REPORT FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL

Projects of the Public health programme committed in 2003-2004
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(Text with EEA relevance)

1. INTRODUCTION

1.1. Public health policy and its contribution to Community health strategy

Article 12.1 of the Public Health programme Decision\(^1\) lays down that the programme shall report annually to the European Parliament and the Council on its activities. The following Report has been drafted for this purpose.

The programme became operational on 1 January 2003, constituting a key instrument for financial execution of actions resulting from a broader policy context in the form of health strategy\(^2\).

Building on the experience of eight separate health programmes\(^3\), the programme’s principal aim consisted of establishing a comprehensive and coherent approach to Public health, by concentrating on three key priorities: health information, health threats, and health determinants. Together, the three strands endeavoured to contribute to a high level of physical and mental health and well-being throughout the EU. Actions were designed to create self-sustainable mechanisms which enable the Member States to coordinate their health-related activities.

The strands were echoed in successive annual work plans for public health. One of the most important means of implementing the 2003 and 2004 Public Health work plans was through annual calls for proposals. Other important activities consisted of health analyses and reports, pilot projects, contributing to legislation, establishing data bases, common indicators and information systems.

The programme’s initial budget allocation of € 312 million was increased to € 354 million in the context of the 2004 enlargement to accommodate the 10 new Member States.

1.2. Enlargement

Since the beginning of the Public Health programme, accession countries have been involved in various aspects of the programme. Memoranda of understanding were concluded with all


\(^{2}\) See also [http://europa.eu.int/comm/health/index_en.htm](http://europa.eu.int/comm/health/index_en.htm)

accession countries and candidate countries. They participated as observers in programme committee meetings and submitted proposals in the 2003 call for proposals. Considerable efforts were undertaken to inform these countries of funding possibilities and to involve them in various aspects of the Public health programme. Since accession in May 2004, the new Member States have participated fully in the programme.

The programme is also open to EFTA/EEA countries\(^4\), and Bulgaria, Romania and Turkey\(^5\), who contribute financially to the programme. In 2003 the EEA countries contributed with €1.1 million and the Candidate Countries (including the 10 Accession Countries) with €3.6 million to the operational credits. In 2004, these figures amounted to €1.1 million for EEA and €1.3 million for the three Candidate Countries.

1.3. Impact from previous and current programme(s) – legacy of past projects and policies

A final evaluation\(^6\) on the eight action programmes on public health 1996-2002 has been carried out. The effectiveness, efficiency, utility and sustainability of each programme was considered in view of the public health framework adopted in 1993 and as expressed in the programme Decisions. On this basis, it made recommendations that could be used to manage, implement and develop the Public health programme.

2. OVERVIEW OF 2003 ACTIVITIES

2.1. Adoption of the 2003 work plan

The 2003 work plan\(^7\); the rules, criteria and procedures for the selection and funding of actions for the new programme\(^8\); and the 2003 call for proposals\(^9\) were published in the Official Journal on 15 March 2003.

The call for proposals implementing the 2003 work plan was open for two months with a deadline of 16 May 2003.

2.2. Information about the call for proposals

An information campaign for potential applicants was held on the implementation of the 2003 work plan. This included an official launching event on 18.3.2003 in Brussels by Commissioner Byrne and MEP Trakatellis, EP rapporteur on the programme decision. A large-scale information day was organised in Luxembourg on 13.3.2003 in which ca. 300 persons representing potential programme participants were present. Assistance was specifically given to encourage accession and applicant country participation. A new public health website was developed.

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\(^4\) Norway, Iceland and Liechtenstein
\(^5\) Croatia was not eligible to participate in 2003 and 2004.
\(^6\) Further information: http://europa.eu.int/comm/health/ph_programme/evaluation_en.htm
\(^7\) OJ C 62 of 15.3.2003, p. 21
\(^8\) OJ C 62 of 15.3.2003, p. 14
\(^9\) OJ C 62 of 15.3.2003, p. 7
2.3. Evaluation procedure

A total of 427 projects were received requesting a total funding of over €500 million, or ten times the sum available. Proposals were evaluated by officials with knowledge in the field of the proposal. Where appropriate, proposals were also evaluated by officials from other DGs to ensure that no duplication or overlap occurred with ongoing projects. A total of 58 projects were considered suitable for funding, 12 projects were placed on reserve list A and 55 on reserve list B. The remaining 302 projects were considered unsuitable for funding and were rejected.

