



EPHA Briefing for members

Subject	New Health and Consumer Protection Programme 2007-2013
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Why a new programme?

On 6 April 2005 the European Commission issued its proposal for a new **Health and Consumer Protection Programme** for the period 2007-2013. There are two reasons why the Commission launches its proposal now. First, the Public Health Programme (2003-2008) and Consumer Programme (2004-2007) will be drawing to a close. Second, the debate on the EU financial perspectives for 2007-2013 is currently taking place.

The aim according to the Commission, is to **improve EU citizens' quality of life** with respect to health and consumer issues. This is reflected in the title of the programme: '*Healthier, safer, more confident citizens: A Health and Consumer protection Strategy*'. Another goal is to increase the Union's competitiveness in line with the Lisbon agenda. However, the proposal also reflects a forward looking Commission, anticipating the constitutional treaty, in the way it refers to some of the additional



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responsibilities in public health that were written into the new Treaty.

The programme package

The package of documents produced by the Commission (COM 2005 115 final) is bulky and quite confusing. It consists of three separate elements which, for easy reference, we have labelled I, II and III:

- I. The **Communication from the Commission** for a proposal for a joint programme (pages 1-17)
- II. The **proposal for a decision** of the European Parliament and of the Council (**the draft legal text**, pages 18-35 including 3 Annexes)
- III. The legislative **financial statement** (pages 36-74)

In addition, the Commission has produced a 79 page 'Extended Impact Assessment' as a staff working paper and annex to the proposal.

The **structure** of the programme outlined in the draft legal text (II) is also tripartite:

- Section common to both health and consumer protection
- Health specific section
- Consumer protection specific section

The language throughout the Commission's proposal (I, II and III) reflects the above mentioned structure and there are certain important **key phrases**:

- **Common objectives** – are overarching objectives relating both to health and consumer protection
- **Specific objectives** – are objectives relating either to the health or consumer protection parts of the programme
- **Actions** – each objective, common or specific, is divided into several actions
- **Measures** – each action consists of several measures

Status of the proposal

The proposal is subject to **co-decision**, which means both the European Parliament (EP) and the Council have to agree on the legal text. The Committee of the Regions and the Economic and Social Committee will offer opinions and have appointed rapporteurs. This process is likely to take approximately 18 months. In the European Parliament, the proposal is about to start first reading. The Environment, Public Health and Food Safety (ENVI) committee is the lead committee and has appointed Antonios Trakatellis (EPP-ED GR) as rapporteur. Marianne Thyssen (EPP-ED BE) will be the rapporteur for the Internal Market and Consumer Protection (IMCO) committees. The Budgets (COBU) Committee will also provide an opinion. The Council held an orientation debate on the new programme on 2 June 2006 and have scheduled a debate for 28 November 2005.



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Why a joint programme?

Health and consumer issues have previously been dealt with in separate programmes. The Commission proposal for a joint programme is based on several considerations. Firstly, Treaty articles 152 (public health) and 153 (consumer policy) **have similar objectives** such as 'promoting health protection, information and education, safety and integration of health and consumer concerns into all policies' ¹. Secondly, the **types of actions required** to pursue these objectives are also similar, e.g. consulting stakeholders, informing citizens, assessing risks and mainstreaming these issues into all EU policies.

In addition, by combining the two policy areas the Commission hopes to draw the benefits from **economies of scale, greater policy coherence and increased visibility**. This creates **savings and synergies** through streamlining administrative and budgetary procedures, the use of common tools and a common executive agency. It is stressed, however, that 'the programme will maintain and develop the core specificities of actions on health and consumer protection so as to respond to stakeholders' concerns'².

The Commission will be assisted in the implementation of the new programme by a **single executive agency**. The current executive agency set up for the Public Health Programme will be extended to include a '**Consumer Institute**'.

The proposed total allocation for the programme is EUR 1,203 million. This is allocated as follows:

- Common objectives and actions - EUR 111 million
- **Health - EUR 804 million**
- Consumer protection - EUR 194 million

For a more detailed breakdown of the budget allocations see Annex 1.

However, it is highly likely that the budget for the programme will be reduced as part of the wider debate on the overall EU budget for this period.

The structure of the new programme

The Commission has stated that it has taken into account evaluations of current programmes and the concerns of different stakeholders in the drafting of the programme. A closer look at the content of the current Public Health Programme 2003-2008 and this proposal, however, reveals an increase in style but not in substance.

