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Healthy Public Policies in Europe – Integrating Health in Other Policies

FINAL REPORT



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**HEALTHY PUBLIC POLICIES
IN EUROPE
– INTEGRATING HEALTH
IN OTHER POLICIES**

FINAL REPORT

This series of Occasional Papers on Global Social Policy is designed to provide early access for a wider readership of research work being undertaken in association with the Globalism and Social Policy Programme.

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Introduction

This is a report of a project on “Healthy Public Policies in the European Community”. The project had three aims:

- i) To review the theoretical background, current practices and experiences of health impact assessment at policy level;
- ii) To assess the direct and indirect mechanisms of how health is affected by policies at European Community level and suggest requirements for, and ways of, integrating health requirements into all Community level policies;
- iii) To provide background documentation for further analysis, discussion and action on healthy policies in the European Community and in Member States.

The project has received support from the European Community DGV/F and from the Finnish Ministry of Social Affairs and Health. However, all the views expressed are solely those of the authors. The project was made up of four distinct parts. First, reviewing and analysing the state-of-the-art and experiences of health impact assessment. Second, focusing on capacities for health impact assessment in the European Community and Member States, and, third, presenting a case study focusing on transport policies. Finally, the fourth part of the project gathered the views of European experts in a seminar organised in Helsinki 11–14 February 1999 (see Appendix 1). In this report the main conclusions and inputs of the seminar are included, but in addition a separate report is also being produced.

This report consists of six main sections, summary, overview, literature and appendices. The analysis has been done mainly by Meri Koivusalo and Päivi Santalahti. Tuija Partonen was involved in organising and co-ordinating the seminar. Raija Rimpiläinen carried out some background research and collected material for this report, while Jane Seymour has edited the text. We are also grateful to the many people we interviewed during the project as well as all those who participated in the seminar. Advice and assistance from Michael Hübel in DGV/F has been particularly helpful.

As with any policies, different approaches to public health measures and health impact assessment exist in the European Community and amongst researchers. These are, inevitably, influenced by the historical and political context in which decisions take place. Our work has been informed by the perspective of European citizens’ rights to a high level of health protection, as articulated in the Treaty of Amsterdam (1999), and the consequent requirements for so doing through critically evaluating the current process. We have tried to focus on necessities, concentrating first on issues at the European Community level and, second, on policies as whole. We hope that this report will be useful and constructive in future work and activities in this area.

Helsinki, 29.6.1999

Meri Koivusalo

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Abbreviations

CAP	European community, Common Agricultural Policy
DG	Directorate General
DALY	Disability Adjusted Life-Year
DPSEEA	Driving Force – Pressure – State – Exposure – Effect – Action
ECJ	European Court of Justice
ECU	Euro
EIA	Environmental Impact Assessment
EFPIA	European Federation of Pharmaceutical Manufacturers
EMEA	European Medicines Evaluation Agency
ENHPA	European Network of Health Promotion Agencies
EUPHA	European Public Health Association
EPHA	European Public Health Alliance
EC	European Community
HIA	Health Impact Assessment
NEPA	National Environmental Protection Act
OECD	Organisation for Economic Cooperation and Development
QUALY	Quality Adjusted Life-Year
RA	Risk Assessment
SEA	Strategic level Environmental Impact Assessment
SIA	Social Impact Assessment
TEN-T	Trans-European Transport Network
UNEP	United Nations Environmental Programme
WHO	World Health Organisation

1 Summary/Abstract

The project reviewed theoretical background for mechanisms, capacities and experiences for the purpose of implementing healthy public policies at European Community level with a case study on transport policies. The legal grounds for assessment of health implications of other policies at Community level are based on European Community treaties and directives. On the basis of Community level commitments the assessment of implications to health policies should be considered rather than merely health impacts. Capacities at both national and Community level are limited and further attention is required to ensure that appropriate administrative structures, human and financial resources are ensured. Experience from environmental impact assessment and healthy public policies support a greater focus on political will, transparency, participation and accountability in contrast to mere technical issues or mechanistic approaches to address health implications. A suggestion for an action plan with necessary structures and a combined approach for the systematic assessment and review of policies is presented. In addition, better integration of health impact assessments in environmental impact assessments could be encouraged as one part of the process. In both transport policies and other areas considerable support might be gained from highlighting mutual interests with environmental and consumer policies.

2 Background

2.1 Historical and political context of understanding healthy public policies

The role that all public policies play in health has been most explicitly exhibited by the early public health activists, such as Frank's call for "medical police"; Virchow's statement that health is nothing but politics; Chadwick's work which led him to be considered the father of the British public health movement; or Engels in making the important associations between social structures and health. While many have seen health policies as an intrinsic part of social reforms, the different approaches to health and public health have always reflected the debates between freedom, rights and responsibilities of individuals and those of society.

In the health promotion and public health movement a major recurrent theme has been that of the balance between individual and societal responsibilities. In the World Health Organisation's definition of health promotion there has been a shift from the individual towards the role and possibilities of public policies. This issue was explicitly elaborated by Labonte and Penfield in their critique of Canadian perspectives on health promotion (Labonte 1994; Labonte and Penfield 1981).

"The argument was simple. The health of oppressed people (poor, women, persons from minority cultures, workers, and others) was determined at least as much, if not more, by structural conditions (poverty, hazards, powerlessness, pollution, and so on) than by personal lifestyles. Moreover, personal lifestyles were not freely determined by individual choice, but existed within social and cultural structures that conditioned and constrained behaviour. Behavioural health education, social marketing, or wellness approaches to health promotion fostered victim-blaming by assuming that individuals were entirely responsible for their choices and behaviour. They also blamed the victim indirectly by ignoring the structural determinants of health, those causes that are embedded within economic, class- and gender-based patterns of social relationships."

These or similar arguments have been presented frequently during the past two decades and have infiltrated, to a certain extent, the more mainstream approaches of the WHO (1984).

In the late 1980s and 1990s the rising costs of healthcare have been the driving force behind an emphasis on health-promoting policies which do not involve medical care articulating a different political agenda which places more emphasis on individual responsibilities for staying healthy or paying for health care. This has included a re-emergence of an articulation of public health policies and other policy measures as a means for more effective resource allocation in terms of health outcomes (see World Bank 1993, Poland et al 1998).

2.2 Theoretical and conceptual background to healthy public policies

The term “healthy public policies” has been associated with Hancock who was among the first to use the term. The idea of healthy public policies has been separated from public health and sectoral health policies by being intrinsically multisectoral and founded on public participation in policy formulation and implementation. In practice, healthy public policy has been given a number of slightly different connotations. For example, the WHO has tended to use it interchangeably with health promotion policy, while Health Canada has used it to refer to public policies for health, using health in a broad ecological sense – that is, policies that are ecological in perspective, multisectoral in scope, and participatory in strategy. In this case healthy public policy incorporates a broad vision of health, crossing traditional departmental and ministerial boundaries, and involving dialogue between the policy makers and the public. However, it also recognises that there is no such thing as a homogeneous public. The stated objectives of healthy public policies have not been just to make health the only goal of public policy, but to put health higher on the political agenda. (see Pederson et al. 1988, Frankish et al 1996, Pederson et al. 1994).

“Healthy public policies” is a concept which has been developed in the context of activities related to the global strategy of Health for All (WHO 1981) In this context the broad definition of health combined with intersectoral action has been a starting point. It has been an important element of the European Health for All policies and became Target 13 in the policy accepted in 1984 (WHO 1985). It was also included as one of the key elements of health promotion in the Ottawa Charter in 1986 (Ottawa 1986). In developed countries it has been most frequently used in relation to the networks of Health Promotion and Healthy Cities hosted under the auspices or closely linked to the World Health Organisation strategies, especially in the European region.

2.2.1 Health

Healthy public policies deal with health and thus, it is important to consider how health is understood in the articulation of these policies. The World Health Organisation defines health in the positive sense of physical, mental and social wellbeing (WHO 1948). While the WHO definition may not be directly operational in some cases, it does make the important distinction that health is not merely an absence of physical disease. Other definitions have emphasised functional capacities as a core element in health. However, broadening the definition of health can lead to the growing medicalisation of society. We emphasise that, while health is a resource for everyday life, it is not the aim of living.

Health may also be understood in terms of individual health, population health, perceived or medically defined health. The concept of population health has dominated the traditional approach of public health policies with a focus on groups and differences between groups of people rather than individuals (see Pearce 1996, Susser 1998, Susser and Susser 1996). Individual health has in contrast been reflected in clinical medicine and outcome oriented approaches with an emphasis on the ability to show determinants of health at an individual level. Antonovsky has presented health in contrast to the focus on

disease, which dominates much of the medical literature (Antonovsky 1996). Perceived health refers to reported health by people, whereas medically defined health relates to medical diagnoses and considerations. Analyses and studies from historical, geographical and cultural viewpoints have emphasised the fact that health is socially and culturally constructed. For example, there are important differentials between European countries which need to be acknowledged.

It is clear that for any analysis dealing with health at Community level attention needs to be drawn to the definition of health and the potential to stay healthy. This potential is usually considered either in the more dynamic terms of driving forces for health or simply as determinants of health.

2.2.2 Determinants of health

Any measures intended to improve the health of individuals need to incorporate an understanding of the driving forces or determinants of health. The understanding of determinants of health sets the basic framework for the scope and nature of policies to address health issues. Thus the way in which determinants of health are understood is of importance in seeking mechanisms to address health implications. In biomedical sciences, health and disease have predominantly been seen as the result of both genetic and environmental influences and their expression. Environmental influences include all those factors that affect the capacity of humans to stay healthy (such as nutrition, stress and so on) as well as those which have traditionally been seen as causes of ill health at an individual level, such as organisms (e.g. viruses, bacteria), biological and chemical substances (e.g. heavy metals, toxins) and physical (e.g. radiation, heat), social and psychological (e.g. social contacts, sense of dignity) aspects of the environment.

Where public policies are concerned it is necessary to limit the focus to elements which shape environmental influences. The history of the promotion of eugenics in the context of public health needs to be considered and explicitly excluded from our discussions – even though some European countries may include genetic screening procedures as part of their public health programmes.

In public health and epidemiology, the 1990s have seen more explicit debates about the theories of health that underlie the assumptions about causality, and the research and mechanisms which are used to address the ultimate and proximate determinants of health and illness (see Krieger 1994, Krieger and Zierler 1996, McKinley 1994). The main concern has been to what extent existing public health research may be biased in focussing more on the proximate causes of diseases while leaving aside the more ultimate ones. While research has examined single substances and exposures, the broader settings in which people become exposed has received less attention. The quest for ever more distinct understanding of specific causal mechanisms at an individual level has been challenged by approaches which emphasise society, policy and population level causal factors. Our understanding of health determinants and proposed causal pathways is based on our understanding of health and society. The emphasis on individual level determinants of health has led to criticism over individualisation of policy prescriptions and claims of a “blaming the victim approach” in research. It is claimed that in epidemiological research major structural issues in society, which determine the capacities at individual level to act

in a health promoting way, are replaced by assumptions based on free individual choice of lifestyle (see Tesh 1987, Crawford 1977, Labonte and Penfield 1981, Krieger and Zierler 1996).

The role of various health determinants has been presented in different conceptual models. The WHO model of DPSEEA (Figure 1), the traditional “sunrise” (Figure 2), “mandala/health fields” (Figure 3), and the sociological two-by-two table approach (Figure 4) represent examples of different ways to conceptualise health determinants. Several of these also make an analytical difference between the proximate/downstream and ultimate or upstream factors that determine people’s capacity to maintain their health, exercise their choices and fulfil their potential in terms of lifestyles, social contacts or in their ability to avoid exposure to disease-causing agents.

Biomedical and epidemiological studies have been good at acquiring information on proximate determinants of health, but the more ultimate issues, and especially those where public policies matter, have received much less attention from researchers. It is technically more easy to show outcomes of specific substances or measures (e.g. pharmaceuticals, vitamin or hormone supplements, etc.) to address a health problem, while it is much harder to show clear cut changes in relation to public policies. The emphasis on scientific accuracy has often shifted the articulation towards individual based interventions and emphasis on outcomes and randomised clinical trials as the main source of information and valid evidence. However, just as in risk assessment, requirements for quantitative evidence may act against public measures linked to legitimate concerns or health protection efforts in issues where clear cut outcomes are harder to demonstrate.

European level policies not only promote distinct exposures or interventions with health implications, but also a broader set of activities which may have relevance to health and the implementation of health policies. Just as how we understand health is of importance to subsequent policy choices, the way we define determinants of health and appropriate levels of analysis influence our policy choices and priorities.

2.2.3 Public Policies

The relevance of public policies to health has gained a theoretical background from various sources that have discussed “healthy public policies” and social determinants of health. In the 1990s there has been a re-emergence of the recognition of the importance of public policies and health regulations as a basis for people’s ability to lead healthy lives. This has been reflected as well in a consequent debate amongst epidemiologists on relevance and role of epidemiological methods (see Susser and Susser 1996, Susser 1998, Wing 1998, Rothman et al. 1998, Pearce 1996).

The McKeown hypothesis on health improvements is based on the argument that medical care played only a minor role in the production of health (McKeown 1976). Geoffrey Rose has provided insights on the importance of considering population health implications rather than specific risk groups and the implications of health policies over time (Rose 1985, Rose 1992). The Canadian Lalonde Report, which introduced health fields concept was one of the first to operationalise the idea in the context of public policies (Lalonde 1974). In the 1990s there has also been an increasing focus on public health policies to tackle inequalities in health. The importance of other policies has emerged

especially in the context of studies of social inequalities, social cohesion and health (see Wilkinson 1996, Blane et al. 1996, Kawachi et al. 1997).

