eu2006.fi

Health in All Policies

Prospects and potentials

Edited by
Timo Ståhl, Matthias Wismar, Eeva Ollila,
Eero Lahtinen & Kimmo Leppo

MINISTRY OF
SOCIAL AFFAIRS AND HEALTH
Finland

European
Observatory
on Health Systems and Policies

Health in All Policies

Prospects and potentials

This volume was produced as a part of a project entitled “Europe for Health and Wealth”, which was supported by funding from the European Union Public Health Programme.

It was published by the Finnish Ministry of Social Affairs and Health, under the auspices of the European Observatory on Health Systems and Policies.

The European Observatory on Health Systems and Policies is a partnership between the World Health Organization Regional Office for Europe, the Governments of Belgium, Finland, Greece, Norway, Slovenia, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, CRP-Santé Luxembourg the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

The advice and help of the members of the advisory editorial board have been indispensable. They have not only given general directions for the book, but many of them also made comments on individual chapters. Two anonymous external reviewers reviewed the chapters. The editors want to thank the external reviewers for their significant contribution to the publication. Their advice and constructive criticism was instrumental in achieving the final form and content of this book.

Editorial board:
Dr Jarkko Eskola (former Director-General at the Ministry of Social Affairs and Health, Finland)
Dr Josep Figueras (Director, European Observatory on Health Systems and Policies, and Head of the WHO European Centre on Health Policy, Brussels, Belgium)
Dr Maarike Harro (Director-General, National Institute for Health Development, Estonia)
Dr Anna Hedin (Desk Officer, Ministry of Health and Social Affairs, Stockholm, Sweden)
Dr Meri Koivusalo (Senior Researcher, STAKES, Finland)
Dr Tapani Melkas (Director, Ministry of Social Affairs and Health, Finland)
Dr José Pereira Miguel (High Commissioner for Health, Portugal)
Dr Horst Noack (Professor, Medizinische Universität Graz, Austria)
Dr Don Nutbeam (Pro-Vice-Chancellor, University of Sydney, Australia)
Dr Pekka Puska (Director-General, National Public Health Institute, Finland)
Dr Rolf Rosenbrock (Professor, Social Science Research Center Berlin, Germany)
Ms Imogen Sharp (Head, Health Inequalities – UK Presidency of EU, Department of Health, England)

We would also like to thank Mike Meakin for the copy-editing and his involvement in the project management of this book.

Health in All Policies

Prospects and potentials

Edited by

Timo Ståhl PhD
Senior Researcher, STAKES, Helsinki, Finland

Matthias Wismar PhD
Health Policy Analyst, European Observatory on Health Systems and Policies

Eeva Ollila MD, DMedSci
Senior Researcher, STAKES, Helsinki, Finland

Eero Lahtinen MD, PhD
Ministerial Adviser, Ministry of Social Affairs and Health, Helsinki, Finland

Kimmo Leppo MD, PhD
Director-General, Ministry of Social Affairs and Health, Helsinki, Finland

© Ministry of Social Affairs and Health, 2006

All rights reserved. Please address requests for permission to reproduce or translate this publication to:

Ministry of Social Affairs and Health
Health Department
Finland
kirjaamo.stm@stm.fi

The views expressed by authors or editors do not necessarily represent the decisions or the stated policies of the Finnish Ministry of Social Affairs and Health, the European Commission, or the European Observatory on Health Systems and Policies or any of its partners.

ISBN 952-00-1964-2

Printed and bound in Finland

Further copies of this publication are available from:

asiakaspalvelu@stakes.fi

Contents

List of figures

List of tables

Contributors

For those contributors based at STAKES (The National Research and Development Centre for Welfare and Health), the address is P.O. Box 220, Helsinki, FIN-00531, Finland.

Franz Baro Professor of Psychiatry, Collaborating Centre on Health and Psychosocial and Psychobiological Factors, Rue de l'Autonomie 4, 1070 Brussels, Belgium

Julia Blau MSc, Research Officer, European Observatory on Health Systems and Policies, WHO European Centre for Health Policy, Rue de l'Autonomie 4, 1070 Brussels, Belgium

Mojca Gabrijelčič Blenkuš MD, Specialist in Public Health, Head of the Department for Health Promotion, Institute of Public Health of the Republic of Slovenia, Trubarjeva 2, 1000 Ljubljana, Slovenia

Konrade von Bremen MD, MHEM, Senior Researcher, Institute of Health Economics and Management, University of Lausanne, César Roux 19, 1005 Lausanne, Switzerland

Liselotte Schäfer Elinder PhD, Director, Associate Professor, Department of Health Behaviour, Swedish National Institute of Public Health, S-103 52 Stockholm, Sweden

Eva Elliott, Senior Research Fellow, The Cardiff Institute of Society, Health and Ethics, 53 Park Place, Cardiff CF23 3AT, UK

Kelly Ernst MPH, Research Officer, European Observatory on Health Systems and Policies, WHO European Centre for Health Policy, Rue de l'Autonomie 4, 1070 Brussels, Belgium

Rainer Fehr MPH, PhD, LÖGD (Landesinstitut für den Öffentlichen Gesundheitsdienst NRW), Institute of Public Health, North Rhine-Westphalia, Westerfeldstrasse 35–37, D-33613 Bielefeld, Germany

Alison Golby PhD, Research Associate, The Cardiff Institute of Society, Health and Ethics, 53 Park Place, Cardiff CF23 3AT, UK

Gabriel Gulis PhD, Associate Professor, Unit of Health, University of Southern Denmark, Niels Bohrsvej 9–10, 6700 Esbjerg, Denmark

Riitta-Maija Hämäläinen PhD, Researcher, Finnish Institute of Occupational Health, Topeliuksenkatu 41a A, FIN-00250 Helsinki, Finland

Loes van Herten PhD, Team Manager, TNO Quality of Life, P.O. Box 2215, CE 2301 Leiden, The Netherlands

Jorma Järvisalo DMedSci, Research Professor, Health Policy and International Development, Social Insurance Institution, Peltolantie 3, FIN-20720 Turku, Finland

Pekka Jousilahti MD, PhD, Research Professor, National Public Health Institute, Department of Epidemiology and Health Promotion, Mannerheimintie 166, FIN-00300, Helsinki, Finland, and School of Public Health, Tampere, Finland

Thomas Karlsson MSc, Researcher, Alcohol and Drug Research, STAKES

Tapani Kauppinen MSc, Project Manager, STAKES

John Kemm, Director, The West Midlands Public Health Observatory, Birmingham Research Park, Vincent Drive, Birmingham B15 2SQ, UK

Meri Koivusalo MD, DMedSci, Senior Researcher, STAKES

Eero Lahtinen MD, PhD, Ministerial Adviser, Ministry of Social Affairs and Health, P.O. Box 33, FIN-00023 Government, Helsinki, Finland

Teresa Lavin MPH, Public Health Development Officer, The Institute of Public Health in Ireland, 5th Floor, Bishop's Square, Redmond's Hill, Dublin 2, Ireland

Kimmo Leppo, Director-General, Ministry of Social Affairs and Health, P.O. Box 33, FIN-00023 Government, Helsinki, Finland

Kari Lindström, Director, Centre of Expertise, Finnish Institute of Occupational Health, Topeliuksenkatu 41a A, FIN-00250 Helsinki, Finland

Karen Lock MD, Clinical Research Fellow, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK

Pia Mäkelä PhD, Senior Researcher, Alcohol and Drug Research, STAKES

Marco Martuzzi PhD, Scientific Officer, World Health Organization, European Centre for Environment and Health, Via F. Crispi 10, 00187 Rome, Italy

Odile Mekel MPH, LÖGD (Landesinstitut für den Öffentlichen Gesundheitsdienst NRW), Institute of Public Health, North Rhine-Westphalia, Westerfeldstrasse 35–37, D-33613 Bielefeld, Germany

Tapani Melkas, Director, Ministry of Social Affairs and Health, P.O. Box 33, FIN-00023 Government, Helsinki, Finland

Kirsi Nelimarkka MSc, Researcher, STAKES

Eeva Ollila MD, DMedSci, Senior Researcher, STAKES

Esa Österberg MSc, Senior Researcher, Alcohol and Drug Research, STAKES

Kerttu Perttilä PhD, Development Manager, STAKES

Anna Ritsatakis PhD, 14 Tsangaris Street, Melissia 151 27, Greece

Nina Scagnetti, Institute of Public Health of the Republic of Slovenia, Trubarjeva 2, 1000 Ljubljana, Slovenia

Marita Sihto DSocSci, Senior Researcher, STAKES

Martin Sprenger MPH, Medical University of Graz, Schubertstrasse 22/6, 8010 Graz, Austria

Timo Ståhl PhD, Senior Researcher, STAKES

Ingrid Stegeman, Project Officer, EuroHealthNet, Rue Philippe le Bon 12, 1000 Brussels, Belgium

Marius Strička, Researcher, Kaunas University of Medicine, A. Mickevičiaus g. 9, 50009 Kaunas, Lithuania

Christoffer Tigerstedt PhD, Senior Researcher, Alcohol and Drug Research, STAKES

Ismo Tuominen LLM, Ministerial Adviser, Ministry of Social Affairs and Health, P.O. Box 33, FIN-00023 Government, Finland

Rudolf Welteke MD, LÖGD (Landesinstitut für den Öffentlichen Gesundheitsdienst NRW), Institute of Public Health, North Rhine-Westphalia, Westerfeldstrasse 35–37, D-33613 Bielefeld, Germany

Gareth Williams, Professor, School of Social Sciences, Glamorgan Building, King Edward IV Avenue, Cardiff University, Cardiff CF10 3WT, UK

Matthias Wismar PhD, Health Policy Analyst, European Observatory on Health Systems and Policies, WHO European Centre for Health Policy, Rue de l'Autonomie 4, 1070 Brussels, Belgium

Foreword

Ensuring a high level of human health protection in all Community activities is a central part of our responsibilities. This has been a constant theme throughout the development of the Community. Even before the specific public health article was introduced, health was integrated into other areas of policy such as agriculture and free movement, and the Single European Act stipulated that a high level of health protection should be taken as a basis for completing the internal market.

A great deal has therefore been achieved towards the aim of Health in All Policies (HiAP). Within the Commission we have established coordination mechanisms to ensure that the health dimension is integrated into activities of all Commission services. We have also developed detailed methodologies for health impact assessment (HIA), in particular through projects under the public health programme. Together with work on impact assessment in other specific areas such as the environment, these methodologies have laid the foundations for the integrated approach to HIA now used throughout the Commission. More can still be done; for example, we are working with Member States to develop a specific methodology for assessing the impact of proposals on health systems. Nevertheless, the Commission's integrated approach to HIA is an important achievement, bringing together consideration of the full range of potential economic, environmental and social impacts in a single mechanism.

Beyond these technical developments there is also growing recognition of the importance of health for the overall objectives of the Community. Health is a key foundation stone of the overall Lisbon strategy of growth, competitiveness and sustainable development. A healthy economy depends on a healthy population.

Without this, employers lose worker productivity and citizens are deprived of potential length and quality of life. This is doubly important as the European population ages in the coming decades. The impact of this demographic ageing will crucially depend on our ability to keep our citizens healthy and active throughout their longer lives. We are adding years to life, but we must also add healthy life to years.

A wide range of policies can help to influence this, ranging from employment and social protection strategies to the food we eat and how much we walk rather than drive. European policies and rules shape many of these areas, and this underlines how vital it is to ensure the integration of health protection into all policies and actions.

This is not just work for the Commission. After all, although we produce the proposals for Community action and the HIA that accompanies them, it is then up to the Parliament and Council to decide on them. Ensuring the integration of health protection into Community policies therefore also depends on the members of the European Parliament and the Member States in the Council.

Moreover, even if all best efforts are taken to integrate the health dimension into Community measures, health is a complex topic, and it is simply not always possible to anticipate all the impacts of new measures. Initial HIAs must therefore be accompanied by constant monitoring and evaluation in practice. At European level, we already have the important overall key indicator of Healthy Life-Years. But more research and statistical work is needed to develop more detailed indicators for particular areas and outcomes to ensure that the integration of health into all policies is not simply a one-off exercise, but a constant activity guiding our actions for the future.

I welcome this publication as part of the Finnish presidency and hope it will lead to greater awareness of the importance of HiAP and to future progress.

Robert Madelin
Director-General
Health and Consumer Protection
European Commission
Brussels

June 2006

Preface

Health in All Policies (HiAP) – the main health theme of the Finnish European Union (EU) Presidency in 2006 – is a natural continuation of Finland's long-term horizontal health policy. While the health sector has gradually increased its cooperation with other government sectors, industry and nongovernmental organizations in the past four decades, other sectors have increasingly taken health and the well-being of citizens into account in their policies. The key factor enabling such a development has been that health and well-being are shared values across the societal sectors.

The Finnish population is now healthier than ever, the health of the elderly is constantly improving, the increased years of life are predominantly healthy years, and we have also been able to prevent major diseases. These outcomes are not only based on advancing preventive and curative health care services, but, in particular, on the creation of and support for healthy living conditions and ways of life. In concrete terms, this has meant increasing the opportunities for healthy choices, not only health education.

Our contribution to the EU public health policy can also be considered as quite consistent. In 1999, during the first Finnish EU Presidency, a Council resolution was adopted "on ensuring health protection in all Community policies and activities" on Finland's proposal. Now, seven years later, it is very encouraging to see how the EU public health discourse has changed towards what was suggested and how some of the activities anticipated have been implemented – most importantly, the impact assessments of the Commission's initiatives. Even more positive, however, is to notice that our understanding of the matter itself has improved.

Despite its solid background in science, HiAP is a politically challenging strategy that requires deliberate efforts to be promoted. This is why we persistently want to draw attention to it. Determinants of health, their surveillance and related methodological issues are demanding questions that most naturally, practically and effectively are developed in a European collaboration, not by any single Member State acting alone. The EU Public Health Programme project, of which this book is one of the outputs, is an excellent example of worthwhile and productive collaboration between Member States, strongly supported by the EU Commission and the European Regional Office of the World Health Organization.

Major diseases – both "old" and emerging – are challenges to public health. A systematic response is considerably facilitated by the fact that the risk factors are mainly the same. Instead of seeing major diseases as a challenge to the health sector only, HiAP highlights the fact that the risk factors of major diseases, or the determinants of health, are modified by measures that are often managed by other government sectors as well as by other actors in society. Broader societal health determinants – above all, education, employment and the environment – influence the distribution of risk factors among population groups, thereby resulting in health inequalities. Focusing on HiAP may shift the emphasis slightly from individual lifestyles and single diseases to societal factors and actions that shape our everyday living environments. It does not, however, imply that any other public health approaches, for example health education or disease prevention are undermined or treated as less important.

Effective and systematic action for the improvement of population health, using genuinely *all* available measures in *all* policy fields, is an opening for a new phase of public health. As the EU has the unique mandate to act for health across all policy sectors and as we in Europe have all the other necessary means, I would like to see Europe as the world leader in such a modern approach. Whether Europe will achieve this position depends on all of us.

Dr Liisa Hyssälä
Minister of Health and Social Services
Helsinki
Finland

July 2006

Introduction

Matthias Wismar, Eero Lahtinen, Timo Ståhl, Eeva Ollila, Kimmo Leppo

The countries of the European Union (EU) have achieved historically unprecedented levels of health and wealth. In recent decades life expectancy has grown substantially. People now live longer and are in better health than 20 years ago. Simultaneously the wealth of the EU countries has grown steadily since 1980. However, wealth and health inequalities between and within countries have largely remained or even grown.

Health and wealth are related. The link is especially strong at lower levels of affluence. It has been shown that better health boosts rates of economic growth,[1] while countries with weak conditions for health have a hard time achieving sustained growth.[2] For high-income countries, gross domestic product and life expectancy correlate less strongly at national levels. However, for high-income countries, it has been demonstrated that good health contributes positively to the economy while poor health can have substantial negative effects. It is noteworthy that greater socioeconomic inequality in society is associated with poorer average health.[3–5]

Health and well-being are undoubtedly major societal objectives in their own right, and these objectives are not limited to the contribution of health to the economy. In the EU health systems are seen to form a central part of social protection, as well as providing an important contribution to social cohesion and social justice. In the development of their health policies the European countries share the values of universality, access to good care, equity and solidarity.[6] The same values have also been guiding the development of the Health for All Policy of the World Health Organization (WHO). Recently, the Member States of the European Region of WHO endorsed an update of the

European Health for All policy, which places health in the framework of human rights, stressing the common European values of equity, solidarity and participation.[7]

Because of the solid evidence that health can be influenced by policies of other sectors, and that health has, in turn, important effects on the realization of the goals of other sectors, such as economic wealth, this book proposes Health in All Policies (HiAP) as a strategy to help strengthen this link between health and other policies. Health in All Policies addresses the effects on health across all policies such as agriculture, education, the environment, fiscal policies, housing, and transport. It seeks to improve health and at the same time contribute to the well-being and the wealth of the nations through structures, mechanisms and actions planned and managed mainly by sectors other than health. Thus HiAP is not confined to the health sector and to the public health community, but is a complementary strategy with a high potential towards improving a population's health, with health determinants as the bridge between policies and health outcomes. Regarding the overall contribution of health both to the social capital and to the economy, it is hoped that *Health in All Policies: Prospects and potentials* will attract readers from across all societal sectors.

For Europe, it is vital to further strengthen the link between health and other policies. It cannot be taken for granted that the positive developments of the past will last into the future. Through the looming obesity crisis,[8] the expected rise in chronic diseases and the cognitive decline associated with ageing, European societies provide examples of the challenges lying before us.

In parallel, concerns regarding the prospects of European economies have been growing in recent years. The European Council has addressed these concerns by agreeing on new strategic goals for the EU to strengthen employment, economic reform and social cohesion as a part of a knowledge-based economy. This strategy, endorsed by the Council in 2000 and better known as the Lisbon Agenda, addresses some of Europe's economic weaknesses. Among them are the low employment rate characterized by insufficient participation in the labour market by women and older workers, and long-term structural unemployment and marked regional unemployment imbalances that remain endemic in parts of the EU. The Lisbon Agenda is seen as a response to the challenges posed by globalization and the need for European economies to maintain a competitive edge in a rapidly changing globalized world.[9]

The Lisbon Agenda refers to the need to modernize the European social model, social protection and promoting social inclusion. The essential role of health, however, is not reflected properly in reality although health plays an important role in addressing the challenges highlighted by the Lisbon Agenda,

and this role is even more important regarding demographic development in Europe. The proportion of the population beyond retirement age is growing, so creating a further downturn in the employment rate. The remaining workforce is ageing, and the proportion of older workers is increasing, putting even more emphasis on appropriate and effective strategies to integrate older workers into the labour market. Declining populations and dwindling labour market participation could result in shrinking economies unless there are gains in productivity and income. Again, this could put pressure on the European social model in terms of financial sustainability, undermining social cohesion.

This book is linked to the Lisbon Agenda by assuming that better health and well-being can contribute to a rise in productivity and add productive life-years. Healthier populations will have more years of healthy life expectancy and a reduced number of years suffering from chronic diseases. Improving a population's health will reduce the foregone national income from sickness. In this regard, better health is one way of addressing the economic challenges of Europe. It may help to support the financial sustainability of the European social model and it may help to strengthen social cohesion. To this end, the contributions in this book are exploring the prospects and potential of HiAP to improve population health.

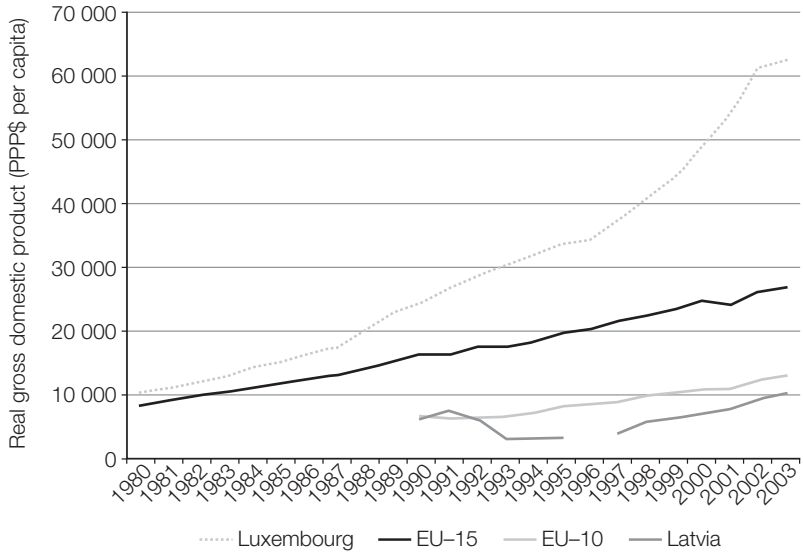
The wealth and health of Europe have been growing

The wealth of the nations, measured in GDP purchasing power parities per capita, (GDP PPP$ per capita) has grown steadily since 1980 for the EU-15 countries. A similar trend is observable for the ten Member States that joined the EU in 2004.

Both the EU-15 and EU-10 averages show a considerable growth in life expectancy since 1980. Some countries, such as Sweden, have already reached a level above 80 years of age.

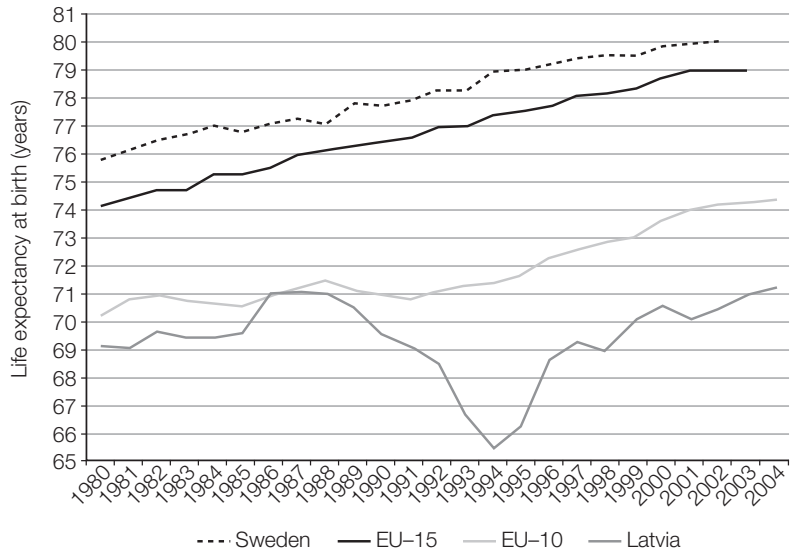
Despite these positive trends, inequalities between countries in health and wealth have remained. The gap in the wealth of the nations between the EU-15 and the EU-10 countries has been growing, and the gap between the richest country and the poorest, as depicted in Figure I.1, is enormous. The gap in life expectancy at birth between the EU-15 and the EU-10 countries has also grown as shown in Figure I.2. The difference between Sweden and Latvia, the countries with the highest and the lowest life expectancies at birth, was 9.5 years in 2002.

There are also substantial inequalities in health within countries. Mackenbach (2005) has summarized the available evidence in regard to mortality:[10]



Note: EU-15: EU Member States prior to May 2004; EU-10: new Member States joining the EU in May 2004.

Figure I.1 *Europe's growing wealth. Adapted with permission from European Health for All database (HFA-DB) [online database]. Copenhagen, World Health Organization Regional Office for Europe, 2006.*



Note: EU-15: EU Member States prior to May 2004; EU-10: new Member States joining the EU in May 2004.

Figure I.2 *Europe's increased health. Adapted with permission from European Health for All database (HFA-DB) [online database]. Copenhagen, World Health Organization Regional Office for Europe, 2006.*

- In all countries with available data, rates of premature mortality are higher among those with lower levels of education, occupational class or income.
- Inequalities in mortality exist from the youngest to the oldest and in both genders, but tend to be smaller among women than men.
- Inequalities in mortality can also be found for many specific causes of death including cardiovascular disease, many cancers and injury.
- These inequalities in mortality lead to substantial inequalities in life expectancy at birth (4–6 years among men; 2–4 years among women).

These inequities between and within countries, regarding both the wealth and health of the nations, should be tackled as part of the Lisbon Agenda. Without serious effort there is little hope that these inequities in health and well-being between and within countries will diminish over time.

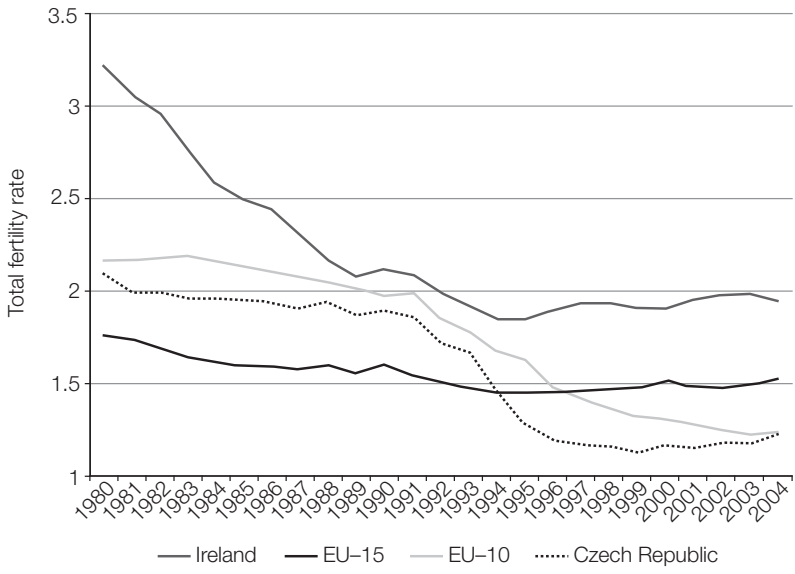
Demographic development challenges Europe

Europe's population is ageing and simultaneously shrinking. The ageing is a result of the historical decline in the fertility rate below the replacement level and the growth in life expectancy.

Since 1980, the total fertility rate has declined in all EU countries, to below the replacement level. On average, the EU-15 countries already had a low fertility rate in 1980 and the decline since then has been rather moderate. However, as the trend for Ireland shows, it was the EU-15 country with the highest total fertility rate in 1980, and some Member States have experienced a substantial drop. For the EU-10 countries the fertility rate has plummeted.

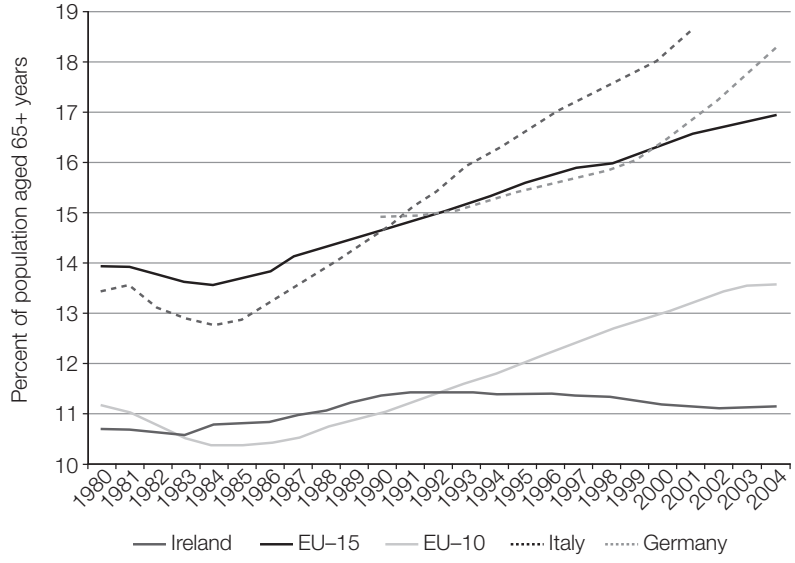
The averages for the EU-15 and EU-10 countries show a steady increase in the percentage of the population aged 65 or older since the mid 1980s. However, there are marked differences between the countries. The Finnish, Italian and German populations have aged more rapidly than the EU-15 average, while for Ireland the percentage of the population aged 65 or older has remained fairly stable over the last two decades.

As a consequence of low fertility, population projections assume that Europe's population will be shrinking. According to the world population monitoring of the United Nations, the population of Europe (including the Russian Federation) is predicted to fall by almost 6% from 728.0 million in 2000 to 685.4 million in 2030. In view of the population growth in other regions of the world, Europe's share of the world population is declining.[11] In fact, the new Member States, with the exception of Cyprus and Malta, all had decreasing populations.[12]



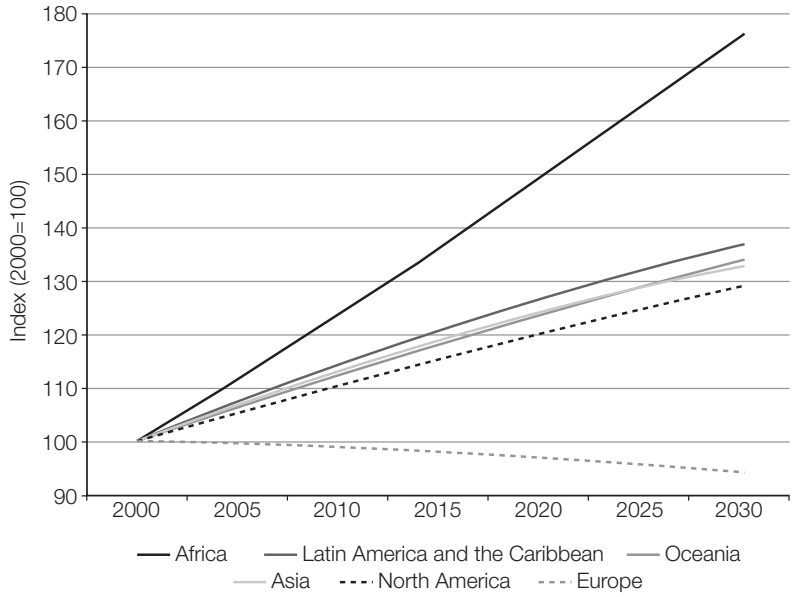
Note: EU-15: EU Member States prior to May 2004; EU-10: new Member States joining the EU in May 2004.

Figure I.3 *Europe's declining fertility rate. Adapted with permission from European Health for All database (HFA-DB) [online database]. Copenhagen, World Health Organization Regional Office for Europe, 2006.*



Note: EU-15: EU Member States prior to May 2004; EU-10: new Member States joining the EU in May 2004.

Figure I.4 *Europe's ageing population. Adapted with permission from European Health for All database (HFA-DB) [online database]. Copenhagen, World Health Organization Regional Office for Europe, 2006.*



Note: EU-15: EU Member States prior to May 2004; EU-10: new Member States joining the EU in May 2004.

Figure I.5 *Europe's population is shrinking. Adapted with permission from 13.*

Declining labour market participation: shrinking economies?

If demographic trends continue into the future as they are now and no effective countermeasures are taken, labour market participation will dwindle. This can be illustrated by the projected growth of the dependency ratio. The dependency ratio (expressed as a percentage) calculates the part of the population aged 0 to 14 years and over 65 as compared to the population aged between 15 and 64. It therefore expresses the part of the population that is typically not in employment. Projections for the EU state that the demographic dependency ratio will rise from 49% in 2005 to 66% in 2030.[12] Undoubtedly, this will result in a decline in labour market participation. As the population of Europe is unlikely to grow, this will, for most countries, result in a decline in absolute numbers of people in the labour market.

It must be pointed out, however, that the existence of a healthy "grey population" can also have positive impacts on national economies, both through increased consumption of services and through other non-fiscal resources through which the elderly can contribute to society. And the elderly are taxpayers too. In this light, the dependency ratio predictions can only give a limited vision of the future and their significance should not be overemphasized.

Is there additional pressure on health care systems?

A larger number of elderly people may result in more people with chronic diseases. Chronic diseases such as cardiovascular conditions, mental illness, obesity, diabetes, tobacco and alcohol-related conditions already constitute a considerable burden on the economy.[13] Projections for the year 2015 suggest that forgone national income due to heart disease, stroke and diabetes will increase.[14]

The ageing of the population is also reflected in the workforce and poses challenges for human resources for health care systems. There are more "older workers" aged 55 to 64 and this proportion will steadily grow.[12] Countries such as Denmark, Iceland, Norway, Sweden, France and Finland are witnessing a greying of the nursing workforce.[15, 16] The difficulties in maintaining the nursing workforce and the expected rising demand may result in an increased cross-border mobility of health professionals with a shift from low-income to high-income countries.[17] This may result in serious staffing problems in some countries and affect service delivery.

Solidarity for health care finance may come under additional pressure too. Current patterns for distributing the financial burden of health and health care between the healthy and the sick, the better off and the poor, the young and the old, the employed and the unemployed may be challenged. As an effect, the universal availability and accessibility of services may be affected. And this will certainly result in a further increase in inequities within countries.

How health can contribute to meeting these challenges

The two preceding headings were formulated as questions, indicating that these are possible and plausible consequences of demographic developments. However, there are strategies that may counterbalance these consequences; one of these strategies is HiAP.

Alternative policy options can be formulated in terms of a virtuous and vicious cycle. Investing in health and maintaining and raising the health status of European populations will contribute not only to increased well-being but also to economic stability and growth. This, in turn, may strengthen the financial sustainability of health care systems. In effect, a productive investment in health is the chance to embark on a virtuous cycle.[18] However, the danger is to enter into a vicious cycle by which a decline in economic performance and health status put double pressure on health care systems and health, steadily reinforcing each other.

The virtuous cycle is not just an illustrative concept; it can be based on evidence. The work of the Commission on Macroeconomics and Health,

based on empirical evidence from low- and middle-income countries, made a strong case for investing in health.[2] This work has recently been complemented by a report on the contribution of health to the economy in the EU. The report, commissioned by the European Commission, states that:[13]

> there is a sound theoretical and empirical basis to the argument that human capital contributes to economic growth. Since human capital matters for economic outcomes and since health is an important component of human capital, health matters for economic outcomes. At the same time, economic outcomes also matter for health. A recurring theme throughout this book is the existence of feedback loops offering the scope for mutually reinforcing improvements in health and wealth.

The report has identified various channels for high-income countries through which health can contribute to the economy. Two of them are essential in the context of this book. First, a healthier workforce is a more productive workforce. Productivity could increase due to enhanced physical and mental activity. More physically and mentally active individuals could make more efficient use of technology, machinery or equipment. Second, good health can result in a higher labour supply. Good health may reduce the number of sick days an individual takes. It may also allow workers to postpone retirement age and extend the number of economically productive life-years in the labour markets.[13]

Health is not the only precondition for enhancing productivity and expanding labour market participation. Especially in regard to older workers, there are many factors that affect employability.[19] However, health is an important prerequisite for extending the number of economically productive life-years. There is plenty of scope for expanding labour market participation for men, and especially for women. In most EU countries, workers retire well before their official retirement ages. The average exit age from the workforce across the EU-25 countries in 2004 was 60.7 years. The average, however, covers large variations between countries and sexes. Poland and Slovakia are the countries in the EU where women leave the workforce earliest at 55.8 and 57 years, respectively. The countries with the earliest exit age for men are France at 58.4 years and Belgium at 59.1 years.*

But is it really possible to extend the number of healthy life-years or will the expansion of life expectancy go hand in hand with a growing number of years in ill health? In epidemiology this issue has been addressed by the compression

* Data from EUROSTAT http://epp.eurostat.ec.europa.eu/portal/page?_pageid=1996,39140985&_dad=portal&_schema=PORTAL&screen=detailref&language=en&product=sdi_as&root=sdi_as/sdi_as/sdi_as_pub/sdi_as1330, accessed 1 July 2006.

