European Centre for Disease Prevention and Control (ECDC): the mandate's review.

EuroHealthNet is a European Partnership of organisations, agencies and statutory bodies working on public health, disease prevention, promoting health, and reducing inequalities. Our initial contribution to the ongoing debate on the revised ECDC's mandate stresses out that **its future remit should extend to prevention and surveillance of chronic and Non-Communicable Diseases** (NCDs), as well as respond to our long-standing calls[1] for **comparable disaggregated data and indicators to monitor, inform and promote evidence-based policies and act on health inequalities and determinants of health across the EU**.

The above is in line with both the European Parliament's resolution from July 2020 on the "*EU's public health strategy post COVID-19*"[2] and the conclusions of the independent external evaluation of the ECDC in 2019[3] to which EuroHealthNet contributed. Both call, among others, on the European Commission (EC) to "*propose a revised mandate for the ECDC to increase its budget, staffing and competences, which would enable the ECDC inter alia to extend its competences to non-communicable diseases*".

Furthermore, it calls on the EC to "*adopt a common set of health determinants to monitor health inequalities by age, sex, socio-economic status and geographic location and establish a methodology for auditing the health situation in the Member States, with a view to identifying and prioritising areas in need of improvement and increased funding*".

While appreciating the desire for some urgency to improve common and emergency efforts in the COVID-19 pandemic context, we remain cautious that the current partial package – as it has been put on the table - may be premature before full learning of lessons from the crisis can be taken into account. Our national members, many involved in front-line measures, have not yet had time to review syndemic-pandemic impacts in their entirety (e.g. on various disadvantaged groups, gender dimension, Non-Communicable Diseases plus mental health). These aspects cannot be left outside any future-oriented reviews of institutional structures and their remit of work. The process must be transparent, consultative, and carefully crafted. This requires time.

Since there is an established link between communicable and non-communicable diseases, one that is also strongly characterised by unequal distribution along a socio-economic gradient (as highlighted by COVID-19)[4], synergies and more integration at ECDC and at national level should be promoted. There should also be extension and use of more regional and municipal data collection

[1] https://eurohealthnet.eu/sites/eurohealthnet.eu/files/publications/PP_%20Health_Inequalities_07_WEB.pdf
[2] https://www.europarl.europa.eu/doceo/document/TA-9-2020-0205_EN.html
[3] https://www.ecdc.europa.eu/sites/default/files/documents/Third-External-Evaluation-ECDC.pdf
[4] https://eurohealthnet.eu/media/news-releases/research-covid-19-pandemic-and-health-inequalities-shows-we-are-not-all-it

to capture diversities beyond national figures[5], but cross sectoral sources are also vital (for example links with the long excellent Health Behaviours in Schools programmes) as fragmented and silo approaches should be avoided. **Partial regulation which risks excluding health promotion and disease prevention, may risk increasing and perpetuating inequalities gaps, adding to an existing challenge of integrating marrying governance for health with social, economic and environmental barriers** which the revised European Semester, EU Political Priorities and the Next Generation EU recovery and resilience vision seek to achieve.

A crucial factor will be how this will support the Action Plan for the implementation of the European Pillar of Social Rights and the revised Social Scoreboard, with **new prevention-based metrics required and implementation of preventive and curative rights in the Pillar's Principle 16 insufficiently well defined**. ECDC – and the role of the EMA in ensuring timely and equitable access to affordable medicines – could play vital roles through 2030 in these respects. Furthermore, we have also **not seen it well-reflected in the scope of the Conference on the Future of Europe**, scheduled to finalise under the French Presidency next year. This timeline should be used for careful considerations for which measures should be adopted in policy and practice to meet priority health and social needs at EU levels in an impactful and sustainable manner.

The extension of the agency's mandate to cover gaps in health information, monitoring, health determinants, behaviour and promotion has been identified needing a stronger basis, infrastructure and cooperation mechanism at the EU level. There is a **critical lack of comprehensive, comparable and quality data and evidence-based guidance between and for all Member States regarding health inequalities and the comparable burdens of non-communicable and infectious disease in a demographically changing Europe**. The situation is patchy and certain crucial and emerging health data, especially regarding capturing and accounting for vulnerabilities are not covered everywhere in the region. There are plans for setting up 'European inequalities registries' (in particular in a context of Europe's Beating Cancer Plan), but how those would be integrated and aligned with the ECDC or other data systems and infrastructures remains unclear. ECDC could be a suitable existing central hub linking with enhanced national and regional institutions for improving and analysing data collection, standards and use. **The existing expertise, experience and pre-established networks amongst national public health authorities can be better utilised to this end and should be extensively consulted and involved in planning, design and implementation as well as the national government ministries and authorities.**

While strengthening the collaboration and complementarity with the work of national authorities and the WHO, it has potential to provide for a more permanent structure and more sustainable results, in comparison to the current approach based on EC-Member States-other actors periodic and thematic cooperation (Joint Actions, project-based structures).

[5] https://eurohealthnet.eu/sites/eurohealthnet.eu/files/publications/EuroHealthNet%20input%20Roadmap%20Reducing%20disparities%20in%20the%20EU_Final.pdf

While keeping our eyes on the future expansion, however, a **firm focus must be kept on quality assurance, inter-institutional and agency coherence to avoid overlaps and duplication**. The ECDC must be able to present information, which is relevant, reliable, scientifically 'state of art', yet understandable, joined-up and actionable for public health authorities. The agency should be **empowered to deliver messages which will pro-actively inform European evidence-based policy and priority setting, help adjust existing strategies, steer modern research towards a more psychosocial measures of the results of health and related policies and practice**. For this reason, behavioural and social scientists should form an integral part of its staff if interventions to improve health, quality of life and wellbeing of European citizens are to be effective, aligned with the TFEU's Article 168 explicit promotion of a 'health in all policies' approach.

Having appropriate and accountable resources will be essential. These must be financial but also human, with the capacity for ECDC to fairly recruit the necessary standards of skills and knowledge both short term and in development without draining national and regional resources. **Alongside the EU institutional central agencies, it will be vital for sustainable investment in training and capacity building for skills in professions and communities for modern public health, disease prevention and health promotion.** Here, a focus on prevention as well as the curative skills for which Europe is renowned must be firmly placed. The enhanced ECDC in the context of the European Health Union needs to become a beacon by 2030 for world class public health wider workforce training. This must include equitable digital skills and health literacy, closely aligned with the needs of the Green Deal and tackling climate change and in liaison with the new Climate and Health and other relevant Observatories and institutes. It also needs to integrally incorporate social fairness, including principles of gender equity at its core, to ensure support and leadership at all levels for the 'Social, Green, Health Promoting and Digital' Europe.

We hope this is just a **start of a wider and long-term process, which needs to be carefully planned, assessed, and analysed, with full and direct engagement in design, planning and implementation with and support to (sub)national responsible bodies and civil society**. While the history of EU public health policy development very much results from successive crises, a hasty 'knee jerk reaction' should be avoided without a genuine assessment of evidence and reflection on lessons learnt, including the voices of those people who often bear the brunt of crises like this, yet chronically lack recognition, resources and capacities to act: local context is often crucial yet disregarded in EU level debates. **We therefore look forward to a wide consultation and full impact assessment with involvement from all relevant stakeholders and informed citizens**.

Thank you.

Brussels, March 2021.