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

on the implementation of the programme of Community action on health promotion, education, information and training (1996-2000)

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Introduction

Following the adoption of the programme of Community action on health promotion by the European Parliament and the Council, the Commission, in accordance with Article 7 of Decision N° 645/96/EC[1], presents hereunder an interim report.

In this report, the Commission highlights the degree of consistency and complementarity reached between this plan and the other relevant Community policies, programmes and initiatives, gives an overview on the international co-operation in health promotion and also reports on the adjustments which are deemed necessary as a consequence of the information gathered.

Based on answers to a questionnaire which was dispatched to the Member States representatives in the programme committee the links to Member States' policies and an impact on the development of health promotion in their countries have been drawn up.

Furthermore the Commission presents first results of an evaluation which was carried out by a group of independent experts, who under contract to the Commission analysed the decision-making procedures of supported projects and the levels of activity in the different priority areas in the three years 1996-1998. Within this part, particular regard has been given to effectiveness and the achievement of the objectives of the measures undertaken.

Consistency and complementarity

The Commission sought consistency and complementarity between its health promotion and other Community policies, programmes and initiatives by a multitude of efforts on different operational levels, in particular:

The implementation of the 4th Framework programme for research, technological development and demonstration (1994 – 1998) of the European Communities was closely followed by means of the inter-service consultations on publications of calls for proposals and on adoption of projects for financing.

The preparation of the 5th Framework programme for research, technological development and demonstration (1998 – 2002) was actively followed by means of the inter-service consultations on the draft proposal, and consultations on project proposals, in order to ensure consistency and complementarity.

Further, officials of the public health directorate were invited to all meetings of the programme committees for the specific research programmes; likewise, officials from the research directorates were invited to the meetings of the programme committee.

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1 OJ EC L 95, 16.4.1996.

In the course of the implementation of the programmes, applicants seemed also to have better understood the difference between health and health services research as foreseen under the framework programmes for research and the health promotion measures covered under this action plan.

International co-operation

Based on a mutual understanding of health promotion and its impact on people's health and on infrastructural and environmental changes, the Commission has from the beginning onward closely co-operated with other international bodies, in particular with WHO. Thus, some conferences and international workshops on specific issues have jointly been organised and the Commission Services significantly contributed to the 4th World Health Conference on health promotion in Jakarta.

Monitoring and Adjustments

Monitoring of the specific actions has been performed mainly through a continuous follow-up by the Commission Services of the contractual obligations of the projects financed.

To improve the European added value as an important general objective, the Commission Services have embarked on a strategy to ask for enhanced networking of applicants to ensure better cross-border co-operation, e.g., as a means of dissemination of best practice in Europe.

To cover areas of Community interest, which were not covered by specific actions selected to date, following a thorough analysis of the active portfolio, the Commission adopted annual work plans. In turn, the annual work plans aided in establishing priorities for the next calls for proposals as well as in the selection of the newly proposed actions.

To further improve transparency and simplify dissemination at the same time annual reports have been produced for 1996[2], 1997[3] and 1998[4] by the Commission's Services, which give a comprehensive picture of the work of the respective unit of the Commission's services.

Following external suggestions and internal review of shortcomings the linkages between the health promotion programme and other public health programmes have been improved.

Programme management

Programme management since the first years of the implementation of the health promotion programme has improved, but there are still opportunities for further improvement.

This programme came into force end of March 1996. Thus, the creation of the formal management infrastructure, including the setting up of the programme committee and its rules of procedure and working practices, only occurred after the formal commencement of the programme.

There has been continuity in the management of public health actions by the Commission, from the period prior to the establishment of the health promotion programme, to the development of management practices of the new programme in its first years.

Due to the late setting up of the formal management structure for the programmes, a proper evaluation of the management can only be done in the second phase of the evaluation. However, it is possible to make some preliminary comments at this stage of the implementation. A more detailed evaluation of management will be undertaken during the second phase of the evaluation.

A number of suggestions for further improving the timing and procedures for processing and deciding on project applications have been established by the independent experts:

- The Commission services should strive to increase the transparency of its decision-making procedures and the timeliness of its communications to the Health Promotion Committee.

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2 Directorate Public Health and Safety at Work, Unit V/F/3, Community action programme on health Promotion, Information, Education and Training, Projects subsidised in 1996, CE-V/3- 97-001-EN.

3 Directorate Public Health and Safety at Work, Unit V/F/3, Community action programme on health Promotion, Information, Education and Training, Projects subsidised in 1997, CE-V/3-98-011-EN/FR/DE-C.

4 Directorate Public Health and Safety at Work, Unit V/F/3, Community action programme on health Promotion, Information, Education and Training, Projects subsidised in 1998 by the European Commission, CE-V/3-99-003-EN/FR-C.

