Is health recognized in the EU’s policy process? An analysis of the European Commission’s impact assessments

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Background: The European Commission has an Impact Assessment (IA) procedure that aims to inform decision-makers of the all important impacts that decisions may have. This article studies how health is considered in the IA procedure and how it is reflected in the reports: what aspects, whose and simply in what context health is mentioned in the IA reports. Methods: Half of the Commissions IAs from 2006 were studied. The analysis was text based and informed by content analysis. Results: Five DGs (29%) and 10 reports (21%) made no reference to human health, public health or health systems. Five DGs were clearly considering health impacts more often than others; DG EMPL, SANCO, AGRI, ELARG and ENV. Health systems/services were most often and human health next most common referred to (39% and 29% of all, respectively). Health impacts were usually referred to in the sections on the definition of problems and the analysis of impacts. Seldom were they reported on in the sections on policy options, comparing options, or in the monitoring and evaluation sections. Conclusion: The results partly support concerns about the potential neglect of health impacts. The results also suggest that health is not considered an important factor when discussing alternative policy choices, and neither does it seem to be an important objective. There is a clear need for further exploration on ways in which health could be more appropriately considered when impacts of other policies are considered by the various DGs.

Keywords: health, impact assessment, European Union.

Introduction

Impact assessment (IA) is understood to be an aid to political decision-making and thus promotes evidence-informed policy-making. Ideally, all decisions should be based on a sound analysis of the best data available. As a tool in the context of the European Union, the European Commission (hereafter, simply ‘the Commission’) introduced an integrated IA procedure in 2002. The IA procedure is expected to facilitate co-ordination within the Commission, demonstrate openness to input from a wide range of external stakeholders, show the Commission’s commitment to transparency, be based on a careful and comprehensive analysis of likely social, economic and environmental impacts and improve the quality of policy proposals by keeping EU intervention as simple as possible. It aims to contribute to meeting the specific commitments of the Lisbon and Sustainable Development Strategies. Also, it is expected to explain why an action is necessary and that the proposed decision is an appropriate choice or, to demonstrate why no action at the EU level should be taken.1

The history of IA as a systematic administrative procedure in the policy process of the European Union is not a long one. Demands for the assessment of legislative proposals can be traced back to 1996, when Regulatory Policy Guidelines were first launched.2 The first guidelines and procedural rules for routine integrated IAs were given in 2002, followed by revised guidelines in 2005.3 According to the procedural rules of the guidelines, a formal IA is required for all items on the Commission’s Work Programme, including all regulatory proposals, White Papers, expenditure programmes and negotiating guidelines for international agreements.4

During the Finnish EU Presidency, the role of IAs from a health IA perspective was questioned. Concerns were raised that the IA reports were not being utilized in all law-making institutions (i.e. European Commission, Council of the European Union and the European Parliament) and that health is not always considered in an appropriate way.5 There were also concerns that problems seemed to be framed and analysed according to the perspective of whichever DG was conducting the IA.6 For example, DG Sanco would focus on health in IAs and other DGs would do so only rarely.

An analysis of the first round of IAs (2003) considering sustainable development suggests that the range of impacts assessed was limited. The greatest attention was paid to short-term economic costs and less to environmental and specifically social impacts.5 Similar conclusions were presented to the EEAC Working Group on Governance in 2006 emphasizing further the dominance of numbers over qualitative approaches and the inadequate quality assurance of the IAs.5 Health has not been the main study component in these or other previously published studies. Some internal, unpublished reviews from a health perspective exist suggesting that health impacts may be partly neglected in the assessments.6

The purpose of this article is to investigate these challenges. The objective is to study to what extent health is considered and how it is reflected in the reports: what aspects of health; whose health; and simply in what context it is mentioned in the IA reports.

