EUROHEALTHNET EXTERNAL EVALUATION 2020

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Executive Summary

The 2020 evaluation sought to better understand a) EuroHealthNet's impact on the understanding of health inequalities at EU level; and b) its contribution to strengthening EU policy and funding initiatives. It did so through interviews with key policy stakeholders and decision-makers at EU level, including the European Commission and Member State representations.

Broadly speaking, the reduction of inequalities in public health is seen as a varying priority for the EU institutions over time, mainly as a result of the general socio-economic situation in Europe with occasional boosts as a result of political choices and scientific input. Public health competes with many other inequalities issues within social policy; social policy competes with other policy spheres.

Action on health is curtailed by the fact that the EU's legal competence to act is rather limited and such action has been resisted on the whole by Member States. Because the competence is contested, the EU institutions have sometimes used their soft rhetorical powers to draw attention to health inequalities but have then lacked the policy-making and funding capacity to follow through on these – with some notable exceptions – creating the sense of a gap between rhetoric and action. Furthermore, as there are numerous determinants of public health across all policy fields, policy-making – whether hard law-making or soft guidance-setting is perceived as inconsistent.

The COVID19 pandemic changed the landscape quite dramatically and has pushed public health to the political fore, in terms of pandemic response. However, there are doubts as to whether the EU response is addressing the pandemic through the lens of health inequalities and their social determinants.

Within this overall landscape, the influence of EuroHealthNet and of other organisations which campaign on (social and health) inequalities is seen as *secondary* to the factors above, i.e. economic trends and political choices. However, this does not mean such influence is insignificant: rather, the consistent voice of NGOs on inequalities has been important for keeping those issues on the EU agenda, resisting political attempts to limit or downplay the EU's role in these areas and *keeping the door open to greater movement when the political mood is more supportive.*

"EuroHealthNet is one of the more effective networks in Brussels."

As to EuroHealthNet itself, it was felt that the organisation has been influential in the development of thinking and action on specific initiatives relating to health inequalities, once a political choice had been to launch such initiatives. There are a high number of indicators of policy impact, on which EuroHealthNet performs well, for example establishing frequent productive interactions with policy stakeholders, providing ongoing support to policy implementation. Indeed, by its nature, EuroHealthNet acts as an intermediary between academics and policymakers, which is another indicator of policy impact.

Returning to the EaSI strategic objectives, we can have confidence that EuroHealthNet is been among the actors which have improved understanding of health and social inequalities – and of what works in reducing them (SO3). In addition, we can have confidence that EuroHealthNet has contributed to strengthening policy initiatives at EU level, where they are already underway, and to their implementation in practice.

0. Introduction

The 2020 evaluation report seeks to understand EuroHealthNet's contribution to the understanding of health inequalities at EU level (adapted from EaSI strategic objective 1) and its contribution to strengthening funding initiatives [at EU level] that aim to reduce health inequalities.

Considering these broad aims from a different angle, the 2020 evaluation sought to investigate a number of questions of strategic importance to EuroHealthNet:

- How/where do external stakeholders and funders feel that EuroHealthNet adds value? (ToR 1)
- How visible is EuroHealthNet at the EU level? Has its visibility increased over the period 2018-2021? (ToR 5)
- What are the keys steps and changes needed to further consolidate and scale up EuroHealthNet's work, reach, and impact? (ToR 6)

These are taken from the evaluation terms of reference.

The eight interviewees were from the following organisations: DG Employment and DG Health, European Commission; the Permanent Representations of two Member States to the EU; two different offices of the World Health Organisation; one other European health network; and one policy consultancy. The EuroHealthNet office provided valuable context prior to the interviews and reinforced the case studies under heading 2.

The full set of questions for the semi-structured interviews is to be found in annexe 3 under three headings:

1. EuroHealthNet's contribution to the prioritisation of health inequalities at EU level;
2. EuroHealthNet's contribution to strengthening policy and funding initiatives [at EU level] that aim to reduce health inequalities:
3. EuroHealthNet's performance on indicators, which typically make it more likely that knowledge is utilised by policy-makers.

The present report follows the same structure, attempting to draw a line from the interview findings back to the evaluation questions above and also providing commentary on the implementation with the relevant strategic objectives. Furthermore under heading 4, there is a discussion based on the interview findings of the strategic choices available to further consolidate and scale up EuroHealthNet's policy impact.

