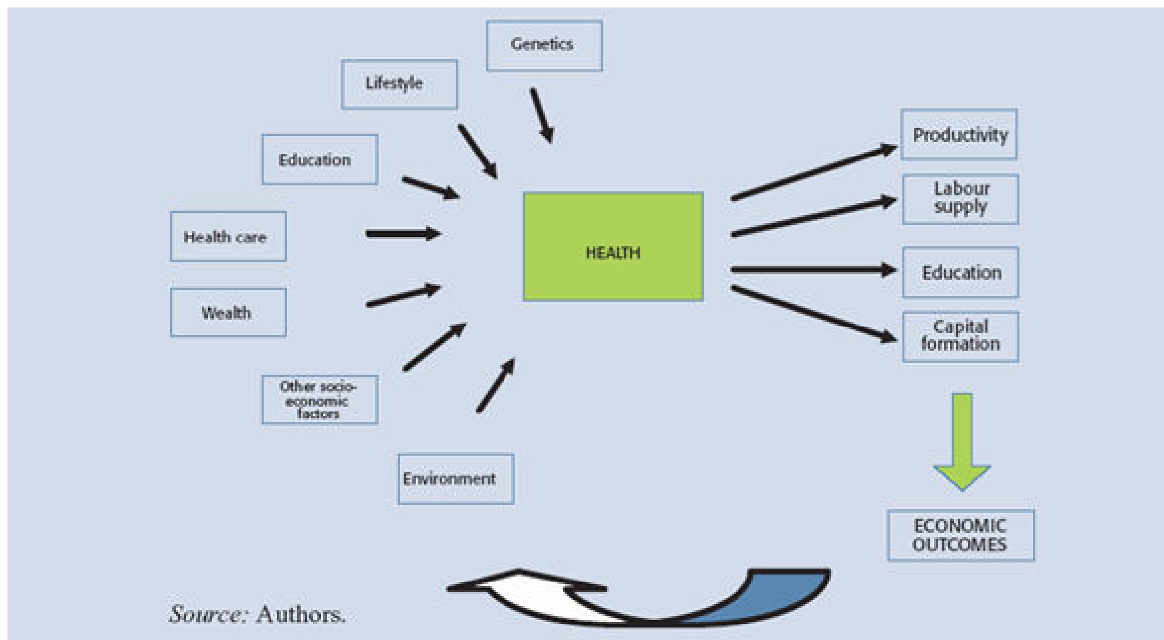

Figure 1: 'Health Means Wealth' Source: M. Suhrcke, M. McKee, R. Sauto Arce, S. Tsolova, J. Mortensen The contribution of health to the economy in the EU, Brussels 2005

The theoretical underpinning to the 'health means wealth' argument was developed by Becker (1964)[118] and then further developed and strengthened by Grossman (1972)[119] and others. As Suhrcke, McKee at al explain,[120] according to neo-classical economic theory, economic growth depends on three factors: the stock of capital, the stock of labour, and productivity, the latter depending in turn on technological progress and, in neo-classical theory, considered to be an exogenously given factor (i.e. external and unaffected by economic growth). Becker and Grossman argued that in fact technological progress can be seen as an 'endogenous' process that could be driven in particular by investments in human capital, largely understood as skilled labour. In their research, Becker focused primarily on effect of education, while Grossman added an analysis of the impact of health improvements. Grossman distinguishes between health as a consumption good and health as a capital good. As a consumption good, health enters directly into the utility function of the individual, as people enjoy being healthy. As a capital good, health reduces the number of days spent ill, and therefore increases the

[117] Suhrcke, McKee et al, The contribution of health to the economy in the European Union, European Commission 2005, p. 12.

[118] Becker, G. S. (1964), *Human capital: A theoretical and empirical analysis with special reference to education*, Third Edition, Chicago and London: The University of Chicago Press.

[119] Grossman, M. (1972), *On the concept of health capital and the demand for health*, Journal of Political Economy, 80(2): 223–255.