Evaluators endeavoured to use a consistent approach and common evaluation standards. An Evaluation Committee was set up in conformity with the financial rules. Grants were allocated a maximum total funding of 60% of total eligible costs. Innovative projects with significant involvement from candidate countries could receive up to 80% funding of total eligible costs.

At its meeting of 16-17 July 2003, the Programme Committee gave a unanimous favourable opinion to finance the proposals selected by the evaluation procedure. It reversed the ranking order of two proposals on the reserve list.

2.4. Adoption of the list of selected projects

The initial work plan was modified on 17.12.2003\textsuperscript{10} to take into account the increased programme budget following the conclusion of memoranda of understanding with accession and candidate countries. This further delayed the negotiation procedure for concluding grant agreements with projects selected for funding. The revised work plan was submitted to the Programme Committee for opinion at its meeting of 9 October 2003. On 19 December 2003, following the adoption of the new work plan, the Authorising Officer decided to finance 70 projects and accepted another 55 projects on the reserve lists, as established by the Programme Committee. The global commitment for these proposals amounted to € 50.4 million. The remaining 302 projects were rejected.

A total of 72 projects were funded under the 2003 budget. 10 projects were cancelled: 4 from the list of accepted proposals and 6 from the reserve lists. The reserve list was used until the 12\textsuperscript{th} project in the ranking order.

2.5. Methods of dissemination and exploitation of results

A complete list of project summaries on the financed projects is available on http://europa.eu.int/comm/health/ph_projects/project_en.htm. The summaries contain administrative information of the main beneficiary, financial information, a list of the associated beneficiaries, and a project description with the outcomes and methods used.

\textsuperscript{10} Commission Decision C/2003/4701
3. OVERVIEW OF 2004 ACTIVITIES

3.1. Adoption of the 2004 work plan

The 2004 work plan for the Public health programme was published on 27 February 2004\(^{11}\). A call for proposals\(^{12}\), implementing the 2004 work plan, was launched on the same day and remained open for two months.

3.2. Information about the call for proposals

An information day was held in Luxembourg on 22 March 2004 to provide information to potential project submitters on how to present proposals to the Public health programme. The event gathered ca. 300 participants from the EU, Candidate Countries and EEA/EFTA Countries.

The Public health programme website contained all relevant information required to submit proposals, e.g. the call publication notice, 2004 work plan, application forms, a guide for applicants, evaluation criteria and a model grant agreement.

A help-desk was set up which received over 500 requests for information or assistance.

3.3. Evaluation procedure

231 proposals were submitted, requesting a total EU contribution of €180.8 million. Although fewer compared to 2003, their quality had generally improved. Each proposal was evaluated by an official and one of 20 independent external experts. In case of disagreement between two evaluators, a third internal or external evaluator provided a consensus evaluation report. The decision of the Evaluation Committee was submitted for formal consultation of other DGs to avoid duplication or overlap with other ongoing projects.

The document *Rules, criteria and procedures for the selection and funding of actions under the Public health programme*\(^{13}\), served as the basis for the evaluation criteria.

79 projects were recommended for funding of which 12 projects were placed on a reserve list. The reserve list was significantly reduced compared to 2003 in order to offer a more realistic possibility of funding. 139 projects were rejected and 9 were ineligible. 4 proposals were excluded due to non-compliance with the submission date.

The projects submitted under the 2004 call for proposals were presented to the Programme Committee at its meeting of 8 July 2004. The projects were generally considered innovative and of high quality.

The Committee introduced minor adjustments: one project had its budget corrected and two projects were prolonged. As in 2003, the order of two projects on the reserve list was reversed. The Committee gave its unanimous favourable opinion on the updated list of accepted proposals and the reserve list.