¹ COM(2005) 115 final, p.2 - http://europa.eu.int/comm/health/ph_overview/Documents/com_2005_0115_en.pdf

² COM(2005) 115 final, p.2



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What is **new** is the **structure** of the programme and its division into:

- **Common objectives and actions**
- **Health specific objectives and actions**
- **Consumer protection specific objectives and actions**

There are three **common objectives**³:

1. To **protect citizens from risks and threats** that are beyond the control of individuals (e.g. health threats which affect the society as a whole, unsafe products, unfair commercial practices)
2. To increase the **ability of citizens to take better decisions** about their health and consumer interests
3. To **mainstream** health and consumer policy objectives

The Commission also identifies six **actions** for the pursuit of the above common objectives:

1. **Improve communication** with EU citizens on health and consumer issues
2. **Increase civil society and stakeholders' participation** in policy-making related to health and consumer protection
3. Develop a common approach for **integrating health and consumer concerns into other community policies**
4. Promote **international co-operation** related to health and consumer protection
5. Improve the **early detection, evaluation and communication of risks**
6. Promote the **safety of goods and of substances of human origin**

In the **health part of the programme** there have been several changes. It is structured as four specific objectives which will be delivered through six actions (also known as strands). **Three new strands** have been added to reinforce the three strands of the current Public Health Programme (information, threats and determinants):

1. *Objective:* protect citizens against health threats
Action: Enhance surveillance and control of health threats
Action: Deliver response to health threats (**new strand**)
2. *Objective:* promote policies that lead to a healthier way of life
Action: Promote health by tackling determinants
3. *Objective:* contribute to reducing the incidence of major diseases
Action: Prevent disease and injuries (**new strand**)
4. *Objective:* improving effectiveness and efficiency in health systems
Action: Achieve synergies between national health systems (**new strand**)

In addition there is an action contributing to all the above objectives:

Action: To improve health information and knowledge for the development of public health

³ COM(2005) 115 final, p. 26-28



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The Commission has added the strand on response to health threats because of the increasing number of global health threats that Europe faces and the need to address both monitoring of health threats and actually mobilising resources to address these threats.

The new strand on disease and injury prevention is introduced to reinforce and complement the strand on health determinants. The logic of creating two separate strands is that the disease and injury prevention will focus on avoidable conditions, diseases and mortality.

The strand on health systems cooperation is included in the programme as a concrete follow-up to the high level reflection process on patient mobility and the subsequent High Level Committee on healthcare services. The Commission states that the new strand will bring benefits for patients and health systems facing common challenges.

The Commission proposes two key indicators to measure success of the programme: quality of life for citizens will be measured using the Healthy Life Years (HLY) Structural Indicator and the other more detailed health indicators. A Health Impact Assessment methodology will be developed and used to mainstream health concerns into other policy areas.

Aspects of public health that are missing

What is of concern is the **issues** that were specifically listed in the legal text of the Public Health Programme but which are **totally missing in the draft legal text** (II). The new programme does not mention the following:

- activity-impairing disability
- gender and age considerations
- personal data and confidentiality
- the consequences of accession
- coordination of the position of the EU and Member States in other fora
- personal and biological factors
- environmental agents and adverse effects like radiation and noise
- antibiotic resistance
- genetic determinants and genetic screening

There are two possible explanations for this. Either these issues were omitted due to an oversight, or the Commission finds these issues adequately addressed and solved by the current programme.

Aspects of the programme that need more consistency

In the consultation of stakeholders on health strategy in summer 2004, **obesity** was raised as an issue of concern. Obesity is mentioned in the Commission's introduction (I) to the proposal as one of the



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areas of focus with respect to tackling health determinants, and as an issue to be dealt with in relation to addressing childhood diseases. However, in the draft legal text (II), obesity is only mentioned as one of the cross-cutting issues that can be addressed through possible **synergies** between the two policy areas of health and consumer protection. Under the action on tackling health determinants, nutrition and physical activity are explicitly mentioned as lifestyle related determinants. It could be argued that obesity will fall under these categories, but considering the recent political focus on obesity, it is puzzling that the topic does not feature more prominently.

The important issue of **HIV/AIDS** also lacks specific mention in the draft legal text (II) and may only be inferred as part of the lifestyle-related health determinants of sexual and reproductive health. HIV/AIDS is mentioned in the introduction (I) as part of an overall approach consisting of several existing community strategies to address health determinants. The issue is also treated in the financial statement (III) as an area for mainstreaming into other policies and as a trans-border threat. Neither of these is specifically mentioned in the legal text itself. Considering the severity of the HIV/AIDS problem within the EU, especially in some new Member States, as well as its magnitude internationally, a specific reference in the legal text is essential.

Another inconsistency is the way that different age groups are mentioned. The Commission's introduction (I) identifies **childhood diseases** and health issues relating to **young people's health** as needing special attention and that information campaigns targeting young people will be implemented. Recognising the special health needs of children and young people is important but this is not reflected in the draft legal text (II). **Ageing** is another issue that is treated inconsistently, appearing in parts I and III of the Commission package but notably absent in the draft legal text (II).