"EuroHealthNet's work is really concrete because it works with public health agencies in the Member States"

1. EuroHealthNet's contribution to the prioritisation of health inequalities at EU level.

1.1 How to rate the prioritisation of health inequalities on the EU policy agenda?

Interviewees had to give considerable thought to this macro-level question. The issue of health inequalities is considered to be a visible EU priority but:

- There is a limited legal basis on which to pursue that priority per the Treaty as evinced by Article 168 explicitly limiting EU action after calling for "a high level of human health protection"
- Member States tend to resist efforts towards joint action on health policy and social policy generally – leading to a lack of action on health inequalities.
- As a result, there is a mismatch between the rhetoric and the resourcing needed to deliver on it
- Because the social determinants of health are present in many policy areas, it is extremely difficult to achieve consistent policy-making, even where the EU does have the legal competence to act.

It seems overall that the EU is concerned about health inequalities in its population and is willing to make strong statements but only within its soft policy-making sphere. More informally, one interviewee called it "wishy-washy", another spoke of it as "paying lip-service". Another pointed to the difficulty of trying to mainstream health as leading to it being "everywhere and nowhere" at the same time, as perhaps evinced by Art 168(1): "A high level of human health protection shall be ensured in the definition and implementation of *all* Union policies and activities." (evaluator's italics). Interestingly, a high degree of polarisation in a given policy context is usually not conducive to policy action (C. Fox et al, p252) [1]. Here, even if there were political consensus in understanding the phenomenon of health inequalities, there would not be consensus on the level at which to construct the solution.

As a counterweight to this, one interviewee noted that the EU had taken specific EU policy action on tobacco (permitted by TFEU Art 168(5) and was considering it on alcohol, sugar and trans fats, showing that with broad consensus and possibly pre-existing initiatives by a number of Member States, it was possible to achieve substantive EU-wide public health policy.

The EU institutions make firm statements or arguments for tackling health inequalities, whilst knowing that they lack the legal competence or financial resources to deal with them. The EU is probably trying to keep the issue on the agenda of those (i.e. national and regional governments, economic actors) which do have the competence and resources to tackle social determinants. However, it also creates the impression that the EU is saying one thing but not following through, hence the comment above about 'lip-service'. They may well be doing so under the influence of stakeholders who want more EU responsibility for health, but then are disappointed with the EU, when it does not come to fruition.

The policies that shape the social determinants of health are understood to be at the level of Member States (national or regional), whereas the EU's role is primarily in shaping macroeconomic policy as well as some technical areas like trade, competition, food safety and pharmaceutical regulation Because of this EU limitation, many interviewees recognise the importance of

[1] C. Fox, R. Grimm, R. Caldeira (2017): An Introduction to Evaluation. Sage, London

EuroHealthNet as a partnership of national public health agencies: this is the level at which concerted action can be taken, not only lip-service be paid.

The EU has had significant influence on national policy competences in some cases and at some points in time, mainly at the peak of the public debt crisis in the first half of the 2010s. It was then setting the tone of public expenditure and in Troika cases in effect negotiating national budgets in detail with governments. In this context it began to look at health care policy through the lens of expenditure, but not really at social determinants of health.

1.2 How has that prioritisation changed over time?

It is striking that there is no consensus on this question among interviewees at the broadest level. Three felt that health inequalities were a higher priority in 2020 than in the past; three said it was lower; two said that it had either not changed or had varied over time. Some again queried what was meant by health inequalities and what kind of EU action constituted a priority.

Several referred back to the 2009 communication "Solidarity in Health"[2] as a high point of policy-makers' interest in the subject. Among those who felt health inequalities was a lower priority now, they cited a journey through the post-2008 financial crisis leading to a focus on macroeconomic policy to the Juncker Commission commitment to 'less Europe' in some areas including health and social policy. Among those who felt the issue had become a higher priority, there was a view that more social and health recommendations had found their way into the European Semester and that the European Pillar of Social Rights was a step in the right direction.

One hypothesis could be that the 2009 communication was seen as a high point because it first put health inequalities on the European agenda – it had that term on the front cover. Then, the challenge was how to address health inequalities in a wide range of policy areas (mainstreaming), in only some of which the EU could take firm action. When the approach shifted towards mainstreaming, health inequalities lost visibility as a stand-alone term, leading to a perception that it was no longer a priority. There was no follow-up paper that directly addressed the recommendations of the white paper.