Health policies are part of public policies and at the same time influenced by other public policies. It is clear that not only the determinants of health, but also the nature and contents of health policies are influenced by other public policies. In addition, in health policies other aspects than those associated directly with health outcomes may be important and legitimate grounds for action, e.g. equity in access to care, education and research, registration, palliative care or high level of health protection with precautionary regulatory measures to ensure healthy environments and nutrition for people.

Any discussion of public policies needs to recognise the importance of the mechanisms through which public policies are conducted. Transparency, public accountability and participation have been seen as major issues in the implementation of healthy public policies. It has been seen that appropriate implementation of healthy public policies requires healthy public processes. The transparency of processes and policies is important especially when health considerations are not seen as a priority.

In practice one of the main benefits of implementing health impact assessments has been seen in highlighting the role of health considerations in the arena of broader public decision-making. The legal commitments and obligatory commitments in healthy public policies are of less relevance where mutual interests exist and voluntary informal measures may provide faster results in some areas. However, where conflict of interest or varying priorities prevail between health issues and other policies, the importance of obligatory measures and legal grounds for activities are of more crucial importance.

2.3 Conclusions and relevance to the Community level policies

The definition of health, theories of causation and disease, and the respective role of public policies are bound to historical, cultural and social factors and so are a part of a broader set of policies being promoted. In any dealings with health and determinants of health there are implicit assumptions about the factors which influence health and the capacity of people to lead healthy lives. Understanding the basis of assumptions and definitions is necessary for further understanding of the context and measures promoted for the assessment of health implications.

Other Community policies may directly or indirectly influence the practice of national or local level health policies and the level of health protection ensured. This has emerged as an issue with respect to internal markets regulations and health care provision (Nickless 1998, Berman 1999). Similar dilemmas may be found also elsewhere, for instance, pharmaceutical policies and priorities, trade negotiations and foreign policies (see Nickless 1998, Koivusalo 1999).

Healthy public policies have so far been considered predominantly in the context of national policies. Any consideration of healthy public policies needs to consider not only the general implications, but also varying national level policies within the European Community. In the European Community both common and nationally-based health and policy related issues may be found. As an example of common European issues can be defined as smoking, social inequities and homelessness, whereas policies with respect to some public policy issues such as alcohol abuse or the need to address specific health

issues may vary amongst European countries. At the Community level both the European Parliament and the Ministerial Council exert power on European Community issues. In addition, layers of decision-making from European Community, national, regional and local level take place enacting a variety of public policies with health relevance further complicating the context in which public policies are implemented.

3 Mechanisms for assessing health impacts and integrating health considerations in other policies

3.1 Intersectoral Action and Health Promotion

The general approach to healthy public policies has been dealt with predominantly in the context of intersectoral¹ action, acknowledging the need for multisectoral approaches to improve the determinants of health. The emphasis on intersectoral action and health promotion activities that deal with other sectors seems to have been based predominantly on negotiations and broader legislative efforts on specific issues, such as taxes on products hazardous to health like tobacco or alcohol. Despite being the generally approved approach, it seems that even the most active countries in the field, such as Canada, have gained only limited ground in producing fundamental policy changes (see Hancock 1994). In the Nordic countries, such as Finland, broad and universal social policy issues, such as housing, the family and reducing social inequities, have been a part of a wider set of social policies. More health-related attention has been focused on specific issues such as alcohol, tobacco and nutrition, triggered by worries about high mortality rates (see Koivusalo et al. 1997).

Intersectoral action and health promotion have in principle been based on national negotiations between Ministries, joint issue-based Committees, research, health reporting requests and in some cases, such as tobacco policies, in legislative action. In general the experiences within countries suggest that policies towards intersectoral action have achieved only limited success in the broad areas of health or policy choices influencing social settings where people live their lives. In principle, countries have tended to follow well-trodden paths rather than new avenues and mechanisms (Ritsatakis 1998). Healthy public policy initiatives, such as Healthy Cities, have also been more influential at local level and it appears that intersectoral activities and collaboration is more easily reached at local rather than national level.

Results from intersectoral action and health promotion-based activities have been most successful in areas where mutual gains can be achieved (Colomer et al. 1996). In some fields, such as environmental, social or consumer policy, intersectoral collaboration is frequently taken as granted.

The main means of achieving intersectoral action and health promotion at national level seem to have been through administrative negotiation, reporting and legal judgements extending to other sectors. When health has been in the personal interest of those in position in other sectors or mutual interests have emerged this has supported intersectoral activities. This implies that, in practice, the mechanisms which raise issues on the policy agenda may vary, but that coalition building is of particular importance.

¹ Recently intersectoral action has been used to describe collaboration between public and private sectors, however, in here intersectoral action is understood in the context of collaboration between different public sector areas, e.g. health and transport, financial policy, trade and industry, etc.

Issues of relevance for Community level

In principle mechanisms of intersectoral action are easily applicable to Community level activities especially when national level issues are considered. Joint Committees linking health with other policies such as transport policies and health and legal measures with a health dimension such as tobacco advertising regulation, highlight ways in which intersectoral action could take place at Community level.

Many of the same problematic aspects arising at Community level are parallel to those at a national level. Typically these relate to administrative willingness, resources and practice. The barriers to intersectoral action are greatest in areas where mutual interests are not perceived, are scarce or human time and resource-allocation is not clearly defined. Without adequate resources and structures in place sectoral issues with more direct accountability tend to take priority within different parts of administration structures.

The practice of intersectoral action may also lack adequate breadth when pursued as simple administrative practice and where emphasis might be driven towards easy health promotional measures or single issues rather than broader or structural policy issues. A similar problem may be faced in the context of priorities where, for example, in transport policies safety measures and reduction of accidents may be gained easily, but attempts to create more health promoting transport systems and policies as whole might fail due to a need for more fundamental structural and policy changes.

In the longer term those working in other areas than health are important in order to ensure a broader understanding of how health issues may be tackled at policy level in a particular sector or area. One example of preparing for further long-term action can be found through hosting multisectoral research programmes focussing on new areas of concern and policy choices, thus paving the way for broader policy discussions, intersectoral collaboration and activities.

Experiences in trying to promote intersectoral action have led to more formalised and sustained procedures with a more systematic and legally binding nature in order to tackle more difficult policy areas. A typical solution for this problem at local, regional and national levels has been the proposal to require health impact assessment. In principle similar pressures at a Community level, can be seen. These are reflected in the strengthening of earlier public health and health integration commitments in the recently ratified Amsterdam Treaty (1999) and an emerging interest in the procedures and experiences of health impact assessment.

3.2 Health Impact Assessment (HIA)

3.2.1 Environmental Impact Assessment (EIA), Environmental Health Impact Assessment

The quest for compulsory assessment of the health implications of all policies is often presented in the form of a call for required health impact assessments. In practice reference is often made to environmental impact assessment (EIA) procedures. The practice of predicting how human actions affect the environment has a long history, but the current application of environmental impact assessment has its origins in the United States National Policy Act (1969) (NEPA). This Act requires all US federal agencies to consider the environmental impacts of their decisions and includes “action-forcing provisions” to ensure that agencies give more than lip-service to their new responsibilities (Ortolano and Shepherd 1995). While NEPA created a legislative basis for action, it was far from sufficient. To generate full implementation litigation by environmental groups was important and shaped the development of EIA. There has been much EIA litigation in the USA and by 1984 over 1600 NEPA related lawsuits were filed, and of them almost 40% by environmental groups (Kennedy 1988). According to Wathern the US policy experience and litigation has also been reflected in the reluctant adoption of mandatory EIA measures by other countries, such as United Kingdom (Wathern 1988).

Risk assessment (RA) may be defined as the major form of health impact assessment in use especially as part of environmental impact assessments. Whereas EIA was adopted to increase accountability to citizen groups, RA was adopted to increase internal management control and on the part of some advocates, it was envisaged as a means of increasing accountability not only to oversight agencies, but also to business lobbyists seeking to limit risk regulation (Andrews 1988). Social impact assessment and risk assessment have long been considered an integral part of EIA in the normative literature of impact assessment. However, they are frequently left out of EIAs for projects in which either social impacts or risks to human health and the environment are significant. (Ortolano and Shepherd 1995)

Amongst international organisations the adoption of environmental impact assessment has been favoured by UNEP and WHO, which formulated policies on intersectoral action during the 1980s and have advocated the use of environmental health impact assessment (see Giroult 1988, UNEP 1997). OECD has devoted attention to EIA since the 1970s and passed recommendations which call upon member countries to establish procedures for assessing the environmental impacts of significant public and private projects (Kennedy 1988). Amongst bilateral agencies USAID was in the late 1980s the only agency with a legal requirement to carry out EIAs, which was adopted only after NGO litigation (Kennedy 1988, Ortolano and Shepherd 1995). The World Bank has been a specific target of complaints concerning the destructive social and environmental impacts of its projects (see Rich 1994, Wilks and Hildyard 1994). The World Bank has currently substantive formal environmental impact assessment procedures, but the organisation also has a substantial record in practice of not implementing effectively its own requirements (see Ortolano and Shepherd 1995, Rich 1994, Wilks and Hildyard 1994). Environmental impact assessment is required, in one form or another, in more than half of the nations in the

world. However, the actual implementation, effect and mandatory requirements differ significantly between countries.

At present, some of the strongest EIA regulations exist in North America and Australia, in Europe European Union has set a directive on EIA and most countries have EIA systems (Therivel et al. 1992). In the 1990s' aims for EIA implementation have been moved towards so called strategic environmental impact assessment which covers policies, plans and programmes, thus broadening the scope of project-based EIA. Specific interest areas have been trade-related issues within the framework of international agreements on trade (e.g. NAFTA, GATT/WTO) and economic policies (see Ortolano and Shepherd 1992, UNEP 1997).

A general problem with environmental impact assessments has been their focus on projects and an evolution towards highly technical but less participatory assessment practices which at times blur the actual policy choices and their implications. EIAs are in practice often conducted by consultancy companies or other contracted agents as a part of routine administrative practice. The downside of this has been the 'business as usual' procedural approach of the activity as well as problems in terms of agency as those doing environmental impact assessment have had a direct interest in gaining further projects. This interest has the potential to influence their recommendations. In practice, health considerations have remained rather narrowly interpreted in the context of legal standards of environmental and health regulations or are presented in the form of quantitative risks and cost-benefit assessments.

The participatory aspects and emphases in EIAs are thus not only related to concerns over views of affected populations and their interests, but also to problems of the toothlessness of EIAs when implemented without appropriate transparency, participation and public accountability. However, at the other end of the scale are problems associated with the magnitude and scope of impact assessments and their increasing administrative burden.

The limitations of project level EIAs have led to a recognition of a need for EIAs at the level of policies, plans and programmes. These have been dealt with under the concept of strategic EIAs (SEAs). According to Therivel et al (1992) strategic environmental assessment (SEA) is:

"The formalised, systematic and comprehensive process of evaluating the environmental effects of a policy, plan or programme and its alternatives, including a preparation of a written report on the findings of that evaluations, and using the findings in a publicly accountable decision-making."

SEAs can be applied to three main types of actions: 1) sectoral policies, plans and programmes, 2) area-based policies, plans and programmes which cover all activities in a given area and 3) actions which do not give rise to projects but nevertheless have a significant environmental impact such as agricultural practices or privatisation. (Therivel and Partidario 1996) In practice public health implications have been frequently referenced as an area of SEA assessment drawing attention more to health issues. In addition, both in EIAs and SEAs more attention seem to have been given recently to cumulative impacts, indirect impacts and those due to interaction.

Relevance to Community level activities

In the European countries, the EU directive on Environmental Impact Assessment already includes the assessment of human impact and, in effect, includes commitments to health impact assessment as part of EIA procedures. However, this has not been widely utilised and in practice HIA lags far behind EIA. In principle the EIA procedures consist of a set of measures to ensure that the environmental impacts of projects are considered, but do not lead administratively to extensive reports or practical delays. Environmental impact assessments require a final environmental impact statement which considers whether the project should or should not proceed. The EU directive sets the framework of EIA in the following way (COM 85/337, COM 97/11):

The environmental impact assessment shall identify, describe and assess in an appropriate manner, in the light of each individual case and in accordance with the Articles 4 to 11, the direct and indirect effects of a project on the following factors:

- human beings, fauna and flora
- soil, water, air, climate and the landscape
- material assets and the cultural heritage
- the inter-action between the factors mentioned in the first, second and third indents.

EIA is governed by environmental administration and in principle at Community level within the DG XI. At national level it tends to be more of an issue of environmental administration rather than health administration. EIAs have traditionally been applied in the context of planning and to construction and building projects. The common activities on EIA at Community level have ensured, in principle, coherence across Member State activities. However, as there are freedoms given to the means how the activities are implemented the level of which health is considered might differ more. Finally, it is necessary to point out that current EIA directive do not cover all projects but a more defined set of areas.

In addition to the EIA directive a new Council directive on SEA dealing with assessment of the effects of certain plans and programmes on the environment is to be dealt with in 1999. In line with the EIA the proposed directive covers as well health implications in the proposed amended version of Article 5 second paragraph (COM 96/511, COM99/73):

2. In the environmental statement the significant direct and indirect effects of implementing the plan or programme on human beings, fauna, flora, soil, water, air, climate, landscape, material assets and the cultural heritage as well as the interaction between these factors shall be identified, described and assessed in an appropriate manner.

However, so far health seems to have had a rather limited role in environmental impact assessments as such. On the other hand, the current process of environmental health impact assessment seems to be enhancing at the Community level in the intersection of environmental health and general environmental impact assessments. In practice environmental risk assessments also incorporate health considerations and risks.