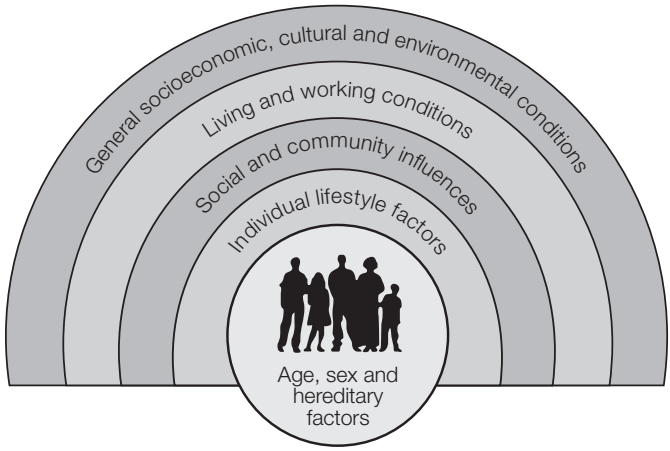


Figure I.6 *The determinants of health.*

of morbidity hypothesis. This states that most illness is chronic and occurs in later life. It postulates that the lifetime burden of illness could be reduced if the onset of chronic illness could be postponed and if this postponement could be greater than increases in life expectancy.[20] Evidence from the United States, Australia, Canada, France and Japan suggests that increased life expectancy has not been accompanied by an increase in the time spent with severe handicap or severe disability in these countries.[20, 21] Improvement in the functional capacity of the population has also been reported in Sweden and Finland.[22, 23] However, contradictory results have also been obtained.[24]

Health in All Policies: strengthening the link between health and other policies

Policies shape the conditions in which we live and work and these conditions may have positive or negative consequences for the health of a given population and individuals. Factors that are found to have the most significant influence on health are called determinants of health. Figure I.6 provides a model of the determinants of health, as conceptualized by Dahlgren and Whitehead (1991).[25] The model distinguishes between five categories of determinants. Some of the determinants are amenable to change while others are not. There are also important interrelationships between the different determinants. Living and working conditions, or social and community influences, may have effects on individual lifestyle factors such as drinking habits, smoking and physical activity.

Health in All Policies is an encompassing approach which goes beyond the boundaries of the health sector. It addresses all policies such as transport, housing, the environment, education, fiscal policies, tax policies and economic policies. It is based on values and principles similar to those in the WHO's call for multisectoral action for health,[26] and the concept of building healthy public policies,[27] or the whole government approach.[28]

Policies, determinants and the population's health are conceptualized as a chain of causation. Health in All Policies starts at the source of this chain and it may help to make policies more consistent overall and therefore contribute to better regulation. A policy with negative consequences for the health of the populations will put an extra burden on the economy and health care systems. Compensating the negative health effects of a policy by health care interventions may turn out to be difficult and costly.

The European Union has a unique mandate for Health in All Policies

Policy-making in European countries occurs in the framework of a multilevel system. Many national policies are co-determined by European policies. Therefore Health in All Policies will often require changes in the policies on various levels.

There is a strong legal basis for HiAP at European level. The Treaty Establishing the European Community (TEC) provides a strong mandate for the European institutions to support HiAP actively. In its current version, Article 152 on Public Health states "[a] high level of human health protection shall be ensured in the definition and implementation of all community policies and activities." Undoubtedly, on the grounds of the TEC, much has been achieved over recent years. But as several chapters in this book show, there is still a long way to go, and it is a winding road towards better integrating HiAP.

Countries may also benefit from experiences of HiAP across Europe. What has worked in one country may contribute to the implementation of appropriate measures in others.

The structure of this book

This book is divided into five parts. Part 1 – "Health in All Policies: the wider context" – summarizes the theories, concepts and challenges in regard to HiAP and puts HiAP in the European context.

Part 2 – "Sectoral experiences" – introduces concrete examples of how HiAP has been implemented in the fields of heart health promotion, working life, food and agriculture, alcohol policy and the environment.

Part 3 – "Governance" – focuses, in a more concrete way, on the implementation of HiAP and starts with reviewing present mechanisms and challenges of horizontal healthy public policy. The other chapter, based on Finnish experiences, introduces a means of getting other sectors involved with and committed to intersectoral cooperation through the preparation of the national health reports.

Part 4 – "Health impact assessment" – is devoted to health impact assessment (HIA). It considers HIA as a means of realizing the principles of HiAP. The section starts with a more theoretical chapter focusing on the rationale and theory of HIA. The next two chapters present results from a Europe-wide study of the use of HIA. A case study on the role of HIA in implementing a welfare strategy at local level closes the section.

Part 5 – "Conclusions and the way forward" – provides a summary and conclusion, and proposals for the future implementation of HiAP in the EU and Member States.

A note on terminology

In this book we have, in general, used the term European Union (EU) when referring to the EU/EC level policies, but European Community or Communities (EC) when referring to specific EC regulations. However, in everyday use the two terms are used interchangeably. In this book we have been faithful to the original texts and their use of the terms.

REFERENCES

1. Bloom D, Conning D, Jamison D. Health, wealth and welfare. *Finance and Development*, 2004, 41(1):10–15.
2. Commission on Macroeconomics and Health. *Macroeconomics and health: investing in health for economic development. Report of the Commission on Macroeconomics and Health*. Geneva, World Health Organization, 2001.
3. Marmot M, Wilkinson R. Psychosocial and material pathways in the relation between income and health: a response to Lynch *et al*. *British Medical Journal*, 2001, 322:1233–1236.
4. Wilkinson R, Pickett K. Income inequality and population health: a review and explanation of evidence. *Social Science and Medicine*, 2006, 62:1768–1784.
5. Wilkinson R. *Unhealthy societies: the affliction of inequality*. London, Routledge, 1996.

6. Council conclusions on common values and principles in European Union health systems (2006/C 146/01). *Official Journal of the European Union*, 22 June 2006.

7. World Health Organization Regional Office for Europe. *The Health for All policy framework for the WHO European Region: 2005 update.* Regional Committee for Europe. Fifty-fifth session (http://www.euro.who.int/Document/RC55/edoc08.pdf, accessed 1 Nov. 2005).

8. Green Paper: *Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases*. COM (2005) 637 final. Brussels, European Commission, 2005 (http://ec.europa.eu/health/ph_determinants/life_style/nutrition/documents/nutrition_gp_en.pdf, accessed 22 May 2005).

9. The Council of the European Communities. *Presidency conclusions: Lisbon European Council 23 and 24 March 2000* (http://ue.eu.int/cms3_applications/Applications/newsRoom/loadBook.asp?target=2000&bid=76&lang=1&cmsId=347, accessed 22 May 2005).

10. Mackenbach JP. *Health inequalities: Europe in profile*. London, COI, 2005.

11. *World population to 2030*. New York, United Nations, 2004.

12. Communication from the Commission. Green Paper: *Confronting demographic change: a new solidarity between the generations*. COM (2005) 94 final. Brussels, European Commission, 2005.

13. Suhrcke M et al. *The contribution of health to the economy of the European Union*. Luxembourg, Office for Official Publications of the European Communities, 2005.

14. *Preventing chronic diseases: a vital investment: WHO global report.* Geneva, World Health Organization, 2005.

15. Dubois C-A, McKee M, Nolte E. Analysing trends, opportunities and challenges. In: Dubois C-A, McKee M, Nolte E, eds. *Human resources for health*. Maidenhead, Open University Press, 2006:15–40.

16. Laine M *et al. Työolot ja hyvinvointi sosiaali- ja terveysalalla [Working conditions and well-being in the field of social and health care].* Tampere, Finland, Finnish Institute of Occupational Health, 2006.

17. Buchan J. Migration of health workers in Europe: policy problem or policy solution? In: Dubois C-A, McKee M, Nolte E, eds. *Human resources for health in Europe*. Maidenhead, Open University Press, 2006:41–62.

18. Frenk J. Comprehensive health system analysis for health system reform. *Health Policy*, 1995, 32(1–3):257–277.

19. *Live longer, work longer. Ageing and employment policies*. Paris, Organisation for Economic Co-operation and Development, 2006.

20. Fries FJ. Measuring and monitoring success in compressing morbidity. *Annals of Internal Medicine*, 2003, 139(5):455–459.

21. Robine JM, Romieu I, Cambois E. Health expectancy indicators. *Bulletin of the World Health Organization*, 1999, 77(2):181–185.

22. Ahacic K, Parker MG, Thorslund M. Mobility limitations in the Swedish population from 1968 to 1992: age, gender and social class differences. *Aging*, 2000, 12(3):190–198.

23. Aromaa A, Koskinen S, ed. Health and functional capacity in Finland. Baseline results of the Health 2000 Health Examination Survey. Publications of the National Public Health Institute B12/2004. Helsinki, National Public Health Institute, 2004.

24. Parker MG, Ahacic K, Thorslund M. Health changes among Swedish oldest old: prevalence rates from 1992 and 2002 show increasing health problems. *Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, 2005, 60(10):1351–1355.

25. Dahlgren G, Whitehead M. *Policies and strategies to promote social equity in health*. Stockholm, Institute for Future Studies, 1991.

26. Glossary of terms used in the "Health for All" Series No. 1–8. Geneva, World Health Organization, 1984.

27. *Ottawa Charter for Health Promotion*. First international conference on health promotion. Ottawa, 21 November 1986, WHO/HPR/HEP/95.1 (http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf, accessed 28 July 2006).

28. Bangkok Charter for Health Promotion in a Globalized World. The 6th Global Conference on Health Promotion. Bangkok, August 2005 (http://www.who.int/healthpromotion/conferences/6gchp/hpr_050829_%20BCHP.pdf, accessed 28 July 2006)

Part 1

Health in All Policies: the wider context

Chapter 1

Principles and challenges of Health in All Policies

Marita Sihto, Eeva Ollila, Meri Koivusalo

Introduction

The purpose of this chapter is to clarify and contextualize a Health in All Policies (HiAP) approach for further integration of health aspects into European policy-making at all levels. HiAP is a strategy with a solid background in science which aims at influencing health determinants so as to improve, maintain and protect health. An HiAP approach has its analytical and scientific roots in public health sciences, hygiene and epidemiology. It is especially rooted in the broader policy-level interventions on health problems and the focus on population health. The ultimate aim of HiAP is to improve evidence-based policy-making. As health inequalities are prevailing or even increasing both within and between countries, and as health determinants are unevenly distributed within societies, increasing inequalities in health pose a special challenge for HiAP.

This chapter deals with the fact that health is largely constructed in other sectors beyond the health sector. It concludes that changes in policy-making forums have made it increasingly challenging for those aiming at improved population health to integrate health aspects into policy-making. Other policies have other aims and priorities, and integrating health considerations in other policies requires a solid information base, personnel with appropriate public health training and a good knowledge of the policy-making system and structures, as well as negotiating skills. Implementation remains a challenge for HiAP and five aspects of key relevance in the context of implementation are

discussed. The means and mechanisms for implementing HiAP are discussed in more detail in Chapter 8.

This chapter starts by looking at the scientific background and principles of HiAP, stressing the importance of the public health movement in developing the approaches to it, as well as the importance of structural health determinants in the construction of health. It then continues by describing the complexity of the context of the policy-making environment and the specific policy challenge of globalization. This is followed by describing strategies for HiAP, and the need to reconcile the aims and values of the various policies. We then discuss the challenges in the implementation of HiAP. Finally we deal with the aim of decreasing health inequalities and the fact that while addressing inequalities in health is an intrinsic part of HiAP, it needs special emphases and attention, as addressing health determinants does not automatically also address determinants of health inequalities.

What is a Health in All Policies approach?

HiAP is a horizontal, complementary policy-related strategy with a high potential for contributing to population health. The core of HiAP is to examine determinants of health (see Box 1.1), which can be influenced to improve health but are mainly controlled by policies of sectors other than health.

The HiAP approach is based on the recognition that population health is not merely a product of health sector activities, but to a large extent determined by living conditions and other societal and economic factors, and therefore often best influenced by policies and actions beyond the health sector. In addition to the recognition that HiAP is about population health and health determinants, it also concerns addressing policies in the context of policy-making at all levels of governance, including European, national, regional and local levels of policies and governance. These two aspects of HiAP are of core relevance as they imply that the focus of this approach extends beyond individual factors and lifestyles to addressing how these are influenced by public policies.

HiAP is closely related to other terms with similar agendas such as “healthy public policies” and “intersectoral action for health” (see Box 1.1) developed under the auspices of the World Health Organization (WHO) as part of the “Health for All” agenda. The terms may have different roots, but they share the core message of the need to integrate health considerations into other policies and sectors beyond the health sector.

Box 1.1 *Concepts*

Determinants of health refers to factors found to have the most significant influence – for better or worse – on health. Determinants of health include the social and economic environment and the physical environment, as well as the individual's particular characteristics and behaviours.[1] Social and economic conditions – such as poverty, social exclusion, unemployment and poor housing – are strongly correlated with health status. They contribute to inequalities in health, explaining why people living in poverty die sooner and become sick more often than those living in more privileged conditions.[2] **Social determinants of health** can be understood as the social conditions in which people live and work. These determinants point to specific features of the social context that affect health and to the pathways by which social conditions translate into health impacts.[3]

Health is, according to the official WHO definition, a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[4] Within the context of health promotion, health is seen as a resource for everyday life, not the object of living; it is a positive concept emphasizing social and personal resources as well as physical capacities.[5]

Health promotion is the process of enabling individuals and communities to increase control over the determinants of health and therefore improve their health. It represents a strategy within the health and social fields which can be seen on the one hand as a political strategy and on the other hand as an enabling approach to health directed at lifestyles.[5]

Health sector includes government ministries and departments, social security and health insurance schemes, voluntary organizations and private individuals, and groups providing health services.[6]

Health in all policies is a horizontal, complementary policy-related strategy contributing to improved population health. The core of HiAP is to examine determinants of health that can be altered to improve health but are mainly controlled by the policies of sectors other than health.

Intersectoral action for health could be defined as a coordinated action that explicitly aims to improve people's health or influence determinants of health. Intersectoral action for health is seen as central to the achievement of greater equity in health, especially where progress depends upon decisions and actions in other sectors. The term "intersectoral" was originally used to refer to the collaboration of the various pubic sectors,[7] but more recently it has been used to refer to the collaboration between the public and private sectors. The term "**multisectoral action**" has been used to refer to health action carried out

cont.

Box 1.1 *cont.*

simultaneously by a number of sectors within and outside the health system, but according to the WHO Glossary of Terms,[6] it can be used as a synonym for intersectoral action.

Healthy public policy is, according to the Adelaide recommendations,[8] "characterized by an explicit concern for health and equity an all areas of policy, and by an accountability for health impact. The main aim for healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes health choices possible and easier for citizens. It makes social and physical environment enhancing."

Public policy is policy at any level of government and may be set by heads of government, legislatures and regulatory agencies. Supranational institutions' policies may overrule government policies.[9]

The scientific background and principles of Health in All Policies

The HiAP approach is solidly rooted in the public health sciences and the interaction among and knowledge of health, governance and public policies. Knowledge about factors outside of health care which contribute to health and ill health is well established.[10] The current discussions on health and its determinants in particular have their roots in the approaches and debates since the 1970s on public health and medicine. McKeown highlighted the role of broader policy measures in his critique of the role of medicine and health services in improving health[11] and Geoffrey Rose articulated the relevance of population-based strategies for prevention.[12] The Rose prevention paradox – which deals with the issue of population health in comparison to the more individual and target-group focused high-risk groups approach – articulates that preventive measures that offer little to each participating individual may bring great benefits to the community. A population health strategy aims to control determinants of health and to lower the mean level of risk factors.[12, 13]

The understanding of HiAP is also intrinsically linked to the rise of environmental and ecological analysis in the 1970s and 1980s.[14] This ecological view of health, also called the socioenvironmental approach, emphasizes that the contexts in which people live and the ways that people relate to them are profoundly influenced by public policies.[15] This approach applies particularly to HiAP because it pays attention to decisions and actions on other sectors which are damaging to health. It emphasizes that many contemporary health problems are social rather than individual by nature and in order to tackle the underlying mechanisms of these health problems there is a need to address policies in other fields.

The term "determinants of health" was introduced in the 1970s; it was argued that too little attention was devoted to populations and their health.[16] "Determinants of health" refers to those factors that have been found to have the most significant influence – for better or worse – on health. Health is an outcome of a multitude of determinants, including those relating to individual, genetic and biological factors, and those relating to individual lifestyles, as well as those relating to the structures of society, policies and other societal factors. The term is used much more in the context of addressing structural rather than individual, genetic or biological determinants of health, but public policies also influence or guide individual behaviour and lifestyle choices. Conceptualizing health through its determinants is important because determinants can often be directly and quickly influenced through policies and interventions in the various arenas of policy-making, as well as in the various settings in which people live and work. The same determinants typically influence a multitude of health issues, while individual health problems are typically a product of a variety of determinants. This means that policies, interventions and actions outside the health sector can address determinants of health more directly than they can address health outcomes. The improvement of health through determinants can thus be made easier and more straightforward than through more traditional disease- or health problem-based approaches.

Key health determinants are unequally distributed among population groups. Social determinants of health refer to social conditions in which people live and work and address, in particular, the ways in which social inequalities and poverty affect health and health inequalities. Tackling determinants of health does not automatically tackle determinants of health inequalities and thus an *explicit* focus on the social determinants of inequalities in health is necessary because social determinants of inequalities in health could be partly different from the determinants of health.[17]

The WHO compilation *The Solid Facts* [18] has summarized research around the social determinants into 10 important topics.* WHO has established a Commission on Social Determinants of Health with the aim of recommending interventions and policies to improve health and to narrow health inequalities through action on social determinants. The commission differentiates between structural determinants consisting of social structure (labour market, education system and welfare state) and individuals' social status (socioeconomic position, gender, ethnicity and social cohesion) and intermediary or pathway factors (living conditions, working conditions, behaviour, and health and social care).[3]

* The ten topics are: the social gradient; stress; early life; social exclusion; work; unemployment; social support; addiction; food; and transportation.

The international public health "movement"

HiAP can be traced all the way back to and beyond the Alma Ata Declaration in 1978, which raised the profile of other sectors in health policy-making. In the European Region, issues central to the global Health for All movement were reflected in the development of a regional Health for All strategy and targets, which had a stronger focus than the global strategy on the prevention of health problems and lifestyle dimension (lifestyles conducive to health). The targets adopted in the European Region emphasized the structural and contextual matters, while those in the United States emphasized individual behavioural factors.[19] The emphasis on structural and contextual matters in relation to lifestyles conducive to health in the WHO European strategy and targets document gave ground for systematic preparation of health promotion, which can also be seen in the background of the HiAP approach.

The international public health movement and the organization and agenda of international health promotion conferences have been important for the articulation of the HiAP approach, and in particular in the conceptualizing of health promotion and healthy pubic policies (see Box 1.1). According to the Ottawa Charter for Health Promotion,[20] the product of the First International Conference on Health Promotion in Ottawa in 1986, "health promotion is a process of enabling people to increase control and to improve their health." The charter identifies the fundamental conditions and resources for health and emphasizes a commitment to diminishing inequalities in health. Expanding the focus on lifestyle determinants to broader determinants of health, the Ottawa Charter sets out five strategies for health promotion:

1. build a healthy public policy
2. create supportive environments
3. strengthen community actions
4. develop personal skills
5. reorient health services.

This emphasis on broader policy measures also prevailed in the subsequent conferences in Adelaide in 1988 (which focused on healthy public policies) and in the Sundsvall conference in 1991 on creating supportive environments for health (which emphasized that a broad understanding of the environment contained various dimensions: the social aspects and the political and economic dimensions). The more recent conferences in Jakarta in 1997, and in Mexico City and Bangkok in 2005 have brought up the challenges of globalization, trade and global inequalities for the promotion of health.

The Sixth Global Health Promotion Conference in Bangkok addressed health promotion especially in the globalized world with an emphasis on the need to address all the harmful effects of trade, products, services and marketing strategies at global level.

The global health promotion conferences and their agendas are thus directly and indirectly linked with the evolution of policies and priorities of the HiAP approach. While policies have not necessarily been promoted as HiAP, but rather as health promotion, healthy public policies or supportive environments for health, it is clear that in practice all these measures have contributed to the articulation, priorities and practice of the HiAP approach.

The context for Health in All Policies

The nature of policy-making is increasingly interdependent and multidimensional; the public health policy experts need to identify the crucial policies and policy processes that affect health determinants in an increasingly complex and demanding environment. In order to gain influence this requires that they build alliances and partnerships at these levels and with new participants.

The fact that health is affected by policies of other sectors has been recognized for a long time; also, the need to cooperate with other sectors is in principle not new. Health impacts are already largely considered as part of inherent decision-making in many sectors, such as environment and housing. The need to interact with sectors such as those of education, social affairs, transport, and agriculture and nutrition is also generally well known to public health specialists, while it may well be that influence from trade and industrial policies on health have been traditionally less well recognized, but have become increasingly important with the European integration and globalization processes.

Integrating HiAP has become complex due to the changing structure of decision-making and the existence of different levels of decision-making on health from global to local levels. While in many countries responsibilities, such as health and social service provision, are being delegated to local levels, other issues such as crucial decisions on financial, trade, industrial and agricultural policies have been shifted to international level. This has implied that responsibilities of health outcomes have remained at local level, while crucial decisions influencing the determinants of health are made at European Union (EU) or even global level. While it is essential that action is sought at local level, this may be of limited value if regional and global levels of policy-making restrict the choices that can be made and policy space that can be

taken at local level. This is also of special importance to broader, public policy measures, which are important in curbing the consumption of health hazardous substances, changing nutrition patterns and influencing social determinants of health as these can rarely be implemented only in the context of local policies.

Health policy priorities are dependent on broader priorities and aims of governments and it is in this context that politics of implementation are of importance. Ministers and ministries of health are not necessarily the strongest players within the government. The aims of enhancing competitiveness of the economy or priorities of trade and industry are often substantially higher priorities in the context of national policy-making. This has led to a situation where, rather than articulating how economic, industrial and trade policies could contribute to the health and well-being of European citizens, health policies and especially the organization and financing of health services provision are scrutinized themselves in terms of their compliance with and contribution to industrial, trade and economic policies.

Globalization, economic integration and the strengthening of the commercial legal framework at global and regional levels have also implied that the interests of the private sector, markets and competitiveness are considered to be of greater importance than health. In this policy environment, implementation of such regulatory, public health, social determinant- or equity-oriented policy measures, which restrict the free mobility of goods, services and people or limit commercial and investment opportunities, has become more easily contested. It is also of crucial importance that HiAP is taken seriously as part of the definition of policies in the context of internal markets, EU industrial policies and in relation to commercial policies and bilateral and multilateral trade and investment negotiations. This is also the context in which a national policy space for public policies – which, for example, aim to reduce the consumption of products and goods that are hazardous to health, or enhance healthier nutrition – needs to be ensured, even if this would limit investment and commercial opportunities and markets. Another crucial challenge can be found in terms of addressing social determinants of health and the ways in which the quest for competitiveness and economic, commercial and industrial policies relates to these.

Strategies for Health in All Policies

The understanding of the scientific basis and articulation in the background of the concepts used in the context of broad understanding of health is useful as a learning process. However, the real test of any policy or approach is at the

level of practice. The policy implications of the broad understanding of health and of population health imply that a major share of policy work needs to be performed outside the particular remits of the health sector. However, as Dahlgren notes, more work needs to be done to convince even the health sector of the importance of the HiAP approach, owing to the following issues:[21]

- there is still a tendency within the health sector to "medicalize" – or neglect – the many external causes of poor health and the role of other sectors in promoting health and preventing disease;
- the health effects of environmental, social, agricultural and economic policies and programmes are still neglected by the professional groups responsible; and
- there is an urgent need to strengthen and coordinate health development at international, national and local levels.

It is also clear that in the context of increasing interdependence and multi-dimensionality of policy-making, health is not the only sector that needs cooperation and collaborative forms with other sectors, but that other sectors also need collaboration to achieve their own goals. "Joined-up" policy-making has been seen as a crucial feature of modern and better institutional policy-making.[22] The joined-up approach takes into consideration that cross-cutting objectives are clearly defined at the outset; that joint working arrangements with other sectors are clearly defined; that barriers to effective joined-up policy-making are clearly identified with a strategy to overcome them; and that implementation is considered as part of policy process.[22]

A starting point and the major challenge of HiAP is to make the case for understanding the importance of health implications of other policies and taking these into consideration in policy-formulation and implementation at all areas and levels of policy-making. The literature available gives the impression that the adoption and implementation dimension of HiAP seems to be the most difficult issue in terms of practical policy-making.[23–25]

The central issue facing HiAP is how to enhance the feasibility of placing health criteria on the agendas of policy-makers who have not previously considered health as part of the agenda. The first strategy is to get other sectors – or stakeholders inside sectors – to contribute to improving health or promote factors related to health determinants. This strategy could be called a health strategy where health is kept as a main objective. The aim is to achieve health gains and to transfer responsibility for promoting health to various agencies, actors or the government as a whole. One example of this kind of policy is the smoking control policy where actors inside health sectors do try

to convince other sectors to make health-related decisions.[26] Achieving this is easier if taking health implications into account is not in conflict with other sectors' aims and values; ideally, mutual gains can be found. However, in other instances the aims may be more incompatible, if not directly in conflict. For instance, in the European Union the aims of the Common Agricultural Policy concerning the future of alcohol production and consumption (see Chapter 6) are different than they would be if assessed from the health policy perspective. According to the Commission, European health care systems are based on the principles of solidarity, equity and universality, and equal access to services on the basis of need – COM(2002/774) final – are aims and values of importance from the health policy perspective, whereas in the context of internal markets equitable treatment of businesses is more important. In these cases when the aims and values are not entirely compatible, a more thorough debate on the fundamental values and aims of policy-making, as well as implications of policies from the various sectors, needs to take place. It is also crucial in these situations that the health experts and proponents as participants to the policy debate have clear, adequate and evidence-based information on health implications, so as to aid evidence-based policy-making.

The second strategy aims to achieve mutual gains or outcomes for all actors involved in this process. This strategy could be called a mutual gains strategy or a win-win strategy. In this case the initiator might be somebody other than actors from the health sector. The goal is to achieve health gains but not to diminish the primary intention of various sectors or agencies. The aim is to look at expected health gains, but also, for example, social and economic gains. This strategy could be also called the synergy model whereby partner organizations would be able to achieve more together than they would by working on their own.[27]

In practice, it often seems that policies are advanced in times of crises, which implies that health objectives are taken higher on the political agenda in times of health crises, such as during the food scare produced by BSE. However, when such crises emerge, they will only lead to good policies if there is expertise to produce good solutions and alternatives for the situation. This can also be put in Kingdon's framework of policy change processes.[28] This argues that three conditions for policy change exist:

1. the problem (problem stream) that puts the issue on the agenda
2. the alternatives and solutions produced by experts (policy stream) and
3. the politically determined solutions (politics stream).

A crisis situation opens a window of opportunity as it enables all three conditions to exist at the same time, thus allowing policy change.

The implementation challenge

The implementation challenge is influenced by a minimum of the following factors.

First, in sectors where health interests are compatible with main sectoral interests, such as often in environmental, social or education policies, gaining common ground is not problematic as win-win options can be found more easily. On the other hand, in sectors where there are contrasting immediate or long-term interests this is much more challenging and requires further work, action and pressure. This can take substantial time and measures even for specific issues. For example, controlling smoking in public places, and now in restaurants and bars, results from much longer campaigning.

Second, success in implementation is limited by the extent to which health policies or intersectoral action of selected sectors can address improvement of health determinants on their own. This is the case, for example, with measures that try to ensure that children eat healthier food and have better nutrition. Public policies may be in place to ensure healthier eating at schools, using pricing mechanisms and labelling of foods, restricting advertisements and providing more information and education for parents. However, at home parents' choices are dependent on other constraining factors, which depend on policies in other sectors and are not necessarily directly related to food, such as working times, employment conditions and requirements, availability of parental leave, and other measures influencing the scope and context in which parents can make choices.

Third, the costs of the strategies are important and any health policy measures that negatively influence the cost structure of another public policy area will face further problems in implementation. It is likely that health promotion and protection efforts will not be in everyone's immediate interests and that if only easy, "nice" and voluntary measures are implemented, the implementation of HiAP will remain, in practice, ineffective. While some fears of costs of health interventions seem to have been overestimated – such as those concerning the economic impact of the prohibition of smoking in restaurants – the benefits of health measures tend to be more difficult to measure than immediate costs. It is also often easier to address the costs and benefits of a particular or narrow treatment-based intervention in comparison to a change of broader policies.

Fourth, the level of public action is important. Local policies are not meaningful unless scope for implementation at local level is given at national, regional or global levels. This implies that the promotion of local health agendas and measures will only have a limited impact if determinants of other policies are set at national, regional and global levels. It is therefore important that within the EU the importance of HiAP is also recognized at European level and in such European policies as internal markets, competition and trade. Rights to implement public policies have to be at the same level and as important as commercial rights of corporations. European corporations have been very good in adjusting their products to serve different regulatory standards and it is important to seize the potential for the improvement and inclusion of the best public health practices in the emerging common European regulatory process.

Fifth, some issues are tackled more easily than others and some will require constant and long-term attention. The importance of continuity and follow-up needs to be highlighted as people tend to forget the importance of things and new generations engage in different activities. The health impacts of particular policy changes are not necessarily direct and immediate, but may only become evident much later. Voluntary measures and campaigns may tackle some issues very well, but may be of limited use in others. Reducing health inequalities may require substantially different approaches than influencing particular health problems. This implies first that maintaining a long-term policy perspective and educational basis is important; second, that in some issues legal and broader policy measures are more important than campaigns; and third, that broader policies are rarely changed with one-off measures. Sustainability, sustenance and a long-term perspective are therefore of crucial importance in HiAP as well as ensuring that knowledge basis, human capacity and continuity of work are maintained.

The challenge of addressing inequalities in health

In many EU and accession countries socioeconomic differences in health persist and they seem to show growing trends.[29] Inequalities in health – both in terms of the adoption of equity-oriented policies and the implementation process – pose a special challenge to HiAP. However, while there are more epidemiological research data on inequalities in health, there is much less research on how to tackle these inequalities in terms of policies and interventions.

Important issues include the nature of efforts and the level of intervention, as well as processes and the means by which health inequalities are tackled. It is of particular importance that efforts in the form of policies and interventions

should be in place to offer responses to growing inequalities in health at many levels of action: international, national, municipal, and local.

The definition of the target population reflects the strategic entry points in tackling inequalities in health. The first approach emphasizes policies and interventions directed at the people with the worst health (deprivation-focused approach or disadvantaged-groups approach), while the second approach focuses on the gradient in health (inequalities in health or health-gradient approach). According to this approach, inequalities in health do not exist just between the poor and non-poor, but across the entire socioeconomic gradient.[30, 31] The gradient challenge means that in policy-making practice measures should not only concentrate on the people with the greatest health problems or "risk groups" but on the whole population. This discussion is parallel to Rose's prevention paradox. However, there seems to be a tendency to shift attention from the population distribution of health (health inequalities) only to the health of the poorest or the worst-off groups in society and turn to a downstream approach which focuses mostly on health sector measures alone. This problem has been brought up, for example, in the Acheson report, which aimed to tackle health inequalities in the United Kingdom.[32] The Acheson report clearly stated that "we consider that without the shift of resources to the less well off, both in and out of work, little will be accomplished in terms of reduction of health inequalities by interventions addressing particular 'downstream' influence."

The following starting points have been raised in relation to reducing inequalities in health:[33]

- reducing inequalities in power, prestige, income and wealth linked to different socioeconomic positions;
- reducing the effects of health on socioeconomic position, and reducing the economic consequences of ill health;
- reducing the effect of socioeconomic position on the risk of being exposed to specific health determinants ("intermediary" material, psychosocial and behavioural factors) or reducing the effect of these determinants in the lower socioeconomic groups; and
- reducing the health effects (including the consequence of illness) of being in a lower socioeconomic position through health care.

These approaches indicate that many determinants of inequalities in health are beyond the scope of health care and the health sector. It should be emphasized (not undermined) that the role of the health sector can also be important: the

Box 1.2 *An English example of cross-sectoral work on inequalities in health*

England's experiences could be described as an interesting example in terms of cross-sectoral approach in tackling inequalities in health. The pace and scope of policy programmes and initiatives addressing health inequalities has been enormous since 1997 (the start of the Blair government). The various policy documents on reducing inequalities in health contained the broad range of social policy measures. For example, in the government document *Reducing health inequalities: an action report*[34] it was recognized for the first time that the broad range of social policies influence the reduction of health inequalities.[35] The specific policies include, among others, the following: raising living standards; reducing road traffic accidents; and developing safe walking and cycling routes. It is also worth recognizing that HM Treasury[36] produced the *Cross-cutting review.* The aim was to narrow the in-health outcomes by taking concerted action through joined-up policy-making across departmental boundaries and to work in partnership with other stakeholders.[36] This review addressed multisectoral plans and future priorities for inequalities in health. It confirmed the broad determinants-focused approach. It also stated that health inequalities follow the social gradient, inequality policies need to be mainstreaming in the context of government action and interventions are to reach more than just deprived areas and the most disadvantaged to make progress.

health sector can act as an initiator, advocate for the reduction in health inequalities and work together with other sectors in making progress. Also, in reducing health inequalities, it is just not sufficient to merely set goals and measurable targets – and propose possible means – the important detail is how they work in practice. An essential question is how it is possible to reach different socioeconomic groups with different needs (since it is conventional for the system to offer standard solutions only, so that a needs-based approach may not often to be taken into account) (see Box 1.2).

Typically, in England, the action orientation is targeted more at disadvantaged groups than at a broader orientation to health gradients.[37] A challenge in England, as well as in other countries, is to get measures to reduce inequalities in health embedded within mainstream policies and to develop comprehensive "upstream" policies, such as alcohol and food policies.[38, 39] The importance of "upstream" policies in the context of reduction of inequalities implies that these would represent a more population-based approach to tackle the issue in comparison to efforts that focus predominantly on disadvantaged groups.

Conclusion

In this chapter HiAP has been illustrated as an essential approach in improving a population's health and diminishing health inequalities. HiAP has a great potential for making an important contribution to health policy development since population health is largely determined by social and economic factors outside of the health sector. There is a need to focus on those factors that create, maintain and protect health.

This chapter aims to clarify and contextualize the HiAP approach for the purpose of further European work and activity in this area at all levels. While many successes can be recorded, in other areas there is much scope for improvement. As HiAP is part of the complex policy-making processes, success should not be presumed to be easy or without complications. In many issues and areas, years – if not decades – of work have preceded public action and policy measures. In other areas action remains constrained even when evidence for HiAP exists and in still others past gains have been lost due to changes in policy priorities. Even though addressing HiAP has the potential to be one of the most effective means of tackling health problems, it is still part of the broader policy context and priorities.

Persistent or even growing health inequalities are a concern for all of Europe. It is important to note that tackling these inequalities requires a special focus on determinants of health inequalities, since determinants are unevenly distributed within and between societies.

Action and implementation of HiAP is dependent on the availability and existence of human resources and knowledge of public health issues, health impacts and social determinants. Focus on HiAP therefore needs to be set in a long-term and institutional context. This requires a sufficient basis of training and research on matters of public health, health policy and determinants of health. It also requires that action on HiAP has sufficient priority and a critical mass of support within the government and among policy-makers, including nongovernmental organizations (NGOs). This is of particular importance in the context of tackling more complex and long-term problems and policy-level issues.

Globalization and pressures to limit public policies that restrict markets will provide further challenges to addressing health in other policies and to action on social determinants of health. This is further complicated by multilevel governance and differences in national, regional and local-level priorities. The current policy context is also often more complex in terms of variety of stakeholders and interests involved. However, while this may imply challenges for HiAP it does not imply that it would not be possible. In contrast, it is also

the very reason why HiAP is of increasing importance and relevance to the current policy-making context. As part of this, HiAP can be seen as crucial in highlighting accountability, implications and priorities of health policies in the broader policy-making process and in placing health higher on the political agenda.

HiAP is based on public health sciences and has its roots in the development and evolution of the public health movement in Europe and worldwide. The potential for health gains on the basis of implementing HiAP remains extensive. In the context of future European policies, ensuring HiAP is of importance not only because of the Treaty of Amsterdam, or because it helps in containing costs and improving the well-being of citizens, but also because it makes sense.

REFERENCES

1. Health Impact Assessment: determinants of health. World Health Organization (http://www.who.int/hia/evidence/doh/en/, accessed 19 April 2006).
2. Socioeconomic determinants of health. WHO Regional Office for Europe (http://www.euro.who.int/socialdeterminants, accessed 19 April 2006).
3. Commission on social determinants of health. Towards a conceptual framework for analysis and action on the social determinants of health (draft 5 May 2005) (http://ftp.who.int/eip/commision/Cairo/Meeting/CSDH%20Doc%202%20-%20Conceptual%20framework.pdf, accessed 19 April 2006).
4. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June 1946; signed 22 July 1946 by the representatives of 61 states (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
5. Nutbeam D. Health promotion glossary. *Health Promotion*, 1986, 1(1):113–127.
6. Glossary of Terms used in *Health for All* series No. 1–8. WHO, 1984.
7. *Intersectoral action for health. The role of intersectoral cooperation in national strategies for health for all*. Geneva, WHO, 1986.
8. *Healthy Public Policy*. Second international conference on health promotion, 5–9 April 1988, Adelaide, Australia. Extract available from http://www.who.int/hpr/NPH/docs/adelaide_recommendations.pdf.
9. Milio N. Glossary: healthy public policy. *Journal of Epidemiology and Community Health*, 2001, 55:622–623.
10. Rosen G. *A history of public health*, expanded edition. Johns Hopkins University Press, 1993.
11. McKeown T. *The role of medicine: dream, mirage or nemesis*. Oxford, Blackwell Publications, 1979.