There was a consensus that COVID19 brought a narrow window of opportunity – as yet, unrealised – to bring health inequalities and social determinants back to the top of the agenda. The pandemic response had mostly been about protecting societies from epidemiological crises, not (yet) looking deeper into the social determinants of why some groups were worse affected by the pandemic than others or how that trend was reflective of wider health inequalities.

There are multi-level battlegrounds for priorities: social versus economic Europe; social policy versus health; health care versus health promotion; access to health care versus prevention.

[2] https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0567:FIN:EN:PDF

1.3 What were the crucial factors in determining the prioritisation of health inequalities?

There was a mixture of factors shaping the position of health inequalities on the EU agenda: political, socio-economic, academic, civil society advocacy, but also the COVID19 pandemic as a shock to the system. Any of these factors had the potential to push health inequalities up the agenda or down.

a) Socio-economic factors

The 2008 financial crisis and its aftermath the sovereign debt crisis shaped the EU's priorities for many years, leading to a greater focus on macroeconomic policies and the reduction of public expenditure. In turn, as the adverse social impacts of this approach became apparent, social justice and health equity rose again as a priority. Those economic events led to a greater albeit indirect influence of the European Central Bank and the International Monetary Fund on public spending.

b) Political factors

Some Member States would push health inequalities up the agenda under their Presidencies, such as Finland, Sweden and the UK. President Juncker, having sought a more streamlined Europe, consulted on dropping the heath competence from the EU Treaty, which was countered by an alliance including civil society networks. The European Parliament was also seen as playing an increasing role throughout the 2010s, tending to support more EU policy action. New President Von der Leyen is herself a medical doctor with a public health specialism. This has made her more supportive of this priority and she has appointed a political ally to the health commissioner role. This alone would not be sufficient to transform EU health policy: the constitutional framework remains the same.

c) Civil society influences

Interviewees did consider that civil society as a whole had been influential on the prioritisation of health and social inequalities on the EU agenda in ways it was hard to quantify. Most seemed to cite the more political advocacy of EAPN and Social Platform than the health NGO networks. One interviewee pointed out that European civil society had also been shaped by the European Commission in that it had sought to develop a link between citizen groups and itself independently of the Member States. The Commission may provide funding to civil society networks but it also requires services from them in exchange, including information, advocacy and capacity-building for the use of EU tools and funds by members in the Member States.

d) EuroHealthNet's impact

Within this context, EuroHealthNet is seen as standing a little apart from civil society networks in that its membership is different (public agencies) and the positions it take are more research-based/technical rather than political or ideological. This characteristic was seen by several interviewee as a real advantage, in that the Commission or Parliament could invite EuroHealthNet to give input without this being seen as a political statement or without it leading to political controversy. The Commission's own judgment is that EuroHealthNet's EaSI programmes have a higher European added value because they link health to social issues.

Although the question here was originally thought of as assessing which European networks had been more or less influential, it was answered in a more rounded way, which looked at this range of factors and pointed to the relatively low degree of influence from what might broadly be called civil society.

2. EuroHealthNet's impact in key EU policy processes

Here, the semi-structured interviews were designed to focus on the example of the Multi-annual Financial Framework 2021-27. However, interviewees specialised in a range of policy fields through which they knew EuroHealthNet, so the evaluator invited them to speak about those fields: the European Semester and the next MFF.

2.1 European Semester

Two Commission officials, one Member State representative and one independent analyst contributed on the Semester.

Whereas the Semester started out focusing on macroeconomic and fiscal policy, societal considerations have become more visible over time. Commission interviewees noted that a growing number of country-specific recommendations relate to health systems efficiency, but fewer to tackling health inequalities.

The Semester is an example of an EU policy process in which the EU institutions are sometimes willing to make strong statements e.g. on reducing social inequalities but lack the power to enforce those statements. It was noted that country-specific recommendations only rarely determine policy in the Member States on their own: some see it as useful guidance, others see it as interference. Another interviewee noted that CSRs used cumulatively over time across Member States do build up pressure and can themselves be utilised in ongoing advocacy toward policy-makers, rather than being seen as the end-point of advocacy.