A process of health impact assessment arising from environmental impact assessments and health considerations have slowly been gaining strength through the development of environmental health policies and National Environmental Health Action Plans (NEHAPS). Environmental health impact assessment activities have evolved in the context of WHO/

EURO co-ordination, OECD activities on environmental impact assessment as well as being linked to more general efforts to ensure that health considerations are appropriately dealt with in environmental impact assessment. The London 1999 Conference on transport and health and the resulting Charter have further strengthened the impetus for more environmentally linked health impact assessments (WHO 1998).

Thus, in practice HIA at Community level may have been set already to follow the practices of environmental health impact assessments at the level of projects as well at the level of strategic environmental assessments. The directives passed on the issue imply that a process of legal requirements is at place in each Member State. Environmental impact assessments are a process undertaken under the governance of environmental administration requiring more 'intersectoral collaboration' for appropriate action in terms of health assessment if this is to be the route towards better assessment of health impacts at national or Community level. Finally, in spite of the activities on EIA and SEA at Community level a separate process for integration has been set at the Community level on environmental integration suggesting that in certain respects similar complementarity could be relevant also in the field of health.

3.2.2 Health Impact Assessment

The current articulation of health impact assessment has been gaining ground from three different backgrounds. These are firstly, environmental impact assessment related efforts in health impact assessment with strong emphasis on environmental health issues, secondly development projects and health impact assessment requirements in the context of these and other similar impact assessments such as social and gender impact assessment and thirdly, in the context of enhancing chances for healthy public policies operating more in the socio-environmental and administrative context. While health social and health impact assessments tend to be seen as additions or improvements to administrative mechanisms originating from environmental impact assessment procedures. Others, for example Becker, have seen their origins in the work of Concordet and Chadwick already centuries before (Becker 1997).

In principle, HIA has in many countries been associated with and implemented for defined projects with impacts on defined populations as part of a general procedure similar to EIAs. This procedure can consist of steps of screening to decide if health issues are to be considered, scoping of the magnitude of the hazards and considering alternatives, profiling of health risks in relation to the specific population in question and its vulnerability, appraisal process including qualitative health risk assessment, risk assessment and analysis of health risks, estimation of uncertainty and possible cost-benefit calculations leading ultimately to an impact statement with consultation and broader participation and appraisal. This is followed by risk management and a negotiation phase, follow-up and surveillance (BMA 1998). In practice many of the project impact assessments in EIAs and HIAs linked to EIAs or development projects are conducted so as to include terms of reference for a consultancy company to carry out the assessment.

In addition to the more project oriented methods of HIA, elements of broader mechanisms for enhancing health considerations in policy-making have been more explicit in the HIA methods developed in Canada, where the British Columbia guidelines has been

used as a reference (Figure 5). These have been seen as administrative devices rather than technical assessment methods, with focus on qualitative viewpoints and questions structured on the basis of research and participatory questionnaires rather than modelling techniques. The British Columbia toolkit has been recently revised and in practice many health impact assessment procedures tend to combine elements of both aspects of HIA, employing both technical and administrative aspects (see Putters 1997, Putters and van Grinten 1998, Scott-Samuel et al. 1998ab, Winters 1997, Berensson 1998).

As the nature and existence of health impact assessment has not so far been formalised it has been used in rather broadly differential meanings. The 'British Columbia' model of broader understanding of health determinants has been clear in the 'Liverpool' (Scott-Samuel et al 1998) and Swedish (Berensson 1998) models in comparison to more 'health outcome' or 'disease' oriented approaches. In comparison to more environmental health and technical process oriented impact assessment practices, some have been more open to providing mechanisms for public administration (Putters 1997) or for policy-makers (Berensson 1998).

Relevance to Community level activities

The current process of EIAs and nature of environmental impact assessments sets limits to the use and applicability of the more policy oriented definitions of HIA at European level. This is due to the fact that if a more defined environmental health impact assessment process already exists within Europe it would be problematic to design another procedure with a similar name and different content. While Health Impact Assessment is currently still used to describe and define a broader array of practices there is a high probability that these become closer to the practices of environmental impact assessment due to currently more established practices in the area. Similar problems as with the concept of risk assessment procedures² and differences in what is understood to form a standard risk assessment may emerge with respect to understanding what can be considered as a standard health impact assessment.

The other issue of relevance to Community level activities is the emphasis on estimating implications to defined populations. This is possible on the level of projects and to some extent some plans and programmes of action. However, in the context of other European Community policies it is necessary to consider that health implications – and health policy implications – may vary between Member States thus complicating activities at European level with less possibilities to emphasise definite populations. In addition, focus on health impacts on defined populations is not sufficient in scope to fill requirements for high level of health protection or to take into account variations in health policies at national level. Community policies in e.g. pharmaceuticals have substantial impacts on national health policies and yet have less measurable health impacts at Community level.

It is clear that if a formalised and systematic procedure is to be sought an adaptation of current health impact assessments could be used in the process. In addition, mechanisms to ensure that EIA and SEA cover more broad health impact assessments could be started.

² The European Community vs. United States/Canada debate on risk assessment, precautionary measures and the hormone-beef case have dealt with differences in approaches to assessing risk. In principle this could be seen as standard and defined process of scientific risk assessment or a broader analysis covering a broader range of risk management and precautionary aspects in comparison to mere scientific quantitative risk assessment (see WTO 1998ab).

However, one may need to consider a two-track approach at Community level in enhancing HIA as part of EIA and SEA measures as a separate legitimate strand with another process of addressing issues of health and health policy implications of all Community policies.

3.3 Quantitative health assessments

3.3.1 Health risk assessment

In health policies, quantitative assessments of exposures, disease rates and causal outcome measures such as population attributable risks are useful in exploring the size of a problem and in provision of background estimates for public action. In principle much of 'evidence-based' activities or policies bound to definite outcomes deal with risk assessment procedures and various mechanisms for addressing the role and relevance of various risk factors in the production of health and disease. Quantitative assessments tend to be preferred by many due to the possibility of acquiring numerical values and estimates of health scourges and health impacts.

However, quantitative assessments have as well their setbacks and necessarily measure only what can be measured. In addition risk assessments tend to be biased towards more easily addressed through specific and measurable interventions and outcomes. While health implications of smoking may be calculated relatively easily, those of homelessness, housing policies or social inequities may not be so easily quantified.

Quantitative assessments tend to give estimates on uncertainty. However, this needs always to be related to the actual problem as otherwise precautionary measures may receive insufficient attention in areas where maintenance of high level health protection is of importance. In traditional public health concerns over infectious diseases and with respect to potential long-term consequences due to time lag or possible catastrophic implications due to breadth of exposure or nature of risk involved (e.g. food or drinking water contamination, antibiotic resistance) the appropriate level of precaution might become compromised on the basis of the large uncertainties involved in estimating health impacts.

It is known that risks are perceived differently in relation to their anticipated implications. According to Lanska (1998) perceived risk can be considered along three key dimensions: dread, unfamiliarity and exposure. Dread risks are characterised as being potentially catastrophic, fatal, involuntary, posing a high risk to future generations, increasing in magnitude, uncontrollable and not easily reduced. Unfamiliar risks are characterised by being new, unobservable, unknown to those exposed, and delayed in manifestations of harm. An adverse effect, occurring with a hazard that is both dread and unfamiliar, will have much greater social impact than an adverse effect with a similar immediate effects occurring with a known hazard located elsewhere in the psychometric risk space, especially if the number of people exposed is high (Lanska 1998).

While quantitative risk assessments may be important in conveying better understanding with respect to specific risks, the assessment of health implications or health risks is necessarily a broader process as has been articulated in the context of European Community vs. United States and Canada hormone-beef case in the World Trade Organisation (WTO 1998ab).

Relevance for Community policies

There is clearly more scope in research collaboration and better assessment and analysis especially concerning more population-level based issues such as health implications of social exclusion, environmental pollution and transport or food policies. This may be seen as well in the new emphases in the Fifth Framework Programme on research where more problem oriented nature of research activities is to be welcomed. However, the further use of quantitative assessment techniques could cause problems if used inappropriately to settle problems of policy definitions, priorities and practice as a seemingly neutral administrative technical device. This is due to problems described in previous section, but as well due to the nature of health problems in the European Community as major health problems and nature of health policies does vary between countries.

The major challenge in assessing health implications at European Community level and policies, in the main, may not be in the lack of biomedical or epidemiological data, but in four major aspects which are needed to be dealt with in the process. 1. Drawing issues – including quantitative and qualitative evidence – together in a broader framework of policies; 2. Giving high enough priority to this assessment in the policy-making at Community level also in areas where common interests may not be perceived; and 3. In taking into account how other European policies might impact on social and health services provision and national health policies and 4. in taking into account differences between areas and Member States in health policies in a way which would not punish those Member States with more comprehensive policies at place. One of the mechanisms to deal with the first and third issues has been carried out in policy assessment and review process, while other aspects are dealt with more in the next chapter on European Community level policies.

3.3.2 Economic assessments

In public health emphasis on evidence-based medicine and health outcomes have been reflected in subsequent calls for estimation of costs of measures implemented as part of public health policies. Costs and benefits are emerging as a standard reference point for public health measures, not merely in HIAs but also in broader policy assessments. This is the case especially when public sector allocations or reallocations of funds are to be justified. Summary assessments, such as Quality Adjusted Life-Years (QUALYs) or Disability Adjusted Life-Years (DALYs) have been studied intensively during recent years within health and health care policies and have been suggested as one way of setting priorities for health policies.

However, especially Disability Adjusted Life-Years have gained criticism as a mechanism for priority setting in policies because of the assumptions and value judgements made in their calculation as well as due to more technical arguments on costs and mechanisms of assessment (e.g Barker and Green 1996, Wiseman and Mooney 1998). Simplified assumptions made may also lack broader public acceptance as the appropriate way of decision-making as values of population may vary in comparison to those used as basis of the assessments (see Nord et al. 1995)

Cost-effectiveness and cost-benefit studies are used frequently to assess potential costs and benefits, often as part of a broader health impact assessment. In spite of their problems

some proponents see these as the most optimal means for intersectoral action (Drummond and Stoddardt 1995). While understanding the scope of costs of policy decisions is important, cost-benefit analyses may lead to an overemphasis of short-term costs and underrating of precautionary measures. This is because levels of health protection can seldom be translated into simple numerical terms but may be necessary to safeguard a level of precaution. While calculation of costs might seem to give a common measure for comparing different measures these may not, in practice, be comparable and thus not give adequate information for decision-making on the issue. It is thus important to recognise the limits and appropriateness of quantitative as well as qualitative evidence when decisions on policies and evidence are made.

Relevance for Community policies

There have been some attempts to assess preventable deaths or quality adjusted life-years at European Community level as response to the High Level Committee on Health. In this study a sample of determinants were chosen and subsequently disability adjusted life-years were calculated for these (National Institute 1997). It is open to what extent this approach is still considered within the European Community as important means for further research. Another recent calculation of preventable deaths in Europe ended in more emphasis on health systems based interventions (see Simonato et al. 1998).

The efforts of quantitative assessments give scope and background for articulation of European health issues necessitating appropriate grounds for comparable health data and outcome measures at European level. However, while acquiring more coherence and comparability in data between Member States should be seen as necessary activity, it cannot be seen as sufficient one even in the light of expected improvements in the epidemiological methods or geographical imagination techniques.

The use of economic assessments may open new insights in health-related issues, but in many cases also entail value judgements or implicit assumptions which may become problematic especially when requiring to put economic valuation to life or disability. In addition, using willingness to pay when dealing with peoples' options in health issues – including services provision and access – does have clear limits. In general health (public health and service provision) has more of a public good nature which alongside with citizens rights may become unduly compromised in more cost-benefit focused calculations. It may thus be wise to recognise the necessary limits and the need for appropriate caution in the use of cost-benefit and summary measures in health assessments at Community level.

3.4 Policy assessment and review

3.4.1 Policy analysis and review

Policy assessment studies and analysis are used in comparisons between policies and programmes without necessarily limiting these in impacts on defined populations or outcomes, thus drawing more from a broader combination of existing studies as well as from more managerial and functional aspects of administration. In this respect these may be seen as distinct exercises from health impact assessments, which are focused on specific populations. While policy reviews and analysis are in general drawing from existing experiences and situation, these can be used in anticipating potential implications of new policies or negotiated treaties.

Policy assessment and review has been used to provide a basis for discussion and analysis on various issues by the OECD. The OECD has traditionally produced policy reviews by experts working with the national authorities in an evaluation process, which has been extended to a broad range of policy issues. In the OECD the organisation has acted as the co-ordinating body, while experts from different OECD countries have provided expertise for the assessment procedure. The policy review process consists of expert panels from elsewhere with a dialogue at national level and final debate and discussion with national authorities on the review. The WHO has used the same system to evaluate national health policies in the context of Health for All in Finland (WHO 1991). The World Bank has a tradition of conducting broad sectoral reviews of policies based on expert evaluation mostly in the context of economic policies.

Policy reviews and assessment tend to give scope for looking at a broader set of issues and analysis and provide means to address legislative or policy implications of other policies. However, they have also major in-built problems in terms of the expertise chosen, nature of review process and assumptions set in the beginning of the process. These all require due attention to choice of expertise and openness of the process. While the end results of policy reviews tend to be public, the process is often too closed exercise carried out by experts. Policy reviews also tend to be assessments of past policies rather than anticipatory exercises, even though they may provide the major means to answer to major challenges in anticipating implications of policies in other sectors or negotiated trade agreements or other legal agreements to the principles and practice in national health policies.

Relevance to Community policies

In principle, policy analysis and review might be the only existing mechanism for assessing health implications of policies where specific populations are hard to define and issues need to be considered in a broader context of health policies. Health impacts of a road may be easily assessed and quantified, but a more complex set of arguments and assumptions are required when health implications of transport policies as a whole are debated.