The **environment** is included in the draft legal text (II) under health determinants but without much detail. Not only does it lack topics covered by the current public health programme, but also reference to the basis for environmental actions set out in the introduction (I) - the **Environment and Health Action Plan 2004-2010**. The introduction mentions indoor air quality, environmental tobacco smoke and health outcomes related to the environment as the focus for action. These issues are not in the draft legal text (II) nor is **bio-monitoring** which is a key priority in order to be able to measure the impact on human health of environmental factors such as chemicals.

Finally, the Commission emphasises the **Lisbon** process in its introduction (I). Reference is made to the link between good health and economic productivity, as well as mentioning the Council's statement that EU support for health care systems can provide added value. The Commission sees the inclusion of the strand on **cooperation between health systems** as a response to this. The words 'Lisbon' and sustainable development are missing from the draft legal text (II).

Taking all of these missing issues and inconsistencies into account show that the Commission's proposal is far from perfect. **The reason that it is so important for key topics to be in the legal text**



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is that this will be the basis for all action programmes and funding. Getting the legal text right is critical. The combination of health and consumer protection issues into one programme does, as is stated, involve room for the creation of synergies. However, they will not do so automatically, and a re-integration of the missing areas into the legal text will ensure that these issues are addressed in the new programme.

Missing elements in the programme

The draft legal text (II) **ignores several important elements of health**. A number of different target groups have not been mentioned and the gender aspects of health are not acknowledged despite recent work to highlight the gender differences and inequalities in health of women and men. In addressing health inequalities the proposal needs to reach marginalised communities that experience the poorest health and are the least integrated into health policy and service provision, such as migrants, homeless, Roma communities, sex workers and prisoners.

Dental health is not mentioned anywhere in the programme. This is an issue hardly ever discussed in the context of public health but that should be on the agenda. An OECD working paper on the use of health care ⁴ points out that dental care has a strong pro-rich distribution, and that the difference is even more striking in countries where few people seek dental care. This illustrates that, besides dental care being an important issue in itself, it also needs to be addressed in the context of health inequalities. The WHO⁵ points out that poor oral health is not just about dental caries but also includes oral cancer, HIV/AIDS and diabetes.

Visual health is another issue which deserves attention. In the context of active ageing good eyesight is an important part of being able to remain active as one gets older. The WHO points out that although the number of people who are blind or visually impaired is going down, the number of people who are blind from conditions related to longer life spans are increasing⁶. Similarly, for children increased activity levels could possibly be assisted by paying attention to their eyesight. Regular eye tests can diagnose not only visual problems but conditions such as high blood pressure and high cholesterol levels.

Other concerns

From a health perspective the potential **effects of a joint programme** are twofold. On the one hand, as the Commission argues, combining the two policy areas may bring greater visibility and profile. Despite the fact that health has more funds than consumer protection the latter is more influential

⁴ ['Income-Related Inequality in the Use of Medical Care in 21 OECD Countries'](http://www.oecd.org/dataoecd/14/0/31743034.pdf)
<http://www.oecd.org/dataoecd/14/0/31743034.pdf>

⁵ [WHO and oral health see: http://www.who.int/oral_health/en/](http://www.who.int/oral_health/en/)

⁶ <http://www.who.int/mediacentre/factsheets/fs282/en/>



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politically. Therefore health policy may benefit from the link to consumer issues but there are dangers of the 'consumerisation' of health. This could be a risk of reducing health policy to discussions about consumers of healthcare rather than an approach which looks at equity and overall population health. There are some situations where there may be a contradiction between consumer rights and public health. For example, the extensive availability of cheap fast food may be convenient for consumers but is linked to rising levels of obesity and poor nutritional status. The increases in 'travellers allowance' to import alcohol and cigarettes for personal use has been hailed by some MEPs as a victory for consumer rights despite the direct negative impact on health of these products. Although it could be argued that there is no direct link between the programme and the development of EU policy, there will be a significant challenge for the European Commission to ensure that perceived consumer interests do not dictate the wider public health approach.

The draft programme has a significant allocation for **health information and knowledge** (154 million Euros). In addition, 20 million Euros are allocated to improving communication with citizens under the common objectives. Amongst the actions proposed are **information campaigns**, particularly targeted at young people. Although lack of information can be linked to poor health, information alone cannot guarantee behaviour change or improvements in health. This is particularly true in the case of public information campaigns on reducing the use of alcohol, tobacco or healthy eating where health advice has to compete with a much greater volume of sophisticated commercial communication that is designed to encourage consumption. Traditionally it is PR and advertising agencies that win the EU contracts to run information campaigns rather than civil society organisations. A rigorous evaluation should be undertaken about the potential impact of an EU information campaign before scarce resources are used.