\(^{11}\) OJ L 60 of 27.2.2004, p. 58
\(^{12}\) OJ C 52 of 27.2.2004, p. 22
\(^{13}\) OJ C 62 of 15.3.2003, p. 14
3.4. Adoption of the list of selected projects

Following the Programme Committee meeting, the Authorising Officer approved the list of 67 projects recommended for funding and the order of the 12 projects on the reserve list as approved by the Programme Committee. The remaining 152 projects were rejected. The total commitment for the retained proposals amounted to € 48.8 million.

On 15 December 2004, following the availability of additional funds, the Authorising Officer allocated another € 6.6 million to the 2004 call for proposals, thus financing all 12 projects on the reserve list.

3.5. Methods of dissemination and exploitation of results

A complete list of the names and brief descriptions of projects which have been selected for funding are available on the Europa web-site for Public health on http://europa.eu.int/comm/health/ph_projects/project_en.htm.

Once all the contract agreements have been signed, further information will be available on administrative information of the main beneficiary, the associated beneficiaries, financial information, project descriptions, their outcomes and methods used.

4. MAJOR ACTIONS LAUNCHED UNDER THE 2003 AND 2004 WORK PLANS

4.1. Cross-cutting themes

Actions of strategic importance, linking several programme objectives were grouped under cross cutting themes in 2003. Key projects covered networking of health NGOs; strategies for action and networking for reducing health inequalities; and the establishment of a Europe-wide, multidisciplinary network on drug prevention in prison.

Cooperation between Member State health services was covered by three projects on prevention of cardiovascular disease, mapping access to health services and evaluating public health in the European border regions.

In 2004, the cross cutting themes were incorporated into the three strands of the programme.

4.2. Health information

In 2003, the programme strove to integrate work carried out under the eight former Community public health programmes. This concerned essentially: (i) health indicators projects addressed to create a EU common list (ECHI) as well as to develop indicators in areas as diseases, health systems, pharmaceuticals, mental health, life styles, etc. (ii) projects focusing on routine and sustainable data collection (e.g. Injury Database, Cancer databases), (iii) projects focusing on the improvement of mechanisms of health reporting (Health Interview Survey projects, Hospital Data projects), and (iv) projects addressed to improve or establish best clinical and codification practices.
Particular attention was given to synergies with the Community Statistical Programme. The World Health Organisation (WHO) and the Organisation for Economic Co-operation and Development (OECD) are associated to the most part of EU projects in the area.

A sustainable health monitoring system is being established which aims to produce comparable information on health and health-related behaviour of the population, on diseases and health systems. The statistical element of the system is being developed using as necessary the Community Statistical Programme. It is based on European-wide common agreed indicators and instruments with regard to their definition, methods of data collection and use. Seven working parties forming a network took forward previous work on health monitoring by concentrating on indicators and data collection.

Work was also carried out to create, in a first step, a short list of Community health indicators with the intention to expand this list in the coming years; develop instruments for collecting comparable information together with the Community Statistical Programme; and develop a series of European Health Reports presenting analysis and information for policy makers, specific audiences or the general public.

Cooperation in the health systems area was promoted through support to health evidence activities and mapping of access to health services.

A call for tender concerning reporting and analysis of health, and social and economic impacts of alcohol was launched to address existing and planned national, EU and WHO policies on alcohol to identify recommendations and options for potential EU alcohol policy or strategy options. Another tender was launched on the development of public health performance indicators for the pharmaceutical sector to monitor the extent to which the pharmaceutical sector is aligned with public health and other social objectives.

In 2004, work continued on information and diffusion, health systems, major and chronic diseases, the Injury Database, mental health and rare diseases. Within information and diffusion, work concentrated on the concept and elements of the future European Union Health Information and Knowledge System, on the development of public platforms for dissemination of the EU health action (the Health Portal) and for the dissemination of the short list of Community health indicators, on the creation of a platform for dissemination of a similar short list at sub-national level; on a health broadcasting platform; and on the policy impact of public health reporting.

In the area of health systems, a network of authorities and institutions involved in pharmaceutical affairs was set up to exchange information on pharmaceutical pricing and reimbursement information. A hospital data project began to improve the comparability of registration methods on discharges and surgical procedures, increase the scope of data collection, and extend this work to the new Member States. Free movement of services and professionals is also foreseen by developing EU-wide commonality in methodology on patient safety in healthcare institutions.