"They reach out across DGs which is a great asset."

The Commission is well aware of EuroHealthNet's Semester analysis and its involvement in strategic dialogue in the Semester process, not only with the Commission but also with particular Member States. For example, EuroHealthNet was invited to a policy focus workshop as part of DG Health's Expert Group on Health System Performance Assessment concerning the post-Covid19 Recovery and Resilience Fund and the Semester. This resulted in EuroHealthNet's Semester analysis being forwarded on to the central coordinating team for the RRF and their country desks in the Secretariat General (SG). The Director was then invited to a bilateral follow-up meeting about EuroHealthNet's further work on the combined Semester and RRF process with the SG colleagues. The SG reports directly to the Commission President and is responsible for the coordination and prioritisation of EU policy initiatives. The analysis EuroHealthNet provided on one particular country is being by DG Employment in its negotiations with that country's government on EU support for its post-Covid recovery in the context of the RRF.

Even if the EU could make recommendations on tackling specific social determinants of health of the kind that EuroHealthNet might endorse, those would probably not lead to policy change, unless there were other political factors at national level driving in that direction. There again, this is why EuroHealthNet's role in amplifying EU recommendations and endorsing EU tools that could fulfil them is highly valued by the institutions.

2.2 Next MFF

"EuroHealthNet is key to finding out how current programmes are working in practice."

One Member State, one other network and one EC official contributed on the MFF.

Interviewees pointed out that the MFF negotiations are not yet complete as a pre-emptive caveat. There was no consensus as to whether the public health provisions were stronger or weaker in the next MFF than the current one. A Commission official noted that many EU tools in the current period were underused for fighting health inequalities. The same interviewee hinted that there may be more uptake of opportunities in the aftermath of the pandemic, but noted the difference between the coordination opportunities of the Health programme and the service delivery opportunities of the Structural and Investment Funds. The three interviewees strongly emphasised EuroHealthNet's potential to activate its members and partners to take full advantage of such opportunities.

Another stakeholder felt that public health should be stronger in the next MFF because it is present in Next Generation EU, InvestEU, the Common Agricultural Policy and so on as well as in in the EU4Health programme as a specific or general objective, but queried whether the potential would be realised in programme delivery. This interviewee also felt that the Commission was more open to dialogue on public health under Von der Leyen than previously under Juncker presidency.

A Member State interviewee noted that, though he is aware of EuroHealthNet's position on the MFF, he takes instructions from the national Ministry of Health for the Council negotiations. He felt that the European Parliament would be more open to listening to EuroHealthNet at European level. He felt that EuroHealthNet's position or identity (i.e. who it represents) on the MFF had not been clear, compared to issue-specific advocates like the cancer lobbies.

The evaluator has seen numerous emails from the EuroHealthNet office to Ministers/Attaches in the Council and to MEP rapporteurs on aspects of the MFF proposals. These show consistent and sustained advocacy for health equity approaches in general, but the office does not hear back on whether the advocacy is taken on board in policy positions.

"EuroHealthNet has worked to build capacity in health authorities to utilise EU funds and instruments so they are better prepared to utilise the opportunities of the next MFF."

3. Knowledge mobilisation: from evidence to policy?

Knowledge mobilisation is an academic field which considers how research knowledge is transferred into policy-making. Even if EuroHealthNet is not itself an academic institution, given that it works in an evidence-based way with its members, and often with universities, it is worth drawing some lessons from this theory, which is described as follows:

> "Knowledge mobilisation describes a more systematic process whereby knowledge is co-produced and channelled to different audiences in order to 'impact' upon policy and practice" (Bannister and Hardhill 2015 in C. Fox et al).

There is a set of indicators of influence coming from 'knowledge mobilisation' literature. Evidence suggests that the following factors tend to enhance influence. This list was mainly adapted from C. Fox et al pp254-256 with the addition of indicator 1 which comes from another paper[3].