In the case of Community level policies the potential gain from a policy approach would be the ability to address changes in relation to national health policies which, necessarily, are a reference point for Community action. It would as well allow the assessment of how other policies may influence policies with respect to provision, structures

and scope of health and social services, health services related costs, regulation and other issues which do matter greatly to health policies but may not be as easily dealt with in those practices focussing on health determinants or outcomes. In principle, the Green and White Papers and Communications of the European Commission represent policy documents against which approved policies and practice can be assessed within a the stated area of policies.

In the environmental scene means to address broader policy issues and structural or fundamental aspects of action seem to have taken the form of policy reviews in terms of requirements of sectoral papers and most lately in terms of producing a paper on trade policy and implementation of trade review (Muguruza et al. 1999). Policy reviews could be used to address e.g. recently debated issues with respect to internal markets and health services provision, trade negotiations and health and health services issues at Community level or how the recent Communication on pharmaceutical policies has taken into account public health priorities and health policy interests at national level in Member States (see COM 98/588, Herxheimer 1999)

The fact that the OECD and the WHO have successfully co-ordinated policy reviews at national level suggests that a team of European public health experts might be able to conduct a review of the health implications of various Community level policies. This would be of more importance in the context of anticipating implications where complex interaction between national health and social policies and other Community level policies, such as trade or competition policies, may take place.

Due to the inherent problems in terms of expert choice and process and nature of policy reviews, additional emphasis might be needed at Community level. Any policy analysis or assessment depends on the views and skills of those carrying it out and careful consideration should be given to both the process and the choice of personnel who make up the review teams. A public distribution of the review with required approval from the Parliament and/or the Council of Ministers could provide a route towards achieving better accountability. Opening the review process to be followed by non-governmental public interest organisations, such as the European Public Health Alliance or the Network of Health Promotion Agencies, could also help towards broader public participation at EU level.

3.4.2 Auditing, evaluation and benchmarking

Auditing and evaluation practices are based on external evaluation of how actual policies and practices meet their aims and so need a reference point for activity with often emphasis on the implementation side of the policy process. They are also frequently used for improvement of specific administrative practice or reform processes towards more efficient practices. However, just as benchmarking could be used to serve aims of health protection also auditing and evaluation mechanisms could be used to evaluate the extent to which a high level of health protection has been taken into account in other policies.

The OECD public management section has brought forward methods of benchmarking and best practice assessment as part of public sector management practice (OECD 1997) In principle, benchmarking has been a process of seeking best practices in terms of effectiveness either through internal comparison or through using external assessment to

allow external reference to achievable levels of standards. Many of the benchmarking exercises are qualitative assessments which emphasise improving practice and setting guidance. While some of the benchmarking methods quantify qualitative scores, this is frequently done in a rather unsophisticated way. There are often problems in interpreting the results as opinions and assessments are churned to produce apparently objective numbers with little actual resemblance to facts. The same applies for other policy and policy process assessment techniques such as delphi technique, stakeholder analysis or some versions of political mapping.

At best the process of benchmarking exercise could be used to serve health promotional ends in changing the aim of the perspective in setting a reference point for best public health practice or health promoting policies. However, care should be taken in order to avoid too simplistic practices. Thus, while in principle, benchmarking, auditing and evaluation could be used to promote more health friendly policies, this might require substantial rethinking in terms of aims, scope and nature of the current practices of these in commercial and public sectors. It is in practice striking how little these mechanisms have been used to promote differential end points as part of administrative practice or exercises.

Relevance to Community policies

In principle, an auditing and evaluation process could be carried out at Community level. These could be used, for example, 1) to evaluate how high level of health requirements have been ensured, 2) whether and to what extent health impacts have been included in current environmental impact assessments or 3) how health could be integrated into other policies at national or Community level.

Benchmarking and use of best practices have primarily been employed in the private sector, yet with some changes made to their aims and principles these could be applied in a different environment. Benchmarking or assessment of best practice between countries from the health and health policy point of view could be used to ensure that Community policies provide incentives towards more health-friendly practices or enhance and do not disrupt more comprehensive health policies in Member States at national level with respect to both public health measures and health services provision. The identification of best practice can be used to raise the profile of issues within the European Community in enhancing learning from other Member States practices. In practice there are already 'best practice' – references in various Commission activities, including public health and transport policies.

4 Community and Member State level structures, capacities and experiences

4.1 Community level

As this is a report to the European Community DGV/F and as the Commission is undergoing changes with respect to its structures this report does not handle in detail issues dealing with the existing work within the Commission. However, as the report could be read by broader audience and as legitimacy, structures and political power cannot be separated from the issue of appropriate mechanisms these have been shortly dealt with in here.

4.1.1 Legal and administrative capacities

In principle, the legal and formal entitlements for integrating health into other policies do exist at the European Community level. The Maastricht Treaty included public health considerations and in the Amsterdam Treaty amended Article 129 further strengthens this commitment (Box 1). In principle this commitment should be legally binding also in the European Court of Justice, which has been important in contextualising and at times driving European Community policies on health and social policies as the forum for interpretation of Treaties governing European Community action.

Health impact assessment technically exists already in Community legislation and practices as integrated within the directive on Environmental Impact Assessment. This is also the case with the proposed strategic level environmental assessment directive (COM 96/511, COM 99/73). However, the extent to which Member States currently have adopted measures with respect to health or social issues as an explicit part of environmental assessment procedures is unclear.

The relative roles of the European Community and the Member States in health are dealt with in the context of the subsidiarity principle. The subsidiarity principle implies that in matters not under European Community's exclusive competence, the Community intervenes when action, by reason of its scale or effects, may better be carried out at Community level (European Communities 1997). The European Community has also made commitments with respect to public health policies and occupational health and safety, although activities with respect to health and social services are considered subjects to national governance.

The varying practices in interpretation of subsidiarity principle and subsequent variation in boundaries between national and European level action in social and health policies have raised the importance of the legal structures at place. The legal basis and the role of European Court of Justice is important in providing final decisions concerning interpretations of the constitutional grounds for social and health policy activities at European Community level as well as in the context of the negotiation process of new or

revised supranational agreements on trade and investment, where the European Community represents interests of European Member States.

It is important to note that the shared responsibilities as well as recent experiences from European Court of Justice decisions do imply that a broader than merely health impact consideration is needed. In addition, health protection entails precautionary measures and thus a mere focus on health impacts as such may not be sufficient. This is as well related to another process of supranational legal-administrative measures which have emerged in the process of World Trade Organisation dispute settlement procedures, conceptualisation of risk assessment and the European Community argumentation and stand on the issue in the dispute settlement case on hormone beef (WTO 1998ab).

It is possible to see also a more proactive role of the European Community in health and public health policies in encouraging 'healthier' policies in all sectors and in strengthening national health policies and capacities in public health through Community level activities in terms of directives and legal measures set as well as in terms of financial resources, networking, gathering of information and research activities encouraged. The current development and articulation of European Community public health policies in a more explicit form of a set of policies is a good basis and background for this exercise. It might also be used as reference point in terms of addressing health implications in other policies as according to the European Commission articulation (European Communities 1997):

"In the future, elaboration of policies and measures with an impact on health must from the outset take account of and be coherent with, public health policy. This means that other policies, despite their having different legal bases, will also serve the objectives of health protection."

The European Parliament deals with public health issues with co-decision rights in public health issues. Ministerial Council and especially Health Council deals with health issues at Ministerial level between Member States governments. The Health Group consisting of representatives of Permanent Representations of Member States deals more with routine or continuing administrative issues. In principle health considerations may be claimed to have a shared accountability both at Community level to the European Parliament as well as to the Member State national parliaments represented through Health Council and by national administrations in the Health Group.

In the European Commission responsibility for health issues has mostly remained in DGV, although important areas of activity have remained in other directorates. This has also lead to calls for restructuring process in administration towards a more coherent structure on public health within the Commission (Mountford 1998). The responsibility for health in other policies lies within DGV with three main mechanisms used for ensuring this, namely (European Communities 1997):

- i) Consultation requirements on proposals with a bearing on health
- ii) Interservice group on Health as forum for discussion and information exchange
- iii) Annual reporting on the integration of health requirements into the different areas of policy.

In 1999 the European Commission budget allocated 42.7 million Euro on health. However, traditionally bulk of the resources have been further distributed through the specific

programmes governed by the DGV/F. While changing of focus from programmes will release resources, the total amount of health activities is still not a major budgetary allocation. The whole EU budget is 97 billion Euro and the total health budget is less than 5% of the EU premiums paid for tobacco (more than 999 million Euro) (Eisma, 1999).

There has not been so far a specific unit, programme or definite structure of Commission providing contact point and resource allocation for the issue within the Commission. The responsibility for health implications in other policies has so far been within DGV/F general policy unit. This means in practice that this process has not been seen as sufficient priority at European Community level to require more focused structures and human resources within the Commission.

At European level also other than Commission and Government actors matter. Three major non-governmental organisations with a direct public interest in the area can be defined. European Public Health Alliance (EPHA) representing non-governmental actors and hosting European Parliament intergroup on public health issues, European Public Health Association (EUPHA) networking between public health researchers and European Network of Health Promotion Agencies (ENHPA) linking non-governmental organisations and government boards and institutions dealing with health promotional activities. However, the strongest European Community oriented lobbying groups on health are not public interest oriented, but those of corporate nature. The European Federation of Pharmaceutical Manufacturers (EFPIA) has been seen as perhaps the clearest example of interest group sectoral influence at the European Community (Greenwood 1997).

4.1.2 State of practice, experiences and lessons learned at Community level

No systematic evaluation of health implications of other EU policies has been done. Commission reports on sectoral activities are based on reporting activities in other policy areas. In the Commission reports health considerations in different policy areas are dealt with rather narrowly focusing more on activities dealing with health or related to health, rather than broader policy implications (COM 95/196, COM 96/407, COM 98/34).

A Swedish National Institute of Public Health co-ordinated group has done a policy report on Health Impact Assessment of the EU Common Agricultural Policy (CAP) (Dahlgren et al. 1996). Health implications in other policies have been overviewed as well by a British group (McKee et al. 1996). Especially the Swedish study brought up important failures in considering health implications of other policies at the European Community level. While not being a health impact assessment or systematic policy review as such, the policy report on CAP used national health policies as reference point as well as the World Health Organisation policies and action plans at European level. It also suggested further studies into health impacts of CAP as well as more critical assessment of CAP through annual EU Health Audit (Dahlgren et al. 1996).

Council of Ministers has dealt with the issue three times. In 1995 the Commission was requested to draw up appropriate methods and criteria as basis for the integration of health requirements into other community policies. In addition specific policy areas of primary interest were chosen, such as economic policy, in particular taxation; social policy, including questions of unemployment; free movement of goods and persons; agricultural and food

policies; consumer protection; research and technological development; environment and transport (Council 1995). In 1996 attention was drawn to the development of criteria and basis for the integration of health requirements into other community policies as well as drawing up appropriate methods and a formal mechanism for evaluating the effects of Community policies on human health, with special reference to an early and transparent evaluation (Council 1996). Further statement made in 1998 included merely requests for implementation as the third annual report on integration of health protection requirements in Community policies for the year 1996 was finalised only in January 1998 (Council 1998).

High level Committee on Health has hosted a working party on the 'integration of health protection requirements in Community policies' for which a study on determinants of burden of disease in the European Community has been made focussing on areas from health impact analysis methods to a sample of relevant examples of risk factors (National Public Health 1997). The recent Commission communication on public health policies deals with the impact of Community policies on health in this context. It suggests monitoring and assessment on the basis of a developed information system, although it is not clarified how this system would function and what would its scope be (COM 98/230). It is unsure to what extent this would be considered as the mechanism to assess health implications of other policies. In any case care should be taken that expectations for analytical uses of Community wide databases are not excessive as it is unlikely that sufficient analytical understanding will be gained from Community-level data for adequate monitoring or assessment of health implications of policies at Community level.

A strand of standard-setting activity in health already exists in the role of the European Community in occupational health and safety, as well as in the form of regulations and directives mostly related to environmental health and pollution. European Medicines Evaluation Agency (EMEA) has also a central role in evaluation process of pharmaceuticals at Community level. The EU standard-setting part of health protection is straightforward. However, even this should require further attention because of the EC role in trade negotiations and subsequent rise in attention towards environmental, consumer and health concerns in trade-related disputes and priorities set. This is of importance especially in the context of Sanitary and Phytosanitary Measures practised and the interpretation of requirements for assessing risks as set in trade agreements hosted by the WTO. In standard setting, EU policies have been oriented to maintain the precautionary principle in the environmental field and synergies could be gained due to similar concerns in the field of health regulations and regulatory functions.

In the late 1990s attention has been drawn more to the unintended implications of European Community policies on health and implementation of health policies. The Commission report on pharmaceutical sector acknowledges the European Court of Justice cases on price fixing of pharmaceuticals which is of clear relevance to financial balance of social security systems (COM 98/588, Kanavos 1999, Herxheimer 1999, Keck 1999). In a recent Potsdam EU Conference on health attention was drawn to the fact that when drafting treaties, legal instruments etc. the Member states should carefully consider the consequences in terms of the impact on health and health care through pooling knowledge and working together to influence Community policies (Berman 1999).

Experiences from integration of environmental issues

Integration of health in other policies or health impact assessment as such have an important comparison in the area of environmental issues at Community level. In the environmental field a similar commitment exists in terms of sustainability and assessment of environmental impacts of projects, plans and programmes. In addition, part of environmental health activities, risk assessment and standard setting are implemented in close connection to environmental policies. In addition, similar attention to social policies and social exclusion has emerged in the form of requests of social cohesion impacts. The Amsterdam Declaration of social science researchers suggests that all major European policies should be made subject to a social cohesion impact study (Amsterdam 1997). Similar pressures exist also with respect to gender impact assessment and small producers already on the policy scene, with already existing Commission guidelines on gender impact assessment.