12. Rose G. Sick individuals and sick populations. *International Journal of Epidemiology*, 1985, 14(1):32–38.

13. Rose G. Strategy for prevention: lessons from cardiovascular disease. *British Medical Journal*, 1981, 282:1847–1851.

14. Labonte R. *Health promotion and empowerment: practice frameworks*. Toronto, Centre for Health Promotion, University of Toronto, 1993.

15. Milio N. Making healthy public policy; developing the science of art: an ecological framework for policy studies. *Health Promotion*, 1988, 2(3):236–274.

16. Graham H, Kelly MP. Health inequalities: concepts, frameworks and policy. NHS and Health Development Agency, briefing paper, 2004.

17. Whitehead M, Dahlgren G, Gilson L. Developing the policy response to inequities in health: a global perspective. In: Evans T et al., eds. *Challenging inequities in health. From ethics to action*. New York, The Rockefeller Foundation, 2001:309–323.

18. Wilkinson R, Marmot M. *The solid facts*. Copenhagen, World Health Organization, 2003.

19. Kickbusch I. The contribution of the World Health Organization to a new public health and health promotion. *American Journal of Public Health*, 2003, 93(3):383–388.

20. Ottawa Charter for Health Promotion. First international conference on health promotion, Ottawa, 21 November 1986, WHO/HPR/HEP/95.1 (http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf, accessed 19 April 2006).

21. Dahlgren G. The need for intersectoral action for health. European health policy conference: opportunities for the future. Volume II. In: Harrington P, Ritsatakis A, eds. *The policy framework to meet challenges: intersectoral action for health*. Copenhagen, World Health Organization Regional Office for Europe, 1995.

22. Bullock H, Mountford J, Stanley R. *Better policy-making*. London, Centre for Management and Policy Studies, 2001.

23. Nutbeam D. How does evidence influence public health policy? Tackling health inequalities in England. *Health Promotion Journal of Australia*, 2003, 14(3):154–158.

24. Joffe M, Mindell J. A tentative step towards healthy public policy. *Journal of Epidemiology and Community Health*, 2004, 58(12):966–968.

25. Wanless D. *Securing good health for the whole population*. London, HMSO, 2004.

26. Leppo, K, Vertio H. Smoking control policy in Finland: a case study in policy formulation and implementation. *Health Promotion*, 1986, 1(1):5–16.

27. Mackintosh M. Partnership: issues of policy and negotiation. *Local Economy*, 1992, 7(3):210–224.

28. Kingdon JW. *Agendas, alternatives and public policies*. Glenview and London, Scott, Foresman & Co., 1984.

29. Mackenbach J. *Health inequalities: Europe in profile*. Produced by COI for the UK Presidency of the EU, 2005.

30. Marmot M et al. Contribution of psychosocial factors to socio-economic differences in health. *Milbank Quarterly*, 1998, 76:403–448.

31. Marmot M. Acting on evidence to reduce inequalities in health. *Health Affairs*, 1999, 18:42–44.

32. Acheson D. *Independent inquiry into inequalities in health: report*. London, The Stationery Office, 1998.

33. Mackenbach J et al. Strategies to reduce socioeconomic inequalities in health. In: Mackenbach J, Bakker MJ, eds. *Reducing inequalities in health: a European perspective*. London, Routledge, 2002:25–49.

34. Department of Health. *Reducing health inequalities: an action report*. London, The Stationery Office, 1999.

35. Benzeval M. National experiences: England. In: Mackenbach J, Bakker MJ, eds. *Reducing inequalities in health: a European perspective*. London, Routledge, 2002:201–213.

36. HM Treasury & Department of Health. *Tackling health inequalities. Summary of the cross-cutting review*, 2002 (www.DH.gov.uk/healthinequalities/ccrsummaryreport.htm, accessed 26 April 2004).

37. Graham H. Tackling inequalities in health in England: remedying health disadvantages, narrowing health gaps or reducing health gradients? *Journal of Social Policy*, 2004, 33(1):115–131.

38. Exworthy M, Blane D, Marmot M. *Tackling health inequalities since the Acheson inquiry.* Bristol, The Policy Press, 2003.

39. Grinson I. The direction of health policy in New Labour's third term. *Critical Social Policy*, 2005, 25(4):507–516.

Chapter 2

Moving health higher up the European agenda

Meri Koivusalo

The task of moving health higher up the European agenda is grounded in the institutional history of the European Union (EU) and health is highly valued by citizens of Member States. Health issues are also of increasing importance in the context of the EU. European policies influence not only the health of European citizens through impacts on determinants of health, but also the available policy space at national and local level for health promotion, protection, and the financing and organization of health systems. Thus European policies influence the scope and nature of regulatory measures both at European-level and within Member States. The European agenda is influenced by different priorities and aims. The aim of moving health higher up the European agenda implies a higher importance of health policy priorities and needs as part of broader European-level decision-making. The task and challenge of moving health higher up the European agenda thus does not only imply a focus on how to ensure that health is integrated in other policies or whether different policies are coherent, but also ensures that health-policy priorities, public interests and high levels of health protection remain respected, recognized and acted on as part of all European policies and processes. Therefore moving health higher up the European agenda is important so that we can be sure that European policies and processes do not hinder the scope of national policy space for healthy public policies within Member States.

European Union policies and determinants of health

The state of health in Europe and the means for European citizens to stay healthy are influenced by the physical, social and cultural environments in

which people live and how they behave. The availability of healthy choices and the scope for a healthy life are determined by external factors, including policies that shape the context and living environment where choices take place (or do not take place). Public policies thus frame and mould the behaviour and lifestyle choices of individuals. Public health literature provides a wealth of examples of how public policies and population-based measures have been important in this quest.[1–5] The work of Rose in articulating the significance of tackling broad population-based issues has been central to shaping this debate and it is in this context that Health in All Policies (HiAP) at European level has special importance.[6]

The European Commission has been reviewing and assessing the state of physical and mental well-being of its citizens since 1994. The most recent report gives us a broad picture of the current health problems and determinants of health in Member States. While citizens of the European Community (EC) have never lived so long, there is still a substantial level of avoidable and preventable morbidity and mortality, and major differences between Member States.[7]

Unhealthy diets and lack of physical activity are leading causes of avoidable illness and premature death in Europe.[7–10] The European Council has invited the Commission to contribute to promoting healthy lifestyles and to study ways of promoting better nutrition within the EU. This has resulted in the publication of a Green Paper on a European dimension for the promotion of healthy diets and physical activity for the prevention of overweight, obesity and chronic diseases.[11]

Social determinants of health have recently also been raised in the global context by the World Health Organization (WHO) Commission on Social Determinants.[12] Understanding social determinants of health is crucial for the reduction of health inequalities, which has been the main context in which they have been raised at European level. Poverty and ill health remain associated and social inequalities in health remain a challenge in Member States.[7, 13] Tackling social inequalities requires public action at all levels of governance, including at European level. A particular aspect of social inequalities, that of addressing the social security needs of migrants, will, indeed, be a special theme of the Portuguese presidency, which will follow the Finnish presidency. Dealing with social determinants of health is a European issue and needs to have a central position on the European agenda. An agenda engaging with the social determinants of health is also one based on public policies and population health and it is in this context that it needs to receive attention at European level.

The European Union and determinants of public policies

European policies influence determinants of health, but it is also becoming increasingly clear that the impact of European policies is likely to be even more important for the scope of national and European policy space for health protection and health promotion, as well as for mechanisms of ensuring equity, cross-subsidization and cost-containment in health systems. While the aims of health policies may still be defined by Member States, the ways in which Member States can reach these aims are debated in the context of European policies in general, and in the context of internal markets and commercial policies in particular. The issue is not only to what extent health policy measures – such as pricing mechanisms, restrictions on advertising and sales, or the introduction of labelling – can be used as part of healthy public policies at national and European levels, but also to what extent health systems as a whole can operate and function without contesting internal markets, or commercial or industrial policy priorities within the European Community.

Health systems-related issues can be seen as another element of engaging with HiAP. "Health system" is the umbrella term used for the institutional expression of health policies, thus covering not only public health measures, such as prevention and health protection and promotion, but also measures concerning the organization, staffing and financing of the health services. Since the 1990s, several European Court of Justice decisions have concerned health services-related issues and it is these decisions that have become part of the broader framework in which the interrelationship between the internal market, patient mobility and health services are being debated.[14–16] The main issue with respect to these decisions and debates is the interrelationship between internal market rules and freedoms set in the context of mobility of patients, goods and services, and the Member States' health policy priorities and policy practices. This issue has further emerged in the context of health services and the completion of internal markets, in particular in relation to the proposed services directive and the definition of services of general economic interest.[17, 18] The free mobility of people and services, including professional services and health professionals, is expected to increase. This is expected to have repercussions in national health systems, in particular in the new Member States, which also have to bear greater disease burdens but with fewer resources.[19, 20]

European citizens have a great reliance on and trust in their health systems, which provide them with a basic sense of security. European policies could provide additional means of supporting this and promoting the well-being of European citizens. Health systems – the combined efforts of both public health measures and health services – exist for a purpose. Moving health higher up

the national and European agenda thus needs to imply that decisions at European level will be taken only after considering the implications of these, first, for health and determinants of health of European citizens and, second, on the financing, operational and regulatory necessities of health systems within Member States.

The institutional history of the European Union and health in other policies

Activities in the field of occupational safety and health were undertaken within the framework of the European Coal and Steel Community, which was established in the aftermath of the Second World War in 1951 by the Treaty of Paris. The creation of the European Economic Community (EEC) by the Treaty of Rome in 1957 further strengthened a comprehensive approach to the health and safety of workers. In 1974 the Advisory Committee for Safety, Hygiene and Health Protection at Work was set up in order to assist the Commission in the preparation and implementation of activities in the field of health and safety at work.[21] Work in the field of occupational health and safety was further enhanced in the context of the Single European Act, which came into force on 1 July 1987. The Maastricht Treaty (1992) broadened the legal competence of the European Commission in Article 3(o) in that activities of the Community shall include a contribution to the attainment of a high level of health protection and, in Article 129, by including the area of public health protection (see Box 2.1).

Over the years the health agenda of the European Commission has broadened from a narrow concern with workers' health and safety to wider issues of health protection, prevention and promotion. These have been embodied in initiatives associated with the public health frameworks and related concerns with HiAP and related tools, such as reporting on health, health and social impact assessment, and health systems impact assessment.

The importance of HiAP emerged in the Public Health Framework (1993). In this document the Commission gave a commitment to produce regulatory reports on health across the full range of its activities and responsibilities.[22] However, it was only later in the context of the Amsterdam Treaty (1997) that public health and ensuring a high level of health protection in all policies was singled out as a European priority. The importance of ensuring a high level of health protection and health as a priority was fuelled by the recognition of failures in the context of food safety and particularly as a result of the bovine spongiform encephalopathy (BSE) crisis. The European Parliament inquiry[23] into the failure of the Community to protect the health of EU citizens strongly

Box 2.1 *The Maastricht Treaty (Treaty on the European Union) (1992). Public Health. Adapted from* Official Journal of the European Communities, *29 July 1992, C191*

Article 129

1. The Community shall contribute towards ensuring a high level of human health protection by encouraging cooperation between the Member States and, if necessary, lending support to their action.

   Community action shall be directed towards the prevention of diseases, in particular the major health scourges, including drug dependence, by promoting research into their causes and their transmission, as well as health information and education.

   Health protection requirements shall form a constituent part of the Community's other policies.

2. Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination.

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

4. In order to contribute to the achievement of the objectives referred to in this Article, the Council:
   - acting in accordance with the procedure referred to in Article 189b, after consulting the Economic and Social Committee and the Committee of the Regions, shall adopt incentive measures, excluding any harmonization of the laws and regulations of the Member States;
   - acting by a qualified majority on a proposal from the Commission, shall adopt recommendations.

influenced the importance given to health as Commission President Jacques Santer responded to the European Parliament criticism by putting health more to the fore in Europe. Obviously, this reaction was designed to ensure that European citizens renewed their trust in Community actions and activities.

Article 152 in the Treaty of Amsterdam thus incorporates a stronger public health statement, requiring the European Union to protect as well as promote the health of EC citizens (see Box 2.2). The Directorate of Health and Consumer Protection (DG SANCO) was established and a new European food safety regime and agency were part of the resulting key measures in the field of health. The broader approach in health has been present in the form

Box 2.2 *The Amsterdam Treaty (1997). Public Health. Adapted from* Official Journal of the European Communities, *10 November 1997, C340*

Article 152

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

   Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education. The Community shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.

2. The Community shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action.

   Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination.

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

4. The Council, acting in accordance with the procedure referred to in Article 251 and after consulting the Economic and Social Committee and the Committee of the Regions, shall contribute to the achievement of the objectives referred to in this Article through adopting:

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

   (b) by way of derogation from Article 37, measures in the veterinary and phytosanitary fields, which have as their direct objective the protection of public health;

   (c) incentive measures designed to protect and improve human health, excluding any harmonization of the laws and regulations of the Member States.

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

5. Community action in the field of public health shall fully respect the responsibilities of the Member States for the organization and delivery of health services and medical care. In particular, measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

Table 2.1 *The 2005 plan for priority areas in work for Community action in the field of public health (2003–2008)*

Health information	Health threats	Health determinants
Developing and coordinating a health information and knowledge system	Surveillance	Supporting key Community strategies on addictive substances:
Operating the health information and knowledge system	Exchanging information on vaccination and immunization strategies	– tobacco; – alcohol; – drugs
Developing mechanisms for the reporting and analysis of health issues, and producing public health reports	Health security and preparedness	Integrative approaches on lifestyles and sexual and reproductive health
Developing strategies and mechanisms for preventing, exchanging information on and responding to noncommunicable disease threats, including gender-specific threats and rare diseases	Safety of blood, tissues, cells and organs	Mental health
E-health	Antimicrobial resistance	Public health actions to address wider determinants of health
Supporting the exchange of information and examples of good practice	Supporting the networking of laboratories	Disease prevention and the prevention of injuries
Health impact assessment	Capacity building	Genetic determinants of health
Cooperation between Member States		Capacity building

Source: Adapted from *Official Journal of the European Communities*, 9 October 2002, L271/1–11.

of three strands which are also in the context of the public health work programme of the Commission (see Table 2.1).

Health in other policies and a focus on social determinants of health are issues which have been at the core of several Member States and also EU presidencies since long before the Finnish presidency of 2006. In the 1990s the Portuguese (1992), German (1994) and United Kingdom (1998) presidencies drew attention to the issue and it was strongly present as part of the Dutch presidency in 2003. The documents published on mental health in connection with – and the aftermath of – the Finnish presidency in 1999 contained broad references to other policies that influence mental health. The United Kingdom presidency in 2005 focused particularly on inequalities in health. Social determinants of

health have also been addressed in the context of earlier Portuguese (2000) and Italian (2003) presidencies. The European Council has also included the integration of health protection requirements in Community policies on the agenda in several resolutions in the 1990s (during 1995, 1996 and 1998).[24–26] The issue of health in other policies has thus been raised and essentially put on the European agenda by the Member States.

The European Commission has worked towards addressing health in other policies, especially in the late 1990s. Reports on health in other policies were already prepared by the Commission during the 1990s based on information from other directorates.[27–29] (Health reports and their uses in policy-making are further discussed in Chapter 9.) However, reporting on health has waned as a practice and never reached as high a profile as was the case, for example, with environmental work, where integration processes and reporting on core sectors were taken to Ministerial Council level. Why health reporting never reached the level and focus that was evident in the environmental field would clearly merit a further analysis. In this context it is of special interest as to what extent institutional capacities and policy guidance in this area could have been improved to ensure that activities were carried out at an appropriate level.
A pilot seminar and study on healthy public policies and health impact assessment (HIA) was organized in 1999. The conclusions of the final report emphasized that 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 a whole, health implications assessment requirements should be set so as to provide a veto on all new directives and policies, including new international treaties.[30, 31] The actual policies that have followed have been rather more modest, but there has been an increasing engagement with HIA efforts. The collaboration with WHO seems to have also provided a basis for some further European cooperation and activities. European Commission work in this area has included further funding on projects looking at HIAs as well as other work, such as undertaking a specific review on tobacco subsidies.[32] More recently, a focus on better addressing the implications of other policies for health systems has been integrated into the work on HIAs.[33] This is more concerned with the ways in which national health policy space, regulatory measures, financing and organizations of care, as well as human resources in health, are influenced by other EU policies. Health systems impact assessment therefore includes the assessment of the area of human resources, which has also gained particular attention on its own.[34]

At the same time, a broader framework on assessing economic, social and environmental impacts has been set in the context of the work and efforts of the Directorate-General for Enterprise and Industry.[35] The main aim of this

Box 2.3 *Impact assessment guidelines (European Commission, 2005)*

Public health and safety

- Does the option affect the health and safety of individuals/populations, including life expectancy, mortality and morbidity through impacts on the socioeconomic environment, e.g. working environment, income, education, occupation, nutrition?
- Does the option increase or decrease the likelihood of bioterrorism?
- Does the option increase or decrease the likelihood of health risks due to substances harmful to the natural environment?
- Does it affect health due to changes in the amount of noise or air, water or soil quality in populated areas?
- Will it affect health due to changes in energy use and/or waste disposal?
- Does the option affect lifestyle-related determinants of health such as the use of tobacco or alcohol, or physical activity?
- Are there specific effects on particular risk groups (determined by age, gender, disability, social group, mobility, region, etc.)?

Access to and effects on social protection, health and educational systems

- Does the option have an impact on services in terms of their quality and access to them?
- Does it have an effect on the educationand mobility of workers (health, education, etc.)?
- Does the option affect the access of individuals to public/private education or vocational and continuing training?
- Does it affect the cross-border provision of services, referrals across borders and cooperation in border regions?
- Does the option affect the financing/organization/access to social, health and education systems (including vocational training)?
- Does it affect universities and academic freedom/self-governance?

broader regulatory reform is to limit the unnecessary regulation of European corporate sector and business prospects so as to contribute to growth and competitiveness of the economy. The assessment of social impacts also includes aspects of public health and social and health services (see Box 2.3). This work has been part of broader work on *Better regulation for growth and jobs in the European Union.*[36] A scoping paper by DG SANCO has been prepared as part of this broader agenda as of 1 July 2005.[37] The relative value

of different impacts is unclear, but this process is expected particularly to enhance and deepen economic impact assessments so as to ensure that it contributes to the broader aims of the Lisbon Strategy. It is also geared towards early consultation with all stakeholders.[36]

In the context of health policies, European action on health was also influenced by the terrorist attacks in the United States on 11 September 2001, which led to reviewing and reinforcing health protection policies, contingency plans and resources in order to prevent and mitigate potential attacks. The Health Security Committee was established in 2001 and was to serve as the coordination platform for public health preparedness and response to deliberate releases of biological, chemical and radio-nuclear agents. This new emphasis on health security, the emergence of the severe acute respiratory syndrome (SARS) epidemic and concern over an avian influenza pandemic also contributed to the establishment of the European Centre for Disease Prevention and Control and to the presentation of more generic preparedness planning for public health emergencies at EU level.[38] These activities have contributed more to strengthening EU public health resources rather than assessing impacts of other policies on health, although experiences from the BSE outbreak and avian influenza have contributed to strengthening links between the human and animal health authorities.

The treaty establishing a constitution for Europe also included some new aspects of security-based measures in its final version. In addition, a requirement for ensuring a high level of health protection in all policies was finally approved as part of the more general cross-sectoral articles. In spite of the fate of the treaty, many changes in relation to health policies have, in practice, become part of European policy through the proposed Public Health Programme and suggested activities.[39] The original proposal combined both consumer and health-related policies and sought to strengthen common interests and measures of consumer and health priorities. The European Parliament, nevertheless, rejected the combining of the programmes in its first reading.[40]

Globalization and the changing context of health policies

In Europe, health has traditionally been predominantly a national policy concern and is set in the context of national or local policies. However, as part of the processes of economic integration and globalization, the regulatory framework and level at which policies are being adopted is changing as agreements and legal commitments are being made at both European and global levels. European action on health in other policies can also be seen – in full accordance with the treaty – as compatible with the subsidiarity principle.

Thus, rather than implying that the EU takes over national health policies and dismantles the sovereignty of Member States in this area, it can be seen as a means to ensure that industrial, commercial and other policies set at European level do not hinder the capacities and means of Member States to promote health, provide a high level of health protection, and ensure equality of access to, and solidarity in the financing of, health services.

Globalization and related processes, with respect to trade and investment negotiations and other measures to improve economic competitiveness at European level, influence national and local health policies and the scope for domestic regulation. There is a risk that, while responsibilities for health are increasingly delegated to the local level, policies that shape the social determinants of health and define the framework in which regulatory action can take place are set at European or global levels. It is only by strengthening the role of health priorities in European level policy-making that national and regional health policy space can be maintained. The importance of health to economic development in the EU has recently been highlighted by research identifying the need to understand health alongside education as a key area of human capital investment for economic growth and the need to recognize the economic benefits of broader public health interventions.[41]

Public health policies and health systems that function well are essential for the competitiveness of the economy and the appropriate functioning of market forces both in the global and European contexts. The SARS epidemic further confirmed the existing knowledge of this matter in showing the importance of hospitals as part of the broader control of the epidemic. In the context of internal markets and enabling the free movement of goods within Europe, the level of health protection is crucially dependent on the capacity of every Member State to ensure adequate public health and safety standards. In addition to public health, the role of health systems is also of central importance in ensuring trust and a sense of security of citizens as well as in limiting overall costs of health care. The costs of care are also dependent on how health policy priorities and financing concerns are recognized and acted on in relation to other industrial policies and priorities, for example, in relation to pharmaceutical policy. This is an issue with increasing importance in the light of recent Organisation for Economic Co-operation and Development statistics demonstrating that the costs of pharmaceuticals have risen faster than overall costs of health services.[42] This is a critical issue, particularly for the new Member States, which struggle with a greater disease burden, lower health budgets and a higher share of pharmaceutical costs. It is also a relevant issue in the context of the EU policies on trade and intellectual property rights. It is likely that Member States cannot afford pharmaceutical policies driven

predominantly by industrial policy interests and need to strengthen their cooperation and work on the basis of common health policies and public interest aspects.

The BSE crisis and the European Parliament inquiry on food safety were responses to fundamental concerns over the trust and reliance of European citizens on the priorities and policies of the EC. The same sentiments have been reflected in the context of health services in recent debates on the draft Constitutional Treaty and in relation to services and internal markets. It is impossible for the EU to thrive if its policies are seen to undermine citizens' needs, values and priorities. European health systems are highly valued by European citizens who recognize the fundamental values of equity, universality and solidarity, and are supported by recent statements by several European ministries of health in the International Forum on equal access to health services.[43, 44] In this context, European health systems, despite their organizational differences, are built on a set of common values, as was stated by the Health Council in June 2006.[44]

The challenges and pitfalls of moving health higher up the agenda

An essential challenge of the task of moving health higher up the European agenda is the context and basis on which this process takes place. The focus on coherence in policy-making is not necessarily beneficial to health priorities, but could also backfire, especially in the context of European-level policies and strategies oriented to improve competitiveness, such as the Lisbon Strategy. While health is now a part of the Lisbon Strategy, it has also become essentially measured and seen as a means of enhancing competitiveness of the economy while being subservient to the priorities of limiting public budgets. Rather than ensuring that health priorities have become part of broader European priorities, the aims of integrating HiAP or ensuring coherence of different policies may end up with health policies becoming subservient to priorities set in the context of commercial policies.

The same concerns are present in the context of impact assessment as part of "better regulation" processes because the main focus of these processes is on enhancing competitiveness and diminishing any regulation that might hinder the aims of competitiveness of the economy. This was also reflected in the "less red-tape = more growth" argument in the context of the initial proposal.[45, 46] The Commission thus intends to deepen the economic analysis of the true impact of all its proposals. The potential problems in terms of the balance of different impacts are reflected in the explicitly stated aims of giving

competitiveness issues their proper weight. Therefore, even though it has also been promised that social and environmental consequences of proposed measures will be properly assessed, it does seem rather obvious where the core emphasis of impact assessment lies in the context of the better regulation process. The importance of competitiveness is also clearly present in the first Commission screening of legislative proposals.[46] Another problem in this context is that it could represent a European process, where the initial language and aims of the activities do not necessarily make it clear that one crucial purpose is to hinder such regulatory initiatives, which could limit the competitiveness of commercial actors. As health regulations, including regulations on occupational safety and health, often impose further constraints on commercial actors, there is a danger that in spite of the language of impact assessment, these constraints and the broader process of improving regulation could, in practice, decrease and not increase the scope and policy space for healthy public policies and high levels of health protection within the EU.

The emphasis on the early inclusion of stakeholders as part of the impact assessment process is also not without pitfalls in the context of European policies as it allows the immediate influence of industrial and corporate actors. Health and social issues have always been a primary focus of many nongovernmental organizations and actors in public health, health promotion and service provision. The commercialization of health services provision in many countries has strengthened the role of corporate providers and insurers in the provision of care. In addition, a broader health-related commercial sector has had a longer European existence as part of industrial policies. All nongovernmental actors are not equal in terms of power, and they differ significantly in their abilities to influence policies at national level and even more so at European level. Nongovernmental actors may also differ in terms of their aims, focus and constituencies representing both public interests (health promotion, public health) as well as particular interest groups (patient organizations, professional organizations, commercial representative organizations). Some interest groups are particularly strong, such as the pharmaceutical industry, which has been able to turn a regulatory threat of a restricting directive on medicine prices into a directive requiring Member States to produce transparent criteria for pricing decisions and to provide detailed justifications where price rises were refused.[47] Participation, openness and transparency are important elements in the process of moving health higher up the European agenda. However, it is also necessary to ensure that dialogue and partnerships serve and contribute to public policy development on the basis of substantive and public interest concerns, and that these are not compromised or taken over by private or commercial interests or priorities.

Finally, the institutional basis for the analysis of other policies and their impacts on health remains, so far, insufficiently developed at both Member State and European level. Analysing health impacts of other policies is not always a simple task and without a public health and policy focus easily leads to support for medical and individual-based interventions in comparison to public policy measures. European environmental policies are supported by the work of the European Environmental Agency. The capacity to tackle public health and health policy issues within Europe should be strengthened both in relation to national policies and as part of European activities. At European level there is a risk that various health issues will become fragmented into various sub-institutions dealing with particular aspects of health or health systems, while at the same time capacity to deal with health policy issues within Europe remains underdeveloped and lacks the ability to draw together crucial information on public health and broader health systems issues. A European approach in strengthening and maintaining the institutional vigour, training and human resource basis for understanding public health issues, health in other policies and assessment of health and health systems impacts of other policies is necessary if action at European level is to be long term. This institutional basis also needs to be further strengthened by supporting the presence and activities of institutional frameworks allowing for intersectoral exchange and joint debates and discussions. This is important not only as part of Commission work in the context of practices, such as interservice groups, but also in the context of the work of the European Parliament and issues, such as cross-cutting committees and potential for specific, problem-based or thematic work and analysis.

Conclusion

European action and common activities across sectors have clearly occurred more easily in areas that are more open to cooperation. Environmental and health concerns, for example, often aim at similar policy results. However, action must also be taken with more difficult choices, policies and sectors, despite conflicts of interests or limited opportunities for win-win options. This is the case with aspects of industrial and agricultural policies and the completion of internal markets. It is also in this context that the greatest challenges will be met.

Standards for goods and practices with an impact on health are crucial to ensure a high level of health protection. However, for the improvement of health status focusing on standard setting it is necessary but insufficient if health promotion policies are ignored. The role of European policies is especially important in the context of curbing consumption that is hazardous

to health; alcohol and tobacco cannot be considered as ordinary commodities. The taxation of alcohol and tobacco has clear and effective impacts on consumption patterns, yet the ability of Member States to pursue this strategy can become compromised by internal markets-related requirements. It is also clear that tackling a future epidemic of obesity cannot be accomplished by relying on individuals' health education. Consumers need choice, but their choices are made in the context of a broader regulatory framework under which producers, consumers and suppliers operate. Choice is meaningless if healthy choices are not available. European policies need to take seriously the task of ensuring that European citizens and consumers have healthier, accessible and affordable choices.

European policies do not merely influence the health status of European citizens, but also the financing, organization and regulatory policy space that Member States have in the field of health. For example, industrial and trade policy priorities on pharmaceuticals influence the cost of pharmaceuticals and mechanisms that governments can use to manage such costs. Requirements for the free movement of goods, such as alcohol, influence what kind of national public policies can be used to tackle the consumption of alcohol (see Chapter 6). Internal market-related priorities may influence not only the provision and establishment of services, but also what kind of public health policies and regulatory framework can be maintained for the protection and promotion of health, as has been apparent in the context of debates concerning the proposed services directive.

Moving health higher up the European agenda is a necessity, but it is a necessity that needs to be driven by health policy priorities and concerns. These include not only the aim of high levels of health protection in all policies, but also the recognition of the fundamental values of equity, universality and solidarity in European health systems. Finally, the task of moving health higher up the European agenda implies that a policy space and capacity to debate health issues exists, and that these decisions and debates take place in the context of the democratic structures of decision-making both in Member States and the EU.

Acknowledgements

This chapter has benefited from kind comments from the reviewers of earlier versions as well as from comments from the editors and the editorial board of the book; however, any faults or mistakes remain those of author.

REFERENCES

1. Marmot M, Wilkinson R. *Social determinants of health*. Oxford, Oxford University Press, 1999.
2. Dahlgren G, Whitehead M. *Policies and strategies to promote social equity in health*. Stockholm, Institute of Future Studies, 1991.
3. Milio N. *Promoting health through public policy*. Philadelphia, FA Davis, 1981.
4. Ashton J, Seymour H. *The new public health*. Milton Keynes, Bucks., Open University Press, 1988.
5. Puska P et al., eds. *The North Karelia Project: 20 years, results, and experiences*. Helsinki, Helsinki University Printing House, 1995.
6. Rose G. *The strategy of preventive medicine*. Oxford, Oxford Medical Publications, 1992.
7. *The health status of the European Union. Narrowing the health gap*. Brussels, European Commission, 2003.
8. WHO/Food and Agriculture Organization. *Diet, nutrition and the prevention of chronic diseases*. Report of a Joint WHO/FAO Expert Consultation. Geneva, WHO, 2003.
9. *World Health Report 2002*. Geneva, WHO, 2002.
10. Luzzi AF, Gibney M, Sjostrom M, eds. Nutrition and diet for healthy lifestyles in Europe: the EURODIET evidence. Special issue. *Public Health Nutrition*, 2001, 4(2B):437–438.
11. *Promoting healthy diets and physical activity: A European dimension for the prevention of overweight, obesity and chronic diseases*. COM (2005) 637 final. Brussels, European Commission, 2005.
12. Marmot M. Social determinants of health inequalities. *Lancet*, 2005, 365:1099–1104.
13. Menke R et al. *Report on socio-economic differences in health indicators in Europe.* Bielefeld, Germany, Institute of Public Health, 2003.
14. *The internal market and health services. Report of the high-level committee on health.* Brussels, European Commission, 2001.
15. *Follow-up to the high-level reflection process on patient mobility and healthcare developments in the European Union*. COM (2004) 301 final. Brussels, European Commission, 2004.
16. *Judgment of the Court. Yvonne Watts vs. Bedford Primary Care Trust.* Brussels, European Court of Justice, 2006.
17. *Directive of the European Parliament and of the Council on services in the internal market.* COM (2006) 160 final. Brussels, European Commission, 2006.
18. *White Paper on services of general interest*. COM (2004) 374. Brussels, European Commission, 2004.
19. McKee M, MacLehose L, Nolte E. *Health policy and European Union enlargement*. Maidenhead, Open University Press, 2004.
20. Dubois C-A, McKee M, Nolte E. *Human resources for health in Europe*. Maidenhead, Open University Press, 2006.

21. *Health and Safety at work*. http://www.europa.eu.int/, accessed 14 Dec. 2005. Brussels, European Commission, 2005.

22. *Commission communication on the framework for action in the field of public health.* COM 93 559 final. Brussels, European Commission, 1993.

23. *Temporary Committee of Enquiry into BSE.* Bulletin EU1/2-1997. Brussels, European Parliament, 1997.

24. *Council resolution of 20 December on the integration of health protection requirements in Community policies.* (Brussels), European Council, 1995.

25. *Council resolution of 12 November on the integration of health protection requirements in Community policies.* (Brussels), European Council, 1996.

26. *Council conclusion of 30 April on the integration of health protection requirements in Community policies.* (Brussels), European Council, 1998.

27. *Komission kertomus neuvostolle, Euroopan parlamentille, talous/ ja sosiaalikomitealle seka alueiden komitealle terveyden suojelua koskevien vaatimusten liittamisesta osaksi yhteison politiikkoja* [*Report from the Commission to the Council, the European Parliament and the Economic and Social Committee on the integration of health protection requirements in Community policies*]. COM (95) 196 final. Brussels, European Commission, 1995.

28. *Komission toinen kertomus neuvostolle, Euroopan parlamentille, talous/ ja sosiaalikomitealle seka alueiden komitealle terveyden suojelua koskevien vaatimusten liittamisesta osaksi yhteison politiikkoja* [*Second Commission report on the integration of health protection requirements in Community policies*]. 96/407. Brussels, European Commission, 1996.

29. *Komission kolmas kertomus neuvostolle, Euroopan parlamentille, talous/ ja sosiaalikomitealle seka alueiden komitealle terveyden suojelua koskevien vaatimusten liittamisesta osaksi yhteison politiikkoja* [*Third Report on the integration of health protection requirements in Community policies (1996)*]. 5868/98. Brussels, European Commission, 1998.

30. Koivusalo M, Santalahti P. *Healthy public policies in Europe – integrating health in other policies.* GASPP Occasional Papers 5/1999. Helsinki, STAKES, 1999.

31. Koivusalo M, Santalahti P. *Healthy public policies in Europe – Integrating health in other policies. Seminar proceedings.* GASPP Occasional Papers 6/1999. Helsinki, STAKES, 1999.

32. *Commission staff working document. Tobacco regime. Extended impact assessment.* Brussels, European Commission, 2003.

33. Wismar M. *Health systems impact assessment.* Background document. Brussels, European Observatory on Health Systems and Policies, 2006.

34. Lerberghe W, Adams O, Ferrinho P. Human resources impact assessment. *Bulletin of the World Health Organization*, 2002, 80:525.

35. *Communication from the Commission on Impact Assessment.* COM (2002) 276 final. Brussels, European Commission, 2002.

36. *Communication from the Commission on Better Regulation for Growth and Jobs in the European Union.* COM (2005) 97 final. Brussels, European Commission, 2005.

37. *Preparing a scoping paper: the first step.* (No date given but the scoping paper is effective as of 1 July 2005.) Brussels, European Commission, 2005.

38. *Communication from the Commission on Strengthening Coordination on Generic Preparedness Planning for Public Health Emergencies at EU Level*. COM (2005) 605 final. Brussels, European Commission, 2005.

39. *Healthier, safe, more confident citizens: A health and consumer protection strategy.* COM (2005) 115 final. Brussels, European Commission, 2005.

40. *Community action programme in the field of health (2007–2013)*. P6TA (2006) 0093. Brussels, European Parliament, 2006.

41. Suhrcke M et al. *The contribution of health to the economy of the European Union*. Brussels, European Commission, 2005.

42. *Health data.* Paris, OECD, 2005.

43. *International forum on equal access to health care.* Stockholm, Regeringskansliet, 2005.

44. *Council conclusions on common values and principles in EU health systems.* 2733rd employment, social policy, health and consumer affairs Council meeting. Luxembourg, European Council, 2006.

45. *Less red-tape = more growth: Commission tables package for better regulation.* IP/05/311. Brussels, European Commission, 2005.

46. *Communication from the Commission. Outcome of the screening of legislative proposals pending before the Legislator*. COM 2005 (462) final. Brussels, European Commission, 2005.