1. Productive interactions being "exchanges between researchers and stakeholders in which knowledge is produced and valued"
2. Presence of an intermediary who can translate research evidence into the policy domain
3. Encouraging ownership by the policy-makers of the recommended actions
4. Credibility in scientific and social terms, supported by other credible stakeholders
5. Personal contact with decision-makers showing enthusiasm for position/evidence
6. Ongoing support to enact and implement the proposed policy changes
7. Mapping who are the potential beneficiaries of the knowledge/evidence
8. Contextualisation: Adapted/translating evidence to the specific policy context
9. Building shared goals by co-designing research or policy advice guidelines

EuroHealthNet is seen as performing against those indicators in the following ways:

1. **Productive interactions**: EuroHealthNet is seen as a consistent presence in the EU policy community on public health. Most recognised that EuroHealthNet staff are always present in the key meetings and conferences. Interviewees had an average of six interactions with EuroHealthNet per year. Moreover, interviewees on average engaged with printed or online outputs 7 times in a year, half reading in detail, half only scanning the outputs.
2. **Presence of an intermediary[4]:** when researchers attempt to transfer knowledge into policy environment, they would need an intermediary, and EuroHealthNet is by its nature an intermediary, which is seen as able to translate research knowledge (produced by itself or others) into relevant policy options (see also indicators 4 and 8).
3. **Encouraging ownership**: On nine occasions in total, interviewees requested specific information from EuroHealthNet and received such information reliably and promptly, two of which were on the European Semester process. The two Commission officials highly appreciated its impartial annual analysis of the European Semester.
4. The **quality of evidence** on which EuroHealthNet bases its views is judged highly by most, especially highly where that evidence related to public health strategies in practice as implemented by its members. Two interviewees noted that this was not necessarily academic quality evidence, but also it did not need to be for the intended purposes.
5. **Personal enthusiasm** about its work and its positions – the Director is mentioned individually by three interviewees, but other staff are seen as less visible.

[3] J. Spaapen and L. van Drooge "Introducing 'productive interactions' in social impact assessment" in Research Evaluation 20(3), Sept 2011, pp211-218

[4] Commentary on indicator 2 is the evaluator's own assessment rather than from the interviews

6. **Ongoing support**: EuroHealthNet is seen as supporting EU decision-makers and stakeholders with the implementation of their goals – its work with members making EU tools and process more accessible is particularly highly valued and seen as an important future role and it is known for its portfolio of Horizon 2020 products

The above are the indicators about which interviewees were most emphatic concerning EuroHealthNet's behaviour and attributes. The advocacy materials on the MFF seen by the evaluator demonstrate several of the behaviours listed here including scientific credibility, personal contact and ongoing support – behaviours that are conducive to knowledge mobilisation.

"Collaboration with EuroHealthNet and WHO is great – we always invite them."

There are three other indicators on which interviewees were ***slightly*** more hesitant or nuanced regarding EuroHealthNet's behaviours:

7. **Mapping**: here, they affirm that EuroHealthNet has a good understanding of who decides on EU-level health policies, but query whether it has access to higher-level decision-makers via informal channels on political issues rather than on technical content of policies. One interviewee pointed out that big decisions on priorities are not generally made via the formal stakeholder consultation processes.
8. **Contextualisation**: here, EuroHealthNet provides useable outputs in a timely fashion within and outside specific funded projects, but there are slight doubts about the circumstances in which policy-makers would be in a position to use those.
9. **Goal-sharing**: whilst there were considered to be shared goals with the Commission and WHO, the Member State interviews point to possible areas of tension in goal-sharing – a) the balance of competences between the EU institutions and the Member States; b) the pursuit of health or of social policy goals; c) the attention on health systems versus the social determinants of health. However, specifically for the Commission as a long-term funder, there is a firm contractual and financial expression of shared goals.

Overall, EuroHealthNet's behaviours were seen as highly consistent with knowledge mobilisation indicators. The only area of doubt was its access to higher-level political decision-makers through informal and more senior channels. The advocacy materials on the MFF show clearly that EuroHealthNet is strong at mapping decision-makers but contextualisation and goal-sharing appear less prominently. Further investigation in this area would lead to clearer conclusions and advice.

4. Consolidating reach and impact at EU level

There may be a question for EuroHealthNet's future strategy about where resources are best deployed: in the softer policy areas in which the EU is trying to influence its Member States (European Semester, European Pillar of Social Rights) or in the harder areas in which the EU can legislate or regulate (trade, competition, single market, medicines, four freedoms of the single market). It is also interesting to consider whether it is desirable to have health inequalities as a stand-alone priority (e.g. a new White Paper) or to pursue a single social/economic determinant of health within a current EU priority (e.g. Green Deal).