In the environmental field, current experience highlights the importance of the political process with recognition and follow up at the highest level (Ministerial Council). Integration at policy level has also been chosen to be implemented under a more independent process at Community level aside from environmental impact assessment or strategic environmental impact assessment. Integration process has been dealt with at Ministerial level and certain core sectors have been reported directly to the Council meetings. In addition, guidelines for integration are set at the Ministerial level (European Commission 1998). A sustainability review has also been commissioned on trade policies and trade negotiations viewpoint as part of efforts to ensure that environmental issues are adequately considered in the context of trade negotiations (Muguruza et al. 1998).

The experiences in the transport sector have emphasised the role of research programmes and policy documents (Green and White Papers) as building bridges towards better integration. The principle of subsidiarity has been seen as an additional complication in dealing with the issues at Community level as subsidiarity principle could be raised in politically more difficult areas in order to limit action. The variation of policies and their position in a nation's priorities was reflected especially in relation to attention drawn to environmental issues. In addition, the enlargement process was emphasised as an important part of overall policy priorities.

In environmental impact assessment much of the focus has been at national level. Attempts to screen environmentally sensitive projects in other fields have not been successful in practice. At strategic level the technical emphasis on methods for assessment has been seen as well as a way of postponing the process. At policy level much of the emphasis has been seen to be too much geared towards technical changes and improvements in standards within near technical reach, rather than on broader policy implications as political compromises are made more easily through that route. Experiences in strategic environmental impact assessment (SEA) draw attention to the importance of processes and participation. In the SEA made on Trans-European Network these aspects were practically lacking (Dom 1998).

At the level of fundamental changes of values towards sustainability in the European Community policies, the success can only be described as very limited in the environmental scene. This is reflected in blunt the views of Collier (Collier 1997):

“The subsidiarity principle is being exploited in the interest of national sovereignty, and the change to a more market-based approach for environmental instruments has mainly focused on self-regulatory tools with dubious effectiveness. In general, EU environmental policy has lost momentum in recent years and there has been little progress with the integration of environmental concerns into other policy areas, beyond marginal adjustments.”

However, amongst environmental actors there seems to be a clear interest in collaborating with public health and consumer advocates within the Community to build on their common interests to produce a stronger voice at policy level. Considering the current state of European policies, special emphasis needs to be drawn to certain aspects in the process of assessing health implications. Firstly, in principle there seems to be both legitimacy and political will for the activity at Community level. However, the extent to which this is realised in the policies remains limited. Factors contributing to this situation could include the relative lack of attention, resources and clout in policy issues, legislative mechanisms and intersectoral action of both Member States and European Commission in their health administration with predominance of trade and economic viewpoints at Community level interaction and policy-setting.

4.2 Member States

This overview is based on literature, some interviews, networking and information gathered from the Member States. It is thus not a survey of activities nor a detailed study and cannot be. High level of Health Committee questionnaire to health administration did already deal with problems in trying to set a scope of administrative activities on the basis of a questionnaire.

4.2.1 Legal structures and administrative capacities in Member States

An emerging issue with respect to national and Community level legislation is the extent to which legal or constitutional commitments made on the basis of health and social policy considerations may become compromised by Community level negotiated or set policies. When Finland joined the Community, it did change some public health related policies (Koivusalo et al. 1997). On the other hand the review process associated with the joining of the three countries and their stricter environmental standards resulted in designing stricter standards also in some Community level practices (COM 98/745).

In principle, health seems to remain still predominantly an issue of Ministries of Health where public health or health policy considerations tend to be weaker in comparison to efforts related to directly medical and health services related questions. Ministries of Health remain, also in general, weaker actors in national policy-making and in articulation of priorities in comparison to other areas such as finance, trade, agriculture or transport. Variation in health systems organisation, predominance of national emphasis on policy-making as well as some aspects in policy priorities have also kept Ministries of Health focussed on national level activities with comparatively less exchange and interaction with other ministerial counterparts such as those dealing with environmental issues. All

these aspects have effectively limited the scope and potential for realising common concerns or issues with respect to health and social policies.

Health and social policies are still considered predominantly in the national context with international exchange in linkage with international agencies, mostly the regional office of World Health Organisation. The World Health Organisation hosted networks seem to have given grounds for the European exchange in health issues especially in the form of Healthy Cities or National Environmental Health Action plans. In addition, the OECD has provided forums for certain networking activities with respect to cost-containment and health services and in influencing health care reform policies as part of public sector management and reform changes. In addition, the OECD has worked actively in environmental impact assessment and review processes.

In health issues the dominant framework of activities seem to be a promotional one 'adding health to other sectors' on specific issues rather than systematic or policy oriented in nature. In addition, there seems to have been an undue emphasis on national issues and sovereignty in health policies with much less focus on perhaps more common problems occurring systematically at Community level due to similar constraints. At the same time the subsidiarity principle seems to keep health issues out from European arena with subsequent lack of forum. The fragmentation of policy interests in the area due to 1) differences in national policies of health interest (e.g. alcohol, transport), 2) health services organisation and financing as well as 3) variation in training and articulation of public health issues may also limit the capacities and action by Member States at Community level.

In comparison to environmental policies Member States seem to lack as well a forum, public interest support groups and basis of resourced Community level oriented policy and information collection such as the European Environmental Agency or European Environmental Bureau. The WHO/EURO offices seem to have served to some extent for these functions, but could as well be used more effectively by Member States as focal health policy points.

Assessment of health implications

In principle it seems that most of Member States have experiences in considering intersectoral issues or addressing health implications of policies e.g. in terms of alcohol, tobacco, transport safety, gender or socio-economic inequities or food policies. However, the success of these efforts as well as articulation in the context of European Community policies seems to be a problematic area especially in the 'harder' sectors of trade, industry and transport.

Health impact assessments seem to be emerging mostly in line of two processes, firstly alongside the development of national health policies or health for all policy action plans and secondly in the context of environmental health. At the moment the production of national environmental health action plans and the European action on transport and health with the charter on issue suggests that in Member States health impact assessments will further strengthen the practices developed more in the context of environmental health impact assessments.

The state of actual implementation of environmental impact assessment is still mixed in many Member States. In practice health seems to be a neglected or narrowly defined area in the process of EIAs where these are a practice and it is not always perceived that health would be part of the process of EIAs. While procedures for health impact assessments may be requested as part of environmental policies there seems to be insufficient co-ordination and conceptualisation in the area and especially with respect to the effectiveness and appropriateness of the already existing practices of EIAs at the level of plans, programmes and policies. EIAs seem to be implemented predominantly as contractual administrative practice where health considerations tend to be defined simply in terms of not exceeding existing legal or administrative limits to exposure levels or measures to mitigate these.

The current activities in Europe which deal with assessing health implications seem to range from straightforward disease and exposure risk assessment to purely policy-oriented measures designed to attract politicians' attention and take health issues up the political agenda. There is a general lack of literature and experiences in the process as much of the literature on EIAs is 'grey administrative' literature and not in standard reach for those working on research. Health impact assessment has not yet been strictly defined in European countries, although it seems very probable that this will happen quickly. In fact the WHO European Centre for Health Policy office has already started a process of dialogue on conceptualisation of HIA.

Health impact assessment practices based on social and environmental determinants of health have used the British Columbia "toolkit" as a model of HIA. This thinking has influenced, for example, the United Kingdom Liverpool approach where HIA is considered within the socio-environmental model with a focus on social determinants of health (Scott-Samuel 1998). In the Dutch approach of Health Impact Screening technical aspects of health impact assessment have been combined with administrative measures taking into account as well the more incremental nature of policy development in practice (Putters 1997). In the model used by Swedish local government the HIA is based on addressing health impacts on the basis of a list developed by a combination of people's perspectives and research information on health determinants; the aim is to encourage politicians to implement more equitable and health-oriented policies (Berensson 1998).

4.2.2 State of practice, experiences and lessons learned

In general capacities for assessment of health implications of policies do exist in all Member States. However, these capacities are not necessarily in direct access and use of Ministries of Health. In addition, Ministries of Health may not be involved to a larger extent in European Community level activities, where foreign affairs or trade affairs may dominate national policy priorities also in the field of health-related issues. While Member States might have activities at place in the academic sphere or in terms of research activities, these may not be geared towards policies and decision-making in practice. These may also become fragmented and become guided by specific scientific practices, technologies and interests rather than those of health considerations. It seems that in practice most of Member States national level activities on other sectoral issues are limited in focus and policy areas especially when other than environmental, social or labour issues are considered. In practice

any consideration of health implications of other policies could be seen also as mutual learning, dialogue and information exchange possibilities within the relevant national administration.

Transparency and participation have been of core importance in terms of environmental impact assessment practices as well as in terms of successful activities with respect to the Healthy Cities initiative. In local level projects this can be linked to affected populations and their participation in decision-making. However, a more general issue is linked to openness of the process, sharing of information and public accountability. Legal obligations and halt/go statement entitlements are seen as an important part of the process in rising the role and relevance of assessment practices. Assessments which remain within the administration have more tendency to become a routinely acknowledged practice without impact on projects or policies.

Intersectoral practices and projects seem to be more linked with regional or local level activities. European Community draws more attention as a resource for local activities and networking with less attention to Community level policies as such. The idea that European Community policies could have relevance to health policies and issues at national level seemed to be relatively new and distant for many working in the area. It may thus be the case that the further one proceeds from local level upwards, the less clearly impacts of other policies are perceived especially as policies become subject of more complex structures and organisation. However, the recent trade-disputes on health issues and Court cases related to internal markets and health services have opened scope towards realising how European policies might influence national and local level practices.

In local level activities emphasis has often been on health promotional side with more capacities geared towards integrating health and life-style considerations in other sectors than in assessing how policies implemented in other sectors contribute to determinants of health or interlink with national health policies and priorities. This is reflected, for example, in relatively wide-spread attention to healthy schools, but relatively less emphasis on the role of education policies, health implications of educational policies or how educational policies intersect with national capacities to implement healthy public policies.

It is clear that capacities to assess health implications seem to exist in all Member States, however, it is less clear what role health considerations play firstly in national policy-making and secondly in national policy-making at European Community level. Shared health interests of Member States may be easily compromised by other shared interests with stronger counterparts and traditions at the Community level. The relative weakness of the Commission in health policy issues and integration of health in all policies is thus further weakened due to similar problems at national level in Member States.

The processes and practices of HIA are at the moment rather open in many of the Member States. It is unclear to what extent member states have included human impact assessments as part of EIA practices. Important issues are to what extent the current practices of EIA or SEA could benefit from a broader more social impact assessment influenced HIA practices. It is also clear that Member States' activities on HIA could benefit from further exchange as well as training and education for implementing health and social impact assessments. EIAs and HIAs seem to be managed by consultants without qualifications thus necessarily limiting the focus towards more reduced models of assessment.

In general there seem to be very limited educational activities in terms of health policies or health impact assessment within the European Community. It may be expected that the development of teaching activities will conceptualise practices on health impact assessment towards one or two dominant models. At the moment teaching on the issue seems to take place at least in Liverpool University in the United Kingdom. However, there would be ample scope for broadening of joint teaching and comparative policy analysis activities at European level. European Community could play a supportive role in this process.

5 Mechanisms for assessing health implications at Community level

5.1 Priority and level of action

On the basis of the prior considerations due attention needs to be drawn to the extent that integration of health is considered as a policy priority both in terms of national level activities as well as Community level action. It is clear that after certain level of voluntary and ad hoc measures have been implemented with meagre results a more formalised action is needed.

If current activities are to be improved or enhanced this requires more than improving effectiveness of current practices and it is clear that no mechanism will be sufficient as such to address the issue at Community level without appropriate structures, political will and resources set at place. In addition, different emphases might be needed in dealing with different policies and questions rather than seeking for a suitable method for all questions for ever.

In here we propose one way of proceeding in the context of an action plan and suggest both changes in structures to ensure action and means of considering more indirect mechanisms. We also suggest one mechanism for assessment of health implications with flexibility in boundaries and more specific methods employed. It is an example to be further developed, evaluated, piloted and improved to serve better European Community level use.

5.2 Preparing an action plan

It is suggested that an action plan dealing with structures and aims at Community level is made on the issue setting at place requirements, priorities and time-table for action. This action plan should discuss:

1. Areas of priority and means to address:
 - 1) Systematic analysis of the existing policies and their relevance to health and health policy concerns. Ensuring that mechanisms set at place allow for the incremental nature of policy-making and continuity in practice.
 - 2) New and negotiated or planned policies, agreements and programmes – how to ensure that health and interests of national health policies receive due attention e.g. in trade negotiations
 - 3) Health-related directives and more specific legislative measures, standard setting on health and health related areas and other functions with Community level reach with need of continuous but lower level attention and use of more rapid mechanisms of assessment.