Assessment of health impacts in the European Union policy-making processes

The roots to considering the health aspects of the Community policies go back to the 1950s, when occupational health and safety were put on the agenda of the European Coal and Steel Community. The founding of the European Economic
Community in 1957 by the Treaty of Rome strengthened the importance of health protection and the safety of workers. A more systematic work that considered the impacts of other sectors activities on health began in 1993, when public health was included in Article 129 of the Maastricht Treaty and in Article 152 of the Amsterdam Treaty (1997), which presumes that ‘a high level of human protection shall be ensured in the definition and implementation of all Community policies and activities’.7 As a response to these challenges and obligations the Commission decided in 1995 to prepare annual reports on the health aspects of other Commission policies to integrate health across the European Community. The first report was produced by the commission’s public health directorate in 1995. The reports were extensive and descriptive, but tended to contain too little analysis of how the integration of health could be improved and what could be performed better. Thus, the last (fourth) report in 1999 suggested that the system of annual overviews of all health-related Community activities should be replaced by more specific work on health requirements. This was also recommended by both the European Parliament and the Council of the European Union.8

Since then, DG SANCO (Health & Consumer Protection) has focused more on concrete action to mainstream health concerns in those key Community policies with the greatest potential to improve health, rather than on reporting about such action. In addition, the Commission has been active on Health IA and Health Systems IA.8 In 2001, DG SANCO launched a practical guide for health IA. It was meant to help ensure that health impacts are similarly addressed and presented to the Institutions across Commission services.7 At the same time there were discussions aimed at more comprehensive assessment procedures.10 As a result of the various communications the guide for integrated IA was launched in 2002, with a second one in 20051 and a third one in 2009.11

As Health in All Policies is one of the main principles in the Health Strategy Together for Health: A Strategic Approach for the EU, 2008–2013, it is of outmost importance to develop proper methods and processes that ensure identification of major health impacts of various policy initiatives so as to enable the Commission to mainstream health in all its policies in accordance with the Amsterdam Treaty, as well as with the draft Lissabon Strategy.

Health in the Commission’s IA procedure

The procedure of IA is described in the Commission’s guidelines. It leads the reader in a systematic way through the principles of IA. The guidelines emphasize the importance of direct and indirect impacts, the identification of who is affected and in what way, the assessment of impacts in qualitative, quantitative and monetary terms, and the consideration of risks and uncertainties in the policy choices. Three sets of impacts are presented: economic, social and environmental. Public health and health system impacts come under the category of social impacts (table 1).

**Table 1** Public health and safety as part of social impacts in Commission IA Guidelines

<table>
<thead>
<tr>
<th>Impacts on</th>
<th>Key questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health and safety</td>
<td>Does the option affect the health and safety of individuals/populations, including life expectancy, mortality and morbidity, through impacts on the socio-economic environment (e.g. working environment, income, education, occupation, nutrition)? Does the option increase or decrease the likelihood of bioterrorism? Does the option increase or decrease the likelihood of health risks due to substances harmful to the natural environment? Does it affect health due to changes in the amount of noise or air, water or soil quality in populated areas? Will it affect health due to changes energy use and/or waste disposal? Does the option affect lifestyle-related determinants of health such as use of tobacco, alcohol, or physical activity? Are there specific effects on particular risk groups (determined by age, gender, disability, social group, mobility, region, etc.)?</td>
</tr>
<tr>
<td>Access to and effects on social protection, health and educational systems</td>
<td>Does the option have an impact on services in terms of their quality and access to them? Does it have an effect on the education and mobility of workers (health, education, etc.)? Does the option affect the access of individuals to public/private education or vocational and continuing training? Does it affect the cross-border provision of services, referrals across borders and co-operation in border regions? Does the option affect the financing/organization/access to social, health and education systems (including vocational training)? Does it affect universities and academic freedom/self-governance?</td>
</tr>
</tbody>
</table>

Methods

The data for this study consisted of the IA reports presented on the Commission web page as of 2 November 2007 (http://ec.europa.eu/governance/impact/cia_2006_en.htm). In total, there were 67 IAs carried out in 2006. Half of the DG's assessments were included in the sample. The sample was drawn such that the amount of the text to be analysed would remain manageable. The sample was drawn by lots. In total 32 assessments were included in the sample (table 2). Some of the assessments included several IA reports. For example, the proposal on the European Neighbourhood Policy had an overall assessment, country-specific progress reports on the implementation of the first seven Action Plans and a more detailed technical assessment on sectoral issues.

Thus, there were 61 reports in the sample. After omitting reports that were in French (six (the French reports omitted were: two country progress reports (Morocco and Tunisia) and a discussion minutes of the cabinet meeting on European Neighbourhood Policy (SEC(2006)1510, 1511, 1536; Communication on European Consensus on Governance and Development SEC(2006)1021; IA on Regulation on setting up teams of international experts to assist re external borders SEC(2006)954; IA on Community Code on Visas SEC (2006)957) and those executive summaries that were based on the reports already in the sample (seven) the analysed data
consisted of 48 IA reports. The French reports were omitted to keep the analysed sample coherent and to avoid any linguistic shortcomings in the analysis.