47. Greenwood J. *Representing interests in the European Union*. Basingstoke, Hants., Macmillan, 1997.

Part 2

Sectoral experiences

Chapter 3

The promotion of heart health: a vital investment for Europe

Pekka Jousilahti

Investing in hearth health is vital for Europe. The reverse of hearth health – cardiovascular diseases – are a major health problem and the leading cause of death in Europe.[1] The occurrence of cardiovascular diseases is mainly determined by three individual lifestyle factors – an unhealthy diet, lack of physical activity and tobacco smoking – which in turn are determined by larger societal influences and conditions. For example, smoking in young people is determined by peer pressure, availability and affordability of cigarettes, as well as marketing and mass media partly defining youth culture.

The aim of health policy should be that the prerequisites for health are taken into account in all decision-making in society. In heart health promotion, sectors important for heart health, besides the health care sector, are the educational, cultural and physical activity sectors, society planning and building, agriculture, food industry and food services, consumer protection, trade, marketing and mass media. Medical and public health research has convincingly shown that cardiovascular diseases are to a great extent preventable, or at least their occurrence can be delayed to a later stage in life. The greatest challenge, however, is to turn theory into practice in health behaviour and thus create the real-life surroundings that support it.

Rapidly occurring globalization greatly affects world trade and economy, communication and people's everyday lives. In addition to the increased movement of goods and people, globalization has implications in terms of trade, regulatory frameworks, taxation policies and the exchange of information, all of which also affect societal contexts and lifestyle factors. Two of the major lifestyle factors which have an impact on heart health – tobacco

Table 3.1 *Mortality rate per 100 000 in the EU in 2002* [1]

	Men			Women		
	Member before 2004	Member after 2004	Total EU Members	Member before 2004	Member after 2004	Total EU Members
Cardiovascular diseases[a]	195	373	224	116	228	135
Cancer	247	321	259	140	164	144
Respiratory diseases	70	64	69	35	25	33
External causes	56	118	66	22	34	24
Infections	11	9	10	6	4	6
Total	822	1256	892	499	686	530

[a] Includes coronary heart disease and stroke only.

smoking and diet – are good examples of globally manufactured and marketed products that threaten health, i.e. cigarettes and food. Close international collaboration is essential for public health protection and for tackling the threats on heart health in Europe. Many decisions made in the European Union (EU) are of critical importance and they can either improve or worsen the heart health of citizens.

This chapter gives a short overview of the heart health situation in Europe, reviews the major determinants of heart health, evaluates the role of the health sector and other sectors (both at local and national levels, using the Finnish experience in cardiovascular disease prevention as an example) and considers the role of decision-making within the EU on heart health and its determinants. Medical treatment, however, is mainly beyond the scope of this chapter.

Heart health in Europe

Every year nearly 2 million people die in Europe because of cardiovascular diseases.[1] In addition to deaths, three major cardiovascular diseases – coronary heart disease (CHD), stroke and peripheral vascular disease – cause permanent disability and affect the quality of life of the people concerned. Table 3.1 gives standardized death ratios (SDRs) of men and women in the EU in five major disease categories. Mortality is markedly higher in those countries that joined the EU in 2004 than in the countries that were already members.

A recent study assessed the economic burden of cardiovascular diseases in the EU.[2] Cardiovascular diseases were estimated to cost the EU €169 billion annually, with health care accounting for 62% of the cost (see Table 3.2). Productivity losses and informal care (such as unpaid care given by relatives) represented 21% and 17% of costs, respectively. Coronary heart disease represented 27% and cerebrovascular diseases 20% of the overall costs. Even though the

Table 3.2 *Costs of cardiovascular diseases (€ million) in different EU countries*[2]

Country	Total health care costs	Production losses due to mortality	Production losses due to morbidity	Informal care	Total costs
Austria	1 989	500	84	579	3 152
Belgium	2 060	563	162	585	3 371
Cyprus	48	39	5	13	105
Czech Republic	847	218	136	176	1 378
Denmark	1 160	537	152	361	2 210
Estonia	74	42	6	21	143
Finland	1 223	462	148	743	2 576
France	12 616	2 418	519	3 420	18 973
Germany	34 909	7 347	2 993	8 533	53 783
Greece	1 541	454	72	306	2 372
Hungary	530	186	55	156	928
Ireland	429	248	77	112	866
Italy	11 692	1 797	478	2 881	16 848
Latvia	55	58	6	19	138
Lithuania	150	53	12	39	255
Luxembourg	115	24	14	34	187
Malta	9	4	0.6	2	16
Netherlands	4 208	1 102	317	1 120	6 747
Poland	1 764	953	529	537	3 783
Portugal	969	322	78	392	1 762
Slovakia	279	67	45	40	430
Slovenia	159	49	15	49	272
Spain	4 016	1 142	660	1 179	6 997
Sweden	2 842	589	583	902	4 915
United Kingdom	20 871	5 209	3 621	6 850	36 550
Total EU	**104 556**	**24 384**	**10 768**	**29 050**	**168 757**

economic assessment of costs resulting from disease has many methodological limitations, it is evident that, in addition to human suffering, cardiovascular diseases impose remarkable cost burdens on health care and on the whole EU society.

Inequity in heart health

Heart health in Europe varies between sexes, socioeconomic groups and different countries. Men have a markedly higher CHD mortality rate than women but the sex ratio varies from two- to fourfold in different populations. With stroke, the sex difference is smaller than with CHD. About half of the sex difference in CHD risk is explained by the differences in the known risk factors, particularly in smoking prevalence and blood lipids.[3] The difference in cardiovascular disease risk between men and women is largest among young people and the difference diminishes with ageing.

At the beginning of the epidemic in Europe in the 1950s and 1960s, cardiovascular diseases mostly affected the well-off in society. However, since then the situation has changed markedly, and in most countries the lower social classes have much higher cardiovascular disease risk when compared to the higher social classes.[4,5] Socioeconomic differences in heart health are partly explained by differences in health behaviour and societal background factors, unequal access to effective treatment and partly some unknown factors.[6,7] Socioeconomic differences in cardiovascular disease mortality tend to be greater in northern than in southern Europe. Even though cardiovascular disease mortality is decreasing in many European countries, the decrease is often faster in the higher socioeconomic groups, and the socioeconomic differences in heart health are not decreasing and may even be increasing in many countries.[8]

In Europe, cardiovascular diseases are more common in central, eastern and northern parts compared to the southern Mediterranean countries. Within the EU, Lithuanians and Latvians, both men and women, have the highest CHD mortality, and the lowest rates were found in France, Spain, Italy and Greece. Table 3.3 describes coronary heart mortality in different EU countries in 2002.

Also, secular trends in cardiovascular disease mortality vary markedly between different EU countries. In those countries that were members of the EU before May 2004, CHD mortality decreased, between 1980 and 2002, from 215 per 100 000 to 131 per 100 000 among men and from 97 per 100 000 to 63 per 100 000 among women, whereas in the new Member States the decrease was much smaller, from 290 per 100 000 to 243 per 100 000 in men and from 144 per 100 000 to 129 per 100 000 in women. Therefore, the inequalities in heart health between the European countries have markedly increased during the past two decades. In the near future we will see if EU membership has a positive effect on heart health in the new Member States, and if the heart health gap between the countries starts to diminish within the enlarged EU.

Even though the development of heart health as a whole has been positive in the EU and age-adjusted cardiovascular disease mortality has decreased markedly in most countries, the total disease burden has not decreased to the same extent. Owing to the ageing of the population, the number of cardiovascular disease patients and deaths due to cardiovascular causes have remained the same or even increased in many European countries. In the elderly population, the majority of cardiovascular disease patients are women.

Determinants of heart health

Major lifestyle factors affecting hearth health are diet, smoking and physical

Table 3.3 *Coronary heart disease mortality rate per 100 000 in different EU countries in 2002 by gender* [1, a]

Country	Men	Women
Austria	176	99
Belgium	122 [a]	53 [a]
Czech Republic	243	134
Denmark	155 [a]	79 [a]
Estonia	460	240
Finland	234	115
France	72 [a]	30 [a]
Germany	170 [a]	89 [a]
Greece	121	56
Hungary	293	171
Ireland	203	101
Italy	100 [a]	49 [a]
Latvia	436	207
Lithuania	459	249
Netherlands	109	51
Poland	182	85
Portugal	88	44
Slovakia	362	229
Slovenia	130	62
Spain	90	39
Sweden	167	80
United Kingdom	182	87
Members before 2004	131	63
Members after 2004	243	129
Total	**149**	**74**

[a] If data for 2002 were not available, the most recent previous figure was used.

activity, which regulate serum cholesterol level, blood pressure and body weight.[9] The role of these lifestyle factors and their biological effects on the development of CHD is given in Figure 3.1.

The amount and content of dietary fat is the major determinant of serum cholesterol level, which in turn is the most important cardiovascular risk factor in industrialized countries, explaining nearly half of the occurrence of CHD risk at population level.[10] Saturated fats, which are mostly from fatty meat and dairy products, increase, and mono- and polyunsaturated fats from vegetable oils decrease the cholesterol levels. Furthermore, high salt (sodium) and excess alcohol intake, physical inactivity and obesity raise blood pressure. High blood pressure is an important risk factor for CHD and it is the major risk factor for stroke. In many European countries half of the adult population have higher blood pressure than recommended.[11] High blood pressure is also considered by the World Health Organization (WHO) as the most important cause of excess mortality in the world.[12]

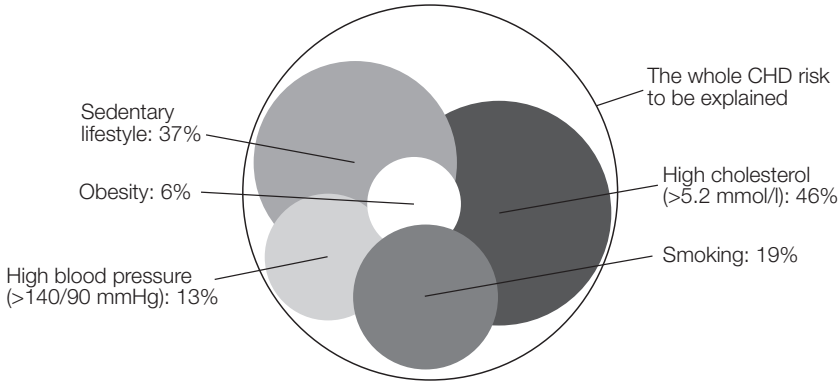


Figure 3.1 *The role of smoking, high-serum total cholesterol, high blood pressure, obesity and physical inactivity on the development of coronary heart disease*[9]

The role of the health sector and other sectors in the promotion of heart health

Despite advantages in modern medicine, the role of health care in the prevention of cardiovascular diseases is limited. A recent study demonstrated that 53% of CHD mortality reduction in Finland between 1982 and 1997 was explained by the decrease in serum cholesterol levels and blood pressure, and a reduction in smoking prevalence (see Figure 3.2). Improved treatment explained 23% of the reduction while 24% of the change could not be explained by the factors included in the analysis.[10] Similar results have also been achieved in other populations even though the explanatory proportions vary between different studies and the role of treatment may be larger in some populations.[13, 14]

Agricultural policies, food policies, and other food- and nutrition-related sectors, such as manufacturing, marketing and trade of foods, have a profound influence on the diet of a population. To improve heart health, low-fat meat and low-fat dairy products, good vegetable oils, fruit, vegetables and fibre-rich cereal products should be available, effectively marketed, adequately labelled, tasty and reasonably priced.

Although modern drugs (particularly statins) effectively reduce serum cholesterol levels and cardiovascular disease risk, the use of cholesterol-lowering drugs was rare in Finland before 1997, and practically all of the decrease in serum cholesterol levels, and consequently in CHD mortality rates, was due to dietary changes. It has also been shown that even a relatively modest change in dietary fat intake decreases CHD risk in a population more than active drug treatment of those with the highest cholesterol levels.[15]

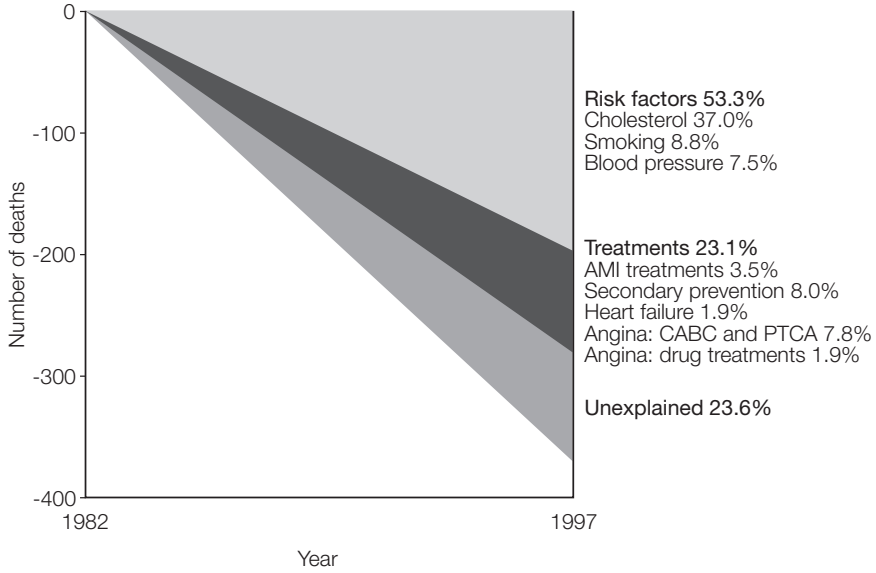


Figure 3.2 *IMPACT model showing the decline in coronary heart disease mortality in Finland between 1982 and 1997.[10] AMI, acute myocardial infarction; CABG, coronary artery bypass crafting; PTCA, percutaneous transluminal coronary angioplasty*

Tobacco policy is the second major area that determines heart health. As wide a range of measures as possible should be used to reduce tobacco smoking. These include price and tax policy, restrictions for marketing, importing and selling tobacco products, the prohibition of illegal imports, smoke-free environments, health warnings on tobacco products and support for smoking cessation.

Physical activity at work, in commuting to and from work, and during leisure time prevents cardiovascular diseases both directly and through its effect on other risk factors.[16,17] Physical activity needs to be promoted during the whole lifespan, that is through childhood, adolescence, adulthood and into old age. A number of policy areas, such as education, sport, building, transportation, work and society planning, have an influence on people's physical activity. In addition to contributing to heart health, a balanced diet and physical activity help prevent obesity, hypertension and type 2 diabetes, which are all increasing health problems in Europe.

It is evident that the roles of other sectors and policies are essential for effective cardiovascular disease prevention. Although people in Europe have the freedom to decide what they eat, whether they smoke tobacco or not, and how much they exercise, social and community influences, living and working conditions, and general socioeconomic, cultural and environmental factors have a marked influence on personal choices. These factors can both prohibit and promote healthy behaviour and good heart health.

However, the role of the health sector cannot be neglected in cardiovascular disease prevention. The health sector can play a crucial role in acting as a catalyst, coordinator and advocate in the creation of an environment that supports heart health. The North Karelia Project – the world's first community-based cardiovascular disease prevention programme – has demonstrated the importance of intersectoral work and the significance of input from other sectors than health, as well as the important role that the health sector played in the very remarkable decrease in cardiovascular disease mortality in Finland.

The North Karelia Project

In the 1970s, Finnish men had the highest CHD mortality in the world (see Figure 3.3).[18] Within Finland, CHD was markedly more common in eastern parts of the country, particularly in the North Karelia province. The North Karelia Project was started in 1972, and later the activities initiated by the project were spread to other parts of the country.[19]

The project was launched in response to a local petition for help in reducing the great burden of cardiovascular diseases in the North Karelia province, and it was formulated and implemented in cooperation with local and national authorities and experts as well as with WHO. The project's aim was to reduce cardiovascular disease mortality and morbidity in the area by carrying out systematic and comprehensive intervention using epidemiological and medical knowledge on cardiovascular risk factors and applying relevant principles of behavioural and social sciences on their background factors.

At the same time as the North Karelia initiative, the new public health law, which was established in 1972, strengthened the legal basis of heart health and other health promotions in Finland. The new law changed the focus of health care systems from curative services to prevention and created a new health service planning and financing system, which created more equal access to health services for all citizens, independent of their socioeconomic situation or place of living. The new law also formulated the framework for the health care sectors' collaboration with other sectors in disease prevention and health promotion, which was first tested in North Karelia and later spread to other parts of Finland. Intersectoral collaboration and cooperation between governmental authorities, nongovernmental organizations (NGOs) and the private sector still comprise the major strategy for heart health promotion in Finland.[20]

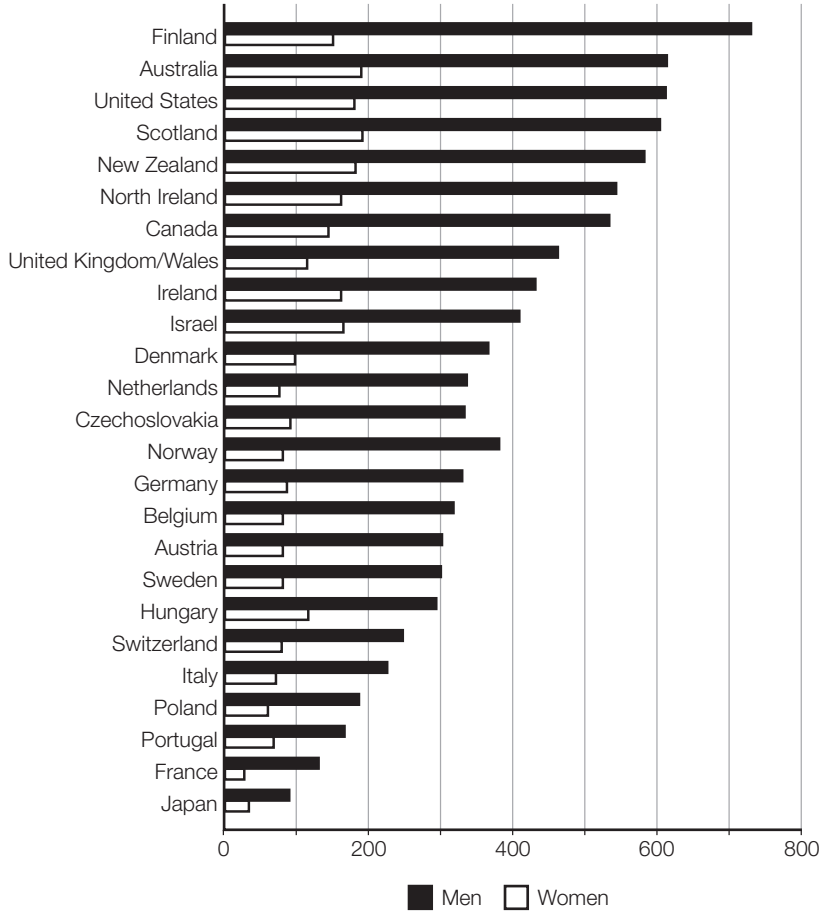


Figure 3.3 *Age-adjusted coronary heart disease mortality in Finland and 24 other countries, per 100 000, from 1965 to 1969*[18]

Activities and results

The major medium-term objectives of the North Karelia Project were to reduce smoking prevalence and lower cholesterol and blood pressure levels among the whole population, but particularly among middle-aged men. The intervention emphasized general lifestyle changes, especially smoking and dietary habits. The implementation of practical interventions was integrated into the existing health service structure and social organizations in the area in close collaboration with other governmental authorities and partners from the private sector. Box 3.1 describes different activities, at national and local levels, related to the North Karelia Project and cardiovascular disease prevention in Finland.

Box 3.1 *Interventions used in the North Karelia Project in terms of the level or sector of intervention*

Legislation

- The new Public Health (1972) Law (more emphasis on prevention)
- Tobacco control legislation
- Legislative changes concerning some foods, e.g. mixing vegetable oil and butter.

Regulation

- Many public places were declared smoke-free areas. Later, smoking was also prohibited in most public places through national legislation
- Regulation promoting healthier school lunches was introduced.

Industry

- "Heart-healthy" food products were developed and promoted in collaboration with local authorities, civic organizations, shops, supermarkets and the food industry
- Low-saturated fat products were developed and marketed in collaboration with local and national manufacturers
- Low-salt products were developed in collaboration with local bakeries and other parts of the food industry
- A new type of rape seed plant was developed, which was effective in cholesterol lowering and grew well in the climate of northern Finland
- A broad collaboration for promoting berry farming was formed, including enterprises to produce berry products.

Information and the mass media

- Public awareness on the health hazards of smoking was raised through the mass media, health services and community organizations
- Several smoking cessation TV courses were started
- In order to reduce serum cholesterol levels, health education campaigns were conducted using a large variety of channels, including TV, newspapers, the health care system, schools and voluntary organizations
- "Keys to health" national TV programmes were broadcast
- Cholesterol measurements were also widely used for education purposes and the aim was that everybody should know their cholesterol values. The primary aim of that, however, was not to screen high-risk subjects for individual intervention but to motivate people to adopt the lifestyle changes promoted in the community
- Intensive collaboration with local newspapers and radio stations, the production of various materials, health fairs, etc., were carried out.

(*cont.*)

Box 3.1 *(cont.)*

Community involvement

- Municipal politicians and authorities
- Lay opinion leaders
- The Martta Organization (a women's organization)
- Heart Association and local Heart Association branches
- Sport clubs.

Education

- Active collaboration with schools and educational institutions, nutritional education as part of home economics courses, etc., were carried out
- Special emphasis was placed on lowering salt and changing fat contents in workplace menus
- Stopping smoking was supported by organizing smoking cessation courses in local health centres and workplaces
- Smoking prevention programmes were organized in schools as part of the North Karelia Youth Programme, which aimed to teach school children the skills of resisting the social pressures to start smoking
- Widespread education on non-pharmacological blood pressure reduction and blood cholesterol reduction through dietary changes and physical activity was carried out.

The changes in health behaviour – diet, physical activity, smoking and alcohol consumption – and their biological consequences have been quite remarkable in the past 30 years. Mean serum cholesterol levels have decreased from 6.9 to 5.7 mmol/l in men and from 6.8 to 5.5 mmol/l in women.[21]

Nearly all of this decrease was explained by dietary changes; the role of drug treatment was marginal. The intake of saturated fats, particularly from dairy products, decreased markedly. Full-fat milk was replaced by low-fat and skimmed milk, and butter was replaced by soft oil-based margarines. In the 1970s nearly all Finns used butter on bread, while in 2003 the proportion was only 4%. Also, mean blood pressure declined markedly. Smoking prevalence decreased from 52% to 33% in men, but an increase from 10% to 23% was observed in women. This increase in the female smoking rate is mainly explained by the cohort effect and the very low smoking rate of middle-aged and elderly women in the 1970s.

The risk factor changes were followed by a clear decrease in CHD mortality.[22] Among men, the age-standardized CHD mortality rate (age range 35–64 years) decreased by 82% in North Karelia and by 75% in the whole country

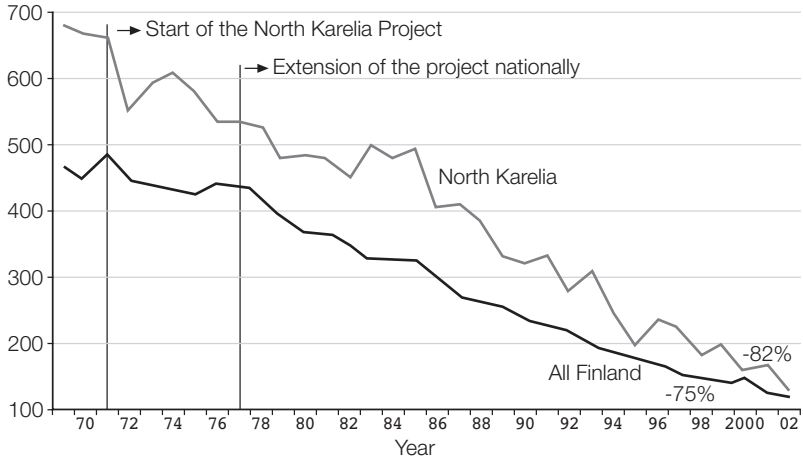


Figure 3.4 *Coronary heart disease mortality changes in the North Karelia province and the whole of Finland from 1970 to 2002 in men aged 35–64 years*[22]

in 30 years from 1969–71 to 2002 (see Figure 3.4). A similar decrease was also found among women. The risk factor and CHD mortality changes were greater in North Karelia during the initial project period in the 1970s, but after that the national change also accelerated. It has been estimated that until the end of the 1980s, all of the observed mortality decrease was explained by changes in risk factors.[23] Since the 1990s, mortality has decreased even more than expected based on risk factor changes. This additional decrease is most probably explained by other preventive factors and improved treatment of CHD patients.

After the first ten years of the programme, the scope of the North Karelia Project was also enlarged to cover other lifestyle-related chronic diseases and to promote general health in North Karelia. Since the late 1970s the project has worked as a national demonstration and model programme for chronic disease prevention in Finland. The comprehensive evaluation system, which was implemented in the project, was later developed as a national risk factor monitoring system for chronic diseases. The principles of the North Karelia Project have also been adopted in many other countries through international collaboration, particularly the WHO CINDI programme.

In 2004, CHD mortality among working-age men in Finland had decreased to one-fifth as compared to the situation 30 years earlier. This reduction may be the fastest observed in any country. Coronary heart disease mortality is still higher in eastern Finland compared to the western parts of the country, but the difference is only marginal compared to the situation 30 years earlier. A further decrease in cardiovascular disease mortality in Finland is possible,

but to achieve it special emphasis needs to put on the strengthening of the health-promoting environment. The EU, however, sets certain specific challenges to heart health promoting policies in the Member States.

European Union policy-making and heart health

Article 152 of the Amsterdam Treaty states, "A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities", and Article 153 requires that "The Community shall contribute to protecting health, safety and economic interests of consumers, as well as to promoting their right to information, education and to organize themselves in order to safeguard their interests". Thus, basically, good public health has a high priority in the EU. However, as mentioned earlier, the level of heart health is largely determined by other sectors than health. Planning, regulation and decisions on funding in the other sectors are not made by the Committee for Health and Consumer Protection, but in other sections of the EU. Even though improving public health is one of the horizontal goals in the EU, effective intersectoral cooperation in order to achieve this goal is scarce.

The Common Agricultural Policy

The role of agricultural and food policy is crucial for heart health. When the European Economic Community (EEC) was set up by the initial six Member States in 1957, one of the key principles was that Europe should never again have a food shortage such as the general population suffered during the war and the post-war years. The Common Agricultural Policy (CAP) was established in 1962. It is the major common policy area in the EU; its share of the overall EU budget is nearly half. The formal objectives of the CAP are to:

- increase agricultural productivity
- ensure a fair standard of living for the agricultural community
- stabilize markets
- assure the availability of food supplies
- ensure reasonable price levels for consumers.

Even though these objectives have had positive public health consequences in post-war Europe, the way they have been implemented in recent decades has clearly had harmful effects on heart health.

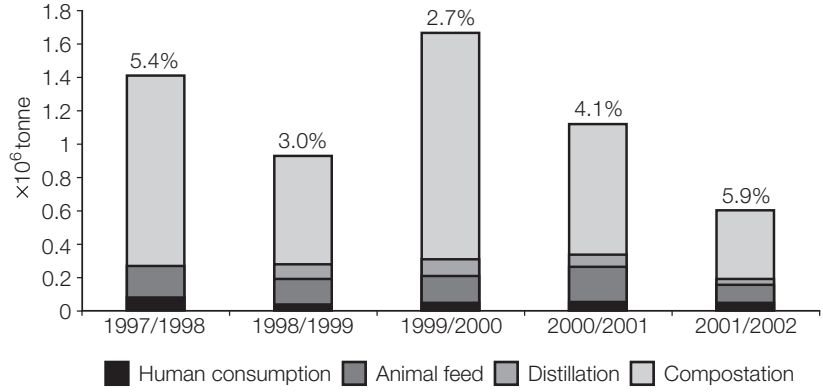


Figure 3.5 *Fruit and vegetables withdrawn in the EU from 1997 to 2001*[24]

Subsidies for fatty milk and meat products

The policy has promoted the practically unlimited production of fatty milk products and low-quality fatty meat, which has been marketed to the consumers at low subsidized prices or exported outside of the EU, particularly to developing countries. One striking example is the School Milk Programme, which intends (by fiscal means) to stimulate the consumption of fatty milk and cheese among school children. At the beginning of the scheme in 1995, the EU heavily subsidized full-fat milk, but skimmed milk was not subsidized at all. In 2001, the subsidy increased with increasing fat content. A child who drinks quarter of a litre of whole milk (instead of skimmed milk) every day at school consumes 1.5 kg of additional saturated fat every year.[24] Thus the scheme is clearly harmful to the health of future European generations.

Fruit and vegetable production

A high intake of fruit and vegetables reduces the risk of cardiovascular diseases and many other diseases, including cancer. However, the price level of fruit and vegetables is maintained in the EU by withdrawing a substantial part of the produce from the market. Most of this withdrawn produce is destroyed, instead of promoting and subsidizing their use among EU citizens (see Figure 3.5). Thus the CAP actively promotes the use of unhealthy animal and dairy products, whereas it is passive about or even limits the use of healthy foods (such as fruit and vegetables). It is evident that in its current structure the CAP hinders the attainment of lifestyle modifications, which are needed to reduce the cardiovascular disease burden in the EU. Even though a major CAP reform was agreed in 2003, health and nutritional objectives were not included in the revised policy.

Sugar production and export

The CAP sugar production process has been constructed so as to preserve sugar beet production in the EU. Within the EU, an artificially high price for sugar is maintained. This enables sugar beet to be farmed economically and in such quantities that there is very considerable overproduction. Without price control there would be no sugar production in the EU, and so the EU would rely on imported cane sugar. Substantial export subsidies are paid to sell the overproduction on the world market. These subsidies depress the price of sugar on the world market, which in turn make cane sugar production scarcely viable in many developing countries. Furthermore, EU sugar used for manufacturing within the EU (such as for confectionery) can be obtained at a subsidized world price if the product is exported, but the higher EU price is used if the identical product is sold within the EU. Even though the CAP sugar production process does not subsidize sugar consumption in the EU, it reduces the price level and increases sugar production on the world market. An increasing amount of world sugar production is used for manufacturing sweets ("candy"), soft drinks and other products, all of which are nutritionally completely useless, but have a high amount of energy, and which are an important cause of the world's obesity epidemic.[24]

At present, sugar policy in the EU is under revision. The CAP sugar reform, however, is not driven by health needs, but mainly by the principles of global free trade policy. In fact, the agreed cut of sugar production in the EU may lead to a reduction of sugar prices and increased consumption.

EU policies and regulations on tobacco production, marketing and smoking control

Since the 1980s, tobacco control policy has had a central role in the public health policy of the EU. In addition to public health, tobacco-related activities have been implemented in three other major policy areas: agriculture; taxation; and health and safety in the work place.

According to the World Health Report 2002,[12] tobacco smoking is the leading risk factor for premature death due to cancers and cardiovascular diseases in the EU. Over 650 000 Europeans are killed every year because they smoke; this is one in seven of all deaths in the EU. Of tobacco-related deaths 184 000 (136 000 men and 48 000 women) are due to cardiovascular causes (see Table 3.4). Also, 13 million people suffer from tobacco-related chronic disease, comprising 12% of the total disease burden in men and 6% in women. Although the tobacco epidemic is at different stages and smoking prevalences

Table 3.4 *Overall mortality due to smoking as a proportion of all deaths in the EU (year 2000 data)*[25, a]

Cause	Deaths due to smoking / total deaths (%)		
	Male	Female	All
Lung cancer	156 000/171 000 (91)	34 000/53 000 (65)	190 000/224 000 (85)
All cancers	239 000/626 000 (38)	46 000/493 000 (9)	285 000/1 119 000 (25)
Cardiovascular diseases	136 000/46 000 (16)	48 000/1 028 000 (5)	184 000/1 873 000 (10)
Respiratory diseases	78 000/194 000 (40)	34 000/178 000 (19)	113 000/371 000 (30)
All causes	508 000/2 214 000 (23)	148 000/2 238 000 (7)	656 000/4 452 000 (15)

[a] The denominator of each fraction is the number of deaths due to that disease; the numerator is the number attributable to smoking.

vary in different EU countries, it is clear that millions more EU citizens will die or suffer ill health as a result of their smoking in the coming decades.

Tobacco production in the EU

In 2000, the EU subsidized tobacco production by almost one billion euros (that is €1 000 000 000), constituting 78% of tobacco farmers' incomes. In fact, tobacco is the most heavily subsidized crop per hectare in the EU.[25] The share of the tobacco production in the CAP budget is 2.3%, even though only 0.1% of agricultural land is used for it. During the 1990s and in the early 2000s a number of measures were introduced to curb the production of tobacco, which, in addition to the negative health effects of smoking, is also economically and ecologically harmful. In spite of the efforts, subsidized tobacco production did not markedly decrease between 1993 and 2001, and the yearly subsidies even increased during the same period. However, owing to recent developments, it has been agreed to stop tobacco subsidies by 2010.

Domestic tobacco production, however, is not the main reason for smoking and smoking-related diseases in the EU. Most of this tobacco cannot be marketed in the EU because of its low quality, and it is exported beyond the EU, particularly to developing countries. The EU is a net importer of raw tobacco and a net exporter of manufactured tobacco products, providing approximately 20% of the world's cigarette supply. Tobacco farming and manufacturing jobs represent a mere 0.13% of total employment in the EU.

Taxation and price policy

Policies and practices on taxation and price policies of cigarettes, tobacco manufacturing and product regulations, sales and promotion bans, package labelling and consumer information, smoke-free working and public places,

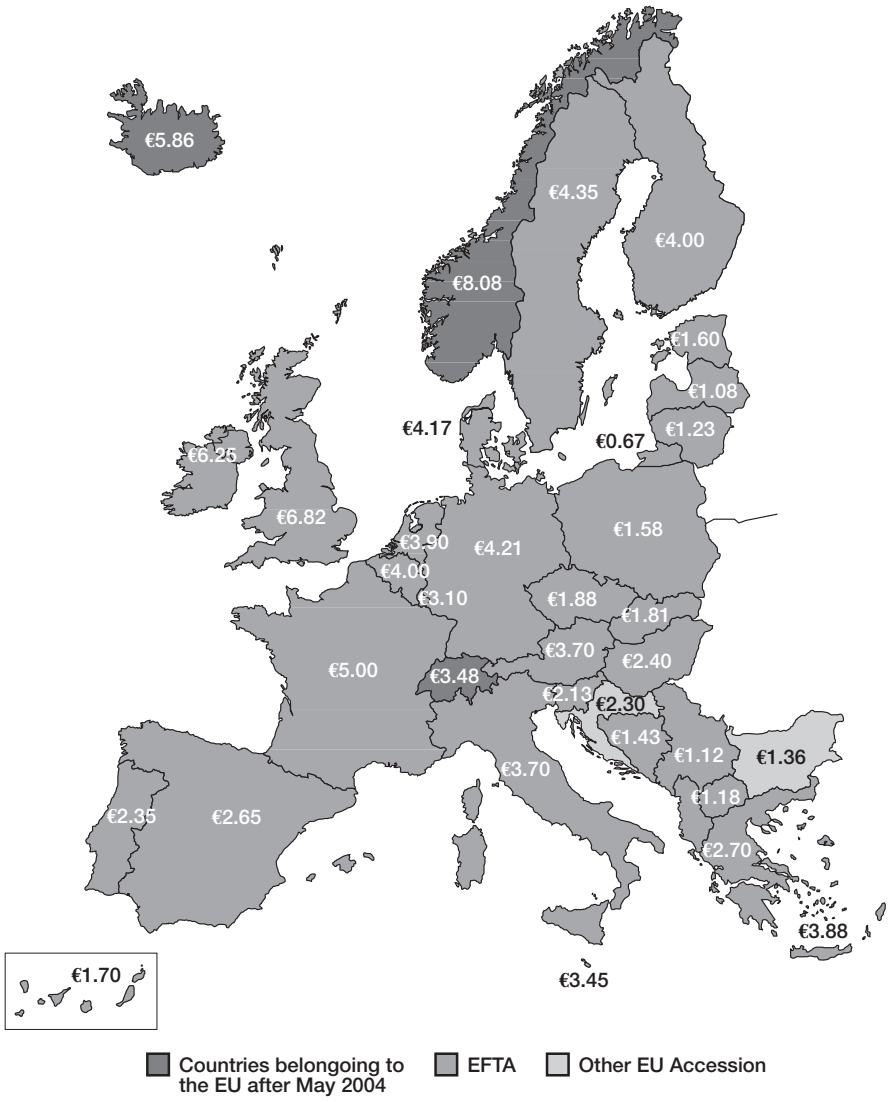


Figure 3.6 *The price of cigarettes (Marlboro) in Europe in January 2005*[25] (Adapted with permission from Citigroup Smith Barney. *The Startling economics of Tobacco*. April 2005, p.34)

and cessation strategies vary largely between different EU countries (see Figure 3.6). Owing to free trade and communication within the EU, Member States have only limited capacity to control tobacco consumption in their area, which emphasizes the role of the common EU policies in smoking reduction.