[120] Suhrcke, McKee et al, ibid.

number of days available for both market and non-market activities. Thus, the production of health affects an individual's utility not only because of the pleasure of feeling in good health, but also because it increases the number of healthy days available for work (and therefore income) and leisure.

Accordingly to this theory, the following factors affecting the economic outcomes can be observed[121].

- Labour productivity - healthier individuals could reasonably be expected to produce more per hour worked. Productivity could increase directly due to enhanced physical and mental activity but also due to the fact that more physically and mentally active individuals could also make a better and more efficient use of technology, machinery or equipment. A healthier labour force could also be expected to be more flexible and adaptable to changes (e.g. changes in job tasks, in the organisation of labour). A number of studies also find a significant impact of physiological proxies for health (e.g. height or body mass index) on earnings and wages, not only in developing but also in some high-income countries. It is, however, likely that some of the links between these physiological measures and labour market outcomes can be accounted for by the social status attributed to height, and by social stigma in the case of obesity, rather than by a direct effect on productivity.

- Labour supply - the impact of health on labour supply is theoretically ambiguous. Good health reduces the number of days an individual spends sick, but health also influences the decision to supply labour through its positive impact on wages and earnings. Several studies from high-income countries show that poor health negatively affects wages and earnings. In addition, health also increases labour force participation (also for household members of ill people) and is likely to delay retirement (some economists, however, argue that income effect might result in early retirement).

- Education - according to human capital theory, more educated individuals are more productive (and obtain higher earnings). Since children with better health and nutrition tend to achieve higher educational attainment and suffer less from school absenteeism and early drop-out, improved health in early ages indirectly contributes to future productivity. Moreover, if good health is also linked to higher life expectancy, healthier individuals would have greater incentives to invest in education and training, as the depreciation rate of the skills acquired would be lower. This link while theoretically plausible and empirically supported in the case of developing countries, so far has not been sufficiently tested in high-income countries.

- Savings and investment – the state of health of an individual or a population is likely to impact not only upon the level of income but also the distribution of this income between savings and consumption and the willingness to undertake investment. Individuals in good health are more likely to look ahead to the long-term future and their savings ratio may consequently be higher than the savings ratio of individuals in poor health. In the same way as the education argument however, although plausible, there is little published research in this area as far as high income countries are concerned.

Therefore, there is a sound theoretical and empirical basis to the argument that human capital contributes to economic growth. At the same time, economic outcomes also matter for health.

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121 Ibid.

Surprisingly, however, despite the evidence supporting the link between health and economic prosperity, it is **not always adequately taken into account**. The Lisbon Agenda did not mention health during the first years that it was in place. In 2005, the Healthy Life Years indicator was included as a Lisbon Structural Indicator, recognising that the population's life expectancy in good health was an important measure in understanding and supporting economic growth. The Commission pointed out in its report to the 2006 Spring European Council that Member States need to reduce the high numbers of people who are inactive because of their ill-health[122] and that Europe cannot afford to have people drop out of the labour market when they are in their fifties[123]. This report urged action; rather than just seeing health as a negative cost, it recognised that policy in many sectors has a role in improving health for the benefit of the wider economy.

Although increases in the share of GDP spent on health can be seen as problematic, provided expenditure is well-founded and effective, these increases may represent **necessary investment** in health. ECFIN have estimated that if healthy life expectancy evolves broadly in line with change in age-specific life expectancy, then projected increase in spending on healthcare due to demographic ageing would be halved[124]. Effective investment in health can lead to more efficient health systems, more people avoiding illness, and therefore to greater future financial sustainability. It is important to balance the consideration of spending on the healthcare sector with investments in **public health and prevention** policies. These have been shown to have substantial effects on reducing major and chronic diseases through action on better nutrition, prevention of smoking, prevention of alcohol related harm, reduction of accidents and injuries and specific approaches for different genders as well as groups like children, older people, and migrants. For example, a study based in Nordmaling, Sweden, found that a group of older people who received home visits from a health professional showed a decrease in indicating pain and anxiety, a decrease in GP visits and lower mortality than the control group.[125] The investment in this kind of prevention is much less demanding than that required to treat or cure diseases which could have otherwise been prevented. At the same time, there is underinvestment in these cost-effective preventative measures. OECD data show that Member States spend an average of 2.9% of their overall budget for health on prevention, health promotion and public health.[126] A new Health Strategy would increase opportunities for Member States to share good practice in relation to health promotion and prevention.