- 4) Indirect policy influences with relevance. How could, for example, structural funds, be used better to serve to improve public health capacities in Member States or support by the European Communities to training, education and research networking in Member States. How can it be ensured that the process of enlargement will strengthen public health capacities rather than weaken them at national and Community levels.
2. Ensuring action and due consideration of issues at Community level with recognition of national policy priorities and structures in health policies
 - 1) Mechanisms to ensure that assessments matter in European level policymaking. Amsterdam Treaty sets a basic framework for health considerations. In principle consultation process exists as well. Due attention needs to be given to means to ensure that health considerations are taken into account before plans, agreements or policies are approved and that adequate structures to respond to these needs exists at national and European Community level.
 - 2) Considering how to improve the position of public health issues in higher level politics at Community level. Putting special attention to areas where share of work between Member States and the Community are undefined or under change of actors differ either between Community and Member State levels or in both of these. A good example of a problematic area can be found from the EU external policies.
 - 3) Ensuring mechanisms for improved transparency of activities as well as openness towards citizens' Europe so as to ensure that Community level activities represent citizens interests and priorities.
 - 4) Ensuring mechanisms for legitimacy and appropriate share of accountability as well as grounds for continuity in work.
 3. Consideration of structures and mechanisms for setting a process at pace.
 - 1) There is a clear need to set at place structures and resources for integration of health both at the level of Commission structures as well as in ensuring that adequate linkages are made with Member State national administrative structures.
 - 2) Due consideration needs to be made whether to improve the health part of current practices of environmental impact assessment procedures or try to start a process of health impact assessments as such.
 - 3) Ensuring that work and linkages with European networks on public health and health policies take place at Community level on policy issues and that similar interests in other fields, such as social, consumer and environment, are adequately recognised and utilised.
 - 4) Ensuring continuity and sustainability of activities with both shorter and longer term considerations thus allowing scope for processes of education and training to take place.

5.2.1 Issues to consider with respect to structures set at place

It is clear that if integration of health is to be taken seriously at the European Community level not only Commission or Community level structures and emphasis need to be considered, but as well how Member State health policy viewpoints receive due attention in the process. This is of importance especially as implications of other policies to national health policies may vary greatly within the Community.

As part of the process due consideration should be given to the necessity of formal structures which would give contact points and set accountability on the issue both at Community and national levels. The possibility of starting either a Committee on issue with Member State representation or a sub-group of health group with a specific commitment on the issue should be considered in order to build links with Member State administration and ensure that appropriate linkages with national health policy interests are made. Health in other policies is not a one stop issue and thus continuation of a process needs to be considered.

In here the mechanism on assessment of health implications has been set to consist of a team of expertise from Member States. In practice structures to which this team reports are needed with respective accountability to three actors, namely the European Commission, European Council/Member States and European Parliament. A formal structure for this process and choice of expertise is thus required to exist both at European Community level as well as at Member State level. While it is not a matter of this study to set this or any other structures at place special emphasis needs to be given to the aspects of transparency and accountability to all three actors involved in the process.

Structures of open and explicit nature should serve as well to ensure that like minded interests strengthen each other both within Commission structures as well as between Commission and non-profit public interest organisations and Member State actors. Interservice group may be too broad and closed to ensure appropriate action. These 'coalition building' efforts should be seen as appropriate basis for better integration of policies at Community level.

Active formation of Forums or other means of ensuring of viewpoint exchange on the issue could be sought as well as enhanced collaboration with other international organisations working on health and related issues – with special reference to the WHO Regional Office and European Environmental Agency.

Building links with research community and ensuring that appropriate knowledge exists at Community level is of crucial importance in a more long-term perspective. In practice, European collaborative efforts could be used for example in enhancing education and training on health impact assessment and public health in a way which would foster more common use of concepts as well as enable exchange of information at European level better.

Finally, there seems still to be limited appreciation of importance of public health and health policy issues as essential prerequisites for adequate functioning of internal markets. The emergence of public health crises and related problems in various common market areas might well open more scope for this. Last, but not least, health and access to health care is highly appreciated by European citizens and if any articulation of citizens' Europe matters it is necessary to ensure that these citizens' social rights are enhanced and will not become compromised due to European Community level policies.

5.2.2 Proposed mechanisms for assessment

In the light of the prior findings and experiences certain conclusions over potential mechanisms at Community level may be made. In the light of what is known about mechanisms of assessment several means could provide a starting point for further consideration of practices at Community level. However, our example for a mechanism has been based on the following considerations:

1. Health Impact Assessment already exists in environmental impact assessment procedures at Community level and due to respective directive in principle also at national level in many Member States.
2. HIA seems to develop most strongly towards more standard practices of environmental health impact assessment. The problems in 'reinventing' the wheel under another different conceptualisation of the term might cause problems in practice.
3. The legal commitments – as amended in the Treaty of Amsterdam – cover a broader array of measures than mere health impacts in requiring a high level of health protection with emphasis on planning and implementation of all policies. This implies that focusing merely on impacts on health or health determinants may not be sufficient means for addressing the issue as precautionary measures may be left inadvertently aside.
4. Health policies are still considered as primarily national issues and articulation merely in terms of health would set aside important implications to national health services provision and costs.
5. Although health considerations have become more explicitly articulated at European Community level. Health represents still relatively weak political interest at Community level in practice, with danger of becoming compromised unless sufficiently formal, open and binding mechanisms are sought to back up policies and unless sufficient political will is sought to enable this in practice.
6. The level of complexity in assessing health implications rise with each level of activity from project to Community level. At the level of Community policies quantifiable assessments may be of lesser validity and use in comparison to project level as variation in magnitude of problems as well as in their influence on health and other policies may vary to a large extent between Member States limiting further the usefulness of quantifiable outcome considerations as the only means for gaining evidence.

A mechanism for assessing the health implications of other policies could be created by combining some aspects of systematic procedures in 'Health Impact Assessment' with 'Policy Review' practices. This would be based on a systematic assessment of all policies with an explicit focus on health protection, health promotion and health policy implications. It would use expertise in various fields during the assessment procedure with active participation from the respective policy areas in dialogue and source of materials. The systematic assessment could:

- i) **Screen** the main issues and measures where health implications emerge in the defined policy or sectoral area;
- ii) **Scope** the magnitude of health implications and their relevance in the context of national health policies and major incentives and policy measures provided by the Community level activities and support;

- iii) **Profile** the activities in terms of assessing issues which are of concern in the context of health policies of all Member States and those which are more relevant in the context of specified national health policies and health services;
- iv) **Assess and review the qualitative and, where relevant, quantitative evidence** with respect to implications for public policies on health (e.g. social policies and cohesion, equity, economic incentives, access to health services and organisation, regulatory measures and capacity at national level), health protection requirements (health standards, environmental exposures (biological, physical, social), health and safety measures), health promotion (incentives/disincentives and measures for capacity to lead healthy lives and known means for health promotion);
- v) **Assess confidence** (e.g. definite, probable, possible, speculative), **magnitude** (potentially affected populations, Member States, regions) and **nature** (level of choice by people, new/old risks involved, how are risks and benefits distributed, immediate/long term, relation to children/ageing/poorest section of society) **of main implications on the basis of prior knowledge**, including where there is no knowledge to use of employ in the assessment;
- vi) **Decide to what extent follow up** of policy implementation in terms of health implications is necessary or when the assessment procedure should be repeated;
- vii) **Go/Halt decision** with explicit basis for articulation and, in case of “Halt”, explanation of reasons and how this could be changed.

These seven procedures could provide a basis for the initial piloting of the approach while in practice more rapid measures to assess health implications of single policy measures or, for example, directives, could be sought.

The standard practice of assessments made in the European Community has been that of contracting out studies. It is, however, suggested in here that a more formal public procedure could be set place to begin the activity and take adequately into account the variation of national issues and policies as well as ensure sufficient transparency and accountability to both Member States and European Parliament. In addition, this could be used as means to involve national administrations in the process in a way which would help in taking into account potential national level implications. International intergovernmental agencies, such as the WHO or non-governmental organisations such as European Public Health Alliance could be used as additional participants in the process. The actual choice and further deliberation of proposed practices is beyond this study.

6 Transport policies

6.1 Introduction

This article investigates how environment and health is taken into consideration in EU transport policy. During the study, between October 1998 and January 1999, about twenty civil servants, academics and non-governmental organisation workers, one MEP and adviser of a political group of the European Parliament were interviewed on the subject. The discussion part of this chapter is duly influenced by these conversations.

6.2 Background

The environmental and health problems associated with current patterns of transport use are widely acknowledged. For example, an OECD document draws attention to the contradiction between transport, usually considered an essential factor for economic growth, and its current and future impact on that growth. "Transport has been an important factor in the successful economic growth of OECD countries. However, current patterns of transport activity are not only beginning to sap the very foundation of that growth, they are also contributing to a real decline in environmental and social welfare" (OECD 1999). The British Medical Association recently published a book on road transport and health (BMA 1997) in which not only the health effects of air pollution, noise and accidents but also those of reduced physical activity due to increased use of motorised transport, social equity in transport and other social impacts of road transport are discussed. WHO is preparing for a Ministerial Conference on transport and health to be held in June 1999 in London. A charter on health and transport, to be launched at the London meeting, is also under preparation.

The health problems of transport are caused via air pollution, noise, accidents, the sedentary lifestyle which ensues when motorised transport is used even for short trips, and by creating barriers to normal life-hindering children's independent mobility, for example. Transport of dangerous goods carriers potential big risks. According to current knowledge, air pollutants result in more frequent hospital visits for people with asthma and increase mortality for respiratory and cardiovascular diseases (Dockery and Pope 1994, Dockery et al. 1993, Pope et al. 1995). It has been estimated that, on average, 65% of the population of European countries is exposed to outdoor sound levels above 55 dB (Stanners and Bordeau 1995). Noise disturbs sleep and may have psychosocial effects (BMA 1997).

Fatal accident risks vary considerably between the member states, ranging from 6.5 killed per 100 000 inhabitants in some countries (UK and Sweden) to almost 30 in others (Portugal) (OECD 1997). The time children spend outdoors and the number of social contacts they have varies depending on the perceived danger of the environment (Huttenmoser 1995). Physical activity has a great potential to prevent several common and serious, non-communicable diseases, and increase well-being (US Department of Health

1996). Active commuting to work has been shown to have substantial potential to enhance health and fitness (Oja et al. 1991).

With the creation of the single market, the free circulation of people, goods and services stimulates more demand for mobility. In the past 20 years in the EU, passenger transport has increased by more than 85%, most of the increase being attributable to the use of private cars. The number of the trips made by individuals has remained the same, but between 1970 and 1996 the average daily distance each person travels doubled. Goods transport has increased by more than 50% in the same time period, with road transport accounting for most of the increase (COM supplement 3/93).

The Trans-European Transport Network is a programme built to improve the competitiveness of the European economy by developing an integrated transport system. The hope is that it will serve the single market more efficiently than the existing networks which are fashioned to national needs and are inadequate for future needs. One goal is to form better transport links between the peripheral areas and the central parts of the EU (Directorate-General Transport). In the period 1996-1997, total investment in the TEN-T was 38.4 BECUs; 39% of which went on rail, 38% on roads and 15% on air traffic (around 60% of all the TEN-T budget goes to rail, compared with 15% on roads).

Besides the increase in long distance travel, and travel across national borders, local transport is also relevant at the European Community level. Eighty per cent of the EU's population lives in urban areas. More than three-quarters of all passenger trips are less than 10 km, underlining the importance of local and regional transport (COM 98/431).

Transport equipment is one of the principal industrial sectors of the Community. It is estimated that one in ten jobs depends directly or indirectly on the motor vehicle sector (COM Supplement 3/93). In 1993 about 40% of the public investments of the Member States were investments in the transport sector.

6.3 Measures at the Community level

Transport policy was mentioned in the Treaty of Rome in 1957, but the common transport policy did not develop much before the end of the 1980s, when the creation of a single market produced a demand for changes in the transport sector (Kinnunen 1997). The year 1992 is considered a turning point in the evolution of the common transport policy as it developed into a more comprehensive policy designed to ensure the proper functioning of the Community's transport systems on the basis of an internal market. At the same time it had to take into account new challenges, one of the most important being the integration of environmental objectives (COM 92/494,5). By the end of 1998 it was felt that in the latter half of 1990s, considerable progress had been made in developing a common transport policy, including treating environmental protection as an integral part of that policy. However, one of the areas where progress has been slower than hoped has been in developing a system for charging for infrastructure and external costs, this strategy being one of the key routes of integrating the protection of the environment into the common transport policy (COM 98/716). The transport sector was one of the sectors (besides agriculture and energy) which at the 1998 Cardiff summit was instructed to deliver a report to the Vienna summit on how environmental issues have been integrated into sectoral policies.

6.3.1 Air pollution

The main field the EU has worked on in regard to the environmental problems of transport has been mandating emission (and noise) standards for road vehicles, aircraft and fuel. The first directive on air pollution (on emissions of carbon oxides and hydrocarbons from petrol engines) had already been adopted in 1970. A framework directive on Ambient Air Quality Assessment and Management was adopted in 1996 (Directive 96/62/EC). The framework directive established EU-wide long-term ambient air quality objectives and requires air pollution levels to be monitored and communicated to the public. The directive also requires the limit values to be based on the most recent research data in the epidemiological and environmental fields concerned, with the aim of avoiding, preventing or reducing harmful effects to human health and/or the environment as a whole.

WHO has published Air quality guidelines for Europe (WHO 1987) in order to provide background information and guidance to governments in the setting of standards. The work at WHO is based on the collaboration of a number of scientists. Auto-Oil I programme (Directives 98/69/EC and 98/70/EC) is expected to result in important reductions of pollutant emissions from 2000 to 2005. Auto Oil II, which is currently in progress, is expected to provide for further reductions through complementary measures (COM 98/716). Despite the tightening emission standards the changes in air quality are happening slowly because the new standards have usually concerned only new vehicles and transport activity has increased enormously.

With unchanged trends, CO₂ emissions from transport will increase by about 40% by 2010 and, as the CO₂ emissions from transport represents a quarter of total EU CO₂, considerable efforts have to be made in order to attain the Kyoto target. The Commission communication On transport and CO₂ is presenting several policy approaches, including promoting public transport, revitalisation of the railways, stepwise introduction of fair and efficient pricing, and Strategic Environmental Analysis of TEN-T investments. It also acknowledges that in many cases the proposed measures imply that traditional practices and patterns of mobility will have to be reviewed (COM 98/204).