Price and taxation policy may be the most effective way to reduce tobacco consumption. EU Member States impose both valorem and specific excise taxes on tobacco products, in addition to Value Added Tax. Specific excise

taxes support the EU's public health goals better because they discourage the smoking of all cigarette brands equally, rather than encouraging the substitution of less-expensive brands. The current level of tobacco taxation in the EU is below the optimal level, with respect to both potential revenue generation and public health. Taxation has a major effect on the cost of cigarettes, which are currently quite affordable for most of the EU population. Tobacco consumption is fairly price sensitive and the increase in price reduces tobacco sales more than the consumption of many other products.

The choice of the type of excise tax has profound implications for the amount of tax paid on cigarettes, and is one of the reasons why cigarette prices vary substantially among EU countries. Tobacco taxation policy and price level in one Member State also affect tobacco consumption in other Member States. Large price differences between Member States increase import, both legal and illegal, from countries with a lower price level to the countries with higher cigarette prices. Harmonization of taxation and increases in the price of tobacco, particularly in the countries with the lowest price levels, would have a marked effect on tobacco control and public health in the EU. Effective measures are also needed to prevent cigarette smuggling from countries outside the EU.

Tobacco and public health

All legislation enacted in the EU, whether in the form of directives, regulations, resolutions or recommendations, requires a legal basis in the treaties that created the EU. Even though tobacco policy in the EU is mainly initiated and developed by the Health and Consumer Protection Directorate-General, all the legislation on labelling, advertising and product regulation has been based on the internal market legislation, Article 95 EC (previously Article 100a EC), rather than the public health legal base, Article 152, which does not permit this type of legislation. Partly as a result of this, tobacco control legislation has been the subject of legal challenges and other action against the Commission by the tobacco industry. However, considerable progress has been made in spite of this, even though tobacco control in the EU would have been even more advanced if a dedicated public health legal base had been available.

Major steps in tobacco control policy in the EU include directives on tobacco advertising, labelling and tar yields, a tobacco product directive, tobacco taxation legislation, and health and safety at work directives restricting smoking in the workplace. The Commission has also signed the WHO Framework Convention on Tobacco Control (FCTC) and acted effectively

against tobacco smuggling in some Member States. Ratification of the FCTC by all Member States will ensure that comprehensive tobacco advertising bans are enacted nationally within five years of ratification. In addition to common price and taxation policy, tobacco product regulation, cigarette sales restrictions and enforcement workplace smoking bans in all Member States, may be the most urgent tobacco-control tasks in the EU in the near future.

Physical activity

Common EU policies officially affect fairly limited areas, such as education, sports, transportation, and city and society planning, which determine people's physical activities. In general, Europeans may have better opportunities for daily physical activity than citizens in some other industrialized countries. In many countries walking and cycling are actively promoted, and in many cities there is a tendency to restrict the use of private cars.

Transport plays an essential role in economic and social development. It ensures access to jobs, housing, goods and services, provides mobility for people, and for the opening up of peripheral and isolated regions. However, the continuing expansion of transport – which is heavily dominated by road transport – raises serious concerns about the long-term sustainability of present mobility trends. In particular, the increasing evidence of the environment and health effects of transport places the need to effectively address transport-related issues at the top of the international political agenda.

The Transport Health and Environment Pan-European Programme (THE PEP) was set up to address the key challenges in achieving more sustainable transport patterns and closer integration of environmental and health concerns into transport policies. The priority areas of the programme are:

1. the integration of environmental and health aspects into transport policy, in particular in relation to decision-making processes, monitoring and impact assessment;
2. urban transport, involving measures in land-use planning, and for promoting high-quality and integrated public transport and improving safe conditions of alternative modes of transport; and
3. to demand side management and modal shift, and where special attention is paid to the needs of the countries of eastern Europe, the Caucasus and central Asia and of south-eastern Europe, as well as issues related to ecologically particularly sensitive areas.

Activities in these key areas are coordinated and implemented by the THE PEP Steering Committee, including representatives from EU Member States and international organizations, such as WHO, but the EU is not officially represented at the time of writing.

Free trade and the open market may also have some indirect effects in society, which affects people's opportunities for physical activity. As an example, seeking extreme economical effectiveness in production and trade of goods and services leads to the concentration of people in larger cities, the building of ever larger supermarkets and the closing of small shops, and the concentration and segregation of working places, which in turn means long distances between home and work and services, and the need for building new roads. These factors favour the use of private cars and lead to city planning which enhances a physically passive, motorized society.

During the last few years the EU and the European Commission, especially the Directorate for Health and Consumer Protection, have clearly increased their activities in the field of diet and physical activity, especially to curb increasing trends in obesity in many EU countries. Adopting the WHO Strategy on Diet, Physical Activity and Health gave the EU a good background for its actions. The establishment of the EU Platform on Diet, Physical Activity and Health has been an innovation in this field.[26]

Conclusion

Heart health has markedly improved in the EU in the past 25 years. There are, however, large differences in cardiovascular disease morbidity and mortality, and their secular trends, between different EU countries. In all countries the situation could be markedly improved if existing medical knowledge could be successfully implemented. The occurrence of cardiovascular diseases is mainly determined by three behavioural factors: diet; physical activity; and smoking, and their societal background factors. Decisions made in the EU may both improve and worsen the heart health of citizens. For the further reduction of cardiovascular disease morbidity and mortality special emphasis needs to be put on strengthening the health-promoting environment in Member States, particularly in those with the highest disease rates, and in the EU as a whole.

Even though health protection in general has a high position in the EU agenda, practical tools for health promotion are still scarce. Many decisions affecting heart health are not made in the Committee for Health and Consumer Protection, but, in other instances, within the EU. Therefore continuous intersectoral collaboration, strengthening the role of the Health and

Consumer Protection Directorate-General and systematic health impact assessment (HIA) in all decision-making within the EU are needed. To support health-conscious decision-making and HIA, systematic comparable data collection on morbidity and mortality, behavioural and biological risk factors, and their societal determinants needs to be established within the EU.

Health should be recognized as a major factor in the CAP. This means the active promotion of low-fat dairy products, low-fat meats, high-quality vegetable oils and the consumption of fruit and vegetables. The new sugar policy needs to be formulated so that it does not increase but rather supports the reduction of sugar consumption in the EU. Tobacco should be recognized as a pure health issue in the EU, and all tobacco-related decisions should be moved to the Health and Consumer Protection Directorate-General. An increase in tobacco prices in the whole of the EU, and particularly in those countries with lower prices, and the harmonization of tobacco taxation would have a marked effect on tobacco control and public health in the EU. Finally, even though the policy areas, which determine physical activity, are mainly under national decision-making mechanisms in different EU countries, common EU level policies and activities are also needed to promote physical activity among EU citizens.

A heart health-friendly Europe: a vision or utopia?

In a heart health-friendly EU, people enjoy tasty meals that are greatly influenced by the Mediterranean diet, but which also include the best dietary practices from other parts of the rich European food tradition. They do not smoke and the whole environment is free of tobacco smoke. They can walk or cycle to work (and have some physical activity in that work), and have the time, motivation and opportunities for all types of leisure-time physical activities. People can keep their blood pressure and cholesterol levels low into old age, they have normal weight, and enjoy good physical and mental health throughout their whole lives. Also, disparities in heart health, both within and between the EU countries, have disappeared or at least markedly diminished. Even though cardiovascular diseases still exist, people only suffer from these diseases in very old age, and major cardiovascular diseases, such as CHD, have been eradicated from the working-age population.

REFERENCES

1. European Health for All database (HFA-DB). World Health Organization Regional Office for Europe. Updated January 2006 (http://data.euro.who.int/hfadb/).

2. Leal J et al. Economic burden of cardiovascular diseases in the enlarged European Union. *European Heart Journal*, 2006 (advance access published 22 Feb 2006).

3. Jousilahti P et al. Sex, age, cardiovascular risk factors, and coronary heart disease. *Circulation*, 1999, 99:1165–1172.

4. Mackenbach JP et al. Socioeconomic inequalities in cardiovascular disease mortality; an international study. *European Heart Journal*, 2000, 21:1141–1151.

5. Avendano M et al. Socioeconomic status and ischaemic heart disease mortality in 10 western European populations during the 1990s. *Heart*, 2006, 92(4):461–467 (epub 10 Oct 2005).

6. Pekkanen J et al. Social class, health behaviour, and mortality among men and women in eastern Finland. *British Medical Journal*, 1995, 311:589–593.

7. Hetemaa T et al. Socioeconomic inequities in invasive cardiac procedures after first myocardial infarction in Finland in 1995. *Journal of Clinical Epidemiology*, 2004, 57:301–308.

8. Mackenbach JP et al. Widening socioeconomic inequalities in mortality in six Western European countries. *International Journal of Epidemiology*, 2003, 32:838–839.

9. McPherson K, Britton A, Causer L. *Coronary heart disease: estimating the impact changes in risk factors*. London, The Stationery Office, 2002.

10. Laatikainen T et al. Explaining the decline in coronary heart disease mortality in Finland between 1982 and 1997. *American Journal of Epidemiology*, 2005, 162:1–10.

11. Tunstall-Pedoe H, ed., for the WHO MONICA Project. *MONICA Monograph and Multimedia Sourcebook*. Geneva, World Health Organization, 2003.

12. *World Health Report 2002 – Reducing risks, promoting healthy life*. Geneva, World Health Organization, 2002.

13. Tunstall-Pedoe H et al., for the WHO MONICA Project. Estimation of contribution of changes in coronary care to improving survival, event rates, and coronary heart disease mortality across the WHO MONICA Project populations. *Lancet*, 2000, 355:688–700.

14. Unal B, Critchley JA, Capewell S. Explaining the decline in coronary heart disease mortality in England and Wales between 1981–2000. *Circulation*, 2004, 109:1101–1107.

15. Jousilahti P et al. Serum cholesterol distribution and coronary heart disease risk. Observations and predictions among middle-aged populations in Eastern Finland. *Circulation*, 1998, 97:1087–1094.

16. Hu G et al. Joint effects of physical activity, body mass index, waist circumference and waist-to-hip ratio with the risk of cardiovascular disease among middle-aged Finnish men and women. *European Heart Journal*, 2004, 25:2212–2219.

17. Hu G et al. The effects of physical activity and body mass index on cardiovascular, cancer and all-cause mortality among 47 212 middle-aged Finnish men and women. *International Journal of Obesity and Related Metabolic Disorders*, 2005, 28:894–902.

18. Thom TJ et al. *Total mortality and mortality from heart disease, cancer and stroke from 1950 to 1987 in 27 countries*. NIH Publication No. 92-3088. National Institutes of Health, 1992.

19. Puska P et al. *The North Karelia Project: 20 year results and experiences*. Helsinki, National Public Health Institute, 1995.

20. *Action plan for promoting Finnish heart health for the years 2005–2011*. Helsinki, Finnish Heart Association, 2005.

21. Vartiainen E et al. Cardiovascular risk factor changes in Finland, 1972–1997. *International Journal of Epidemiology*, 2000, 29:49–56.

22. Puska P. Successful prevention of non-communicable diseases: 25-year experiences with North Karelia Project in Finland. *Public Health Medicine*, 2002, 4:5–7.

23. Vartiainen E et al. Changes in risk factors explain changes in mortality from ischaemic heart disease in Finland. *British Medical Journal*, 1994, 309:23–27.

24. Schäfer Elinder L et al. *Public health aspects of the EU Common Agriculture policy. Developments and recommendations for change in four sectors: fruit and vegetables, dairy, wine and tobacco*. Stockholm, National Institute of Public Health 2003:18.

25. The Aspect Consortium. *Tobacco or health in the European Union*. European Commission, 2004 (www.europeancancerleagues.org).

26. *Diet, physical activity and health – a European platform for action*, 2005 (http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/platform/launch_en.htm, accessed 15 March 2005).

Chapter 4

Health in the world of work

Riitta-Maija Hämäläinen, Kari Lindström

Introduction

Occupational health, safety and health protection in the workplace and in workplace health promotion (WHP) can play an important role in health improvement and economic growth. People in good health are more productive and they can participate more effectively in the labour market and education. They are able to stay longer at work, postpone retirement and relieve the welfare state.[1] Both economic growth and investments in health provide parallel benefits and advantages which are not to be dealt with as separate issues.

This chapter describes and discusses Health in All Policies from the holistic perspective of health in the world of work. The emphasis here is the health of workers and how to maintain and improve workers' health and the organization of work to have a positive impact on health in times of a turbulent labour market. The world of work comprises important health determinants, such as living and working conditions, general socioeconomic, cultural and environmental factors, general social and community factors, and lifestyle and individual factors such as age and gender.[2]

A wide range of policies regulate aspects of these health determinants. Among them are sectoral policies such as social policy, employment, enterprise and the labour market and education policies, and practices' influence on people's participation in the labour market and their health development. These policies are regulated by national legislation and partly by agreements between the social partners. Some aspects of these determinants are co-regulated at European Union (EU) level. The principles and recommendations based on

the Lisbon Strategy and its follow-up have had a particularly strong impact on workplaces.[3]

This chapter starts with providing an overview on workers' health and services for health at work. It is followed by reviewing the changes in the world of work and healthy organizations; it then goes on to discuss the importance of and changes in social benefits, and education opportunities in the world of work as a cushion against the unpredictable nature of working life. The chapter then reviews the role and importance of social partners and health at work.

Workers' health and services for health at work

Despite the efforts made, the workplace and work itself cause injuries, diseases, accidents and even deaths. Those suffering from ill health need treatment and care, but the vital question is how to improve workers' health and how to decrease the adverse effects of ill health due to work. Workers have witnessed improved working conditions, more productive working conditions and environments, longer lives and economic growth with increased wealth.

The changing context of work and health

According to the European Foundation for the Improvement of Living and Working Conditions[4] the most common work-related health problems are backache (reported by 33% of respondents), stress (28%), muscular pains in the neck and shoulders (23%) and overall fatigue (23%). In addition a direct relationship between poor health outcomes and adverse working conditions seems to arise from a high level of work intensity and repetitive work. Of the traditional concerns for health at work, exposure to physical risk factors (noise, vibrations, dangerous substances, heat, cold, etc.) and to poor design (carrying heavy loads and painful positions) remains prevalent. The increasingly intensive work applies to over 50% of workers who work at high speed or to tight deadlines for at least a quarter of their working time. Control over work has not increased significantly: one-third of workers say they have little or no control over their work while only three out of five workers are able to decide when to take holidays. The character of work is changing towards more customer demands instead of machinery and production targets, and people are working ever more frequently with computers.

The type of job contract and working time system impacts on well-being and health. The contract types of work have changed as flexibility is widespread in all aspects of work: working time ("round-the-clock" and part-time work); work organization (multiskilled, teamwork and empowerment); and employment status (18% of all employees work under non-permanent contracts).

Temporary workers (employees with fixed-term contracts and temporary agency workers) continue to report more exposure to risk factors than permanent employees.[4] Precarious employment tends to cause work-related injury and illness. There is evidence of increased injury and ill health from outsourcing, labour restructuring and "casualization".[5] Health can also worsen bases on economic and reward systems (competition, long hours, piecework, etc.), disorganization (ambiguity of rules, splintering occupational health and safety management systems, etc.) and the increased likelihood of regulatory failure (laws do not apply to these employment relationships). An increased risk of injury can be found in several sectors, which often also have minimal regulatory protection. The risks are higher for workers in precarious employment situations than for workers in standard employment relationships.

In relation to gender segregation and gender discrimination of professions, work or workplaces are both highly disadvantageous to women. Violence, harassment and intimidation remain a feature of the workplace: from 4% to 15% of workers, both men and women in different countries report that they have been subjected to intimidation.[4]

Health situation, job insecurity and larger social trends influence mortality, cardiovascular disease and lifestyle.[6] Mortality is lower in people with social networks, but higher if a person is divorced or widowed. Mortality in unmarried men is higher than in married men. The risks of cardiovascular and other diseases are higher for people in jobs featuring low control or for people with jobs requiring high effort but offering little reward. Smoking and unhealthy eating are more common in people who believe there is little they can do to prevent illness. Generally, the unemployed show higher mortality and morbidity.

Services for better health at work

The scope of the framework for workers' health actions covers promotional, preventive and curative approaches. These actions can be directed to various levels, such as the individual worker, workplaces and society. Table 4.1 gives examples of the most relevant actions.

The promotion of workers' health covers the life course from education and working age to retirement. At national level this means programmes promoting the health and well-being of working-age people. At workplace level it refers to a culture appreciating workers' health and proactive workplace development activities, like WHP. Access to vocational education and training, as well as support for individual career planning, are important for individuals when they want to strengthen their working abilities or increase their possibilities to extend their working life. Primary prevention aims to prevent exclusion from

Table 4.1 *A matrix of the framework of actions on workers' health (some illustrative examples)*

Health action	Level		
	Societal	**Workplace**	**Individual**
Promotion	• National preventive programmes • Awareness raising	• Appreciation of health in the workplace • Proactive workplace activities (WHP)	• Access to vocational training and education • Health promotion • Career planning
Primary prevention	• Prevention of exclusion from working life/ National European Social Fund programmes	• Health promotion • Organizational interventions • Social support • Job redesign	• Support in crises and treating experiences • Early rehabilitation • Stress management
Secondary prevention	• Early detection of reduced working ability	• Access to preventive OHS • Periodical health examinations for early detection of symptoms	• Early detection of fatigue, burn-out and depression
Rehabilitation	• Legislation about rehabilitation and access to rehabilitation services	• Liaison with health services and employment offices	• Return to work after sick leave practices • Active vocational rehabilitation and care of chronic illnesses, e.g. depression

Note: OHS: occupational health services; WHP: workplace health promotion.

the labour market, which at the level of the individual includes the support of employees in a crisis and all kinds of early rehabilitation activities, when any signs of reduced well-being, ill health or social problems arise.

Secondary prevention at workplace level refers to access to preventive occupational health services (OHS) for all employees, for example periodical health examinations for specific age groups. Signs of "burn-out" and fatigue are common in today's working life and need action at an early stage. Curative rehabilitation actions for working-age people could be based at a national level on the social security legislation and include access for all employed people to OHS. When the individual worker's ability is lowered active measures from health care or the social insurance system should start, for example after a certain length of sickness absenteeism. In this respect there are big differences between countries.[7] Especially when thinking of the increasing number of employees suffering from depression, these active interventions by social security or health care systems are crucial to prevent total exclusion from working life.

These kinds of actions are carried out quite differently in various EU countries. When advanced legislation about occupational health services exists, there is an increased probability of having access to these services. The WHP actions cover promoting measures in the workplace and at individual level. However, the existence of legislation or support from social partners is necessary. Actions complementing these interventions and encouraging carrying them out are dependent on social partners and other existing policies, such as education and social policy.

Occupational health and safety at work are improved by specific legislation focusing mainly on safety, along with health at work, and social and organizational matters. Another method of providing health and safety at work is the enforcement of legislation by inspections to improve occupational health and safety at work practices. Recently the inspections have concentrated more on high-risk sectors and using intermediary organizations such as safety engineers, ergonomics specialists, physicians, sector organizations and social partners to reach specifically small and medium-sized enterprises (SMEs). Also, company management is taking increased responsibility for health and safety matters with workers and establishing occupational safety and health systems. Many countries also campaign about specific targeted issues to improve enforcement and spread information. Many administrations and insurance organizations use incentives to improve safety and health at work. The incentives include different premiums for insuring against diseases and accidents, public subsidies for research and technological development, tax benefits based on investment in safety and health at work, and subsidizing the assessment of occupational safety and health within companies. Safety and health at work can also be promoted by certification of products and services, such as chemical products. Training is becoming more important, especially when focused on different target groups.[8]

Occupational health services have generally been considered as an important occupational and work-related welfare benefit in EU Member States; OHS is a context-dependent phenomenon, which varies according to the development of the welfare state in general and, specifically, is dependent on the cultural, historical, economic and political context of each country. Also, the views of different stakeholders in the EU Member States concerning the impact and possibilities of OHS to improve health vary from evidence-based opinions to the sporadic impact of OHS on occupational health. The tasks of OHS have evolved towards multidisciplinary and more organizational developments and the WHP sphere, rather than than remaining purely as a preventive and protective service for workers. The development of OHS since 1989 in various EU Member States displayed differences depending on the starting position, but indicated the importance of planning and implementation as crucial

phases in the process to achieve better OHS coverage, equity and access. Nevertheless the data used for the planning and legitimization of OHS activities are mainly based on occupational health data rather than on OHS data, which makes decisions on political or policy grounds inaccurate. OHS is still an evolving concept and benefit for workers, but the changing situation of OHS reflects contextual changes, such as the internal market, competition and enlargement. Owing to new epidemics, the epidemiological shift towards new risks, an ageing labour market (and changes in the labour market), stronger cooperation, and integration with health, social and employment services would be an asset for workers. Different methods and approaches are needed in order to study the results of integrated services.[9]

Public health services and primary health care also provide essential health services for workers, for which support with environmental and mental health are important. In relation to work, good mental health increases working ability and productivity; poor working conditions lead to poor mental health, sick leave and increased costs. Beneficial interventions are improvements in individuals' capacity to control work stressors and return-to-work practices. Some participatory workplace and management practices improve health and economic development, employees' well-being, competences and productivity. Participatory interventions and management culture are seen as being worthwhile for mental health at work.

The concept of WHP is a broader-than-usual occupational health prevention and protection orientation including organizational and psychosocial matters at work and responsibilities of the enterprises in making WHP possible at work. The WHP approach provides the promise of enhanced collaboration between different stakeholders such as public health and primary health care services, occupational health services, occupational health and safety services, human resource management and companies with corporate social responsibility (CSR), and regional and national institutes. Workplace health promotion is an evolving concept; best practices in companies have been published by the European Network for Workplace Health Promotion.

Responses by the EU on safety and health at work

Even if the focus of the EU is in economic integration and market creation, the concern of workers' health and safety at work has been in the core action areas of the European Community (EC) since the initiation of increased protection of workers in the coal and steel industries.* Treaties have emphasized workers'

* Health and safety at work was mentioned in the 1951 European Coal and Steel Treaty (Article 2) and in the 1957 Euratom Treaty (Articles 30–39) to cover workers in those specific industries. The Treaty of Rome of 1957 extended this health and safety at work provision to also cover other industries (Articles 117–118).

rights and conditions to facilitate freedom of movement of labour between Member States.* The rights of workers and decent conditions of living and working have been in the agenda of the Community continuously. The rights of workers have progressively expanded to include health and safety at work,† working hours and employment contracts,‡ conditions governing collective redundancies,[10] the environment,§ consumer protection and public health.‡‡ Non-binding provision concerned a social dialogue between employers and employees.** The harmonization of the social protection systems to coordinate the movement of the labour force and social protection has been established by the Treaty of Rome†† and regulations.[11] In 1989 Framework Directive 89/391/EEC was accepted,[12] which outlined general principles of the prevention of occupational risks and the protection of health and safety at work on which the other daughter directives have been built.[13–23]

The EC has implemented action programmes on health and safety at work since 1978. The programmes have included issues such as causes of occupational accidents and diseases, protection against dangerous substances, prevention of the hazards and harmful effects associated with machinery, and information, statistics and research. Whereas in the past the main focus of EU action on health and safety at work has been legislative, the programme on health and safety at work 1996–2000[24] provided a much "softer" approach to health and safety at work and a greater emphasis on information. This emphasis was in the effective enforcement of legislation, promotion of competitiveness through better health and safety standards, and continuous social dialogue in health and safety at work issues. The interim report[25] on health and safety at work set the priorities for the second phase of the programme to prepare for the enlargement and develop the link with employability due to the Luxembourg Employment Summit (1997).

Framework Directive 89/391/EEC created the legislative base for health and safety at work in EU Member States. The Commission evaluated the implementation of Framework Directive 89/391/EEC in 2004.[26] The EU Member States were categorized according to the impact of Framework Directive 89/391/EEC on national legislation. The first group included countries that had inadequate or old legislation and had considerable legal consequences for health and safety at work (Greece, Ireland, Italy,

* Treaty establishing the European Economic Community (EEC) signed in Rome in 1957; Community Charter of the Fundamental Social Rights of Workers adopted in Strasbourg 1989.
† Article 118a of the Single European Act, Framework Directive 89/391/EEC.
‡ Framework contracts: parental leave 1995; part-time employment contracts 1997; and fixed-term employment contracts 1999.
§ Article 100A of the Single European Act.
‡‡ Article 152 of the Amsterdam Treaty.
** Article 118b of the Single European Act.
†† Article 117 of the Treaty of Rome.

Luxembourg, Portugal and Spain). The second group of countries completed or refined their legislation due to the Framework Directive (Austria, Belgium, France, Germany, the Netherlands and the United Kingdom). In the third group of countries the legislation was in place and no major adjustments were required (Denmark, Finland and Sweden). The same report stated that the Framework Directive on health and safety at work with its first five daughter directives [13–15,27,28] were driving forces to increase prevention, rationalizing, and simplifying the national legislation on health and safety at work. Another aspect of the impact was that the Member States had to change from prescriptive detailed legislation towards objective-oriented law.

Health and safety at work is considered as part of the social policy of the EU. The Maastricht Treaty and the Agreement on Social Policy signed in 1992 set out European policy in the area of working conditions.[29–31] The social chapter* formulated social policy including issues of social dialogue† among, for example, labour market organizations, development of working and living conditions, occupational safety and health at work, social dialogue and equal pay.

This was followed by the Nice Summit and its social agenda in 2000. It formed the basis for the process of meetings to formulate the Community strategy on safety and health at work 2002–2006 as adapting to change in work and society. The strategy emphasized a global approach to well-being at work, prevention, information dissemination and better application of laws in addition to building partnerships. Furthermore, the Advisory Committee for Health, Hygiene and Safety at Work and the Committee of the Health and Safety Commission for Mines and Other Extractive Industries were integrated to a single Advisory Committee on Health and Safety at Work. The health and safety strategy for 2007–2012 is under preparation during the Austrian presidency of EU, which started in the spring of 2006. A preparatory seminar was held during the United Kingdom's presidency in the autumn of 2005 with themes of achieving more for occupational health with partnerships and target setting.‡

Changing the world of work and healthy organizations

Owing to changes in employment and the labour market, both enterprises and employees need an enhanced capacity to adapt themselves to changes. The goals of the employment policy of the EU include raising the employment rate and improving the functioning of the labour market. Key measures are to extend

* Articles 117, 118, 118a and 119.
† Article 118c.
‡ www.hse.gov.uk/aboutus/europe/presidency/programme.htm, accessed 24 March 2006.

employees' labour market careers, improve the incentives of tax and benefit systems and wage formation, and improve the balance between labour demand and labour supply.

Employment is closely linked to the financial viability of the welfare state and its benefits. The recent retrenchment and reforms of the welfare state and social policy in many European countries directly reflect the financial concerns regarding the sustainability of the welfare state and its social services in the era of permanent high unemployment. Nevertheless, employment and social policies are preconditions for economic prosperity, trust and social peace, and the well-being of the workforce. The welfare state is often able to act as a buffer between the most striking impacts of globalization on the labour market and social distress.[32–34] Workplace health promotion can contribute partly to keeping the workforce healthy, modify work for the workers, and get people out of unemployment and back to work.

Changing working populations, workplaces and the characteristics of work

Demographic change applies to the increasing ageing workforce, participation of women at work and changing patterns of family life. Health is a valuable asset for creating time for a productive life and for using time effectively. The same applies to extended lifespans and the interest in keeping people working longer instead of retiring. A similar connection with improved health and work can also be made between a decrease in death rates or disabilities and common lifestyle-related diseases such as heart disease. The change in health gains has also enhanced the productivity and earnings of workers in the age group 40–50 years owing to applied advanced technology to save lives and reduce mortality.[1]

The features of a working life play an important part in prolonging working careers. "Working life" covers a large variety of issues, which should be adjusted according to changes due to ageing: work content and demands; the physical and social environment of work; organizational aspects; and the option of regulating and influencing one's own work as well as management and leadership matters. Generally, one of the most important effects of ageing is that individual physical, mental and social differences improve remarkably. Therefore, individual solutions at work should increase with advancing age. This will also increase the empowerment of workers, which has a strong effect on working ability and well-being during ageing. The possibility to regulate one's own work includes taking breaks, changing the order of tasks, changing work methods and changing work speed. The demands of work and existing skill were well met by the majority of older men and women. Generally, about 75% of men and women aged 45 and older felt they had adequate opportunities

to discuss their work matters with their supervisors. The employees often reported positive changes in their work when regular discussions between the employer and employee were conducted.[35]

Work time is of particular importance for older workers. It is perhaps the most powerful way to regulate workload and balance personal needs with working life. Long working weeks (greater than 40 hours), however, seemed to be rather common in the EU in 2000. In five countries, more than a third of men and a fifth of women had long working weeks. Irregular day work, including weekends, was common among older women in another five countries, reflecting the differences in working time cultures between the different countries.[36,37] In addition, indirect age discrimination is more common than direct. However, age discrimination is more common in some countries, and more often women aged 45 and older face age discrimination more than men.[35]

The changing working life and changes in family patterns also have an impact on health. In all European countries women participate more in the labour market; care responsibilities for children and the elderly are under negotiation. In addition, there are changes in family structures towards more single-earner families and these often need help with income assistance and caring. Also, support may be needed regarding volume of and access to care services, flexible working hours from the employer, and increased male participation in household work and caring in families. However, the supporting features and benefits for families will not readily ease the pressures on families and therefore improve the health of working family members leading to greater productivity in the labour market.[38]

The processes of downsizing, technological change and restructuring have proceeded hand in hand with changing employment contracts as many people have moved to non-standard work contracts characterized by more part-time work and with less access to benefits. Thus people in restructured workplaces and environments face new work hazards and new conditions of employment. This is also true in the public sector, where privatization and contracting out are complex, with adverse dimensions of employment with downsizing, restructuring and unemployment, threat of unemployment, re-employment with altered working conditions and reduced wages and benefits. Some of the adverse health effects are summarized in Table 4.2.[39]

The labour movement established living wages, regular working hours, regulated working and employment conditions, and employment-associated benefits. Even the most stable, full-time and well-protected conditions of work have changed to become more precarious. For workers on the edge of the labour market the situation has become even worse in terms of employment

Table 4.2 *Some adverse health effects of changes in workplaces*

Adverse health effects of unemployment	Adverse health effects of restructuring	Adverse health effects of non-standard work arrangements
• Elevated blood pressure • Increased depression and anxiety • Increased visits to general practitioners • Increase symptoms of coronary disease • Worse mental health and greater stress • Increased psychological morbidity and Increased medical visits • Decreased self-reported health status and an increase in the number of health problems • Increase in family problems, particularly financial hardships	• Reduced job satisfaction, reduced organizational commitment and greater stress • Feelings of unfairness in downsizing process • Survivors face new technologies, work processes, new physical and psychological exposures (reduced autonomy, increased work intensity, changes in the characteristics of social relationships, shifts in the employment contracts and changes in personal behaviour) • Changes in the psychological contract and lost sense of trust • Prolonged stress with physiological and psychological signs	• Higher rates of occupational injury and disease than workers with full-time stable employment • High level of stress, low job satisfaction and other negative health and well-being factors • More common in distributive and personal service subsectors where people in general have lower educational attainment and low skill levels • Low entitlement to workers' compensation and low level of claims by those who are covered • Increased occupational health hazards due to work intensification motivated by economic pressures • Inadequate training and poor communication caused by institutional disorganization and inadequate regulatory control • Inability of workers to organize their own protection • Cumulative trauma claims are difficult to show due to mobility of workers • Reduced ability to improve life conditions due to inability to obtain credit, find housing, make pension arrangements, and possibility for training • Fewer concerns for environmental issues and health and safety at work

standards. Increased female participation in the labour market, particularly in service sectors, such as health, the social sector and the education of publicly funded systems, has faced restructuring, the renegotiation of conditions of employment and contracting out. Despite the need for these services among the increased numbers of elderly in need of care, increased female participation in the labour force in other sectors, and the decreasing number of people in the labour market due to the ageing workforce, working conditions have deteriorated. Also, unemployment and other welfare benefits have decreased and their conditions have been tightened towards activation policies and action programmes. The heightened financial problems with precarious employment may increase the possibility of undesirable health effects.

Fixed-term and contractual work contracts mean increased flexibility demands by workers and increasing demands on balancing work and private life. The rigidity of work contracts can result in employment possibilities transferring to countries with less regulation of working hours and contracts. Temporary workers have shown lower rates of absence due to sickness and their health problems result in less absenteeism than permanent workers, although this might indicate presenteeism despite being ill. For some temporary employees, higher job insecurity equated with a larger workload. Temporary employees were less satisfied with their jobs and had less access to occupational training and career planning. For some, however, a temporary work contract acted as a bridge to permanent employment. This kind of labour market differentiation might result in a widening of socioeconomic differences in health.[40]

A good working environment also improves the performance of a company. The quality of a working environment has a strong influence on productivity and profitability.[41] Some positive factors are the combination of business targets with human resource activities, a health-promoting corporate culture, integrating technical innovations with organizational improvements and a continuous evaluation of measures taken. However, many companies are still unaware of the economic aspects of occupational safety and health. Some companies measure their performance in addition to financial terms with a customer, internal business, innovation and learning factors.

According to the survey on working conditions in EU countries, 82% of employees were on a permanent contract and 10% on a fixed-term contract in 2000. Training received by employees on fixed-term contracts and temporary agency contracts had decreased during the previous 12 months. Also, 24% of respondents reported having to work under pressure, and health problems related to working under pressure were perceived by 73%. Stress was reported by 40% and it was clearly more common among those with indefinite work contracts and more-qualified workers. Information or consultation leading to

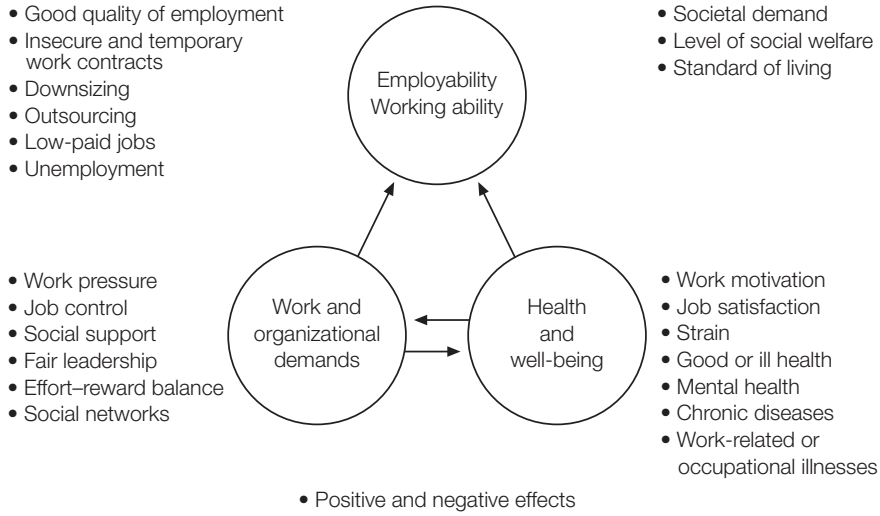


Figure 4.1 *The interrelationship between work, health and employability*

improvements in the workplace were reported by 75% of respondents. The percentage of workers who reported absences over the previous 12 months due to work-related health problems was 9%. There were also clear national differences on such issues as caring for the elderly or for disabled relatives, which could be attributed to national differences in family dispersion and care systems.[42] These survey data clearly show that organizing work and combining work and an individual's private life differ between countries, thereby indicating different practices in working life.

Healthy work organizations and quality of work

Work and organizational factors can have both positive and negative effects on the health and well-being of workers. Together work and organizational factors and health contribute to the working ability and employability of working-age people. Many work-related factors can be health promoting when they are positive, but lead to adverse health effects when unsatisfactory. Figure 4.1 describes the changes occurring in working life that have an influence on employability either directly or via the work demands and health of workers. The main focus here is how different work and organizational factors are influencing the health and well-being of workers.