The health sector itself can also contribute to economic growth. Health represents a high-innovation, high-technology industry, with a growing market and potential high multiplier effects, i.e. many people using similar services. Health systems themselves employ vast numbers of people and contribute significantly to national economies, but the broader health sector can be understood to include not only hospitals, clinics and insurance providers, but laboratories, research, training and education organisations, pharmaceutical and medical device companies, health-related technology, and even spas, fitness centres and health foods which are on the increase as people become increasingly concerned about their own health and wellbeing and want to take responsibility for it. The growth of these areas lead to increased competitiveness at the regional, national and international levels.

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122 Annex to COM(2006) 30 of 25.1.2006.

123 2006 Commission Communication to the Spring European Council - COM(2006) 30, 25.1.2006.

124 DG ECFIN 'The Impact Of Ageing On Public Expenditure', special report 1/2006, p. 133.

125 A cost-utility analysis of preventive home visits in Nordmaling, Sweden, Umea University, project ongoing.

126 OECD Health Data 2006, Statistics and Indicators for 30 Countries. CDROM, Paris 2006.

According to data from the Eurostat Labour Force Survey (LFS) the number of people employed in the area of Health and Social Work in the EU-15 has grown steadily, from 13 to 15 million in total between 1995 and 2000 and represents in 2005 around 20.1 millions in the EU-27. In Germany, despite an economic slow-down, 1.1 million new jobs were created in the health and social sector between 1996 and 2005, and a group of Länder have developed plans specifically for expanding the health industry[127]. Similar patterns are observed for most part of other EU countries in the same period, e.g. 800 000 in the UK, and 600 000 in Spain.

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127 Kickbusch I. Innovation in health policy: responding to the health society. Gac Sanit 2007;21 (in press).

Annex 5: ECHI Indicators – 'First Set'

(indicators are hyperlinks to internet data)

Demographic and socio-economic factors

1.	Population by gender/age
2.	Age dependency ratio
3.	Crude Birth rate
4.	Mother's age distribution (teenage pregnancies, aged mothers)
5.	Fertility rate
6.	Population projections
7.	Total unemployment
8.	Population below poverty line

Health status

9.	Life expectancy
10.	Infant mortality
11.	Perinatal mortality (foetal deaths plus early neonatal mortality)
12.	Standardised death rates Eurostat 65 causes
13.	Drug-related deaths
14.	HIV/AIDS
15.	Lung cancer
16.	Breast cancer
17.	(Low) birth weight
18.	Injuries: road traffic
19.	Injuries: workplace
20.	Perceived general health, prevalence
21.	Prevalence of any chronic illness

22.	Health expectancy, based on limitation of usual activities

Determinants of health

23.	Regular smokers
24.	Total alcohol consumption
25.	Consumption/availability of fruit, excluding juice
26.	Consumption/availability of vegetables, excluding potatoes and juice
27.	PM10 (particulate matter) exposure

Health interventions: health services

28.	Vaccination coverage in children
29.	Breast cancer screening coverage
30.	Cervical cancer screening coverage
31.	Hospital beds
32.	Physicians employed
33.	Nurses employed
34.	MRI units, CT scans
35.	Hospital in-patient discharges, limited diagnoses
36.	Average length of stay (ALOS), limited diagnoses
37.	GP utilisation
38.	Surgeries: PTCA, hip, cataract
39.	Expenditures on health
40.	Survival rates breast, cervical cancer