The analysis was data driven and informed by content analysis. The basis for the analysis was a word search. First, the word [health] was searched from the reports (search command). The context, i.e. the text around the word [health], and the title of the chapter/section were copied into a separate file. Second, the text-data were analysed by DGs with the following questions: (i) what kind of health and whose health is it? and (ii) What is the larger context in which health is being mentioned? Categories for the answers to the first question were formulated on the basis of the data (table 4). The coding was done by the author alone. In the first round of the analysis, more detailed categories were formed. For example, health services/health organizations and health system/health care were kept as independent categories. However, due to the context of the finding it was not always clear in which of these categories the finding should be coded. Thus, the categories were integrated whereafter all the categories were distinct and conceptually clear. The structure of the IA report was used in answering the second question (table 5).

## Results

### Prevalence of health references

The number of health references in the IA reports describes at a general level the importance/role of health in the assessments (table 3). Five of the DGs were considering health impacts clearly more often than other DGs; DG EMPL, SANCO, AGRI, ELARG and ENV (29, 27, 19, 15 and 13 health references per report, respectively). When considering the number of health references per 100 pages, the results changed slightly. The IA reports by DG EMPL referred to health aspects most often, almost four times more often than DG AGRI and SANCO (112, 31, 27 health references per 100 pages, respectively). DG ELARG came in behind DG FISH and REGIO (with 3, 14 and 14 health references per 100 pages, respectively). Five DGs (29%) and eight reports (16%) had no health references.
A detailed analysis of the focus of health references demonstrated whose health is considered and why it is referred to (table 4). Health care/health system (e.g., health insurance) and health services/health as a sector or organizational body were most often referred to (39% of all). Human health was the second most common (29%). The environment and plant health were referred to more often than public health (15 and 10% respectively).

Reports by DG ENV, SANCO, and TREN concentrated more on human and public health than on the health system or services. Reports by DG SANCO often considered the health of plants and animals (49% of all health references). IAs conducted by DG EMP, ELARG, and INFSO focused more often on health services and the health system than human or public health.

The analysis also indicated interesting findings about the variety of the motivation for why health was referred to. For example, in DG Regional Policy’s IA report concerning the Community’s strategic guidelines for cohesion, health was secondary to competitiveness and productivity:

... to facilitate the exchange of views on the strategic dimension of cohesion policy, 2007–2013:
- the inclusion of more innovative elements, such as the emphasis on access to finance and financial engineering, public-private partnerships, investment in health to foster competitiveness and productivity, and administrative capacity-building were widely welcomed and encouraged.

Another example from Commission’s communication on Global Europe illustrates how references to health may not have anything to do with people or the health system:

Trade policy can have a positive impact on competitiveness by ensuring that:
- the domestic market is sufficiently open to provide cheap inputs and allow healthy competition vis-à-vis the rest of the world, as well as to stimulate technical progress.

### Focus of health references

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### Context of health references

The Commission’s guidelines on IA give a structure for analysing and reporting the IA (table 5). Reports by DG EMP, ELARG, and RELEX did not follow the structure proposed by the Commission’s guidelines. Thus, they were not included in the analysis. Results show that reports by DG TREN and AGRI consider health impacts most often in the section ‘analysis of impacts’ (71% and 58% of all health references, respectively). Consideration of health impacts is more spread out in the reports by DG ENV, JLS, and SANCO. Interestingly, reports by DG JLS and ENV consider health in more detail in the section ‘problem definition’ than in the section ‘analysis of impacts’.

Only one report had a health reference in the section ‘Monitoring and Evaluation’: a report by DG SANCO proposed to use indicators for monitoring and evaluation of the future system and one of the themes and indicators were:

Reduction of health risks – availability of low risk PPP’s (Plant Protection Products); number of PPP’s for which comparative assessment provisions have been applied.