6.3.2 Safety

In the Maastricht Treaty (ratified in 1993) an explicit requirement for the Common Transport Policy to include measures to promote transport safety was set out for the first time. Until 1993, the main activities undertaken in the area of road safety had been concerned with the harmonisation of rules relating to vehicle construction (through the adoption of more than 100 directives); maximum driver's hours; the periodic inspection of vehicles; the general standards for obtaining a Community model driving licence; the mandatory wearing of seat belts and speed limits for heavy vehicles. (Two draft directives were on the council table: harmonisation of speed limits for commercial vehicles and the maximum permitted blood alcohol concentration.) (COM Supplement 3/93)

The Commission's first action programme on road safety was launched in 1993 (COM 93/246). The studies included in this programme have focused mainly on the vehicle, telematics applications and analysis of people's behaviour. The most recent directives

have been concerned with vehicle safety and the transport of dangerous goods (COM 97/131).

The new strategy – Road Safety 1997–2001 – is based on the principle that the high costs of accidents should be fully taken into account in the safety policies of Member States. It is intended that the application of this approach will give a major impulse to new efforts at all levels since in the past investments in road safety have typically cost significantly less than the high costs of accidents. The road safety programme for 1997–2001 comprises:

1. Gathering and disseminating information and best practice, notably through the setting up of an EU road safety information system.
2. Accident avoidance measures; for example, curbing alcohol and drug/medicine use by drivers and the applications of telematics for both traffic management and safe driving.
3. Tools to reduce the consequences of accidents when they occur. For example, the type approval directive on pedestrian-friendly vehicle front design. In civil aviation, the Commission has made proposals on the safety assessment of aircraft (COM 97/55) and on the professional qualifications of cabin crew (COM 97/382). In the maritime sector a proposal on the licensing of Ro/Ro passenger ferries has been made (COM 98/71).

6.3.3 Internalising the external costs

By 1993 it had been stated that internalising external costs should be a major element in a transport policy that integrated the protection of the environment (COM Supplement 3/93). A Green Paper on internalising the external costs was published in 1995 (COM 95/691) and a White Paper, Fair Payment for Infrastructure Use, in July 1998 (COM 98/466). The White Paper represents an improvement in the transport pricing system because current charges and taxation in the Member States have given rise to a distortion in terms of competition between the Member States, difficulties in funding infrastructure investments and a failure to consider social and environmental aspects of transport (COM 98/466). Congestion is estimated to cost the EU some 2% of GDP every year, accidents another 1.5%, and air pollution and noise at least 0.6%. The available evidence suggests that existing road taxation falls far short of covering all these costs (COM 95/691) but the process to reverse this situation has developed slower than could be expected (COM 98/716).

6.3.4 Citizens' network

To promote good local and regional passenger transport the Commission has defined its role mainly as a supporter or catalyst and is acting mainly through trying to influence general opinion (COM 98/431). The Commission's citizens' network programme is designed to support the role of local and regional passenger transport in contributing to economic development and employment, reducing congestion and environmental hazards, reducing social exclusion and improving quality of life. Through this programme more use of environmentally-friendly forms of transport, such as clean and efficient public and

private transport, cycling and walking are promoted (COM 95/601, COM 98/431). The work programme covers information exchange, benchmarking, establishing the right policy framework and the use of community financial instruments.

6.3.5 Environmental Impact Assessment

Environmental Impact Assessments are required for the projects that are part of the Trans-European Transport Network (COM 98/614). According to the Commission communication A Strategy for Integrating Environment into EU Policies, the Commission will strengthen its environmental assessments of policy initiatives that have environmental effects (COM 98/333 final tark). These reviews will be based on the work undertaken by the Commission and experts from Member States, together with Eurostat and the European Environment Agency, and will develop more accurate indicators on transport and the environment (COM 98/716).

In the Member States numerous EIAs have been done on transport sector on project level but also strategic environmental assessments (SEA) have been done. For example in Finland SEA of the Nordic Triangle (transport network connecting the capitals of Finland, Sweden and Denmark) was Finland's first SEA for ever. Other SEAs of transport sector have been for example SEA of 'Dennis Agreement' (Agreement between the three largest political parties in the Stockholm region to guide transport investments) in Sweden and SEA on transport policy and introduction of High Speed Rail in Slovenia (Com DG XI, 1997). Also in the development of Health Impact Assessment transport has been one of the first fields where HIA has been used. Two of the first four HIAs conducted by Liverpool Public Health Observatory had been on transport, the HIA on a second runway at Manchester International Airport (Will 1994) and the HIA on Merseyside Integrated Transport Strategy (Fleeman 1999).

6.4 Discussion

At Union level, environmental health is certainly one of the areas where the EU could play a key role in promoting better health among the Community's citizens. Matters of health care belong to the Member States but environmental questions have established themselves as appropriate to be tackled at EU level even if environmental questions have been subordinate to economical views. The importance of environmental health is underlined when taking the enlargement process into account. Currently, big changes are happening in the transport patterns of Central and Eastern European countries. The numbers of motor vehicles are rising rapidly and subsidies for urban public transport are being reduced (ECMT 1996).

For three decades the EU has worked to tackle the environmental problems of growing transport. The work has mainly been concerned with tightening emission standards but, especially in the 1990s, a wider vision has emerged. The generation of the political will for these changes has been brought about by many factors. For example, it was realised that new standards on emissions have not been an obstacle to the growing car market

because the new standards have guaranteed markets for technically more demanding (and expensive) vehicles. It has also been important for the car industry to secure the general acceptance of the image of private cars. There has also been pioneer work done on tighter emission legislation in Japan and USA (Short 1994), which has put pressure on European countries and industry to do likewise. The evidence produced by the scientific community on the health hazards of emissions, such as lead and particulates, has been so clear that it would have been difficult for decision-makers to ignore it.

As has been also true at national level, the separate components in attempts to control different health and environmental hazards have not had a synergic effect and have failed to turn transport onto the sustainable track. For example, measures to promote safety have not resulted in environmental benefits (Lamure and Quinet 1990). From the environmental and health perspective, at the national level more progress has been made in the countries where the environmental and health problems of the transport sector are tackled at government level, such as in the Netherlands (Vleuget et al. 1990).

In the latest European Commission documents (COM 98/716), the traditional view of economic growth being dependent on increases in transport activity is challenged. Instead, it is acknowledged that the traditional practices and patterns of mobility can not be sustained and have to be reviewed (COM 98/204, COM 98/431). To make fundamental changes in transport policies to take them onto a more sustainable track would be a crucially important achievement, bearing in mind the damage the transport sector has done to the environment and people's health.

The health sector at Community level needs to acknowledge and fully support these positive moves and join the forces central to achieving sustainable development, such as the environmental and social sectors. Reducing the growth of transport will not be easy because the economic interests in the sector are huge. For example, 10 of the 15 biggest European car companies are lobbying in Brussels (Kinnunen 1997). With environmental issues at the Community level, the Commission has been the promoter and the Ministerial Council and Member States delayers. The Auto-Oil programme has revealed the division of the Member States between those promoting environmentally better legislation (the Northern countries) and those delaying it (the Southern countries) (European report 1996, N:o 2166, IV, page 12).

Political will not only needs to be strengthened at EU level but also in the Member States. When taking into consideration the big differences between the Member States in accident fatalities, it can only be concluded that many of these premature deaths are preventable. As health is highly valued in all countries, the health sector's better understanding of connections between health and transport, the potential of promoting health with better transport policies, and ways of avoiding these premature deaths, is crucial.

Internalising the external costs is intended to be a key measure in future transport policy but progress has been slower than expected. The external costs of transport are usually considered to result from an enhanced greenhouse effect, air pollution, noise, congestion, road damage and accidents (Maddison et al. 1997). However, some externalities affecting health are seldom considered: a sedentary lifestyle resulting from using motorised transport even for short trips, and the barriers transport systems put between children and their ability to move around and explore their environment independently. These aspects are difficult to quantify and develop indicators for. Nevertheless, studies should be undertaken to explore the possibilities of broadening the scope of externalities that impact

on human health. An important role a health sector could have is producing information on more wider scope about connections of transport and health and make it available at the community level as well as in the Member States.

Environmental impact assessment is an established practice in EU transport policies because all the TEN-T plans are required to have EIAs. The European Commission is also strengthening its environmental assessments of policy initiatives. As in the transport sector, because EIAs have an established role and many of the health aspects of transport are linked to environmental questions, the feasible strategy would be to strengthen the role of health aspects of EIAs (the directive of EIAs includes human health) rather than starting separate health impact assessments.

It has been stated that the health sector tells others what they are doing wrong rather than being able to say what a healthy environment would be like and what each sector's role would be in it. The health sector could participate more on land-use planning and developing sustainable communities, which would not only be environmentally less problematic but would also promote health. The EU level does have a programme on sustainable cities (COM 98/605).

As environmental and health effects of growing transport activity have become apparent and the inadequacy of separate measures to tackle each problem clear, it is time for comprehensive strategies to be developed to integrate environmental and health matters into transport policies. Finding the political will to implement these strategies is difficult due to the very different views of Member States and interested parties. So far the health sector has contributed mainly by identifying health problems but in the future could also contribute more to developing health promoting and sustainable environments.

7 Future challenges

7.1 Challenges for healthy public policies

The major challenges for healthy public policies are grounded in the structures and regulations related to internal markets, European monetary union and increasing global economic integration currently negotiated most effectively in the context of trade. More explicit attention needs to be paid to the health and social aspects of this process in the European constitutional and legal framework in order to ensure that the market does not become the decisive influence on health and social policies (see Nickless 1998, Berman 1999). This has as well been recognised in the context of recent European Court of Justice cases interpreting agreements made earlier (Berman 1999). The phenomena of creeping impacts of other policies to health policy substance and content areas at national level has been called also “euro-creep”³. It is a process which requires attention and potentially further legal action at Community level in order to ensure that “citizens’ Europe” does not become subordinate to corporate Europe.

As the EC is to take on a more crucial role with respect to the external policies of the European Member States, the challenge is to ensure that health considerations are taken into account when the European Community is representing common interests in trade, investment and other multilateral negotiations. This is an issue which has immediate implications in the context of future World Trade Organisation negotiations especially as some aspects of these negotiations could bear major relevance to health services and costs of pharmaceuticals and health technologies. The importance of taking into account health and social considerations as part of general policy priorities needs to be recognised in relation to the increased role of the European Community in external relations if the European Community is to become a citizens’ Community.

At European Community level citizens’ participation is by necessity more limited and more often participation is exerted by various interest groups which may play a substantial role at European Community level. As public health issues are “public interest” issues, these may attract more opposition than support from corporate or other special interest groups that have more focused interests at the European level. This creates a challenge for transparency and public accountability. The European Parliament has been seen as the major forum for European level democratic debates, however, as especially many health issues are strongly linked with subsidiarity and national health policies the role of Council cannot be neglected. While there is scope for improvement in information exchange and openness at Community level practices even amongst those officially involved, even more attention is needed to the distribution and accessibility of policy documents, discussions and plans at Community level to citizens and public interest groups.

The enlargement of the European Community will bring new challenges in terms of public health issues and the health implications of all policies. It is important that it is acknowledged that the health system and public health infrastructure are an essential

³ This term was introduced by Jason Nickless in his presentation in an expert meeting on Healthy Public Policies in February 1999, Helsinki, Finland.

prerequisite for the appropriate functioning of internal markets, comparable to the transport sector. The enlargement of the European Community will give rise to potential changes at policy level as well in areas such as environment and transport. There is a need to consider to what extent health and public health infrastructure and public sector capacities at national, regional and local levels should be seen as areas where European Community resources could provide impetus for better public health practices through funds governed by the Community.

7.2 Future needs and requirements

The future requirements for assessing the health implications of all policies are not excessive and can be realised if sufficient political will and priority is given to the issue. In principle, there is a need for change in structures and resources in the Commission, an issue partly discussed in the context of public health policies at the European level (COM 1998). While some financial resources might be gained from reorganising European Community public health activities, further attention might still need to be given to human and financial resources and their organisation.

Explicit contact points and networks of European expertise may need to be set up, as well as links and functional working relations with international organisations working on the area. In public health issues and policies the WHO hosts most of the European networks. WHO work has already been elementary in DGXI activities on air pollution and WHO/EURO is clearly the most important international organisation with which the European Community needs to collaborate with. In health impact assessment and policy reviews the OECD and European Environmental Agency could provide additional contact points. In the substantive areas of European policies, such as agriculture or transport, further contact with sources of expertise could be sought by substance. This would provide the Commission with the capacity to link and network with European institutions and expertise across the substance fields.

At the current time, health and public health issues are, to a large extent, decided at national level. It is clear, however, that in future more public health and health-related trade disputes, as well as other issues and considerations, will be focused at European level and, merely in order to maintain national governance, more understanding of European policies is needed. In order to ensure that national health policies are given due consideration at European level, and health considerations respected, it may be necessary to bring European expertise in health and public health issues together more to provide exchange of information and forum to discuss ongoing process at European level in more detail. In health this could support further longer term consideration for forum or resource centre on health and public health policies at European level.

There is a need for more openness in the Community policies and allowance for public discussion with respect to mechanisms for ensuring that public health administration and infrastructure get due attention. The current Fifth Framework Programme on Biomedical Research by DGXII provides positive examples of small changes in focus which may provide a channel for better European level articulation of major health issues through hosting a more problem oriented focus. However, all that deals with health may not be appropriate for healthy public policies. Due to emerging health care and health technology

markets, there will be an ample supply of actors eager to share these markets with, at times, little relevance and costly consequences for national health systems. This will require a critical look on how the issues supported at Community level in terms of support to private development investments and development policies fit with aims of Community health policies. In the field of trade and investment it is important that activities related to government procurement practices, foreign investment, market access or trade in services fit in the area of trade will support Community public health policies and do not harm capacities of undertaking health policies in the Member States.