To improve the quality and the sustainability of major and chronic diseases networks of information, support was given to the European Cancer registries and databases systems, to several projects inventorying morbidity sources and to projects creating appropriated monitor

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and indicators systems as well as methods of data collection for several groups of diseases (asthma and COPD, cardiovascular diseases, diabetes, musculoskeletal diseases, etc).

To cover information on rare diseases, a conference was supported to address ways in which awareness of rare diseases, together with cooperation and knowledge-sharing at the EU level can be increased to improve access to information, diagnosis, care, drugs and support. An operational monitoring system for congenital anomalies has been created, a network for rare and congenital anaemia will be set up and a secretariat for a rare disease task force will also become operational.

Mental health was addressed by several initiatives such as health indicators for people with intellectual disabilities, treatment of mentally ill in prisons and mental health economics. A platform on mental health promotion and mental disorder prevention was set up to implement a comprehensive strategy for mental health.

Other areas covered in 2004 consist of environment and health; health surveys, mortality; health impact assessment; injuries and accidents; e-health; and lifestyles.

4.3. Health threats

Activities were carried out to sustain and develop surveillance within bacterial enteric pathogens, influenza, Creutzfeldt Jakob Disease and travel associated legionnaire’s disease. Within early warning and response, a publishing service for the exchange of peer-reviewed scientific information was set up. Efforts to improve communicable disease control and communication were begun.

Health security and preparedness were covered through efforts to counter deliberate releases of biological agents and other potential larger impact natural epidemics; a network of infectious diseases physicians; and a pilot alert system relating to the release of chemicals by terrorists.

Former key projects for rare diseases were linked to new activities. Within tissues and cells, methods to influence tissue quality and security both for transplantation and tissue banking were put forth. Impetus was provided to standard setting, inspection and accreditation for health institutions and facilities involved in haematopoietic stem cell collection, processing and transplantation.

Development of a network for laboratories enabling rapid, effective and co-ordinated responses to health threats resulting from natural infections was begun as well as a programme identifying norovirus outbreaks. Capacity building to strengthen surveillance and control of communicable diseases was encouraged.

An emphasis on surveillance continued in 2004, particularly in the areas of vaccine preventable diseases, reducing threats of nosocomial infections, and providing information on HIV across the EU and Candidate Countries. Surveillance of tuberculosis was enhanced e.g. by developing a European capacity to identify and monitor tuberculosis events of EU interest. Surveillance of sexually transmitted infections and other infectious diseases was also addressed.

With the collaboration of Russian scientists, an improved diagnostic capability in the EU was developed under the heading of health security and preparedness. An alerting system, criteria
for development of a health surveillance system, and training modules for the deliberate releases of chemicals by terrorists were also covered under the 2004 activities. A call for tender was launched to evaluate and improve preparedness for public health emergencies through malicious release of biological and chemical agents and an influenza pandemic.

For increased safety of blood, tissues and organs, a European quality management system network for blood safety was approved. Activities covering legal, ethical and social issues were addressed to improve secure European integrated donation chains in unrelated haematopoietic stem cell transplantation.

Networking was supported between laboratories, for imported viral diseases such as SARS, and for European hospital infection antimicrobial resistance typing. Capacity building was encouraged in the field of training, both for health professionals on rapid response to health threats and for intervention epidemiology in the domain of alert and response.

4.4. Health determinants

In 2003 and 2004 an emphasis was placed on a smooth transition from the eight separate Public health programmes to the new Public health programme. A coherent approach between health determinant actions was developed, with increased attention on strategic approaches.

A network for coherent strategies in the domain of nutrition and physical activity was established, as were networks for preventing obesity in children. Efforts to increase cost effectiveness and efficiency of smoking prevention activities among civil society were further encouraged, for example in the form of cessation programmes for adolescents, smoke free hospitals, and an evaluation of the effects of Irish tobacco legislation15. Also in the field of tobacco, two anti-smoking campaigns were launched and a call for tender on tobacco control was published.