### Table 4 Focus of the health references in the IA reports

<table>
<thead>
<tr>
<th>DG</th>
<th>Number of Health hits,</th>
<th>Environment, animal, plant health n (%)</th>
<th>Human health n (%)</th>
<th>Public health n (%)</th>
<th>Health organization, system, services n (%)</th>
<th>Other n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGRI</td>
<td>19</td>
<td>–</td>
<td>7 (37)</td>
<td>5 (26)</td>
<td>3 (16)</td>
<td>4 (21)</td>
</tr>
<tr>
<td>EMP</td>
<td>29</td>
<td>–</td>
<td>5 (17)</td>
<td>24 (83)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>ELARG</td>
<td>116</td>
<td>9 (8)</td>
<td>4 (3)</td>
<td>6 (5)</td>
<td>52 (79)</td>
<td>5 (4)</td>
</tr>
<tr>
<td>ENV</td>
<td>67</td>
<td>5 (8)</td>
<td>45 (67)</td>
<td>4 (6)</td>
<td>5 (7)</td>
<td>8 (12)</td>
</tr>
<tr>
<td>FISH</td>
<td>1</td>
<td>1 (100)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>INFSO</td>
<td>3</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>JLS</td>
<td>24</td>
<td>–</td>
<td>11 (46)</td>
<td>–</td>
<td>9 (38)</td>
<td>4 (17)</td>
</tr>
<tr>
<td>REGIO</td>
<td>1</td>
<td>–</td>
<td>–</td>
<td>1 (100)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>RELEX</td>
<td>19</td>
<td>4 (21)</td>
<td>2 (11)</td>
<td>4 (21)</td>
<td>9 (47)</td>
<td>–</td>
</tr>
<tr>
<td>SANCO</td>
<td>82</td>
<td>40 (49)</td>
<td>35 (43)</td>
<td>–</td>
<td>5 (6)</td>
<td>3 (4)</td>
</tr>
<tr>
<td>TRADE</td>
<td>1</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>1 (100)</td>
<td>–</td>
</tr>
<tr>
<td>TREN</td>
<td>28</td>
<td>–</td>
<td>4 (14)</td>
<td>18 (64)</td>
<td>4 (14)</td>
<td>2 (7)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>390</td>
<td>59 (15)</td>
<td>113 (29)</td>
<td>38 (10)</td>
<td>154 (39)</td>
<td>27 (7)</td>
</tr>
</tbody>
</table>

### Table 5 Context of the health impacts a in the IA reports

<table>
<thead>
<tr>
<th>DG</th>
<th>Health hits n</th>
<th>Executive summary n (%)</th>
<th>Procedural issues and consultation n (%)</th>
<th>Problem definition n (%)</th>
<th>Objectives n (%)</th>
<th>Policy options n (%)</th>
<th>Analysis of impacts n (%)</th>
<th>Comparing the options n (%)</th>
<th>Monitoring and evaluation Elsewhere b n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGRI</td>
<td>19</td>
<td>–</td>
<td>1 (5)</td>
<td>2 (11)</td>
<td>3 (16)</td>
<td>11 (58)</td>
<td>–</td>
<td>–</td>
<td>2 (11)</td>
</tr>
<tr>
<td>ENV</td>
<td>62</td>
<td>1 (2)</td>
<td>–</td>
<td>19 (31)</td>
<td>7 (11)</td>
<td>5 (8)</td>
<td>4 (6)</td>
<td>3 (5)</td>
<td>24 (39)</td>
</tr>
<tr>
<td>INFSO</td>
<td>3</td>
<td>–</td>
<td>1 (33)</td>
<td>–</td>
<td>1 (33)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>JLS</td>
<td>24</td>
<td>–</td>
<td>3 (13)</td>
<td>16 (67)</td>
<td>–</td>
<td>1 (4)</td>
<td>1 (4)</td>
<td>–</td>
<td>3 (13)</td>
</tr>
<tr>
<td>REGIO</td>
<td>1</td>
<td>–</td>
<td>1 (100)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>SANCO</td>
<td>42</td>
<td>1 (2)</td>
<td>3 (7)</td>
<td>9 (21)</td>
<td>1 (2)</td>
<td>5 (12)</td>
<td>14 (33)</td>
<td>7 (17)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>TREN</td>
<td>28</td>
<td>–</td>
<td>5 (11)</td>
<td>3 (11)</td>
<td>2 (7)</td>
<td>–</td>
<td>20 (71)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>TOTAL</td>
<td>179</td>
<td>2 (1)</td>
<td>9 (5)</td>
<td>50 (28)</td>
<td>13 (7)</td>
<td>11 (6)</td>
<td>50 (28)</td>
<td>11 (6)</td>
<td>1 (1)</td>
</tr>
</tbody>
</table>

a: Human health, public health, organization, sector or system references.