Annex 6: Glossary

Centres of Reference – places accredited with particular expertise in one subject, e.g. a hospital could be a European centre of reference for a particular rare disease

Chronic Disease – a long lasting or recurrent disease, generally non-communicative, e.g. cancer or cardiovascular disease

Comitology - the procedures under which the Commission executes its implementing powers conferred to it by the legislative branch (the European Parliament and the Council), with the assistance of "comitology" committees consisting of Member State representatives

ECDC – European Centre of Disease Control; the EU Agency to defend infectious diseases by identifying, assessing and communicating current and emerging threats to human health

ECHI – European Community Health Indicators; a list of indicators which were developed in collaboration with Eurostat, DG Research, DG Sanco, OECD and WHO with the aim to provide comparable data on health, covering the 27 Member States and Third Countries

EFSA – European Food Safety Authority; specialised on European Union (EU) risk assessment regarding food and feed safety, provides independent scientific advice on existing and emerging risks

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction; the central source of comprehensive information on drugs and drug addiction in Europe

EMEA – European Medicines Agency; evaluates and supervises medicines for human and veterinary use. Some medicines are licensed by the EMEA, others by national administrations

EU-10 - The ten Member States who joined the EU in 2004

EU-12 - The ten Member States who joined the EU in 2004, plus Romania and Bulgaria who joined in 2007

EU-15 – The fifteen Member States who were Members of the Union before May 2004.

EU-OSHA – European Agency for Safety and Health at Work; addresses the diversity of occupational safety and health issues in the EU in order to make Europe's workplaces safer, healthier and more productive

EUPHIX – European Union Public Health Information System; develops a prototype for a sustainable, web-based health information system for the EU

Euratom – European Atomic Energy Community, founded in March 1957, by a second treaty of Rome

European Commission – The executive body of the European Union and one of the three main institutions governing the Union, the Commission produces proposals which are then considered by Parliament and Council

European Community (EC) – a group of institutions at the European level which was originally founded in 1957 under the name of European Economic Community, by the signing of the Treaty of Rome

GDP – Gross Domestic Product; is defined as the market value of all goods and services produced within a country in a given period of time

Health Determinants – refers to Social Determinants of Health (see below) as well as lifestyle choices such as smoking, alcohol use, physical activity levels, etc

Health Inequalities – differences in health between geographical areas, or between different groups (e.g. rich/poor, men/women, old/young)

Health Inequities – inequalities in health which are avoidable and unfair

HIA – Health Impact Assessment; consists of a combination of procedures, methods and tools by which e.g. a policy is judged as to its potential outcomes and effects on the health of a population

HIAP – Health in All Policies; mainstreaming of health, with the aim of integrating consideration of health issues and impacts into all relevant policymaking, both at the European level and national, regional and local levels

HLY – Healthy Life Years Indicator (similar to disability-free life expectancy); measures the number of years which a person of a certain age is expected to live without disability

HSIA – Health Systems Impact Assessment; consists of a combination of procedures, methods and tools by which e.g. a policy is judged as to its potential outcomes and effects on health systems

HTA – Health Technology Assessment; consists of a comprehensive evaluation of medical technologies (e.g. pharmaceuticals, products, services) regarding technical performance, efficacy and effectiveness of the technology application as well as economic, social, legal and ethical aspects

Mainstreaming – see Health in All Policies (HIAP)

OECD – Organisation for Economic Co-operation and Development, group of 30 Member Countries with the commitment to democratic government and market economy. Issues range from macroeconomics to trade, education, development, sciences and innovation

OMC – Open Method of Coordination: a methodology for Member States to work together toward the goals of the Lisbon agenda

Orphan drugs – Medicines to treat very rare diseases for which demand is low and therefore industry cannot expect to recuperate costs of research through sales

Social Determinants of health; comprise economic and social conditions under which people live and which influence their health (e.g. income, social status, education, health literacy, working conditions, social and physical environments, culture)

Troika – A group of current, past and future EU Presidencies who meet to share knowledge and planning