Prevention and reduction of health-related harm associated with drug dependence was addressed through a call for tender. Actions on drugs in prisons and drug prevention in cities were covered under the 2003 and 2004 calls for proposals.

An assessment of abuse of legal pharmaceutical products was begun. Projects enhancing sexual health of young people, and AIDS/HIV prevention in relation to young migrant and mobile populations were selected. This work was strengthened in 2004 by including migrant prostitutes, sexual and reproductive health of people with HIV, and sexual health best practice in new Member States with an emphasis on HIV/AIDS.

In the field of environment, projects concern environment and health information, the effect of noise on children's health, and environment and safety training. Implementation of Directive 2002/49/EEC16 was begun in the field of new threats emerging from increased nocturnal air and rail traffic.

Disease prevention was addressed in the fields of diabetes and cancer. Diabetes prevention was tackled through healthy lifestyle, nutrition and physical activity. Best practice in secondary cancer prevention was assured.

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15 S.I. No. 481 of 2003
Structures for policy making with regard to electromagnetic fields were foreseen, together with healthy lifestyle education being integrated in school curricula. A European master of public health should provide a European dimension to post-graduate training.

Efforts to reduce health inequalities in the Roma community were promoted under the heading social-economic factors. A network on best practice for vulnerable groups within health and social inclusion was set up. A network on health promotion in the workplace was established to disseminate good practice, education and training in accession counties. General public health training has also been emphasised in the new Member States.

5. CONCLUSION

Significant results were accomplished during the first two years of the Public health programme, which solicited vivid interest among European health actors. In the first two years of its existence, the programme received many applications which provided a wide geographical coverage and addressed a vast range of activities under the 2003 and 2004 work plans.

However, it also became apparent that to ensure efficient and effective implementation of this ambitious and complex programme, an executive agency was required as foreseen in the programme Decision. Its establishment was postponed by delays in the overall legal and procedural framework for the creation of executive agencies. As a result, the additional resources needed to implement the programme in an optimum manner were not available. The Agency was created in December 200417 and is successively becoming operational in 2005.

The Public health programme strengthened its collaboration with international bodies such as the WHO, World Bank, OECD, Council of Europe, and European Observatory on Health Systems and Policies.

The importance the Commission attaches to public health in EU policies was reflected in efforts to ensure a global, coherent EU health strategy, close links between public health measures, and health-related initiatives in other policy areas. Such links were supported by new mechanisms and instruments, e.g. health impact assessment of other policies, joint measures with various policies and mechanisms strengthening the coordination of health related activities.

A reflection process on EU health policy was launched by Commissioner Byrne on 15 October 2004 to help shape the future of EU health strategy. National and regional authorities, NGOs, universities, individual citizens and companies were keen to contribute. The process generated a major debate across the EU and beyond.

A number of legislative activities were covered for various aspects within the programme’s remit. Among these could be mentioned Directive 2003/33/EC18 on the approximation of Member State laws, regulations and administrative procedures relating to the advertising and sponsorship of tobacco products. The Council and the European Parliament adopted a

18 OJ L 152 of 20.6.2003, p. 16
Directive setting standards for handling human tissues and cells\textsuperscript{19}. An international network of epidemiological surveillance and control of communicable diseases was set up and work began on establishing a European Centre for Disease Prevention and Control in Stockholm\textsuperscript{20}. It started its work in May 2005.


### Consumption of commitment credits – Mio €

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<thead>
<tr>
<th></th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative expenses</td>
<td>1.975</td>
<td>3.739</td>
</tr>
<tr>
<td>Operational expenses:</td>
<td>50.018</td>
<td>55.898&lt;sup&gt;21&lt;/sup&gt;</td>
</tr>
<tr>
<td>Call for tenders</td>
<td>0.190</td>
<td>2.255</td>
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<tr>
<td>Call for proposals (budget shared equally across the three strands)</td>
<td>49.649</td>
<td>55.286</td>
</tr>
</tbody>
</table>

<sup>21</sup> Figures for 2004 are indicative and remain subject to funding of the selected projects following a successful negotiation procedure and signature of the grant agreement.