b: E.g. annexes, references
Discussion

The purpose of this study was to examine how health is considered in the European Union Commission’s IA reports. Since the basis for sample creation was IAs conducted per DG and not IA reports, DG Enlargement and DG External Relations were overrepresented in the sample. In total, 48 IA reports by 17 Directorate General were investigated. Data for the study were from 2006, a year after the revised Commission guidelines were launched. This has to be kept in mind when interpreting the results. The DGs did not have a long experience in preparing the IAs in 2006. This study merely describes the status of the first steps in implementing the integrated IA in the Commission rather than a status quo.

A rough estimation of the health relevance of those ten reports that did not include any health references showed that there could have been a health element at least in five of them. For example, the IA on Financing SME Growth—Adding European Value could have considered how the proposal affects health systems (small and medium-sized health and social enterprises). Another example is the IA on Programme Fiscalis 2013 which among others deals with tobacco and alcohol taxes from an economic perspective but not from a health perspective.

Information on the prevalence of health references in the Commission’s IA reports is very limited. According to the UK’s National Heart Forum’s internal review for the years of 2005 and 2006, 73 out of 137 (53%) of the Commission’s IAs did not mention health either in relation to health systems or public health. The results from this study suggest that considerations of health have improved since 2005. Ten IAs out of 32 (32%) did not make reference to public health or health systems.

Concerns that impacts are to some extent neglected if they do not come under the domain of the DG carrying out the IA are partly supported by the results of this study. The prevalence of health references per report was highest in the reports by DG EMPL followed by DG SANCO and AGRI (29, 27 and 19 respectively). The prevalence of health references per 100 pages did not change the order but the frequency changed remarkably. Health was referred to almost four times more often in DG EMPL reports than AGRI and DG SANCO reports. Five DGs (29%) i.e. DG DEY, ENTER, MARKT, TAXUD, and TRADE had no human health, public health or health system references in their IAs although based on the author’s assessment, there did exist a potential health perspective to be analysed. This finding further strengthens the impression that the problems are analysed and framed according to the perspective of the DG who is carrying out the assessment.

Health was most often referred to in the context of an analysis of impacts or in definition the problem. Very few mentions were presented in the sections on monitoring and evaluation, policy options, comparing options and objectives. This gives the impression that health is not thought of as an important factor or objective when discussing alternative policy choices.

We have to keep in mind that the analysis was based on occurrences of the word ‘health’ and the context around it. To investigate whether this could be an important problem in recent analysis, a small, random sample was studied. Word search for [sickness, disease] did not seem to change the results: references to sickness or disease were seldom in general, and also in those reports that had many references on word [health]. However, a more detailed analysis is needed to find out whether health really is ignored or is just formulated in a more specific way e.g. as sicknesses (cancer, CVD, etc.).

A more detailed and sophisticated analysis of the IA reports is clearly needed. The different kinds of impacts that are presented in a report and required to be investigated by the Commission’s guidelines should be considered simultaneously. This would require the expertise and co-operation of experts from different sectors and disciplines. Only then can we confidently evaluate whether health is being sufficiently and appropriately considered in the Commissions’ IAs. The revised guidelines launched in 2009 also present new tools for assessing the possible health impacts. The impetus of the new guidelines from a health perspective should be evaluated in the future.

The scientific community should address the issue of quality in the IA reports through appropriate research. The Commission should also encourage the scientific community to do this work by providing more resources for the task. Further research would not only lead to more evidence-based and accurate reports and better understanding of the role of the IA reports in the EU’s policy-making, but would also facilitate evidence-informed decision-making. The law-making institutions of the EU would have better prerequisites to make wiser decisions for all the Member States of the European Union.

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Key points

- Commission IA reports consider health impacts inconsistently.
- Health does not seem to be an important objective in the policy proposals.
- There is a clear need for further exploration on ways in which health could be more appropriately considered when impacts of other policies are considered by the various DGs.

References


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