When characterizing the effects of working conditions on workers' health, the work and organizational demands are of most interest. Factors in the working environment, such as physical and chemical exposures, usually have specific threshold limit values which are not allowed to be exceeded to avoid their adverse

health effects. Psychosocial factors at work usually have an optimal level which can be seen as having a positive effect on health. For example, the content of work should not be too monotonous or too difficult. The theoretical models concerning psychosocial factors at work are based on theories of work stress. When the level of stress is too high people can develop symptoms of chronic fatigue or if it is too low it can lead to lowered motivation and boredom. There are two main models explaining the relations between psychosocial factors at work and their health effects. According to the Karasek job demand–control model,[43] high job pressure with low job control leads to adverse effects and even diseases such as cardiovascular problems. Another common theoretical model is the effort–reward imbalance model. If the effort of the employee is too high in relation to rewards in the job then there is a risk of stress symptoms and illnesses.[44]

The mechanism explaining the adverse effects of the psychosocial demands at work on health can be explained by the physiological and psychological stress mechanisms.[45] There is a lot of evidence that too high a workload leads to symptoms of stress and in due course to conditions such as cardiovascular diseases, depression and musculoskeletal disorders. In addition to the aforementioned job-related factors there is also research evidence that workplace downsizing and poor leadership can lead to increased sickness and absence. Even an elevated risk of death has been found after organizational downsizing. This means that the psychosocial factors at work can be a severe risk factor for health, reduced working ability and even increased mortality. But when these psychosocial factors at work are positive, they can promote workers' health, provide challenging tasks, fair leadership, social support at work and an effort–reward balance.

The model including the most important work and organizational factors and practices promoting workers' health form the concept of healthy work or healthy work organization.[46–48] At the same time, some factors included in this healthy work model are able to promote productivity and well-being at work. There are Finnish examples from SMEs where both the profitability and productivity of the company were positively related to a good social climate and good supervisory practices.[49]

The main characteristics of a healthy work organization comprise the appreciation of people. At workplace level this means trust and fair treatment and the consideration of ethical issues in decision-making. As already mentioned, job demands and control, when optimal, have a positive impact on health and well-being. Also, social support from co-workers and supervisors is important. Good leadership and management practices are important, especially fair leadership.[48]

In today's working life structural and functional changes are frequent. Downsizing and restructuring, as well as other types of organizational change, should be carried out in accordance with workers' participation and appreciation. The possibility of combining the interests of employers and employees is beneficial and the participation of employees in organizational change processes is crucial. Any savings from "downsizing" personnel can be lost because of increasing sickness and absence among those remaining.[50]

The adoption of continuous improvement practices and creating an innovative climate at workplace level promote the idea of lifelong learning and the development of competencies. The competence development of workers is especially important in a turbulent market environment for older people and in general to prevent exclusion from the working life. One crucial characteristic of a healthy work organization is also the work–life balance. The demands of flexibility at work should be balanced with other life spheres of the employees. Here the working time arrangements are of most importance. An awareness of the diversity of personnel is an important topic in healthy work organization practices. Neglecting these issues easily leads to the discrimination and marginalization of older workers, women and people who do not belong to the majority.

The promotion of healthy organization practices

The promotion of healthy work organization practices needs participatory action from management and employees, as well as the occupational health specialists and training experts. Increasing one's own control at work and employee participation in general are fundamental issues for preventing the harmful effects of stress caused by psychosocial factors at work.[51] At workplace level this means the continuous monitoring of critical characteristics of work as well as workers' well-being and health. There are various survey methods for assessing psychosocial stressors at work. Not only is monitoring working conditions important, so are improvements and changes based on the results. Participatory organizational interventions and access to occupational health services and their preventive actions are tools and actions for improving working conditions.

Multilevel approaches are usually the best way to implement healthy work practices. At national level, legislation – or at least agreements between social partners about risk assessment and WHP activities – is necessary. But at EU level guidance, good practice and intervention programmes are important for improving working conditions. When actions at individual level are needed the occupational health services, general health services or employment or educational sector services are needed. The close collaboration among these

actions from various sectors is necessary for effective coordinated actions at national, workplace and individual levels. A framework agreement on work-related stress between social partners is important for preventing stress and to identify problems of work-related stress as well as to prevent and reduce it.[52]

Because of the wide national variation within the EU and also among the various branches and sectors, measures must be tailored and contextualized in order to increase their effectiveness. Therefore actions such as WHP and various risk assessment methods and types of good practice help practical actors such as occupational health experts at workplace level. General action models are needed for various levels and experts such as those who are able to tailor actions to the national, local and workplace contexts.

Setting EU targets for employment and labour market policies

The Luxembourg Jobs Summit in November 1997 launched the European Employment Strategy to decrease unemployment in Europe. The process is called an open method of coordination, in which common objectives, targets and priorities for employment policies are set. Each Member State prepares a national action plan. The Joint Employment Report is prepared for each Spring Council. The Commission presents a new proposal for the Employment Guidelines based on the reports of the previous year.[53] Progress was evaluated in 2002[54] and underlined the need to include the Employment Strategy and to move towards the Lisbon Strategy goals of sustained economic growth, more and better jobs and greater social cohesion by 2010. The overall employment rate in Europe should be increased to 70% and the number of women at work to more than 60% by 2010. The newest targets are related to older workers (that is the 55–64 years age group) and their increased employment and later exit from the labour market.[55] The increased number of older workers needs financial incentives, good health and safety at work, flexible forms of work, access to training, active labour market policies and good quality of employment.[56]

The crucial issue is how to attract young people into the labour market earlier than at present and to keep people in employment for longer. This target is based on the overall employment rate, which is expected to be 70% by 2010.[57] In addition, for older workers (aged 55–64) the target for the employment rate is 50% by 2010[58] and the average age at which people stop working should be raised by five years by 2010.[59] This might be achieved by the modernization of social protection systems, especially health care, child care facilities to combine work and private life, and a benefit system to avoid wage traps.[60]

The Stockholm Spring Council in 2001 outlined the concept of quality of work. The focus on quality of work in employment[61] put forward a plan based on the idea that quality of work depends on a careful balance between job characteristics, work environment and labour market characteristics. Quality of work includes issues such as time, work and personal life, changes in work organization and labour market flexibility to achieve improvements.[62,63] The European Summit in Laeken in 2001 drew attention to the close links between quality of work and productivity.

The increasing mean age of the working population means there is a strong need to make active working lives longer. The primary aims are economic, to increase productivity. European Social Fund projects have promoted the competence level, working ability and health of those groups that are entering working life, or are in danger of being excluded from the labour market. Several national projects have focused on those in working life and those who are unemployed. An evaluation of these activities has shown positive effects on the quality of work contracts and health, too. For example, the JOBS group interventions carried out among unemployed people in Finland and other EU countries, as well as in the United States, have proved to be effective in preventing exclusion and depression. The positive effects of these interventions have lasted longer in countries with better social security and benefit systems.[64] In general, the trials to prevent exclusion from working life and strengthen people's resources have prolonged productive work careers.

Social benefits and education opportunities act as a cushion against an unpredictable working life

Industrial restructuring and labour market changes also reduce the need for certain professionals while also increasing other people's opportunities to gain access to paid and secure work. Furthermore, the continuous need for upgrading knowledge and lifelong learning capacity is needed to keep people in the labour market. The persistent threat of losing work and the stress of maintaining skills, knowledge and professional competence has an influence on job satisfaction and is reflected in health consequences. Therefore the supporting social policies and education opportunities are important to keep, rebound and retrain back into the workforce.

The functioning single market has necessitated the harmonization of certain aspects of national social security policies as significant differences in social security throughout the EU would hinder the free movement of people. Greater convergence of social security systems is expected to prevent social dumping through "social devaluation", which could be used to compete between countries by lowering non-wage costs, which are used to finance

social protection, including health services. In addition, social policy emphasizes equal opportunities for all, which means equality between women and men, combating discrimination and the integration of people with disabilities.

The overall trend in the European countries seems to be to decrease the influence and interventions of the state on social, health and employment benefits and services. However, new challenges, such as long-term unemployment, exclusion and other conflicts increase the legitimacy of social and employment policies. Economic reasons for this are strongly proposed as the coverage and level of social expenditures are increasing during time of reduced funding. Nevertheless, national decisions on the retrenchment of social and health services are based on ideological–political and economic realities, which are conducive from the common economic rules of public sector deficit and criteria of the European monetary union (published in broad economic guidelines annually by the European Commission). In addition, the directive on services[65] imposes challenges to health and social services, including preventive and protective services in health and safety at work.

Investing human capital through education and training softens the impact of a turbulent labour market and industrial restructuring. The different dimensions of human resources such as health and functional capacity, knowledge, skills and competences as well as values, attitudes and motivational aspects are crucial determinants of working ability, the sustainable working career and the employability of employees. In addition, job contents are increasingly mental, emotional and social instead of muscular and manual, and competence demands have therefore changed in the information society. The insufficient or outdated competences of older workers is a challenge for which the competence gap is a remarkable stress factor.[66] The requirements of the present working life emphasize group work and social skills to work with different people. However, the coping mechanisms which develop with experience can significantly improve the working ability of older workers. The demands of working life have transformed the life course towards lifelong learning and retraining processes, and where periods of employment, unemployment, family and voluntary activities may shift and vary.[67]

The challenges faced by young workers include developing their working life skills, finding a job after their education and successfully socializing in their work communities. Resolving these challenges can have a beneficial effect on health.[68] The main challenges are related to personal development and the transition from school to working life,[69] such as end of formal education and finding a job relevant to the person's training, socialization and integration into working life and the work community and the beginning of career planning and later career management.

Education and training in the European countries are within the supporting policy areas for the Lisbon Strategy and the aim is to improve the quality of education and training systems. This will be achieved by an open method of coordination with sharing of experiences, working towards common goals and learning from what works best elsewhere. In 2001 the Ministers of Education adopted a report on the future objectives of education and training systems,[70] agreeing for the first time on shared objectives to be achieved by 2010. A year later, the Education Council and the Commission endorsed a 10-year work programme for joint cooperation in the field of education and training. The major goals are to improve the quality and effectiveness of EU education and training systems, ensure accessibility to education for all, and open up education and training to the wider world. Lifelong learning is the key in all areas of education and training (including the training of trainers), information technology, language training, guidance in lifelong learning, etc.

In vocational training the Copenhagen Process and the Bologna Process for the development of the European Higher Education Area are important. Both contribute actively to the achievement of the Lisbon objectives and are therefore closely linked to the Education and Training 2010 Work Programme. Investment in human capital and lifelong learning are emphasized by the EU to enhance access to employment for all ages, and raise productivity levels and quality at work. Member States aim to establish comprehensive lifelong learning strategies by 2006. Workers, if they are to remain and progress in work, need to accumulate and renew skills regularly. The productivity of enterprises is dependent on building and maintaining a workforce that can adapt to change, which requires action by governments and financial support for various actors.

Social partners and health at work

The link between social policy and industrial relations lies in the concept of bipartite employment-based contributions to the social insurance funds from which employment benefit, sickness and accident benefit and retirement pensions are paid.[71] Social insurance developed mainly as a male-oriented system and family dependants were often built into benefit scales. In addition, rights were tied to years of participation in the employed workforce. A high number of women in the labour market created different conditions for functions of the labour market and welfare state. Employment-based contributions have acquired a new role as the costs of social insurance systems have increased and so have the contribution levels.[71]

The Social Dialogue Committee and sectoral social dialogue committees are forums for ongoing independent bipartite dialogue. Many sectoral social dialogue committees have prepared health and safety at work guidelines, codes of conduct and information campaigns as well as monitored the implementation of legislation.[72]

The social dialogue[73,74] has created some positive actions,* such as joint opinions on the setting up of a cooperation strategy for economic policies, the completion of the Internal Market, the implementation of the Social Charter of the Fundamental Rights of Workers, and progress towards economic and monetary union. In July 2002, a framework agreement on teleworking was concluded, to be implemented by the members of the signatory parties, rather than by means of a directive. However, concrete pay and conditions of employment are not subject to collective agreement at European intersectoral or sectoral level.[75] Also, the European Commission has conducted consultation processes on the Green Paper to deal with demographic change[76], works councils, to promote the active inclusion of the people furthest from the labour market[77] and young people. One example of the results of dialogue between the social partners is that an agreement has been reached on the definition of stress at EU-level.[52,78]

The major responsibility of enterprises in safety and health at work is to provide healthy and safe workplaces and work environments. In addition, the companies should follow and implement legislation according to the requirements and provide services on health and safety at work issues for the benefit of workers. Because of changing working life and organization of work, corporate social responsibility was created to respond to the challenges of globalization. The Organisation for Economic Co-operation and Development (OECD) guidelines for multinational enterprises[79] are not binding but rather are recommendations for good conduct of business in the era of globalization. Also, the EU has its own concerns for CSR and, included in the concept of CSR, concerns for social and environmental issues in business operations and their interactions with stakeholders on a voluntary basis.[80] The major challenges remain in balancing the voluntary nature of corporate social responsibility and the need for regulating such responsibilities.[81] In principle, CSR is a voluntary tool for integrating social and environmental issues into business and also promoting trust and transparency among SMEs[82]. Also, health and safety at work comprises part of CSR.[83] In the study conducted by the European Agency for Safety and Health at Work in 2004 the company case study revealed that CSR is relevant to large and small companies alike and is often managed by

* The social dialogue occurs mainly between ETUC, UNICE and CEEP (plus, more recently, UEAPME and the EUROCADRES/CEC liaison committee).

senior managers with a range of methods. Often CSR-practising companies also have an interest in health and safety at work due to image or taking responsibility regarding social accountability via suppliers. The role of the public sector may include financial support, distribution of tools, expertise and information, and improve dialogue between different actors and issues in CSR.[81]

According to Segal et al.[84] occupational health and safety as part of CSR can be used as a measure of CSR in companies in relation to production and safety, labour standards and working conditions within human rights and equal opportunities. Other issues taken up by CSR and health and safety at work conjunctions are ethical and moral issues in relation to environment, work and life balances, and combining work and care possibilities.[83] If occupational health and safety issues are integrated into CSR, the company may also achieve public appreciation and the fame of being successful, and may produce benefits such as value for a good reputation as an employer, an increase in productivity, consumer loyalty and even additional value for shares.[83] However, investors need some indicators to follow and assess health and safety at work actions in order to make investment decisions.[85] The same applies to WHP activities and their inclusion in CSR.

Company policy and corporate culture facilitate the inclusion of WHP into their activities reflect the importance of workers in the value-added chain and have an influence on decision-making and leadership behaviour. Health determinants in companies may include human resources and leadership, work organization and job design, work environment, job security, and changes to the world of work and health competencies. Company practices enhance quality of life and work, performance and innovation in enterprises.[86] The entrepreneur is often geared to running the business rather than building occupational health and safety systems at work and responding to the requirements to write and document occupational health and safety measures undertaken.

Acceptance of WHP and any other health and safety at work measures should be facilitated by suitable and easy solutions and models for SMEs. In addition, different actors with SMEs need to coordinate so as not to duplicate activities, and to pool resources to make an efficient impact in SMEs and improve acceptance of WHP. Training of new occupational health and safety professionals should incorporate a clear concept of WHP. Wider aspects of WHP, such as safety issues with lifestyle factors, need to be integrated to achieve greater and more profound effects. Workplace health promotion activities need to focus on motivation, cooperation and consultancy to gain interest and acceptance among workers and different types of companies.[87]

Conclusion

The role of policies such as health, employment, the labour market, education and social policies in the world of work are multitudinous, fragmented and sporadic. Therefore the role of cooperation and collaboration in partnership with different policy actors, policy processes, service providers, benefit structures and social partners is very important. Employment policies focusing on the globalization of the labour market and the type of work contracts and work–life balance have a direct influence on the working and living conditions of workers (both at workplace and individual levels). The implementation of the Lisbon Strategy also needs stronger consideration of health and social aspects to balance insecurity and flexibility in the labour market and in people's lives. The integration of education and training policies with employment policies promotes social inclusion in working life and prevents exclusion. At workplaces, improving working conditions by assessing and controlling stress at work and promoting occupational mental health reduces absenteeism and possibly also the productivity of the company. Concluding recommendations are summarized in the following points:

- Good collaboration and horizontal partnership is needed, especially between social, health, education and employment policy-makers, national agents and social partners.
- Improving the health and working conditions and the employability of workers through the generations, through actions directed towards health and working conditions is crucial.
- In enhancing the inclusion of people in working life, their resources should be continuously developed and working conditions improved to strengthen individuals' health and competences.
- Preventing the exclusion of workers, or getting people back to work by social, re-education and employment programmes and integrated services, is important and these services need to become easily available to the working-age population.
- Workplace health promotion activities are of central importance for keeping people at work, to guarantee the quality of work contracts and prevent the adverse effects of psychosocial and other negative factors at work.
- Job efforts and demands, individual rewards and the work–life balance should be maintained to prevent adverse effects on health.

REFERENCES

1. Suhrcke M et al. *The contribution of health to the economy in the European Union*. Brussels, European Commission, 2005.
2. Dahlgren G, Whitehead M. *Policies and strategies to promote social equity in health*. Stockholm, Institute of Futures Studies, 1991.
3. European Communities. *Facing the challenge: the Lisbon strategy for growth and employment. Report from the High Level Group, chaired by Wim Kok*. Luxembourg, 2004 (http://europa.eu.int/comm/lisbon_strategy/index_en.html, accessed 24 Feb. 2006).
4. *Ten years of working conditions in the European Union*. Dublin, European Foundation for Improvement of Living and Working Conditions, 2001.
5. Quinlan M, Mayhew C, Bohle P. The global expansion of precarious employment, work disorganisation, and consequences for occupational health: placing the debate in a comparative historical context. *International Journal of Health Services Research*, 2001, 31(3):507–536.
6. Marmot MG. Job insecurity in a broader social and health context. In: Ferrie JE et al. *Labour market changes and job insecurity: a challenge for social welfare and health promotion*. Copenhagen, WHO Regional Office for Europe, 1999, No. 8.
7. Ziljstra, F. Stress impact: a study on return to work. *Work, Stress and Health 2006* conference, 2–4 March 2006, Miami, Florida. US Book of Abstracts, American Psychological Association, 2006.
8. Priorities and Strategies in Occupational Safety and Health Policy in the Member States of the European Union. Bilbao, European Agency for Safety and Health at Work, 1997.
9. Hämäläinen R-M. *Europeanization of occupational health services – the study on the impact of EU policies* [PhD dissertation]. University of Helsinki, Faculty of Medicine, due 2006.
10. EEC Council Directive 94/45/EEC (22 Sept. 1994). *The establishment of a European Works Council or a procedure in Community-scale undertakings and Community-scale groups of undertakings for the purposes of informing and consulting employees* (OJ. L 254. 30/09/1994).
11. Council Regulation (EEC) No. 1408/71 of the Council (14 June 1971). *The application of social security schemes to employed persons and their families moving within the Community* (OJ. L 149. 05.07.1971).
12. Council Directive 89/391/EEC (12 June 1989). The introduction of measures to encourage improvements in the safety and health of workers at work (OJ. L 183. 29.06.1989).
13. Council Directive 89/655/EEC (30 Nov. 1989). The minimum safety and health requirements for the use of work equipment by workers at work (second individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC) (OJ. L 393. 30.12.1989).
14. Council Directive 90/269/EEC (29 May 1990). The minimum health and safety requirements for the manual handling of loads where there is a risk particularly of back injury to workers (fourth individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC) (OJ. L 156. 21.06.1990).
15. Council Directive 90/270/EEC (29 May 1990). The minimum safety and health requirements for work with display screen equipment (fifth individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC) (OJ. L 156. 21.06.1990).

16. Council Directive 92/85/EEC (19 Oct. 1992). The introduction of measures to encourage improvements in the safety and health at work of pregnant workers and workers who have recently given birth or are breastfeeding (tenth individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC) (OJ. L 348. 28/11/1992).

17. Council Directive 92/32/EEC (30 April 1992). Amending for the seventh time Directive 67/548/EEC on the approximation of the laws, regulations and administrative provisions relating to the classification, packaging and labelling of dangerous substances (OJ. L 154. 5.6. 1992); Council Directive 93/69/EEC (23 July 1993). Adapting to technical progress on the approximation of the laws of the member states relating to fertilizers (OJ. L185. 28.7.1993).

18. Commission Directive 93/90/EEC (29 Oct. 1993). The list of substances referred to in Article 13 (1) (5th indent) of Council Directive 67/548/EEC (OJ. L 277.10/11/1993).

19. Council Directive 90/394/EEC (28 June 1990). The protection of workers from the risks related to exposure to carcinogens at work (sixth individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC) (OJ. L 196. 26/07/1990).

20. Council Directive 90/219/EEC (23 April 1990). *The contained use of genetically modified microorganisms* (OJ. L 117. 8.5.1990).

21. Council Directive 89/392/EEC (14 June 1989). *The approximation of the laws of the Member States relating to machinery* (OJ. L 183. 29. 6. 1989).

22. Council Directive 89/686/EEC (21 Dec. 1989). The approximation of the laws of the Member States relating to personal protective equipment (OJ. L 399. 30/12/1989).

23. Council Directive 92/57/EEC (24 June 1992). The implementation of minimum safety and health requirements at temporary or mobile construction sites (eighth individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC) (OJ. L245. 26/08/1992).

24. COM (95) 282 final. Communication from the Commission on a Community programme concerning safety, hygiene and health at work (1996–2000), 7 Oct. 1995.

25. COM (98) 511 final. Mid-term report on the Community programme concerning safety, hygiene and health at work (1996–2000), 3 Sept. 1998.

26. COM (2004) 62. Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of Regions on the practical implementation of the provisions of the Health and Safety at Work Directives 89/391 (Framework), 89/654 (Workplaces), 89/655 (Work Equipment), 89/656 (Personal Protective Equipment), 90/269 (Manual Handling of Loads) and 90/270 (Display Screen Equipment), 5 Feb. 2004.

27. Council Directive 89/654/EEC (30 Nov. 1989). The minimum safety and health requirements for the workplace (first individual directive within the meaning of Article 16 (1) of Directive 89/391/EEC) (OJ. L 393. 30.12.1989).

28. Council Directive 89/656/EEC (30 Nov. 1989). The minimum health and safety requirements for the use by workers of personal protective equipment at the workplace (third individual directive within the meaning of Article 16 (1) of Directive 89/391/EEC) (OJ. L 393. 30.12.1989).

29. Kari M. *Sosiaalinen Eurooppa ja Suomi. EU:n sosiaalipolitiikka Suomen näkökulmasta.* [*Social Europe and Finland. Social policy of the EU from the Finnish perspective*]. Helsinki, Sitra (Atena), 1997.

30. Savio A. *Soft methods in the European Union social policy. Target-oriented guidance as a welfare strategy*. Helsinki, STAKES (Gummerus), 1995.

31. Nielsen R, Szyszczak E. *The social dimension of the European Union*. Copenhagen, Handelshojskolens forlag, 1997.

32. Deacon B et al. *Copenhagen Social Summit ten years on: the need for effective social policies nationally, regionally and globally*. Policy Briefs. No. 6. GASPP Publications, Helsinki, 2005 (www.stakes.fi/gaspp, accessed 2 Feb. 2005).

33. Deacon B. *Socially responsible globalization: the challenge to social security*. Helsinki, key-note address. World Congress of the International Social Security Association, 25 Sept. 2000.

34. Deacon B. *Socially responsible globalization: a challenge for the European Union*. Publications 1999. Helsinki, Ministry of Social Affairs and Health (Edita), 1999:26.

35. Paoli P, Merllie D. *Third European working conditions survey 2000*. Luxembourg, European Foundation for the Improvement of Living and Working Conditions, 2001.

36. Härmä M, Ilmarinen J. Towards the 24-hour society – new approaches for aging shift workers? *Scandinavian Journal of Work, Environment and Health*, 1999, 25(6, special issue):610–615.

37. Härmä M et al. A controlled intervention study on the effects of a very rapidly forward rotating shift system on sleep–wakefulness and well-being among young and elderly shift workers. *International Journal of Psychophysiology*, 2006, 59(1):70–79.

38. Kröger T, Sipilä J, eds. *Overstreched. European families up against the demands of work and care*. Oxford, Blackwell Publishing, 2005.

39. Ostry AS, Spiegel JM. Labour markets and employment insecurity. Impacts of globalization on service and healthcare-sector workforces. *International Journal of Environmental Health*, 2004, 10:368–374.

40. Virtanen M. *Temporary employment and health. People and work*. Research Reports 61. Helsinki, Finnish Institute of Occupational Health, 2003.

41. De Greef M, van den Broek K. *Quality of the working environment and productivity – research findings and case studies*. Bilbao, European Agency for Health and Safety at Work, 2004.

42. Paoli P, Merllié D. *Third European survey on working conditions 2000*. Dublin, European Foundation for the Improvement of Living and Working Conditions, 2001.

43. Karasek R, Theorell T. *Healthy work*. New York, Basic Books, 1990.

44. Siegrist J. Adverse health effects of high-effort/low-reward conditions. *Journal of Occupational Health Psychology*, 1996, 1:27–41.

45. Lazarus RS. *Psychological stress and the coping process*. New York, McGraw-Hill, 1966.

46. Cox T, Howart I. Organizational health, culture and helping. *Work & Stress*, 1990, 4(2):107–110.

47. Cooper CL, Cartwright S. Healthy mind; healthy organization – a proactive approach to occupational stress. *Human Relations*, 1994, 47(4):455–471.

48. Lindström K, Karwowski W, eds. Work organizations: health and productivity issues. In: *International Encyclopedia of Ergonomics and Human Factors. Vol. III*. New York, Taylor & Francis, 2001:1608–1611.

49. Lindström K et al. The effects of promoting organizational health on worker well-being and organizational effectiveness in small and medium-sized enterprises. In: Murphy LR, Cooper CL, eds. *Healthy and productive work – an international perspective*. London, Taylor & Francis, 2000:83–104.

50. Vahtera J, Kivimäki M, Pentti J. Effect of organisational downsizing on health of employees. *Lancet*, 1997, 350:1124–1128.

51. Cox T, Griffiths A. Assessment of psychosocial hazards at work. In: Schabracq MJ, Winnubst JAM, Cooper CL, eds. *Handbook of work and health psychology*. Chichester, John Wiley, 1996:127–146.

52. Social dialogue. Work-related stress. Framework agreement on work-related stress. Brussels, European Trade Union Confederation (ETUC), 8 Oct. 2004.

53. Ahonen P. Kaukana Euroopan sosiaalipolitiikan "Rooma" ja "Maastricht": avoimen koordinointimetodin näkökulma [It's a long way to the "Rome" and "Maastricht" of European social policy: the viewpoint of the open method of coordination]. *Janus: sosiaalipolitiikan ja sosiaalityön tutkimuksen aikakauslehti* [*Janus: Journal for Social Policy and Social Work*], 2002, 10(1):38–54.

54. COM (2002) 416. *Taking stock of five years of the European Employment Strategy*, 17 July 2002.

55. COM (2002) 9. *Increasing labour force participation and promoting active ageing*. Report from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions. Report requested by the Stockholm European Council and submitted to the Barcelona European Council, 24 Jan. 2002.

56. COM (2004) 146. Communication from the Commission of 3 March 2004. *Increasing the employment of older workers and delaying the exit from the labour market*. Brussels, 16 March 2005.

57. *Presidency conclusions. An agenda of economic and social renewal for Europe*. Contribution of the Commission to the special European Council. Lisbon, 23–24 March 2000.

58. *Presidency conclusions*. Stockholm, European Council, SN 100/01, 2001 (http://www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/ec/00100-r1.%20ann-r1.en1.html).

59. *Presidency conclusions*. Barcelona, European Council, SN 100/1/02 REV 1, 2002 (http://www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/ec/71025.pdf).

60. COM (2005) 24. *Communication to the Spring European Council. Working together for growth and jobs. A new start for the Lisbon Strategy*, 2 Feb. Brussels, Commission of the European Communities, 2005.

61. COM (2001) 313. Employment and social policies: a framework for investing in quality, 20 June. Brussels, Commission of the European Communities, 2001.

62. *For a better quality of work*. European Union Presidency Conference, Brussels, 20–21 September 2001. European Foundation for the Improvement of Living and Working Conditions. Luxembourg, Office for Official Publications of the European Communities, 2001 (http://www.eurofound.eu.int/pubdocs/2001/68/en/1/ef0168en.pdf, accessed 3 April 2006).

63. Noortje W, Dhondt S, Oeij P. *The impact of new forms of work organisation on working conditions and health*. Dublin, TNO Work & Employment (Netherlands) for the European Foundation for the Improvement of Working and Living Conditions, 2001.

64. Vinokur A et al. Two-years after a job loss: long-term impact of the JOBS program on re-employment and mental health. *Journal of Occupational Health Psychology*, 2000, 5:32–47.

65. COM (2004) 2. *Proposal for a Directive of the European Parliament and of the Council on services in the internal market* [SEC(2004) 21], 5 March 2004.

66. Ilmarinen J. *Aging workers in the European Union. Status and promotion of work ability, employability and employment*. Helsinki, Finnish Institute of Occupational Health, and Ministry of Social Affairs and Health, and Ministry of Labour, 1999.

67. Reday-Mulvey G. *Working beyond 60: key policies and practices in Europe*. Basingstoke, Hants., Palgrave MacMillan, 2005.

68. Vuori J, Koivisto P, Salmela-Aro K. Supporting quality employment and readiness for working life among young people proceeding to working life. *Work and People*, 2003, 17:273–274.

69. Nurmi J-E, Salmela-Aro K. Goal construction, reconstruction and depressive symptoms in a life-span context: the transition from school to work. *Journal of Personality*, 2003, 70:385–420.

70. Council of the European Union. Report from the Education Council to the European Council. Concrete future objectives of education and training systems. 5680/01 EDUC 18, 2001.

71. Crouch C. Employment, industrial relations and social policy: new life in an old connection. *Social Policy and Administration*, 1999, 33(4):437–457.

72. *Industrial Relations in Europe 2002*. Luxembourg, European Commission, Directorate General for Employment and Social Affairs, 2002.

73. COM (96) 448 final. Commission communication concerning the development of the social dialogue at Community level, 18 Sept. 1996.

74. Gabaglio E, Hoffman R, eds. *European trade union yearbook*. Brussels, European Trade Union Institute, 1998.

75. Carley M. Developments in industrial action 1998–2002. European Foundation for the Improvement of Living and Working Conditions. Dublin, European Industrial Relations Observatory, 2003.

76. COM (2005) 94 final. Communication from the Commission. *Green Paper confronting demographic change: a new solidarity between the generations*, 16 March 2005.

77. COM (2006) 44 final. Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions. *Concerning a consultation on action at EU level to promote the active inclusion of the people furthest from the labour market*. Brussels, 8 Feb. 2006.

78. Cox T, Griffiths A, Rial-González E. *Research on work-related stress*. Bilbao, European Agency for Safety and Health at Work, 2000.

79. *The OECD guidelines for multinational enterprises*. Paris, OECD, 2000.

80. COM (2001) 366 final. Green Paper. *Promoting a European framework for corporate social responsibility*, 18 July 2001.

81. *Kauppa-ja teollisuusministeriö. Kansainvälisen sijoitustoiminnan ja monikansallisten yritysten neuvottelukunta. Julkisen vallan haasteet vastuullisen yritystoiminnan edistämisessä. Seminaari yritysten yhteiskuntavastuun kehitysnäkymistä.* [*Ministry of Trade and Industry. Finnish Committee on International Investment and Multinational Enterprises. Challenges of government officials to promote responsible entrepeneurship. Seminar on corporate social responsibility and its evolution*]. Helsinki, Ministry of Trade and Industry, 2003.

82. COM (2002) 347. *Corporate social responsibility: a business contribution to sustainable development*. Commission of the European Communities, 13 May 2002.

83. Zwetsloot G, Starren A, eds. *Corporate social responsibility and safety and health at work*. Luxembourg, European Agency for Safety and Health at Work, 2004.

84. Segal JP, Sobczak A, Triomphe CE. *CSR and working conditions*. Dublin, European Foundation for the Improvement of Living and Working Conditions, 2003.

85. Mansley M. Health and safety indicator for institutional investors. A report to the health and safety executive. Claros Consulting, 2002 (www.hse.gov.uk/revitalising/csr.pdf, accessed 2 Nov. 2005).

86. Breucker G et al. *Guide to best practice. Driving business excellence through corporate culture and health*. Essen, Bertelsmann Stiftung, Gütersloh and BKK Bundesverband, 2005.

87. *Small, healthy and competitive. New strategies for improved health in small and medium-sized enterprises*. ENWHP network report on the current status of workplace health promotion in small and medium-sized enterprises, 2001.

Chapter 5

Public health, food and agriculture policy in the European Union

Liselotte Schäfer Elinder, Karen Lock, Mojca Gabrijelčič Blenkuš

The purpose of this chapter is to highlight how European Union (EU) policies can be assessed and reformed to improve the nutrition and public health of Europe's citizens. Whereas food safety has been given a high profile with the recent establishment of the European Food Safety Authority in Parma, Italy, there is substantial room for improvement when it comes to political action to improve nutrition and prevent obesity and chronic diseases. The Common Agricultural Policy (CAP) and the Health and Consumer Protection strategy are two food-related policies that need to become fully coherent with public health goals, which is also a legal obligation according to Articles 152 and 153 of the Treaty of the European Union. Since changes in food production and marketing will have financial implications for the food sector, the evidence on the links between commercial practices and public health is regularly questioned by producers. In the long term a more prominent health profile in the food supply chain could lead to greatly reduced costs to the health care sector, owing to reductions in the rates of chronic diseases such as heart disease, diabetes and cancer, improved health and well-being for individuals and to better welfare for society as a whole.

This chapter discusses how EU policies influence the supply and demand of food and their impact on nutrition and public health, and how the policies can be improved to benefit the health of the European population. Four suggestions are made as to how public health and nutrition can reach a higher profile on the political agenda in the EU. First, increasing the knowledge

among decision-makers and administrators about the obligation to ensure public health and consumer protection in all EU policies and the societal benefits associated with it. Second, development and refinement of methods for assessing health impacts of policies. Third, more interdisciplinary research concerning health impacts of food and agriculture policies. Fourth, establishment of effective public–private partnerships balancing the needs of consumers and industry.

Agriculture and food supply are key public health issues

Food and nutrition are slowly rising on the political agenda because nutrition-related noncommunicable diseases such as cardiovascular disease, diabetes and some cancers cause a significant burden of disease in terms of ill health and premature death. Chronic noncommunicable diseases are the major cause of adult illness in all regions of the world, responsible for an estimated 35 million (or 60%) of all world deaths in 2005.[1] In Europe, noncommunicable diseases caused 86% of deaths and 77% of the disease burden in the region, with cardiovascular disease alone causing 23% of the total burden.[2] The top seven factors found to be responsible for the bulk of the European noncommunicable disease burden are tobacco use, the hazardous and harmful use of alcohol, high cholesterol, low fruit and vegetable intake, being overweight, having low levels of physical activity and high blood pressure. Agricultural products have a major influence on six of these key disease risk factors.

There is also growing concern for the public health impact of the rapid worldwide increase in obesity. Clearly this worrying trend is determined to a large extent by dietary factors and a sedentary lifestyle. Much of the public debate on how to tackle the obesity epidemic relates to how stakeholders from a range of sectors determine the availability, accessibility and affordability of healthy and less-healthy foods, which are key issues for the food sector in Europe.

Policies influencing the supply and demand of food in the EU

Two EU policies have a direct impact on nutrition and health, namely the CAP, which has been in place since 1962 (supply side) and the Health and Consumer Protection strategy (demand side), which was adopted in 2005 and preceded by the Health Strategy from the year 2000. These two policies are interlinked via food safety which forms the basis of any consideration of health issues concerned with food. Another obvious connection between the two

policies is nutrition, which currently ranks lower on the political agenda in Brussels. The broader public health issues, including nutrition, should be at the heart of every EU policy, according to Articles 152 and 153 of the Amsterdam Treaty, but are too rarely considered by decision-makers. Within health and consumer policy several pending pieces of legislation are of importance for food demand. These include the proposal for a Regulation on Nutrition and Health Claims on Foods and the revision of the current Nutrition Labelling Directive. Furthermore, there are still other important areas that have not yet been tackled, for example the marketing of food directed at children.

Both the public and policy-makers continue to perceive food safety as the key health issue, probably because food contaminants are beyond consumer control and because of concerns for the competitiveness of European agriculture. Nutrition is still perceived by many as an issue of individual choice. Therefore it does not attract the same level of attention from politicians and administrators who assume that we are living in a perfect market where the demand for food controls the supply. Nothing could be further from the truth. The CAP regulations influence the availability and the affordability of food and alcoholic beverages and therefore also influence demand.