There are two broader directions in the interview responses: 1) to reinforce EuroHealthNet's advocacy for tackling the social determinants of health at EU level and 2) to reinforce its work with members. However, in the details, interviewees diverge so there is no single clear recommendation here.

Under area 1 on advocacy, three interviewees think three different things:

- To push health inequalities into the new EU priorities, namely the Recovery and Resilience Fund, the Green Deal and the implementation action plan for the European Pillar of Social Rights. This is an actionable recommendation.
- To push health inequalities further up the agenda of DG SANTE itself. This may be allied to the fact that there has not been since 2009 a European Commission communication/white paper solely dedicated to health inequalities.
- To clarify and sharpen EuroHealthNet's own overall position. This was a view that emerged in three interviews. It may arise due to a comparison that occasionally appeared in interviews between single-issue NGO networks whose position is seen as straightforward campaigning for a cause and EuroHealthNet's more complex evidence-based position, which is overall highly valued by policy stakeholders.

Under area 2 on work with members, again there are a range of single points from single interviews, rather than a clear pattern:

- To bring together quantitative data on public health trends and on public health strategies from members. Related to this, there could be an opportunity to monitor the public health impacts of COVID19 and the measures to contain the pandemic.
- To build members' capacity to maximise uses of EU tools and funds to address health inequalities and to use the best available evidence to design effective public health strategies.

Drawing together points from different interviews on the current policy context, EuroHealthNet could choose to advocate with other public health networks for greater political action at EU level to tackle the social determinants of health. Twin factors point to this opportunity: a) the presence at the head of the Commission of a former doctor and public health specialist and b) the attention to public health as a result of COVID19 and associated measures.

One Member State interviewee felt that there were opportunities for EuroHealthNet to monitor and draw attention to the effects of the pandemic on health inequalities in the medium-term and so contribute to discussions around the EU's ongoing role in health policy. This interviewee's judgment was that any new EU powers on public health in the wake of the pandemic would be to do with crisis

management and disease control across borders, perhaps leading to new responsibilities for the European Centre for Disease Control.

A counter-consideration is this: EuroHealthNet is more highly valued for its capacity-building work with members and its apolitical evidence-based input on technical policy-making than for its advocacy. That niche is an important part of its perceived identity. More than this, several interviewees pointed to Member States' resistance to a growth in EU competence (or fuller use of its existing competence). It could be seen as a political campaigning for EuroHealthNet to advocate for the EU to exercise more fully that competence, which may have a reputational downside at EU level and among the Members, which are dependent on national health ministries.

5. Conclusions

External stakeholders feel that EuroHealthNet adds value in the following ways (ToR 1):

- It provides apolitical evidence to support the formation of technical policies.
- It supports the utilisation of EU tools among its members – and their participation in EU processes.
- It links health to social issues

Adding value here is synonymous with EuroHealthNet doing things that no other networks or organisations can do, i.e. this is about the unique niche that it occupies.

EuroHealthNet is considered to be visible (ToR 5) and to have a consistent presence in the specialist health policy community in Brussels. There may be some doubts about whether EuroHealthNet is visible at a more political level, but it is noted that this may not be strategically necessary. There was no firm view on whether visibility had increased or decreased. All interviewees were regular recipients of the newsletters and most had frequent contact with the secretariat, which occasionally prompted them to look at reports etc.

EuroHealthNet is at an advanced stage of organisational development at which there are not obvious steps to consolidate and scale up its policy impact. There are, rather, strategic and tactical choices to be made in a changing political context and in light of how EuroHealthNet is perceived. (ToR 6)

According to last year's evaluation of membership activities, EuroHealthNet appears to have multiple niches:

- its focus on policy implementation in practice
- its firm focus on public health rather than health care
- its connectivity with different stakeholders from research, policy and practice
- its ability to unlock EU funding for members

Perhaps most powerfully, it is the combination of those roles that sets EuroHealthNet apart. The findings of this year's report show that these facets are also appreciated by policy stakeholders.

Returning to the EaSI strategic objectives, we can have confidence that EuroHealthNet has been among the actors which have improved understanding of health and social inequalities – and of what works in reducing them (SO3). In addition, we can have confidence that EuroHealthNet has contributed to strengthening policy initiatives at EU level (SO1), where they are already underway, and to their implementation in practice through its work with members and its own EU-funded projects.