– Extra efforts should be made to increase the participation of project partners from Member States in Southern Europe.

– The guidelines should be revised to state that: (a) Projects with all 15 Member States will receive highest priority; (b) Under normal circumstances, projects with fewer than eight Member States will not be considered for funding, pilot projects investigating transfer of specific, innovative methods to other Member States will be supported if they have fewer than eight participants.

– The guidelines should specify that applicants will be required to demonstrate the following aspects of project design and implementation:

- A sound, scientific methodology;

- In the case of quantitative studies, sample sizes should be representative of the target population, large enough to yield meaningful results, and matched across Member States for age, sex, socio-economic status;

- Analyses of the results should be appropriate to the information collected;

- Evaluation should be carried out;

- Dissemination of the findings should be arranged;

- Evidence of genuine collaboration between Member States must be demonstrated.

– The guidelines should provide a clear set of instructions on the expected structure and word length of the interim and final reports.

– Part One of the application form should contain a section that requires specification of the parts of the budget to be allocated to evaluation and dissemination. Part Two of the form should be revised and expanded to include specific half-page sections for descriptions of the design, methodology, participants, analysis, evaluation and dissemination of projects.

– Evaluation and dissemination of projects should be significantly improved. Evaluation and dissemination activities must be included in applicants' description of tasks and written into contracts. If a project evaluation has not been conducted and/or if sufficient efforts to disseminate the results have not been demonstrated, the final payment to the contractor should be withheld.

For future actions in the area of health promotion they recommended:

– A Decision on future actions should establish an external and independent advisory committee composed of high level experts in European health promotion. The scientific advisory committee should advise the Commission concerning the priorities for the programme, make

recommendations concerning funding, and evaluate the final reports of the supported projects. The members of the advisory committee should be paid fees set a level that is commensurate with their responsibilities and their independence and impartiality should be assured.

- In future actions it should be made possible for projects to be funded for two or more years without the need for re-application.

- Future actions should give greater priority to the role of socio-economic conditions such as urbanisation, housing, unemployment and social exclusion in the promotion of health, particularly for those living in deprived areas.

- Future actions should give priority to research into lay people's health beliefs in the light of different cultures, educational and socio-economic groups so that European health promotion can be made more effective and dissemination can be targeted appropriately at different segments of the population.

As a result of all these suggestions, during the implementation the Commission has continuously tried to keep abreast with procedural shortcomings and has adapted the procedures and practices to the needs found by internal reviews and suggestions put forward by applicants and external experts.

Observations of the Member States

A questionnaire was drawn up and dispatched to the Member States and EEA countries that enabled the following focused reporting exercise:

Thirteen Member States and Iceland stated that the Programme had an impact on the development of health promotion in their countries. Eight Member States and Iceland stated that the Programme has contributed in one way or another to national health promotion policy or developments (A, D, DK, EL, IC, IRL, FIN, P, S). Only three countries (DK, NO, UK) stated that the Programme had not had any impact on the development of health promotion in their countries. Two of these three (UK and NO) stated that their national health promotion policies were already well founded. Two of the three countries (DK and NO) that stated that the Programme did not have an impact on their national health promotion policies, however, did mention some positive impact in particular settings.

The greatest impact was reported to be in projects related to specific settings (such as schools, the workplace etc), with fourteen countries reporting that there had been an impact. This is supported by other comments throughout different parts of the questionnaire. Nine Member States (A, B, E, D, DK, IRL, L, NL, P), Iceland and Norway mentioned the European health promotion networks in a positive light. In addition to these eleven countries, two other Member States (Greece and Finland) mentioned the transnational collaboration that has resulted from the Programme and two others (France

and UK) stated that particular projects had or may have had a positive impact in their countries. Thus, a total of fifteen Member States and countries reported at least some added value from the Programme (albeit minimal in one case).

Greece, Germany and Italy stated that it is too early or too difficult to assess the impact of the Programme at the present time. France commented on the difficulties of establishing networks and the lack of dissemination of the Programme. This latter point was also mentioned by Sweden who also referred to linguistic problems between professionals and lay people, and the different structures and circumstances of the Member States. Seven countries gave a positive reply to the question concerning practice. Only six countries mentioned that health promotion interventions had an impact. Germany implied that there is a lack of evaluated interventions. France also raised the issue of the lack of evaluation of projects. Also, in a preamble to its questionnaire response, France stated that institutionalised health promotion in the future should use well-thought out methodologies.

The impression given by the reports of the Member States and EEA countries is that the Programme is already having a limited but positive impact on the national policies of many Member States. In spite of the different cultures and varying stages of development of health promotion in the Member States and EEA countries, the majority reports that positive influences are already in evidence. In particular, the European Health Promotion Networks are attracting interest among the Member States.