The EU Common Agricultural Policy

The basic aim of many agricultural policies, including the CAP, has been to provide food security for the population. Since the 1970s food surpluses have constituted a costly problem for the agricultural sector in the EU. Long-standing incentives for overproduction led the 2003 CAP reform to partially decouple the financial support farmers are paid from actual production levels in a number of sectors (arable crops and livestock). Today, agriculture policy has additional objectives related to rural development and environmental protection. Unfortunately, nutritional issues are hardly ever discussed in the Agricultural Council or by the Directorate-General (DG) for Agriculture. Other questions related to the competitiveness and commercial interest of the sector are taking up the attention of policy-makers, such as, for example, levels and types of support, food quality standards, protection of origin of foods, agrichemical and biotechnology use, foreign investment, food processing and product branding, the balance between food retail multinationals and primary producers, land ownership and international trade agreements within the World Trade Organization (WTO).

Agriculture policy as well as general improvements in agricultural productivity have lead to rising dietary energy supplies in all regions of the world. Current

food prices are relatively the lowest in history.[3] The per capita food availability on a global basis increased from about 2300 kcal per day in 1961 to 2800 in 1998 and is expected to pass 3000 kcal per day around the year 2015. The daily energy requirement for an adult woman is 1900–2500 kcal (8.1–10.4 MJ per day) and that of a man is 2500–3200 kcal (10.4–10.3 MJ per day) depending on the level of physical activity.[4] According to the United Nations Food and Agriculture Organization the rise in the dietary energy supply will continue worldwide for at least another 25 years.[3] The factors driving changes in global food production and consumption are of interest to the public health sector because the increase in food energy intake has been identified by several researchers as a key driver of the obesity epidemic worldwide in combination with an increasingly sedentary lifestyle.[5–7] Although not all countries have been able to document that the rising food supply is accompanied by rising energy intakes the rise in body weight suggests that food energy consumption is actually increasing worldwide.

How does agriculture policy contribute to this development? Agriculture policies have profound and complex effects on the food supply as well as on demand because policy gives production incentives for many commodities by providing market support. Together, Organisation for Economic Co-operation and Development (OECD) countries plough almost US$ 1 billon per day into agriculture subsidies (at the time of writing this is around €780 million).[8] This is paradoxical considering the huge food surpluses characterizing the agricultural sector in developed countries today. Another paradox is that subsidizing agriculture makes food more expensive for consumers due to loss of efficiency in production,[9] which in itself has a limiting effect on demand.[5] Traditionally in the EU, the most subsidized sectors are cereals, beef, olive oil and milk, whereas the production of fruit and vegetables does not receive production incentives.[10] Even commodities like tobacco, wine and sugar are receiving substantial economic support. A considerable share of the food surpluses in the EU are exported with subsidies, leading to major distortions on international markets, usually to the detriment of developing countries.[11] The rest finds its way into the food chain of Europeans, as subsidized ingredients for high-fat processed foods, thereby most likely contributing to the obesity crisis seen today.[12*] At the same time the protection of domestic markets by tariffs leads to higher consumer prices for imported goods, which

* A "joker in the pack" of global food balance is the recent increase in the demand for biofuel made from sugar, cereals or wine. In the past year the world market price of sugar has been rising in parallel with the price of fossil oil. This aspect opens up a worrying perspective, which politicians should start thinking about very soon. Who is going to make decisions about whether agricultural commodities should be used for food or fuel? Will the increasing demand for biofuel lead to rising food prices? How can we find a sustainable balance between the food supply, public health, the need for renewable energy and environmental protection? These questions need to be taken into consideration when discussing the future of European policies within the areas of food, agriculture, the consumer and the environment.

lowers the demand for certain foods. In the following sections we discuss the health impacts of specific European agricultural policy commodity sectors.

Dairy

In Europe, more than 90% of the population consume higher levels of total and saturated fat than the WHO recommendations.[13] Milk fat and fatty meat are rich sources of saturated fat and intake of these foods is generally recommended to be lowered. On the EU market, milk production exceeds the domestic demand by around 20%, which previously lead to "butter mountains" in intervention cold stores. Today, the market organization for milk grants export subsidies and consumption aids for butter to the food industry which turns it into ice-cream and pastry.[14] In this way surplus butter finds its way into the food chain and contributes to cardiovascular disease, diabetes and obesity in Europe and in developing countries. Furthermore, the level of production is expected to increase by 1–2% due to the extension of milk quotas (national reference amounts eligible for support) until 2015.[15] A consequence of oversupply is a fall in butter prices in the EU, which will again increase demand after many years of falling consumption, which will certainly have negative consequences for public health. Another example where EU policy contradicts health is the EU scheme for school milk support which pays the highest subsidy for full-fat milk. However, this is against dietary guidelines for children. In Slovenia and Sweden dietary guidelines only support the supply of low-fat milk, instead of full-fat milk, to school children.[16] The experiences from Norway, Finland and Poland show that the lowering of saturated fat intake from animal sources played a significant role in the dramatic decrease in cardiovascular mortality experienced in these countries.[17–19] Initially, this move created much opposition from the agricultural sector. Today, this experience should be shared at European level to influence future reforms. The EU dairy sector needs to face the fact that overproduction, fuelled by subsidies, constitutes a public health problem.

Sugar

At the beginning of the 20th century – before the widespread cultivation of sugar beets and imports of sugar from cane – intake in Europe per capita was below 5 kg per year rising to the 40–60 kg per year seen in Europe today. The rise in global sugar production and processing provides the basis for the worldwide increase in soft drink and confectionary manufacture and consumption and is accelerated by aggressive marketing.[20] This trend is expected to continue, driven by the globalization of food industries and the spread of multinational supermarkets.

The EU is the world's third largest sugar producer (after Brazil and India) with the highest production costs, resulting in sugar prices more than three times the world market price, but is also the second largest sugar exporter thanks to export subsidies. Even though consumption is increasing worldwide, there is still an oversupply, including in the EU.[21] Despite global oversupply, sugar is one of the most supported and protected commodities. Irz and Srinivasan have calculated that adherence to WHO norms worldwide, namely 10% of energy intake, would imply a reduction in demand of about the same magnitude as the total European production (20 million tonnes).[22] In other words, sugar subsidies lead to overproduction, which, in turn, lowers the world market price.

Following commitments by the EU in multilateral WTO negotiations to lower export subsidies a reform of the sugar sector was unavoidable. The reform agreed upon in the Council in February 2006[23] implies a 36% cut in the guaranteed minimum sugar price, compensation for farmers and a Restructuring Fund to encourage uncompetitive sugar producers to leave the industry. EU production is expected to fall by one-third (between 6 and 7 million tonnes) in the coming years. The reform was preceded by an impact assessment, considering social, economic and environmental perspectives of different reform options.[21] It is symptomatic that public health aspects were not included as one of the dimensions of social sustainability. Clearly, falling prices will lead to an increase in consumption in the EU. A lower global production will, on the other hand, lead to an increase in the world market price, therefore probably to a lowering of demand outside the EU in the short term.

The example of sugar shows how complex the effects of agriculture policy on public health can be and that all perspectives need to be brought to the table before deciding on new reforms. Sugar subsidies are not in line with public health objectives to decrease sugar consumption and should be phased out, as has already been agreed for tobacco subsidies.

Wine and alcohol

Although adult alcohol consumption levels have been falling in the EU as a whole, the union remains the part of the world with the highest levels of alcohol intake. Alcoholic beverages, especially those consumed in high quantities, have therefore been suggested as contributing to obesity development, at least in men,[13, 24] have many other negative effects on public health, especially among younger people.[2] Just under half of this consumption is in the form of beer (44%), with the rest divided between wine (34%) and spirits (23%).

Since the 1950s there has been a harmonization in the levels of recorded consumption in Europe. Europe has seen declining drinking levels, mainly from falling wine consumption in the wine-producing counties in southern Europe, and increased levels in northern and central Europe during the period from 1960 to the end of the 20th century.

Europe's share of world production of wine has remained virtually the same since the 1990s (around 60%) but it is the "New World" countries which have seen a spectacular growth in wine export. For several decades there has been an imbalance in the EU wine market due to the combined effect of an increase in supply, an overall reduction in internal demand and increased world competition.[10] The overregulated wine market has led to expensive measures like "crisis distillation" of surplus wine, paid for by the EU budget. The current common market organization on wine allows subsidies for the distillation of surplus wine into potable spirits. This aid for distillation has led to the maintenance of the EU surplus of wine. Beer and spirits are the alcohol beverages favoured by young people. EU agricultural funds have been used to support the promotion of wine drinking to 20- to 40-year-olds.[10] The wine-producing Member States and the wine producers are strongly opposed to increasing minimum excise taxes on wine, which could lead to further decreases in consumption. The fact that there is zero tax on wine in most producer countries makes producers of beer and spirits refuse to raise excise taxes on their products with reference to competition between alcoholic beverages. This results in a tax race to the bottom as currently seen in northern Europe where alcohol taxes traditionally have been high. Thus the zero excise duty on wine has become one of several obstacles for countries wanting to use the effective excise duty instrument in their alcohol policies. The dramatic rise in alcohol consumption as a result of the excise duty reduction in Finland and the effect of the increased private import of alcohol in Sweden are examples of this.[25]

Concurrently, some EU Member States, such as Slovenia and the United Kingdom are experiencing some of the highest mortality rates in Europe and alcohol consumption is rising most rapidly in the younger age groups.[16]

The upcoming reform of the wine sector includes an impact assessment due in late 2006. One part of this impact assessment will be on the health impact of the different options in the proposed wine reform. The need to include a health impact assessment has been included in the mandate for the Commission's Inter-Service Steering Group. This is a step forward since the 2003 impact assessment concerning the sugar policy reform,[21] which, despite involvement of DG SANCO, did not consider health issues.

Meat

Meat (from cows, sheep and goats) is one of the most subsidized agricultural products in the EU.[10] As with other products, the aim of the market regulation is to stabilize prices at a certain level.[26] The most important measures in the beef sector are import tariffs, export subsidies and support for private and public intervention storage. Since 2005 most of the support is decoupled from production. In the past two years, the EU has become a net importer of beef. This is the combined result of rising consumption and marginally lower production in the EU.

The industrialization of grain production has produced yields sufficient to feed larger numbers of animals than could be raised on grass and traditional sources of forage. This in turn has facilitated the increase in meat consumption now seen worldwide and is linked to a higher intake of saturated fat. Industrial methods of producing and processing animals for food are now well established for poultry, pork and beef in Europe and the United States.[27] This system is characterized by extensive use of fertilisers, antibiotics and pesticides, and results in environmental pollution. This type of production system carries externalities, which means that the external costs of environmental degradation and other costs are not accounted for and consequently not included in the retail price or in analyses of the industry's productivity.[27] The system provides relatively cheap meat for the consumer, raising the demand. The higher intake of saturated fat contributes to obesity and other noncommunicable diseases. A high-meat diet also consumes many more resources than a plant-based diet. High-income nations feed over 60% of grain to livestock, whereas in developing countries people still consume most grain directly. However, with an increasing demand for meat in developing countries, this balance is changing, which needs to be addressed in the future from both a health and environmental sustainability perspective.

Fruit and vegetables

This sector receives the least support in the EU relative to its market value and the type of support does not give production incentives as in the other sectors. This is the only sector which for public health reasons would be entitled to production incentives, because fruit and vegetables are undersupplied on the European market relative to dietary recommendations,[28] and current low and falling consumption levels. Increasing the intake of fruit and vegetables to 400–600 g per day, that is a doubling of current intake for many European countries, would decrease the incidence of various cancers, obesity, and the incidence of heart disease and stroke by up to 18%.[13, 29]

The market organization of fruit and vegetables includes a withdrawal measure aimed at keeping prices up by limiting the supply in times of seasonal overproduction. The withdrawal of quality produce receiving economic compensation has been lowered considerably during the last decade, not least due to pressure from the public. Still, 80% of it is destroyed in spite of the regulation saying that it should be used for human consumption in the first instance.[10] A Dutch modelling study showed that if all withdrawn produce were marketed and consumed by humans this would result in a modest (2–6 days) increase in life expectancy.[30]

Another measure to protect the EU market is employment of import tariffs. Tariffs vary widely from 10% to 140% of the border price, depending on the product and the season. If consumer prices were raised by 10% due to import tariffs, a likely average level according to the OECD, consumption would decrease by, on average, 5%, assuming a price elasticity of -0.5. This drop in consumption is three times as high as that caused by the withdrawal measure. The consumption-lowering effect is more pronounced for low-income groups who are more price sensitive and who also have the lowest intake. In this way, the higher fruit and vegetable prices in the EU due to existing policy may increase health inequalities. The current EU common market organization for fruit and vegetables is not coherent with the public health goal of increasing consumption. The fruit and vegetable sector will be reformed at the end of 2006. This presents a unique opportunity, as both producers and the health lobby have a common goal of advocating inclusion of health-related benefits, and issues of increasing fruit and vegetable consumption, into the reforms.

In May 2006 the European Commission launched a public consultation on the reform of the fruit and vegetable market. In the consultation document the fall in the consumption of fruit and vegetables in the EU is noticed with concern, which could be taken as an encouraging sign of acknowledgement of the link between agricultural policy and healthy diets in the EU.

Taken together, the CAP with a high degree of market support and border protection is not coherent with other policy objectives such as those in public health, consumer, environment and development policy. Market support fuels an inefficient overproduction of food and alcohol (except for fruit and vegetables), which eventually finds its way into the human food chain. This process is facilitated by multinational food manufacturers and retailers developing global brand names and marketing strategies with an adaptation to local tastes and in this way shapes consumers' preferences. Advantage is taken of people's liking for sweet and fatty foods and of the tendency to overeat when energy-dense foods, low in water and dietary fibre, are consumed.[31, 32] It is clear that the establishment of nutrition goals and recommendations, if

adopted on an EU basis, will have important implications for agricultural production, trade, processing and marketing.

Health and consumer protection strategy

This strategy covers the areas of food safety, public health and consumer protection and is located in DG SANCO. The aim is to give increased priority to consumer policy, and to ensure a more effective and coordinated approach to consumer interests. The strategies for each of the three policy areas have been developed in a coordinated way but are expressed in separate documents. This reflects the different priorities, actions and related time scales.

The Commission has formulated the following mission statement concerning this strategy:

> Consumer policy is a core component of the Commission strategy objective of improving the quality of life of all EU citizens. Implementation of this policy involves the development of legislative and other actions to promote the interests, health and safety of consumers in the internal market, to ensure the proper integration of consumer concerns in all EU policies and to complement the consumer policy conducted by Member States. Within this general context, the Commission actively supports consumer organizations and is seeking to enhance the role of consumer representatives in decision-making.

Two pending directives are of importance for public health: the revision of the current Nutrition Labelling Directive and the proposal for a Regulation on Nutrition and Health Claims on Foods.

Nutrition labelling and health claims directives

Nutrition labelling is currently not compulsory on food packaging unless a health claim is made.[33] A proposal for a revised Nutrition Labelling Directive is expected during 2007, but discussions continue regarding whether labelling should be voluntary or mandatory and the number and nature of nutrients to be included.[34] More than the importance of a consumer's right to information, nutrition labelling is also a potential measure in the overall strategy to combat noncommunicable diseases. In an environment with a high availability of food, cognitive control of body weight is required[35] and adequate labelling of food could be one way of ensuring that everyone has the information and tools needed to manage energy balance and improve their health. Consumer organizations have long called for mandatory labelling on all pre-packaged foods and advocate that a simplified labelling scheme should be developed.[36] Even though it is doubtful whether nutrition labelling in itself will lead to healthier food choices in the majority of the population, all efforts should be made to adopt the Nutrition Labelling Directive as soon as possible and to

ensure that it meets the needs of consumers. In the United States the requirement of nutrition labelling has stimulated the food industry to reduce the amount of salt, sugar and fat in a wide range of products.[37]

Health claims describe a relationship between a category of food, a food product or food constituents and health. Under EU legislation there is no legal definition of a health claim and there are as yet no harmonized rules at EU level to ensure the scientific accuracy and appropriateness of health claims. A proposal adopted by the European Commission in 2003 aims to encourage pan-European harmonization of health claims regulations.[38] Since then a proposal for a regulation has been developed, which was endorsed at a second reading vote by the European Parliament in May 2006. This paves the way for the adoption of this piece of legislation later in 2006 by the Council. Health claims appear to be effective in getting consumers' attention and influencing their behaviour.[39] Such claims are the single most influential factor in consumer choice at point of purchase. The majority of consumers say they trust the claims but do not have good knowledge of nutritional concepts.

To date, there is insufficient evidence concerning effects of health claims on diet and public health.[40] One problematic aspect of the effects of health claims is that their benefits are likely to be restricted to health-conscious, affluent groups who are willing to pay for products with health claims and added functional benefits, and exclude consumers unable to afford premium prices. Another problem is that health claims may have the effect of encouraging excessive intake of certain foods by implying that the consumption of a certain nutrient for which the claim is made leads to good health.[40]

The proposal for a Regulation on Nutrition and Health Claims on Foods requires the use of nutritional profiles.[38] The purpose of these is to ensure that the product genuinely contributes towards a healthy and nutritious diet. The criteria for these profiles will be set by the Commission and Member States based on the opinion of the European Food Safety Authority, within 18 months of the regulation coming into force. It is clearly of great importance that these profiles are set as strictly as possible in order to prevent "junk food" from carrying health claims. After lobbying pressure directed at Members of Parliament, derogation was made from the initial proposal which will now allow nutrition claims to be used if just one nutrient does not meet the required profile.[41] The high level of this nutrient must then be clearly marked on the label. It is expected that the Council will adopt the regulation in late 2006 and the first provisions of the regulation will begin to apply six months from coming into force.

Food safety

The health impacts of agricultural policy and practice rose to prominence in Europe following a series of large food scares in the 1990s. The most important of these was the agricultural crisis caused by the discovery of bovine spongiform encephalopathy (BSE or "mad cow disease") in British cattle and the established link between BSE and variant Creutzfeldt–Jakob Disease (vCJD), the human variant of this disease. A retrospective independent public inquiry recognized that poor agricultural practices and inferior intersectoral policy-making, which did not take public health into account, led to BSE not only becoming an animal epidemic but caused it to be transmitted to humans.[42] Although "only" 155 people have died from this disease in the United Kingdom (probable or confirmed cases as at March 2006), the financial costs to the agri-food industry in Europe have been enormous, estimated to be well over £4.2 billion in the United Kingdom alone.[43] This and other food scares have undermined consumer confidence in the safety of the food chain. Policy-makers have reacted by creating more stringent EU food safety regulations and creating a new agency, the European Food Safety Authority (EFSA). The EFSA was legally established by a European Parliament and Council Regulation (No. 178/2002). Adopted on 28 January 2002, the regulation laid down the basic principles and requirements of food law. It also stipulated that the EFSA should be an independent scientific source of advice, information and risk communication in the areas of food and animal feed safety. Although the EFSA is also consulted on nutrition in relation to Community legislation, its mandate is clearly about contributing to food safety, and as a consequence restoring and maintaining consumer confidence in the food chain. This has resulted in a comprehensive legislative framework, which needs to be regularly updated and its implementation monitored to keep achieving the high European food safety standards that currently exist. The continuing EU focus on food safety emphasizes the chemical and microbiological content of food as the key health impacts that need to be tackled. However, there is clear evidence showing that these are not responsible for most of the food-related disease burden in Europe.[44]

Tackling nutrition and health concerns in collaboration with the food producers and NGOs: the EU platform on diet, physical activity and health

In order to tackle the rise of obesity and noncommunicable diseases in Europe, DG SANCO has set up a public–private partnership called the "EU platform on diet, physical activity and health". This brings together European-level representatives of the food and drinks multinationals, advertisers, retailers, fast-food restaurants, the cooperative movement, the consumer movement

and health nongovernmental organizations (NGOs) in order to formulate EU-wide action against obesity. The purpose of the platform is to create a forum for organizations to commit to concrete actions designed to contain or reverse current obesity trends. Under the leadership of the European Commission, "examples" of coordinated but autonomous actions are volunteered by different platform members and a project database has been created. There have been some potentially interesting commitments by platform members but progress in putting these into action has been slow, with each participant being responsible for reporting what they do. A monitoring tool is being developed by the Dutch National Institute of Public Health and the Environment on behalf of the platform to monitor if the stakeholders fulfil their commitments and to evaluate if they have any effect. Voluntary industry approaches to help tackle obesity have been called into question by a recent analysis of the commitments and practice on diet, physical activity and health of 25 of the world's largest food companies.[45] This report showed that the majority of the 25 had made general statements about diet and health, but less than half had made any policy commitments, with little implementation, and only four had stated support for a voluntary code on advertising to children. Clearly, the major issue in such approaches is the potential for serious conflicts of interest with having partners from some food industry companies, such as soft drink manufacturers and fast-food retailers, claiming to reduce childhood obesity when their products are recognized as some of the leading causes of energy-dense and nutrient-poor foods and beverages in children's diets.

Yet the food industry has enormous potential to improve the composition of diets and to reduce energy density by lowering the amount of fat, sugar and additives in foods. Furthermore, food additives designed to enhance flavour, colour, texture and taste have been suggested as contributing to overconsumption.[46] In the United States about 10 000 new processed food products are introduced every year and almost all of them contain food additives.[46] However, progress has been made already, for example in the cooperation between the United Kingdom Food Standards Agency and parts of the food industry to reduce intakes of salt, fats and sugar by reformulating processed foods and reducing portion size.[47] But there is a risk that the sugar and fat removed is used for the production of other energy-dense types of food and aggressively marketed to vulnerable groups such as children.

How can public health become part of an integrated food and agriculture policy in Europe?

Agriculture and consumer policy have a strong influence on what and how

much food is produced, and how it is produced and promoted as well as its price. These policies are therefore key determinants of what people eat. Yet many policy-makers and administrators outside of the public health sector continue to advocate that diet is merely a matter of personal choice, focusing on what individuals demand and not on the supply-side factors that might assist or impede healthy choices. There still exists an illusion of a perfectly functioning market, particularly expressed by the food industry, where it is hypothesized that demand controls supply and it is often heard that "we are only producing what people want." But agricultural economists agree that the market is highly distorted[9] and in this chapter we demonstrate that "producer-induced demand" is a real phenomenon in the EU today. The European Commission DG for Agriculture has so far been very reluctant to accept the idea that the CAP is of any relevance for food and alcohol consumption patterns in Europe, whereas, for example, the Swedish Government has accepted the links. Health impact assessments have not yet been included in agriculture policy reform, although the evidence of health impacts has repeatedly been presented to the Commission from NGOs, Member States' representatives and academics. CAP reforms are driven by financial concerns arising from EU expansion and negotiations within the WTO leading to more open markets. An exception to this rule, so far, is the phasing out of tobacco subsidies until 2010, where a referral to public health was actually made. Another subtle encouraging sign of increasing public health concern could be the recently launched public consultation on the reform of the fruit and vegetable sector (late 2006) where the decline in consumption in Europe is specifically addressed. It seems obvious that future CAP reforms, including the reform of the fruit, vegetable and wine sectors being considered in 2006, need to take public health into account as outlined in Articles 152 and 153 of the Amsterdam Treaty.

The nutritional and health concerns of consumers are currently best addressed by the Health and Consumer Protection directives (for example those on labelling and health claims). The intention is to help consumers make informed food choices. The European Commission and decision-makers should make every effort to guarantee consumer interests in these directives. Furthermore, decision-makers should take the opportunity to use the TV directive currently negotiated to protect vulnerable groups, such as children, against commercial interests, which may harm their health. Today the evidence is strong that marketing of unhealthy foods and beverages directed at children influences dietary choice and contributes to childhood obesity.[48] It is also clear that voluntary approaches to regulating this with the food industry have not yet produced significant improvements in policy and practice,[45] leading to the need for further regulation.

The WHO Regional Office for Europe – urged by the alarming obesity trends and inspired by the WHO global strategy on diet, physical activity and health[49] – is planning a ministerial conference in November 2006 in Istanbul to counteract obesity. The aim is to produce a European charter addressing issues of food supply and demand and to stimulate more forceful actions in Member States. This process will hopefully strengthen and support the initiatives taken by the European Commission in its work with the green paper "Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases."

Despite the health sector continuing to point out negative health impacts in EU policy, so far there has been little evidence of any improvement. Simply presenting the evidence is obviously not enough to make a change. We propose four ways by which this process could be stimulated.

1. The public health sector should discuss more vigorously the meaning and societal implications of Articles 152 and 153 in the Amsterdam Treaty. In general, there is low awareness among decision-makers and administrators of its implications to non-health sector policies.
2. Methods of evaluating the health impacts of policies before they are introduced need to be developed and refined. Health impact assessment is one approach,[50, 51] but there are other approaches, such as regular intersectoral health forums that could be adapted to the specific policy context.
3. More funding should be given to stimulate interdisciplinary research into the health impacts of agricultural and other relevant policies in Europe. Research findings need to be fed into the policy process and implemented in an effective way.
4. Effective public–private partnerships need to be developed including the public health sector, consumer groups, agriculture and the food industry where equal weight is given to public health, environmental concerns, agriculture and rural interests.

REFERENCES

1. *Preventing chronic diseases: a vital investment.* Geneva, World Health Organization, 2005.
2. *The World Health Report. Reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.
3. Food and Agriculture Organization. *World agriculture: towards 2015/2030. Summary report.* Rome, United Nations, 2002.
4. Nordic Council of Ministers. *Nordic nutrition recommendations 2004. Integrating nutrition and physical activity*, 4th edn. Copenhagen, 2004.

5. Loureiro M, Nayga R. International dimensions of obesity and overweight-related problems: an economic perspective. *American Journal of Agricultural Economics*, 2005, 87(5):1147–1153.

6. Putnam J, Allshouse J, Scott Kantor L. US per capita food supply trends: more calories, refined carbohydrates, and fats. *Food Review*, 2002, 25(3):2–15.

7. Silventoinen K et al. Trends in obesity and energy supply in the WHO MONICA Project. *International Journal of Obesity and Related Metabolic Disorders*, 2004, 28(5):710–718.

8. *Agricultural Policies 2004: at a glance*. Organisation for Economic Co-operation and Development (OECD), 2004.

9. Joint Working Party on Agriculture and Trade. *Agricultural policies in OECD countries: a positive reform agenda*. Paris, OECD, 2002.

10. Schäfer Elinder L et al. *Public health aspects of the EU Common Agricultural Policy. Developments and recommendations for change in four sectors: fruit and vegetables, dairy, wine and tobacco*. Stockholm, National Institute of Public Health, 2003 (http://www.fhi.se/shop/material_pdf/eu_inlaga.pdf, accessed 10 Sept. 2005).

11. Oxfam. *Rigged rules and double standards. Trade, globalisation, and the fight against poverty*. Oxford, 2002 (available from www.maketradefair.com).

12. Schäfer Elinder L. Obesity, hunger and agriculture: the damaging role of subsidies. *British Medical Journal*, 2005, 331:1333–1336.

13. *Diet, nutrition and the prevention of chronic diseases. WHO Technical Report Series 916*. Geneva, World Health Organization, 2003.

14. Schäfer Elinder L. Public health should return to the core of CAP reform. *EuroChoices*, 2003, 2(2):32–35.

15. *Council Regulation establishing common rules for direct support schemes under the Common Agricultural Policy and establishing certain support schemes for farmers and amending Regulations (EEC) No 2019/93, (EC) No 1452/2001, (EC) No 1453/2001, (EC) No 1454/2001, (EC) No 1868/94, (EC) No 1251/1999, (EC) No 1254/1999, (EC) No 1673/2000, (EEC) No 2358/71 and (EC) No 2529/2001*. Brussels, Council of the European Union, 2003.

16. Gabrijelčič-Blenkuš M, Zakotnik J, Lock K. Health impact assessment: implementing the CAP in Slovenia after accession. *Eurohealth*, 2004, 10(1):17–20.

17. Norum K. Some aspects of Norwegian nutrition and food policy. In: Shetty P, McPhearson K, eds. *Diet, nutrition and chronic diseases. Lessons from contrasting worlds.* Chichester: John Wiley, 1997:195–205.

18. Prättälä R. Dietary changes in Finland: success stories and future challenges. *Appetite*, 2003, 41:245–249.

19. Zatonski W, Willett W. Changes in dietary fat and declining coronary heart disease in Poland: a population-based study. *British Medical Journal*, 2005, 331:187–188.

20. Nestle M. *Food politics: how the food industry influences nutrition and health*. Berkeley and Los Angeles, University of California Press, 2002.

21. Commission of the European Communities. *Reforming the European Union's sugar policy. Summary of impact assessment work*. SEC(2003). Brussels, 2003.

22. Irz X, Srinivasan C. Impact of WHO recommendations on world sugar consumption, production and trade. *EuroChoices*, 2004, 3(3):24–25.

23. European Commission. *CAP reform: EU agriculture ministers adopt groundbreaking sugar reform*. IP/06/194. Brussels, 2006 (http://europa.eu/rapid/pressReleasesAction.do?reference=IP/06/194&format=HTML&aged=0&language=EN&guiLanguage=en, accessed 10 Feb. 2006).

24. Molarius A. The contribution of lifestyle factors to socio-economic differences in obesity in men and women: a population-based study in Sweden. *European Journal of Epidemiology*, 2003, 18:227–234.

25. *The 2005 public health policy report*. R2005:44. Stockholm, National Institute of Public Health, 2005.

26. Swedish Board of Agriculture. Marknadsöversikt: Animalier (Market overview – animal products), report no. 25. *Jönköping*, 2004.

27. Walker P et al.. Public health implications of meat production and consumption. *Public Health Nutrition*, 2005, 8(4):348–356.

28. Lobstein T. Suppose we all ate a healthy diet? *Eurohealth*, 2004, 10(1):8–12.

29. *Fruit and vegetable policy in the European Union: its effect on the burden of cardiovascular disease*. Brussels, European Heart Network, 2005.

30. Veerman JL, Barendregt JJ, Mackenbach JP. The European Common Agricultural Policy on fruits and vegetables: exploring potential health gain from reform. *European Journal of Public Health*, 2006, 16(1):31–35.

31. Prentice AM, Jebb SA. Fast foods, energy density and obesity: a possible mechanistic link. *Obesity Reviews*, 2003, 4(4):187–194.

32. Rolls B, Roe L, Meengs J. Reductions in portion size and energy density of foods are additive and lead to sustained decreases in energy intake. *American Journal of Clinical Nutrition*, 2006, 83:11–17.

33. Council of the European Union. Council Directive 90/496/EEC (24 Sept. 1990). Nutrition labelling for foodstuffs. *Official journal L276*, 1990:40–44.

34. European Commission. *Request for information in view of the revision of Council Directive 90/496/EEC on nutrition labelling*. Brussels, Health & Consumer Protection Directorate-General; 2003.

35. Hill JO et al. Obesity and the environment: where do we go from here? *Science*, 2003, 299:853–855.

36. *A simplified labelling scheme. BEUC/X/031/2005*. Brussels, European Consumers' Organisation (BEUC), 2005.

37. Golan E, Kuchler F, Mitchell L. *Economics of food labelling. Agricultural Economic Report No. 793*. Washington, DC, Economic Research Service, US Department of Agriculture, 2000.

38. *Proposal for a regulation of the European Parliament and the Council on nutrition and health claims made on foods. 2003/0165 (COD).* Brussels, Commission of the European Communities, 2003.

39. *Report on European consumers' perception of foodstuffs labelling. Results of consumer research conducted on behalf of BEUC from February to April 2005. BEUC/X/032/2005.* Brussels, European Consumers' Organisation (BEUC), 2005.

40. *Nutrition labels and health claims: the global regulatory environment.* Geneva, World Health Organization, 2004.

41. European Commision. *Questions and answers on health and nutrition claims.* MEMO/06/200, 16 May 2006. Brussels 2006. (http://europa.eu.int/rapid/pressReleasesAction.do?reference=MEMO/06/200&format=HTML&aged=0&language=EN&guiLanguage=en, accessed 23 May 2006).

42. *The BSE Inquiry: The Report.* 16 volumes. London, The Stationery Office, 2000.

43. *House of Commons Select Committee on Public Accounts. BSE: the cost of a crisis.* London, HMSO, 1999.

44. Ezzati M et al., eds. *Comparative quantification of health risks. Global and regional burden of disease attributable to major risk factors.* Geneva, World health Organization, 2004.

45. Lang T, Rayner G, Kaelin E. *The food industry, diet, physical activity and health: a review of reported commitments and practice of 25 of the world's largest food companies.* London, City University, 2006.

46. MacInnis B, Rausser G. Does food processing contribute to childhood obesity disparities? *American Journal of Agricultural Economics*, 2005, 87(5):1154–1158.

47. Food Standards Agency. London, 2005 (http://www.foodstandards.gov.uk/foodindustry/Consultations/, accessed 9 Jan. 2006).

48. Hastings G, Stead M, McDermott L. *Review of research on the effects of food promotion to children. Final report.* London, Food Standards Agency, 2003 (www.csm.strath.ac.uk).

49. *Global strategy on diet, physical activity and health.* Geneva, World Health Organization, 2004.

50. Lock K et al. Health impact assessment of agriculture and food policies: lessons learnt from HIA development in the Republic of Slovenia. *Bulletin of the World Health Organization*, 2003, 81(6):391–398.

51. Lock K, McKee M. Health impact assessment: assessing opportunities and barriers to intersectoral health improvement in an expanded European Union. *Journal of Epidemiology and Community Health*, 2005, 59:356–360.

Chapter 6

Health in alcohol policies: the European Union and its Nordic Member States

Christoffer Tigerstedt, Thomas Karlsson, Pia Mäkelä, Esa Österberg, Ismo Tuominen

Introduction

Worldwide, Europe plays a significant part in the production, trade and consumption of alcoholic beverages. Being the heaviest drinking region in the world, Europe also carries a major burden of alcohol-related problems. In addition to social and health problems affecting users, alcohol also generates adverse effects on third parties. These effects include, for example, traffic accidents, domestic violence, child neglect and public sector costs.

Bearing this in mind, one would assume that social and health concerns related to drinking have occupied a high position on the political agenda in the European Union (EU). This has, however, not been the case. Instead, alcohol as a political issue in the EU has appeared mainly as an agricultural matter. As a result the support of the wine, brewing and spirits industries through the Common Agricultural Policy (CAP) constitutes a considerable share of the EU's overall subsidies (see Chapter 5). This support covers subsidies to agricultural production and the creation of markets for alcoholic beverages, mainly for wine. However, since the late 1980s and into the 1990s alcohol has increasingly appeared as a public health issue and social problem in the EU. This partial redefinition of alcohol issues, including the introduction of an alcohol policy based on social and health considerations, is a fascinating process.

The public regulation of alcohol consumption differs widely within the EU. Although Member States have not conferred to the EU the power to pass laws to protect public health, some policies dealing with the internal market can incorporate health concerns. With their restrictive alcohol policy systems, Finland and Sweden – who joined the EU in 1995 – constitute a special case in this respect. In fact, the confrontation between the Finnish and Swedish alcohol control systems and the operational principles of the Single European Market can be described as a clash between fundamentally different social and economic interests and political practices with regard to alcohol. In the name of social order and public health, alcohol in Finland and Sweden used to be, and still partly is, regulated by powerful national "hard law" that restricted both private profits from and the free movement of alcoholic beverages.

At EU level alcoholic beverages are mostly dealt with as ordinary economic commodities. Consequently, at EU level, legislative force, that is "hard law", aims to guarantee the preconditions of alcohol production and to create markets for alcoholic beverages through the CAP and taxation policy as well as by removing trade barriers. Alcohol is approached at EU level as a social and health issue, and influencing methods are passed to the domain of "soft law". Not surprisingly, tensions arose when Finland and Sweden, by entering the EU, yielded part of their national right of decision to an international body which led to the abolishment of the comprehensive alcohol monopoly systems.

In this chapter we first examine how the EU legislation of removing barriers to trade has affected alcohol policies in the Nordic EU Member States. This section includes bringing the Finnish and Swedish state alcohol monopoly systems in line with the European Commission (EC) Treaty, on the one hand, and the implementation of the EU's rules for travellers' private importation of alcoholic beverages within the Single Market, on the other. Second, we show that in Finland these processes are reflected in a substantial increase in both alcohol consumption and alcohol-related harm. This problematic state of affairs is the object of increasing social concern. Third, we pay attention to the gradual expansion in the EU's mandate on public health issues, paralleled by a growing interest in drinking problems. Finally, we reflect on what political options are at hand after the decisive opening of the Nordic and Baltic alcohol markets in 2004.