What remains to be decided for future strategy is the balance of technical policy input versus more political advocacy for (EU or Member State) action on the social determinants of health. Furthermore, there is also a decision to be made about the priority areas of focus, whether the focus should be on the social/economic determinants of health that lie within the direct competences of EU policy-making (a narrow approach) or on the softer competences that rely on the EU's influencing, convening and funding powers (a broader approach).

ANNEXE: Article 168 TFEU

TFEU Art 168

Article 168

(ex Article 152 TEC)

1. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.

Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education, and monitoring, early warning of and combating serious cross-border threats to health.

The Union shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.

2. The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas.

Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed.

3. The Union and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.

4. By way of derogation from Article 2(5) and Article 6(a) and in accordance with Article 4(2)(k) the European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, shall contribute to the achievement of the objectives referred to in this Article through adopting in order to meet common safety concerns:

(a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;

(b) measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health;

(c) measures setting high standards of quality and safety for medicinal products and devices for medical use.

5. The European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, may also adopt incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-border threats to health, and measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol, excluding any harmonisation of the laws and regulations of the Member States.

6. The Council, on a proposal from the Commission, may also adopt recommendations for the purposes set out in this Article.

7. Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them. The measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

ANNEXE POLICY INTERVIEW QUESTIONS

1. EuroHealthNet's contribution to the understanding of health inequalities at EU level.

- ➔ How do you rate the prioritisation of health inequality on the EU level policy agenda?
- ➔ How has that prioritisation changed since 2014? Can you give any specific examples?
- ➔ Who were the crucial actors or alliances in increasing prioritisation of tackling health inequalities?
- ➔ Among those actors/alliances, how influential was EuroHealthNet? Can you give any specific examples?
- ➔ Do you feel that EuroHealthNet's visibility at the EU level has increased over the same period?

2. EuroHealthNet's contribution to strengthening funding initiatives [at EU level] that aim to reduce health inequalities:

➔ Understanding that the MFF is still under deliberation, how strong is EU funding to combat health inequalities estimated to be in the next MFF?

➔ How strong were such initiatives in the current MFF up to 2020?

➔ Are you aware of the work that EuroHealthNet is doing around EU funding and innovative financing of health promoting services?

➔ How have other public health advocacy groups strengthened such policy initiatives?

➔ What factors do you think prevent EU funding to combat health inequalities from being even stronger in the next MFF?

In some cases, questions along these lines were asked about a different EU policy initiative due to interviewees' specialist responsibilities.

3. Knowledge mobilization indicators.

There are a number of factors which typically indicate that research knowledge is more likely to be utilised by policy-makers. Given EuroHealthNet's strong research dimension, we are including questions based on several of those indicators that will allow a more informed commentary on these indicators. These indicators are drawn from my work supporting research impact on the Horizon 2020 project INNOSI and were then formalized by Prof. Chris Fox in his book An Introduction to Evaluation (Sage, 2017).

- ➔ In the year 2019, can you estimate how many times you met EuroHealthNet staff at events or bilateral meetings? Of these, can you estimate how many times you took further action as a result? *[Productive interactions]*
- ➔ This year, can you estimate how many EuroHealthNet publications you have consulted? Of those times, can you estimate how many times you took further action as a result?
- ➔ How often in 2019 have you requested specific information from EuroHealthNet relevant to a new policy/funding initiative? Of those, how many times did you use the information? *[Ownership]*

- ➔ How do you rate the quality of evidence behind EuroHealthNet's public health positions? *[Credibility]*
- ➔ In your judgment, does EuroHealthNet have a good understanding of who decides issues at EU level? And are they in touch with those decision-makers? *[Mapping]*
- ➔ Are EuroHealthNet staff enthusiastic about their work on reducing health inequalities?
- ➔ Does EuroHealthNet provide you/EU decision-makers with knowledge in a timely fashion and in a format that you/they can use? *[Translation/Contextualisation]*
- ➔ Do you feel that EuroHealthNet supports you/EU decision-makers in your work and shares your goals? *[Ongoing support]*

4. Looking to the future, can you think of any ways that EuroHealthNet could further consolidate its reach and impact at the EU level?