The Commission's stated aim is to increase the **participation of civil society**. Not only are NGOs and other stakeholders to be involved more in policy-making and consultations but the Commission also proposes to provide **core funding** so that health and consumer interests can be effectively represented at the Community level. This core funding is allocated at 60 % except for cases of exceptional utility where it may reach 95 %. Exemptions may also be granted from the rule of gradual decreases in financial support. The opportunity for core funding is strongly welcomed by EPHA. The health sector of NGOs has been comparatively weak and fragmented compared to the environment, development, social and cultural NGO networks all of which have benefited from support for operational costs of pan-European networks. This regular funding has in most cases been at the level of 80 % and sometimes as high as 95 %.

It is unclear from the Commission's proposal how much money would be allocated to this core funding of NGO networks. The budget line entitled "*Increase civil society and stakeholder participation in policy-making*" which has an allocation of EUR 20 million seems the obvious source of funding. Over the seven years of the programme, this amounts to 2.85 million Euros available every year. Under the current Consumer programme budget lines three consumer organisation receive core funding of up to



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2.6 million Euros per year. This raises the question about what proportion of money could be available for health organisations. In response to questions from EPHA, the Commission has stated that this is not the only area of the budget where core funding will be available. As an example the proposed new “Citizens for Europe” programme will support 20 networks every year from a budget of 2.5 million Euros including a significant number of small grants of 50-100 000 Euros per year.

In terms of the co-financing conditions for projects, the Commission proposes to maintain a standard 60 % maximum rate of co-financing except for cases of 'exceptional utility' where Commission funding may reach 80 %. However, the criteria for 'exceptional utility' are not explained which means that it may be based on a subjective judgement. Experience from the Public Health Programme indicates that the relatively low co-financing levels are a significant barrier for participation by NGOs. Many EU budget lines targeted at civil society organisations allow a maximum of 80 % funding as the general rule.

The new joint programme does, however, set out a different co-financing rate for projects where the applicant and participants are public authorities or Member States institutions. The lower levels of 50 and 70 % co-financing go some way towards reflecting the financial capacity of these structures and therefore their capacity to co-financing projects.

Finally, the Commission's intend to spend more money on **large and visible projects** rather than numerous small ones. Although this adds to economies of scale for the Commission because they spend fewer resources managing a small number of projects, it is a disadvantage for NGOs which usually have neither the capacity nor resources to develop large scale projects. It also passes the administrative burden of coordinating consortia of many partners to the project applicants.

Conclusion

The Commission proposal for a new Health and Consumer Programme is ambitious, but the package of documents lacks coherence. The red line which ought to run thorough parts I, II and III of the proposal is not visible. There also seems to be a lack of prioritisation. The Commission identifies several important topics and gives valid reasons for EU action but fails to identify specifically which issues will be considered the most important and how they will be dealt with. Several key elements of health that were integrated in the public health programme need to be put into the new programme.



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Annex : Budget overview

	EUR
COMMON OBJECTIVES	110.9810
Objective: Protect citizens from risks and threats	
Objective: Increase the ability of citizens to take better decisions about their health and consumer interests	
Objective: Mainstream health and consumer policy	
Action: Improve communication with EU citizens	20.0430
Action: Increase civil society and stakeholder participation in policy-making	20.2250
Action: Develop a common approach for integrating health and consumer concerns into other EU policies	18.6190
Action: Promoting international cooperation	13.7810
Action: Detection, evaluation, communicating of risks	17.5420
Action: Promote the safety of goods and of substances of human origin	20.7720
HEALTH OBJECTIVES	804.9950
Objective: Protect citizens from health threats	
Action: Surveillance and control of health threats	149.5010
Action: Deliver response to health threats	119.4660
Objective: Promote policies that lead to a healthier way of life	
Action: Health determinants	154.7080
Objective: reduce the incidence of major diseases	
Action: Prevention of diseases and injuries	113.6240
Objective : development of more effective and efficient health systems	
Action: Achieve synergies between national healthcare systems	113.4760
Common to the above objectives:	
Action: Health information and knowledge	154.2210
CONSUMER PROTECTION OBJECTIVES	193.8380
Objective: Better understanding of consumers and markets	48.3820
Objective: better consumer protection regulation	12.6140
Objective: Better enforcement, monitoring and redress	58.3570
Objective: Better informed, educated and informed consumers	52.3080
All objectives (Projects)	22.1780
EXECUTIVE AGENCY AND OTHER ADMIN/MANAGEMENT	93.1850
TOTAL PROGRAMME BUDGET	1,296.1840