The operational aspects of the Programme received considerable amounts of criticism from the Member States. The majority of national representatives on the Health Promotion Committee believe that there has been a lack of transparency in Commission Services' decision making procedures, that the expertise of Committee Members has not been fully utilised, and that the Committee has had too little influence on the process of project selection. A few Member States reported that improvements have recently occurred. However there are good reasons for believing that the committee procedures are not working well and that some re-structuring of the current arrangements is required. Further efforts also need to be made to improve the efficiency and effectiveness of communication between Commission Services and the Health Promotion Committee.

Although the majority of Member States reported a positive impact of the Programme, only four reported any new developments that had taken place as a result of the Programme. However five more were aware of new developments in specific areas. Seven Member States gave a positive reply concerning, the usefulness of the occurred developments. Two Member States reported that the Programme has extended an interest in health promotion to actors in the field of health. France commented that strategies are needed for identifying and implementing pertinent models and also to improve dissemination.

Effectiveness and the achievement of objectives

COVERAGE OF THE PROJECTS SUPPORTED

Given the kind of objectives laid down in this programme, the actual coverage by specific actions following the first calls for proposals within the period of 1996 and 1997 showed some shortage as indicated by the independent experts:

> The distribution of applications and expenditure varied significantly across the five areas of activity. To date, areas B, C and A have received the most expenditure and areas D and E have received the least expenditure. If the Programme is to be fully implemented in all of the priority fields and achieve its objectives in all areas, special efforts will be needed to distribute activity levels more equally across the five priority areas. Activity E (Vocational Training in Public Health and Health Promotion) appears to have been least implemented to date with 15 small-scale projects using only 1.26 MECU of Programme expenditure.

SUBSIDIARITY OF COMMUNITY ACTION

To ensure subsidiarity, the opinion of Member States was invited through the programme committee as laid down in the action programme. Thus, the necessary support of Member States for implementation of actions selected in their countries was encouraged. At the same time, the programme committee guaranteed the required transparency of the European Commission's actions towards the Member States. The transparency towards the European Parliament was ensured by the prior transmission to that Institution of reports and documents intended for the programme committee as well as an annual list of projects financed.

EUROPEAN ADDED VALUE

There was one reservation that initially the European added value of projects was in many instances under developed, but stress has been placed on the development of network projects in order to resolve this shortcoming. This has been confirmed by the independent experts and Member States' representatives, by stating:

> There has already been moderately high Community added value in comparison to the situation that would obtain if the Programme did not exist. Some high ratings for the Community added value were awarded to projects supported in 1996, especially in areas A, B, and C. The project leaders who received funding were also fairly unanimous in asserting their belief in the Community added value of the projects that they were running.
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> The majority of Member States' reported that the Programme had already added Community value.

QUALITY OF HEALTH PROMOTION MEASURES

To ensure the highest possible standards for the quality of the actions selected, the committee not only gave a favourable opinion on the annual work plans, but was also consulted on the preparation of the calls for proposals, the selection of projects and the follow-up of their implementation. Thus, the independent experts have already identified projects supported in 1996, especially in the areas C, D and A which "award some commendably high ratings".

IMPACT ON HEALTH PROMOTION IN MEMBER STATES

To ensure the highest possible impact on health promotion in Member States, the Commission has gradually put more and more emphasis on projects, which were carried out in all Member States and in the three EEA countries. Therefore, the Commission supported the development of European networks with representatives in all Member States and the EEA countries.

This successful development was confirmed by the independent experts by stating:

> "Future action should prioritise the continued support of the European health promotion networks that have made good progress within the 1996-2000 Programme".

These networks acted on specific issues such as mental health and evidence based health promotion, in specific settings such as workplaces and schools and in favour of specific target groups of the population such as disadvantaged people and children. The efficiency and the impact of these projects were stated by the independent experts and the Member States.

Budget Allocation for the Health Promotion Programme

	1996		1997		1998		TOTAL	
Area	**Number of projects**	**Budget**	**Number of projects**	**Budget**	**Number of projects**	**Budget**	**Number of projects**	**Budget**
A- Health promotion strategies & structures	7	912574.64	6	1252939.12	2	847205.00	15	3012718.76
B- Specific prevention & health promotion measures	18	237314.66	10	1439257.00	4	642521.00	32	2319092.66
C- Health information	9	1126822.69	6	1252939.12	2	67500.00	17	2447261.81
D- Health education	12	1130736.10	8	1524080.47	3	36687.76	23	2691504.33
E- Vocational training in public health and health promotion	4	117435.46	4	365328.74	2	201265.00	10	684029.18
TOTAL	50	3524883.55	34	5834544.45	13	1795178.76	97	11154606.76