It may become important to consider a legislative process in order to further ensure that litigation activities on other issues will not gain precedence over softer regulations on health at national level. In practice this could mean a way of ensuring that internal market regulations are not inadvertently imposed on health and social services or weaken national regulations and activities with a strong public health focus, which has been the case in, for example, negotiations with respect to the alcohol policies of the Nordic countries. At European level environmental, health and consumer concerns tend to have close interests and thus might also provide a joint focus for defined parts of policies. Special reference can be made to those of environmental health, sanitary and phytosanitary measures and implementation of the precautionary principle in environmental, consumer and health protection.

8 Conclusions and recommendations

8.1 Conclusions

Integrating health into other policies and maintaining high level of health protection can be seen as one of those things with which everybody agrees in principle, yet problems may emerge in how these are ensured in practice. It is clear that without sufficient legitimacy and resources – human or financial – very little will happen even though mechanisms for the activity could, in principle, be set at place. This does not merely deal with the personnel working for the Commission but as well with links and networks in public health by the Commission both inwards to the Member States as well as outwards in relation to the international organisations such as the World Health Organisation. While these insights are important they are not novel as they have been presented in recent discussions by the European parliament on European public health policies (European Parliament 1998, Eurohealth 1999).

The legal, constitutional and technical capacities for assessing health implications in all policies at European level exist. However, the “promotion goodwill path” of reporting activities concerning health in other policies through Communication by the Commission, has been tried and shown to be insufficient to provide a comprehensive and systematic review of the health implications of other policies. Assessment of human impact in all projects has been laid out as part of Environmental Impact Assessment. It is unclear to what extent Member States have considered health in the context of environmental impact assessment and how narrowly/broadly health considerations may have been understood. On the basis of experience in EIA a simple requirement for technical health impact assessment of all policies and projects at Community level might not deliver the impetus needed, especially if procedures remain internal with little public access.

Integration of health requirements in all policies is an issue requiring sufficient political will from the Member States to ensure that resources and structures to carry out this activity are put in place. In principle, assessment of health implications is no different from any other area. However, it is clear that there is no shortcut to assessing policy implications through technical modelling of the relationships between policies and outcomes on a European-wide basis. This is because:

- i) core necessities for health protection for precautionary measures make comparisons difficult in terms of mere health outcomes;
- ii) there is variation in implementing European policies;
- iii) there is variation in the basis of European statistical information and major health problems between Member States;
- iv) there is variation in structures and basis of Member States’ health policies and level of precaution and access opted for not directly associated with outcome indicators;
- v) difficulties in interpreting quantitative assessments of broad policy issues lead towards emphasising specific issues and interventions, narrowing the focus and increasing the potential of biases in the estimation process.

In this analysis on mechanisms for assessment of health implications our choice has been to suggest a procedure with aspects of both practices of health impact assessment at procedural level as well as employing skills and practices of policy reviews as part of the process to ensure that national health policies and issues with respect to health services are duly considered in the process. In addition we see it as important to keep this a public process accountable to health authorities in Member States with a possibility for dialogue, learning and exchange of information not only between areas but as well between Member States especially in initial stages where existing practices need to be systematically evaluated.

The major role for the activities is to be found from assessment of new policies, agreements negotiated and directives set by the Commission. In these assessment of health considerations should be required on the basis of halt/go principle ensured through legal commitments at Community level. Capacities and potential for assessing health implications of other policies exist in all Member States. The assessment of the extent to which these are in use of national administration or linked with European level decision-making has been beyond this study. However, further attention could be put on training and education on public health issues, with special reference to health and social impact assessment.

8.2 Recommendations

The main recommendations of this analysis are:

8.2.1 Further attention to be paid to resources and structures,

- i) under Commission governance, there needs to be a focus on health in all policies in order to ensure that human resources and capacities for implementation exist;
- ii) dealing with health issues at European level, including the existing networks and international organisations, in order to provide an accessible forum and source of information at European level on Community policies and health;
- iii) dealing with health policies, public health and assessment of health implications at national and regional levels;
- iv) providing the capacity for the skills to assess health policies and health impacts in Europe.

8.2.2 Necessity of political will and of recognition,

- i) with respective focus of attention and follow up at the Council level;
- ii) with respective attention to involvement of Member States national health administrations;
- iii) involvement of the European Parliament;
- iv) requirement for increased openness and transparency in terms of Commission work as well as clarity in responsibilities of activities in the Commission;

- v) due consideration of health and public health issues as a major prerequisite for the functioning of internal markets and as a necessary part of citizens' Europe and the necessary consequences of this in Community allocation of resources;
- vi) the importance of ensuring that the capacity and practice of national health and social policies are not inadvertently affected by internal market regulation and lack of political space at the Community level;
- vii) of the role of the European policies in moulding national policies, requiring that this should be reflected towards "best practice" from the health policy point of view in public policies. There is also the need to collect information on and comparisons of potential "best practice" in health and health policies at national and regional levels.

8.2.3 Starting a process of assessment of health implications in other policies:

- i) as an explicit plan of action;
- ii) in setting structures at place to ensure due consideration;
- iii) piloting potential of a combination of HIA practices and policy reviews using European expertise and teams for the assessment procedure and opening a debate for the basis of further action (see in detail: 5.1.);
- iv) considering the assessment procedure as part of the process of integrating health in other policies in providing a basis for the process of discussions and changes within respective Directorates;
- v) recognising that changes in the procedure might be needed as experience grows and adjustments in the process are necessary in order to take into account specificities of different policy areas;
- vi) recognising that health implications need to be assessed in terms of policies and not be limited to specific parts or projects;
- vii) enhancing the issue through requiring assessment in planning of new policies, programmes and, in the context of internationally negotiated agreements, as go/no go procedure.

8.2.4 The expert seminar convened as part of the process drew attention to the need for:

- i) networking, exchange and gathering of knowledge on methods, substance areas (e.g. transport policies, agriculture) and experiences of procedures (EIA and HIA) in practice;
- ii) exchanging resources and dialogue on issues related to health impact assessment methods, case studies and capacity building/training in the area;
- iii) clarity in definitions and terms used in health impact assessment, including what is understood as health impact assessment;
- iv) differences in the approaches required at project and policy level and, in accordance with narrower disease and outcome oriented and broader health and social policy aspects, acknowledging those approaches;

- v) requirements for advocacy in terms of information exchange, funds and training to ensure sufficient capacity in the area as well as improving practices, not only in Community policies but also at national, regional and local levels.

9 Overview

This project has been tracking mechanisms for implementing “Healthy Public Policies” in Europe and ensuring that health is considered in all policies. In this we have reviewed the theoretical background for mechanisms to better integrate health, current knowledge on the mechanisms to be employed, experiences at European, national and local levels, as well as a case study focussing on transport policies.

In seeking to understand better the health implications of all policies, health needs to be seen in a context where driving forces for health or determinants of health are dependent on policy measures and public policies, and not solely a result of freely chosen lifestyles, preventive and promoting health programmes and medical care for those who are sick. Health policies need to be seen as interrelated with other policies. In addition to the determinants of health, also provision of health care for those ill is influenced by public policies and priorities.

Public policies play an important role in citizens’ health in general, with normative and regulatory entitlements to ensure a high level of health protection for all citizens. A well functioning public health and regulatory system can be seen as a necessary prerequisite for functioning of European internal markets. Internal markets are, in practice, as weak as the weakest Member States’ health systems.

At the European level basic legal and constitutional requirements for assessment of health implications of all policies exist in the Treaty of Maastricht with further strengthening in the Treaty of Amsterdam. In principle, political will has been expressed, however in practice, activities towards realising this have been very limited. There is a clear need for more explicit allocation of resources and accountability in the Commission to carry out this task as well as to ensure the openness of the process and the results of the assessments. While several reports on the health implications of policies exist, no systematic review on health implications has taken place. Recent European Court of Justice decisions have also cast more attention on the potential problems in terms of national health policies and how these may be influenced through other European Community policies giving further background to the current process.

Experiences of carrying out environmental impact assessments and integrating the environment into all policies have been mixed. Faster results have been achieved in areas with technical requirements and less action in areas where a more fundamental change in policy aims would be required. Environmental impact assessments have tended to remain as technical requirements for project implementation. At times they have been hard to interpret due to complex modelling. Assessment of impacts on human beings is an approved part of an existing directive. However, in practice assessment of human implications seems to have been implemented only to a limited extent as part of the EIA practice both at national and at European Community levels. There is a very limited amount of education available for HIA even at European level and, in practice, standards of what is understood as a HIA are very varied. In order to ensure capacities for assessment of health implications at Community level, attention should be given to strengthening the national level capacities. In addition, especially policy level research on the issue is needed.

In this report we have wanted to emphasise the importance of the broader context in which mechanisms for assessment of health implications are or are not undertaken. In practice processes dealing with environmental health impact assessments seem to be most advanced at Community level and it may be expected that health impact assessment will be mostly defined in this context. The approach we suggest would combine experiences from several mechanisms in order to accommodate the existing assessment approaches to Community level practice. We have discussed the necessity of starting an action plan at Community level and involving national health administrations of Member States in this process. Linkages with national health administration are required as a means of action with the potential for creating structures to ensure that sufficient links exist within all Member States. The assessment team should carry out the assessment of the health implications of policies, in collaboration with the people responsible for policy areas, and would be accountable to national health administration based European level structure, the European Commission and the European Parliament. Intergovernmental organisations such as the WHO or European non-governmental public health organisations could be used as part of the process as brokers or observers of the process. While this activity is possible with rather limited resources, the quality and continuity of the process would require reallocation of resources and the strengthening of capacities in policy review and dialogue, both at the Community and national levels.

The case study on transport policy investigated how health matters have been taken into consideration in transport policy at the community level. Since the 1970s integration of environmental and health issues has taken place mainly by mandating emission standards but the effects on air quality have been limited because transport activity has increased at the same time and the new standards have usually related only to new vehicles. Despite the transport safety programmes big differences in the numbers of traffic accident casualties still exist between the Member States. In the 1990s the need for a more comprehensive approach has been recognised and the Commission's policy documents include strategies for more integrated approaches. However, the policies are still subordinate to the economic growth and the aim of facilitating the mobility of goods and people. Mechanisms such as EIAs and internalising external costs are developed.

In transport policies one means to support better integration of health considerations could be producing information on more wider scope about connections of transport and health, such as health effects of sedentary life style supported by use of motorised transport even for very short trips, and make it available at the community level as well as in the Member States. This would not only improve mechanisms such as internalising external costs or EIAs but also strengthen political will for development of less environmentally harmful and from health perspective better transport policy.

In conclusion, an improvement in the mechanisms for a better integration of health in all policies is possible and necessary if more than fragmented change is desired. However, sufficient political will, resourcing and administrative structures for starting need to be guaranteed. Formal mechanisms for accountability and openness both in relation to Member States and the European Council as well as in relation to the European Parliament would strengthen the process. Due consideration should be given to strengthening health considerations in the process of environmental impact assessments as one part of the task with integration and policy assessment at the Community level as another part of the same process. In order to ensure that requirements for a high level of health protection have

been taken into account as part of the European Commission's work as whole, health implications assessment requirement should be set so as to provide a veto on all new policies, new international treaties and directives.

10 Literature

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10.2 Background literature

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Programme of the meeting

HEALTHY PUBLIC POLICIES IN THE EUROPEAN COMMUNITY 11-13 February 1999 Helsinki, Finland

PROGRAMME

Thursday 11 February 1999

Arrivals and Checking in Hotel. Get-together at the Botanical Garden of Helsinki University, Palm House.

Friday 12 February 1999

Morning Session: Mechanisms for Integrating Health

- 9.00am Opening of the seminar by Jarkko Eskola, Ministry of Social Affairs and Health, Finland
- 9.20 Introduction by Meri Koivusalo, STAKES, Finland
How to Integrate Health in Other Policies?
- 10.00 Invited comments by
Alex Scott-Samuel, EQUAL, University of Liverpool UK
Rainer Fehr, Institute of Public Health, Germany
Kim Putters, Erasmus University, Rotterdam NL
- 10.45 Coffee
- 11.00 Discussion: additions, criticism and commentaries
- 12.30 Lunch

Afternoon Session: State of National Health Policies and Intersectoral Action.

- 14.00 Introduction by Anna Ritsatakis, WHO/EURO, Denmark
State of Health Policies Assessments and Intersectoral Action at National and Regional level.
- 14.40 Experiences at country level, invited comments by:
Concha Colomer, Instituto Valenciano de Estudios, Spain
Karin Berensson, Federation of Swedish County Council, Sweden
- 15.30 Coffee
- 16.00 Concluding session on methods, country level capacities, approaches and ways further.

Saturday 13 February 1999

Morning Session: Integrating Health in other Community Policies

- 9.00 Introduction by Michael Hübel, CEC/DGV
The Current Practice, problems and possibilities for integrating Health in other Community Policies.
- 9.40 Invited comments by
Michael Joffe, Imperial College, London UK
Jason Nickless, Catholic University of Leuven, Belgium
Tapani Piha, Permanent Representation of Finland, Brussels Belgium
- 10.30 Coffee
- 11.00 Discussion: additions, criticism and commentaries.
- 12.30 Lunch

Afternoon Session: What can be learnt from transport policies

- 14.00 Introduction by Päivi Santalahti, STAKES, Finland
Integration of Health and Environment in Transport Policies.
- 14.40 Invited inputs by
Carlos Dora, WHO/EURO, Italy
Tony Fletcher, London School of Hygiene and Tropical Medicine, UK
- 15.15 Coffee
- 15.30 Discussion and debate on potential and possibilities and ways further.
Closing of the seminar by Meri Koivusalo.

Departure for some participants.

Dinner in downtown Helsinki for those departing on Sunday.