Nordic alcohol policies and the removal of trade barriers

Historically, the Nordic countries represent strong temperance traditions. Over the course of time, highly restrictive and protective systems of alcohol production and sales were established in four of the five countries. Before Finland and

Sweden became members of the EU, their alcohol control systems were based on three basic pillars.

- Private profits from alcohol production and sales were minimized, that is the commerce of alcoholic beverages was "disinterested".
- The physical availability of alcohol was strongly restricted. The extreme case is represented by a total prohibition in Finland in the period 1919–1932.
- The economic availability of alcohol was regulated by high taxes and prices, which alleviated the inclination to buy drinks on the one hand, and provided a convenient source for tax revenue on the other.

At an institutional level, in Finland and Sweden these operational principles were tied up by authoritative state monopolies with a huge mandate covering exclusive rights to production, import, export, wholesale and retail sales of alcoholic beverages.

Finnish and Swedish alcohol monopolies under scrutiny

One of the main goals of the EU is to speed up economic growth by introducing the principles of a free market economy. This has necessitated the creation of a functioning Single European Market by abolishing different kinds of barriers to trade and by fostering the free movement of goods, services, labour and capital. If Member States have not put these principles into effect, they have in several cases been brought to the European Court of Justice (ECJ). These court cases include, among others, rulings stipulating that a product lawfully marketed in one Member State should also be legally marketed in other Member States and that equal taxing principles must be used with regard to domestic and foreign alcoholic beverages.[1]

Various monopoly arrangements have been obstacles to the free flow of goods in the Single Market. Consequently, the Finnish, Icelandic, Norwegian and Swedish comprehensive alcohol monopolies already went through a test when these European Free Trade Association (EFTA) countries negotiated for the European Economic Area (EEA) agreement in 1990, and particularly when Finland, Norway and Sweden negotiated for EU membership in the early 1990s. In the opinions of the Commission, regarding the membership applications, it was clearly stated that there were severe causes for concern with regard to the alcohol monopoly arrangements in all three countries. In this regard the Commission also stressed that especially quantitative restrictions and all measures having an equivalent effect in restricting the trade of alcoholic beverages were prohibited according to the EC Treaty.[2]

In the negotiations of the EEA agreement the Nordic countries were not willing to jeopardize the future of their alcohol monopoly systems. Hence the issue was not brought up in the formal negotiations at all. However, the four countries attached to the EEA agreement a unilateral, non-binding declaration recalling that their alcohol monopolies were based on important health and social policy considerations.[3]

In January 1994 just after the EEA agreement had become effective, the Finnish enterprise Restamark tried to import a shipment of alcoholic beverages into Finland. This operation was against prevailing Finnish law, but the importer claimed it was justified according to the EEA agreement. The case went to the EFTA Court, which, in December 1994, concluded that the Finnish import monopoly on alcoholic beverages was not compatible with the EEA agreement and had to be abolished. In practice this ruling also meant that the Icelandic, Norwegian and Swedish alcohol import, export and wholesale monopolies were doomed. The final outcome was that Finland and Sweden abolished their monopolies on production, import, export and the wholesale of alcoholic beverages in January 1995, and later Iceland and Norway followed.[4]

In the membership negotiations between the EU and Finland, Norway and Sweden, the Commission had accepted the existence of the off-premise (off-licence) alcohol retail monopoly. However, by selling wine in an ordinary retail outlet, the Swedish shopkeeper Harry Franzén succeeded in taking the state retail alcohol monopoly first to a national district court, and thereafter to the ECJ for a preliminary ruling.[5]

On 19 November 1997 the ECJ found that the operations of the Swedish off-premise alcohol retail monopoly, Systembolaget, were organized in a non-discriminatory manner and that they were not against the EC Treaty. The outcome of the Franzén case guaranteed the existence not only of the Swedish off-premise state alcohol retail monopoly but also of the Finnish, Icelandic and Norwegian corresponding monopolies. It also ended the legal struggle trying to prove that the existence of off-premise alcohol retail monopolies is in conflict with the EC Treaty.[5]

Although off-premise retail sales of most alcoholic beverages (meaning greater than 4.7% alcohol by volume in Finland and Norway, and greater than 3.5% in Sweden) are still concentrated in state-owned monopolies in these countries, the exclusive rights of state-owned companies on the production, import, export and wholesale of alcoholic beverages were dismantled. Thus the EU legislation both secured an original element of a long-standing alcohol control system and contributed to whittling away the basic pillars of this system. Moreover, it should be emphasized that although the state retail

alcohol monopolies were declared to be compatible with the EC Treaty, such monopoly constructions may in the future become objects of closer legislative scrutiny, for example in negotiations led by the World Trade Organization.

The restructuring of the old monopoly systems have only marginally affected the man in the street. The same cannot, however, be said about the second political process following from Finland and Sweden's engagements in the EU – the release of private import of alcohol within the EU.

Releasing travellers' allowances

In the late 1980s the Commission had serious plans to harmonize alcohol excise duties throughout the EU. However, as the idea was met with strong opposition the directive of the approximation of alcohol excise duty levels, given in 1992, can be characterized as an ineffective watered-down version of the original 1987 proposal to harmonize alcohol excise duties.[6] Expecting that this would be the case, the Commission had already, in the late 1980s, started to encourage neighbouring countries to negotiate bilaterally the possibility of harmonizing their alcohol excise duty rates and introducing the policy of increasing travellers' duty free allowances of alcoholic beverages.[7]

The motive behind increasing the possibilities of importing alcoholic beverages from one Member State to another, without paying taxes on them in the country where consumption takes place, was that increased alcohol imports by travellers would put pressure on countries practising high alcohol excise duties. In this way, market forces, through rational cross-border shoppers, would harmonize alcohol excise duties, which had proven to be impossible through administrative practices and directives. In January 1993, then, at the same time as the Single European Market was realized, all quantitative quotas on travellers' alcohol imports between EU Member States were abolished. Denmark was the only country with an exemption to this rule at the time, which was for distilled spirits.

Before 1995, travellers' duty free alcohol import quotas in Finland and Sweden amounted to 1 litre of distilled spirits, 1 litre of wine and 2 litres of beer *or* 2 litres of wine and 2 litres of beer. When Finland and Sweden joined the EU, they were forced to increase these import quotas. Conversely, these countries managed to receive a temporary derogation on their import quotas. According to this exemption – originally planned to last only to the end of 1996 – travellers returning to Finland or Sweden from other EU Member States were allowed to import duty free 1 litre of distilled spirits or 3 litres of intermediate products, 5 litres of wine and 15 litres of beer.

Together with Denmark these quotas were renegotiated in 1996. Denmark and Finland agreed with the Commission that they would abolish all import quotas with regard to other EU countries by the end of 2003, and before that amounts were to be gradually adjusted. Later, Sweden was also forced to accept this deadline and in January 2004 the import quotas were abolished altogether.

As a result of these operations the alcohol markets in the northern parts of the EU have changed considerably. As market regulations have been relaxed, high-price countries have been forced to cope with low-price countries. This has had far-reaching consequences for both tax levels and the relation between the quantities of domestic sales and border trade of alcohol in all three countries.

Denmark

Denmark had already had a taste of increasing cross-border trade in alcohol in the 1970s and especially the 1980s, when every year there were over 10 million crossings of the German border by Danes (Denmark's population amounting to 5 million inhabitants). For more than two-thirds of all border crossers shopping in [West] Germany was the only objective of the trip, and alcoholic beverages were the most alluring commodities.[8] To combat the anticipated increases in travellers' alcohol imports from Germany in 1993 when the Danish import quotas for beer and wine were abolished, Denmark cut its alcohol excise duties by half for beer, wine and intermediate products in 1991 and 1992. Correspondingly, Denmark prepared itself for the abolition of quotas for distilled spirits in 2004 by cutting its excise duty rate for them by 45% in October 2003. In January 2005 Denmark further decreased its excise duties for beer and wine by 13%.

Sweden

In connection with the abolition of import quotas in 2004 Sweden has not so far touched its alcohol excise duties. However, earlier during its EU membership, Sweden twice decreased its alcohol excise duties. In 1997 the excise duty rate for beer was decreased by 39% and in December 2001 a 19% tax reduction was made for wine.

Alcohol tax changes in Denmark and Sweden can be partly explained by the domino effect: first Denmark has to adapt its alcohol tax levels to the German ones and then Sweden has to adapt its alcohol taxes to the Danish ones. However, so far the Swedish Government has decided not to lower its alcohol excise duties. This is worth noting, first, because there are growing differences in alcohol prices between Sweden and Denmark and, second, there is a voluminous border trade in alcohol especially in the southern regions of Sweden.[9]

The border trade in alcohol between Sweden and Denmark has also been fuelled by the general economic and geographical integration between the countries, which can largely be attributed to the creation of the Single Market. In 1995 the number of border crossings between Denmark and Sweden was 18 million, whereas the corresponding figure in 2004, which was affected by the opening of the Öresund bridge connecting the two countries**,** was 28 million (Sweden's population being 9 million inhabitants). Running in parallel with this, consumption of unrecorded alcohol, most of which was imported by travellers or smuggled from abroad, grew steadily and accounted for 38% of the total alcohol consumption in 2004; in southern Sweden this proportion was substantially higher. The fact that most of the alcohol consumed in southern Sweden is imported by travellers has, in Swedish public debate, been perceived as a threat to the legitimacy of the state retail alcohol monopoly.

Finland

From the point of view of maintaining high taxes, the Finnish situation was quite safe as long as Sweden and Denmark acted as buffers between Finland and Germany, which, before the EU enlargement in 2004, was the nearest EU Member State with low alcohol taxes. However, the Finnish situation changed dramatically when Estonia, with approximately the same level of alcohol taxes as Germany, joined the EU in May 2004.

Before 2004 Finland had only once altered its alcohol taxes during its EU membership. That was in 1998 when Finland decreased its excise duty rates for wine and intermediate products by 17%. However, in March 2004 Finland decreased its alcohol excise duty rates on the average by 33% at a stroke. The motives behind this tax reduction were much the same as in Denmark the year before, namely to try to combat an expected considerable increase in travellers' imports of alcoholic beverages from Estonia. Although Finland does not have a common land border with Estonia, and the traffic between these countries is not nearly as lively as between Denmark and Sweden, an increase in alcohol imports was perceived as such a big threat that Finland decided on a different strategy to Sweden in coping with the abolition of the import quotas.

Given these different strategies, the results have been more or less the same. Alcohol consumption has risen in Sweden and Finland and the national manoeuvrability in alcohol policy has weakened, especially concerning the economic availability of alcoholic beverages. Thus in trying to harmonize alcohol taxes indirectly through market forces the Commission's efforts have also affected national policy areas that do not belong to the EU's jurisdiction.

Trends in consumption and the consequences of use

Differences in drinking cultures

In different cultures people have consumed and still consume alcohol differently. The cultural position and the use-values of beverage alcohol vary from one culture to another, including within the EU countries.

For a long time in the 20th century, the dominant use of alcohol in the Nordic countries was unequivocally connected to its use as an intoxicant; spirits formed the major part of total consumption. Even today, when Nordic countries are labelled "former spirit-drinking countries" and new drinking patterns have been adopted, alcohol is largely used for its mood-changing, intoxicating effects. Drinking most often occurs in the evenings and at weekends, the frequency of heavy drinking is at a higher level than ever, drinking is not typically a part of a meal, and it takes place at special occasions rather than being integrated into the daily lives of Finnish families.

In wine-growing countries most alcohol consumption is in the form of wine, and wine has mostly been used in connection with meals. Hence the most important and visible use of alcoholic beverages has been their use as a nutrient, not as an intoxicant. A recent comparison of European countries showed that indeed there is more youthful drinking for intoxicating effects in the north of Europe and the United Kingdom, and a more frequent, less heavy drinking pattern in Mediterranean countries in particular, and to some extent also in central European countries.[10]

Because of such differences in drinking habits and in what the beverages found under the label "alcoholic beverages" represent in various countries, the determinants of consumption trends, the consequences of use and the social concerns over drinking vary from country to country. Below, we take a closer look at trends in alcohol consumption and the connection between consumption and various harms, with an emphasis on Finland within the EU and in comparison to general patterns in the EU.

Trends in consumption

The Nordic, former spirit-drinking countries and the central European traditional beer-drinking countries experienced a huge increase in alcohol consumption, particularly from the 1950s to the 1970s. In the traditional wine-drinking countries alcohol consumption has decreased considerably since the 1970s – in France this was even earlier.[11] The decrease in consumption in the wine-drinking countries has been related rather to deeper cultural changes than to alcohol control policy measures. Primarily the decrease has been due to a reduction in wine consumption. This decrease is caused by a

general change in lifestyle, with factors such as urbanization, shorter lunches and higher requirements of efficiency at work contributing to water and other soft drinks being increasingly served with food instead of wine.[12, 13] Hence, in wine-growing countries the decrease in consumption is a process whereby one beverage drunk for nutritional purposes and as a thirst quencher has been replaced by others serving the same purpose. A corresponding cultural change regarding beverage choice has taken place in the Nordic countries when the formerly dominating meal-time beverage, milk, has been increasingly replaced with water and other drinks.

In wine-growing countries, beer rather than wine is more often used away from meals for binge drinking. In the same decades when the consumption of wine, and hence per capita consumption, has decreased, the consumption of beer has increased, and this increase has been even greater than that for per-capita consumption in other parts of Europe. In particular, consumption by young people, which often involves binge drinking and deviates from the traditional drinking pattern, has raised concerns.

In addition to general cultural processes, particularly changes in prices of alcoholic beverages, income level and availability of alcohol have been found to affect per capita consumption of alcohol. However, most of the evidence, particularly of the effect of changes in availability, stems from research on Scandinavian and Anglo-Saxon countries.[14]

In Finland, alcohol consumption has increased almost continuously since the early 1960s, from 3 litres per capita aged 15 years or more to over 12 litres (the upper line in Figure 6.1 shows this development since 1969). During these decades, there was a long series of gradual liberalizations in Finnish alcohol policy, with fewer restrictions on days and hours when alcohol can be sold and with a remarkable increase in the number of on-premise and off-premise outlets.[6, 15] Without doubt these changes in alcohol policy have contributed to the increase in alcohol consumption.

The effects of liberalized alcohol policy caused by requirements arising from EU membership are also reflected in the per capita consumption in Finland. In 1995, when the rules for alcohol imports from Russia and Estonia were temporarily slackened, total consumption increased by 10%.[16] In 2004, when restrictions in travellers' allowances were abolished and taxes reduced, total consumption of alcohol increased by a further 10% (see Figure 6.2).

The connection between consumption and harms

Changes in per capita consumption of alcohol have been shown to affect the rate of alcohol-related harms. In the European Comparative Alcohol Study the

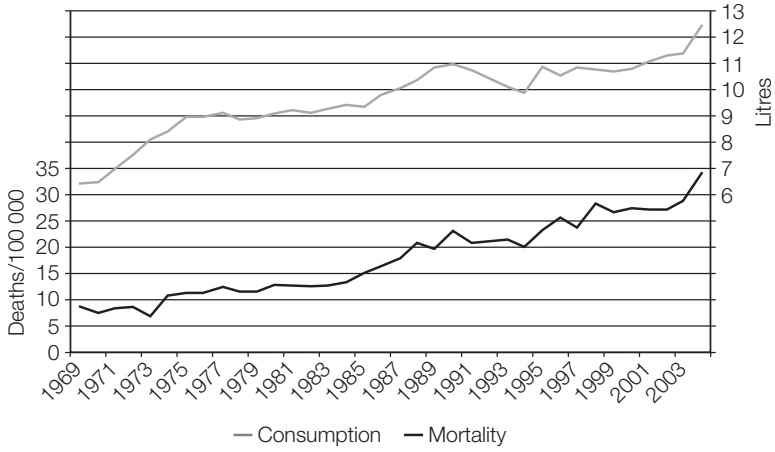


Figure 6.1 *Total consumption of alcohol in litres per inhabitant over 15 years of age, and alcohol-related mortality (alcohol-related diseases and poisonings), 1969–2004. (Reproduced with permission from STAKES.)*

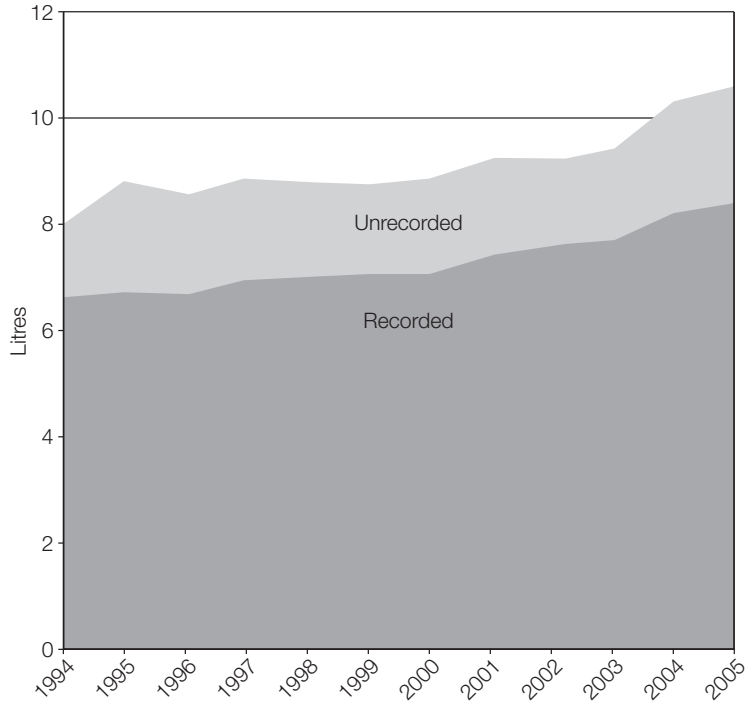


Figure 6.2 *Recorded, unrecorded and total alcohol consumption in litres per capita in Finland, 1994–2005. Unrecorded consumption refers to legal and illegal alcohol imports by travellers, and to the legal and illegal home production of alcohol. (Reproduced with permission from STAKES and STTV.)*

connection between consumption and different types of mortality were examined in 15 European countries both individually and divided into three regions.[17] A connection was found in all three regions and for every country for at least some of the consequences. In general, the connection was strongest in northern Europe and weakest in the Mediterranean countries, while the central European countries were in between. These differences in results were attributed to variations in patterns of drinking, with a much bigger share of heavy drinking occurring in the Nordic countries than in the Mediterranean ones. An exception to this rule was in traffic accidents among men, which were much more closely connected to drinking in southern and, particularly, central Europe than in northern Europe.[18] The conclusion of these observations is that actions leading to an increased level of alcohol consumption result in loss of life in the EU, with the burden distributed unevenly across the countries.

In Finland, different negative consequences of alcohol use have closely followed the development of per capita alcohol consumption, although particular harms tend to increase faster than consumption. This is also true with regard to alcohol-related mortality, as shown in Figure 6.1. The years 1995 and 2004, when per capita consumption rose by 10% each year, offer points of natural experiment with regard to the effect of total alcohol consumption on harms. In 1995, alcohol-related mortality rose by 14%, in 2004 by 20%. In 2004, deaths from alcoholic diseases of the liver increased by 30%, hospitalizations with alcohol-related diagnoses by 9%, the number of people taken into custody due to drunkenness by 11%, accidents involving drunk drivers by 7% (but 18% among 15- to 24-year-olds) and alcohol-related assaults by 3%.

The burden of alcohol-related harms is also unequally distributed within societies. In Finland it has been estimated that one-fifth of the difference in life expectancy between men and women, and one-fourth of the difference in life expectancy between upper class non-manual workers and manual workers, can be accounted for by alcohol-related deaths.[19] Similarly, the increase in consumption in 2004 was the greatest among men with the least education.[20]

Alcohol policy at European Community level

The EU's competence in public health and social policy

The evolution of a public health commitment in the EU can be traced through the founding treaties and their amendments. In fact, the Treaty of Rome did not mention public health explicitly, and before the 1980s alcohol was mostly discussed at EU level from the perspectives of the CAP or as a tax harmonization issue.[21]

Neither was a direct mandate for public health included in the Single European Act of 1986, although it did stress that the Commission should seek a high level of protection of health and safety, environmental issues and consumer protection in relation to the founding of the Single European Market. One modest indicator of the expansion of public health interests during the late 1980s was the establishment of a public health unit within Directorate-General V ("Employment, industrial relations and social affairs").

The adoption of the Maastricht Treaty in 1993 awarded the EU competence in the area of public health through Article 129. This competence was, however, limited to health promotion and encouraging interstate cooperation. Most importantly, the treaty explicitly excluded the harmonization of laws or regulations regarding public health in the Member States. Community activity in the area of public health was to be directed at preventing illness, including drug addiction, through research, health information and education.[22] In 1999 the EU's public health unit was changed to the Directorate-General for Health and Consumer Protection (DG SANCO).

The Amsterdam Treaty of 1999 further expanded the scope of EU activities for improving public health. Article 152 (ex-Article 129) of the treaty is viewed as the first legislative instrument given to public health policy-makers since it provides a basis for introducing public health impact assessment in different policy areas in the EU. On the other hand, Article 152 still excludes any harmonization of public health laws and regulations of the EU Member States which clearly restricts the use of "hard law" for public health purposes at EU level.

The first time alcohol was treated as a potential target of regulation motivated by public health aims was in 1981 in the second programme of the European Economic Community for consumer protection and information.[22] The first time alcohol was mentioned as a public health and social problem in a Council resolution was in 1986. This resolution stated that the increase in alcohol abuse was causing serious concern for public health and social welfare. Since then alcohol has gradually made an entrance on the EU agenda. Areas where alcohol has been introduced are, for instance, the Europe Against Cancer Programme, initiated in 1987, road and traffic safety issues, as well as alcohol advertising in broadcast media. The work of the EU's public health unit has concentrated on building European opinion, developing interest groups, as well as ensuring practical competence in the area.

Towards a Community strategy aimed at reducing alcohol-related harm

The first case of alcohol policy that was processed as a public health issue in the EU was the case of "alcopops" or designer drinks. In 1995 these beverages

hit the market in the United Kingdom, and shortly afterwards found their way into other European markets. The fact that alcopops were aimed at very young consumers resulted in demands for action at the European level by interested organizations and the European Parliament. The alcopops issue was soon also raised within the Council. A declaration by the European Parliament called upon the Commission to introduce Europe-wide guidelines for the promotion, marketing and retailing of alcopops, to enforce regulatory control of the promotion, marketing and retailing of these products, and to examine ways of taxing such drinks at the same rate as distilled spirits. In addition, in 1996 the Commission established a working group on alcohol as a forum for sharing experiences on alcohol-related problems and alcohol policy.

During the process, however, the subject of discussion shifted away from the substance at hand – alcopops – and moved towards dealing with alcohol consumption by the young and children in general. Later the concept of alcopops actually disappeared from the draft versions, and the final Council recommendation, accepted in 2001, dealt solely with young people's drinking. The recommendation (2001/458/EC) encouraged Member States to foster a multisectoral approach to educating young people about alcohol and to increase young people's involvement in health-related policies and actions. The Council also decided on a conclusion to a Community strategy to reduce alcohol-related harm (Council Conclusion 2001/C 175/01). In this conclusion the Council underlined the desirability to develop a comprehensive Community strategy aimed at reducing alcohol-related harm.

In 2002 the European Parliament and the Council adopted a programme of Community action in the field of public health for the years 2003–2008. The programme is meant to complement national policies and it aims to protect human health and improve public health. In 2003 the priority areas were cross-cutting themes, health information, health threats and health determinants. Under health determinants, alcohol, along with tobacco and drugs, were mentioned. Finally, in 2004 the Council adopted a follow-up Conclusion on Alcohol and Young People, which states that special attention should be directed at young people when drafting the Community strategy on reducing alcohol-related harm. The Commission is planning to adopt a communication to the Council and European Parliament on alcohol and health late in 2006.

Conclusion

With the gradual introduction of the Single Market, the basic pillars of Nordic alcohol control have certainly been weakened. That is, Finnish "hard law"

Table 6.1 *Changes in the operational environment in alcohol policy in the EU, from the point of view of the Finnish Member State*

	The level of the Member State Finland	The level of the EU
"Hard law" (binding legislation and regulations)	The key instruments of Finnish alcohol policy (taxes and availability), based on national law, are weakened, because EU laws exceed Finnish laws. Formally, Finland decided independently on regulations concerning national excise duties, drink-driving, purchase age limits, the number of on- and off-premise outlets, advertising, etc. In practice, the free import of alcoholic beverages for personal use and the expansion of the Single Market have reduced the possibility of keeping high excise duties.	The expansion of the Single Market has a heavy influence on the regulation of alcohol consumption and alcohol-related harm in Finland. Social and health conditions are affected by EU laws regulating the Single Market, although national social and health legislation remains untouched. With Article 152 in the Amsterdam Treaty the EU has a mandate to address alcohol-related problems. However, the article excludes any harmonization of the public health laws of Member States, which restricts the use of "hard law" for public health purposes at EU level.
"Soft law" (non-binding agreements: recommendations, conclusions, strategies, etc.)	The focus of Finnish alcohol policy is partly switched to regional and local prevention, services and treatment, and partnerships between governmental and non-governmental actors. Fixed-term national alcohol programmes are being institutionalized.	Social and health aspects related to alcohol consumption are to some extent raised within EU bodies. The Council has agreed, for example, on a recommendation on the drinking of alcohol by young people (2001/458/EC) and a conclusion on a Community strategy to reduce alcohol-related harm (2001/C 175/01). A communication to the Council and the European Parliament on an alcohol policy strategy will be adopted in 2006.

concerning the regulation of alcohol taxes and availability of alcoholic beverages has become more difficult to pursue. The challenge comes from the very centre of the "hard law" domain of the EU, namely the Single Market, where alcohol is essentially treated as an ordinary commodity. Under such circumstances, traditional Finnish social and health considerations are difficult to uphold in the regulation of alcohol consumption.

As this confrontation seems to have tangible effects on the level of alcohol consumption and related harm, much concern is expressed about how to tackle the situation. In principle, several political options are available, as shown in Table 6.1.

The weakening of traditional "hard law" in Finnish alcohol policy does not imply that the price and availability instruments are ruled out altogether, but it has without doubt called for significant reorientations. As alcohol taxes were lowered, the government put more emphasis on local and regional measures to combat alcohol abuse. However, these measures tend to be less effective, particularly in comparison to prices and restrictions of the possibilities of purchasing alcoholic beverages.

At EU level, public health-inspired measures and their integration in a variety of policy areas, covering both "soft law" and "hard law" regulations, are certainly one option to use in preventing alcohol-related harm. However, it should be remembered that the legal base for public health actions – Article 152 (ex-Article 129) – does not give the EU the power to harmonize public health laws and regulations in the Member States. Therefore most of the public health activities at Community level belong to the realm of "soft law".

The attempt to incorporate social and health aspects in alcohol policies is clearly reflected in an initiative made in 2004 by the governments of all five Nordic countries, three of them being EU Member States. The governments set out two concrete goals. The first one aims to reinstate part of the travellers' alcohol allowances by setting maximum amounts on import quotas (55 litres of beer, 45 litres of wine, 10 litres of intermediate products and 5 litres of spirits). The second is to influence excise duties within the EU in three ways: (a) the zero tax on wines should be removed; (b) the minimum tax on alcohol should be raised; and (c) the tax on alcopops should be increased. The novelty of this joint initiative is that the Nordic governments aim at intervening directly in the "hard law" of the Single Market in matters concerning control of alcohol consumption.

The Commission is preparing to adopt a communication on the EU Alcohol Strategy in September 2006. From the Single Market point of view the assumption for Community action is that free trade and economic growth always create welfare. Alcohol, however, is not an ordinary commodity as an increase in consumption (most probably) produces more harm than good.

From a public health point of view one of the main challenges for the Alcohol Strategy will be to address how, in practice, social and health concerns related to alcohol consumption could be more effectively considered within the legislative framework of the EU. Such a task is at the heart of the very idea of bringing health into a variety of policy areas: to incorporate health into all policies, for example alcohol policies. In doing this, innovative combinations of "hard law" and "soft law" governance will be called for.[23]

REFERENCES

1. Germer P. Alcohol and the single market: juridical aspects. *Contemporary Drug Problems*, 1990, 17(4):481–496.
2. Österberg E. Implications for monopolies of the European integration. *Contemporary Drug Problems*, 1993, 20(2):203–227.
3. Ugland T. *Policy re-categorization and integration. Europeanization of Nordic alcohol control policies*. Faculty of Social Sciences, University of Oslo, 2002:110–113.
4. Holder HD et al. *European integration and Nordic alcohol policies. Changes in alcohol control policies and consequences in Finland, Norway and Sweden, 1980–1997*. Aldershot, UK, Ashgate, 1998.
5. Lund I, Alavaikko M, Österberg E. Deregulating or re-regulating the alcohol market? In: Sulkunen P et al., eds. *Broken spirits. Power and ideas in Nordic alcohol control*. Helsinki, NAD publication No. 39, 2000.
6. Österberg E, Karlsson T, eds. *Alcohol policies in EU Member States and Norway. A collection of country reports*. Helsinki, European Commission and STAKES, 2002.
7. Tigerstedt C. The European Community and the alcohol policy dimension. *Contemporary Drug Problems*, 1990, 17(4):461–479.
8. Bygvrå S. Border shopping between Denmark and West Germany. *Contemporary Drug Problems*, 1990, 17(4):595–611.
9. Karlsson T, Österberg E, Tigerstedt C. Developing border regions, regulating alcohol in the Nordic countries. *Nordisk alkohol- och narkotikatidskrift* (English supplement), 2005, 22:102–114.
10. Mäkelä P et al. Drinking and gender differences in drinking in Europe. A comparison of drinking patterns in European countries. In: Bloomfield K et al. *Gender, culture and alcohol problems: a multi-national study*. Berlin, Project Final Report, Charité Campus Benjamin Franklin, 2005:49–72.
11. Leifman H. Trends in population drinking. In: Norström T, ed. *Alcohol in postwar Europe. Consumption, drinking patterns, consequences and policy responses in 15 European countries*. Stockholm, National Institute of Public Health & European Commission, 2002:49–81.
12. Sulkunen P. Alcohol consumption and the transformation of living conditions. A comparative study. In: Smart R et al., eds. *Research advances in alcohol and drug problems*. London, Plenum, 1983:247–297.
13. Gual A, Colom J. Why has alcohol consumption declined in countries of southern Europe? *Addiction*, 1997, 92(1):21–31.
14. Babor T et al. *Alcohol: no ordinary commodity*. Oxford, Oxford University Press, 2003.
15. Sulkunen P et al., eds. *Broken spirits. Power and ideas in Nordic alcohol control*. Helsinki, NAD publication No. 39, 2000.
16. Österberg E, Pehkonen J. Travellers' imports of alcoholic beverages into Finland before and after EU. *Nordisk alkoholtidskrift* (English supplement), 1996, 13:22–32.

17. Norström T, ed. *Alcohol in postwar Europe. Consumption, drinking patterns, consequences and policy responses in 15 European countries*. Stockholm, National Institute of Public Health & European Commission, 2002.

18. Skog O-J. Alcohol consumption and mortality rates from traffic accidents, accidental falls, and other accidents in 14 European countries. *Addiction*, 2001, 96 (Supplement 1):49–58.

19. Mäkelä P. *Alkoholiin liittyvät kuolemat. Yleisyys ja yhteys sukupuoleen ja sosioekonomiseen asemaan* [*Alcohol-related deaths. Incidence and connection to sex and socioeconomic status*]. Helsinki, STAKES, Research Report 105, 1999.

20. Helakorpi S et al. *Suomalaisen aikuisväestön terveyskäyttäytyminen ja terveys, kevät 2005* [*Health behaviour and health among the Finnish adult population, spring 2005*]. Helsinki, Publications of the National Health Institute B18, 2005.

21. Sulkunen P. Economic integration and the availability of alcohol: the case of the European Economic Community. *Contemporary Drug Problems*, 1981, 8:75–102.

22. Sutton C, Nylander J. Alcohol policy strategies and public health policy at an EU level. The case of alcopops. *Nordisk alkohol- och narkotikatidskrift* (English supplement), 1999, 16:74–91.

23. Trubek DM, Cottrell P, Nance M. *"Soft Law", "Hard Law", and European integration: toward a theory of hybridity*. University of Wisconsin, Legal Studies Research Paper No. 1002, November 2005 (available at Social Science Research Network, Electronic Paper Collection).

Chapter 7

Environment and health: perspectives from the intersectoral experience in Europe

Marco Martuzzi

Introduction

This chapter is dedicated to the process that lead to intersectoral action between health and other sectors of civil society in the area of environmental health, in the European context. European interest groups, politicians and citizens at large have been increasingly concerned over the environment. The environment is rightfully regarded as an absolute value per se, carrying the moral obligation to be preserved. In addition, the realization of the importance of all natural resources and ecosystems for supporting health, well-being and economic development (in line with sustainable development) has resulted in greater prominence of the environmental issue in the political agenda in Europe. Much attention is also paid to the health implications of environmental factors. Indeed, concern about the adverse health effects of environmental exposures has been among the main drivers of markedly increased environmental awareness. This has produced intense pressure for more information, more research and more action on environmental health.

As a response to this pressure and to other factors discussed in this chapter, the health sector and other sectors broadly falling within the environmental domain have established various forms of collaboration in the past two decades. The conceptual framework, the long-term strategy, the available methodology and the mechanisms of this interaction have been evolving. While achievements have been impressive, this has not always been the case.

The objective of this chapter is to describe this progress at conceptual and policy levels, in particular examining how intersectoral action between health and the environment has become both a key response to the challenges posed by environmental protection and an effective strategy for promoting human health. In the first part of this chapter, I provide a perspective on how this experience has contributed to developing a view and an approach to health in other policies. I introduce one key methodological tool used in supporting policy-making in environmental health, namely risk assessment, with its advantages and disadvantages; I then illustrate, with strategic environmental assessment (SEA), an important political opportunity for further establishing Health in All Policies (HiAP); and finally I describe an area of work, transport and health, which exemplifies the progress in intersectoral action in environment and health, which can be used as a reference in other fields where intersectoral action is pursued.

Demand for more health–environment intersectoral action

As is emphasized throughout this book, policies in many sectors have important health implications. Given the great potential to improve health and welfare, and minimize adverse effects through influencing strong determinants, it is important that health consequences are addressed when developing public policy. The principle is shared by many and is fully recognized also in the environmental domain, especially in consideration of today's rapidly advancing technologies and increasing complexity of societal organization. More demand for intersectoral action in environment and health is also motivated by the important economic implications of environmental policies; the cost–benefit evaluation of policy and regulation on the use of natural resources often includes significant adverse health impacts (in terms of ill health, morbidity, mortality and health care), for which the health sector is in many cases required to bear the costs. The involvement of the health sector in early stages of policy development is therefore desirable for the sake of public health and in order to "internalize" economic and social costs associated with adverse health consequences.

The need and the value of intersectoral action between health and the environment is increasingly recognized in Europe and around the world. Health considerations in environmental policies have been gaining more prominence over the last 10 to 15 years. Agenda 21 – adopted in 1992 at the United Nations Conference on Environment and Development – and resolutions of the 2002 World Summit on Sustainable Development held in Johannesburg indicate a strategy for environmental health and call for more and closer links between environmental protection and health promotion.

Against this global background, the agenda has also been evolving rapidly in Europe, especially within the framework of the series of Ministerial Conferences on Environment and Health, beginning in 1989 with the Frankfurt Conference. At the Second Ministerial Conference on Environment and Health (held in Helsinki in 1994) ministers of health and of the environment of the Member States of WHO's Regional Office for Europe approved the Environment and Health Action Plans for Europe. Based on this plan, ministers committed their governments to developing National Environment and Health Action Plan for Europe (NEHAPs), which were prepared by all Member States in the following few years. Apart from the specific contents and actions included in the NEHAPs, strong emphasis was given to the need to strengthen intersectoral action.[1] This process reflects the increasing awareness of the multiple linkages between health and its many environmental determinants, at individual level as well as at population level. The health sector has thus been in a position to take on a stewardship role in governance in the environmental domain.

How has this stewardship role in environmental health been developing in Europe, and what were the drivers that can be identified and taken as examples for strengthening the willingness and the ability of the health sector to collaborate with other sectors? I argue that progress has been made thanks to an important transition in the quest for strategies for health-friendly decision-making, in the case of the environment and health. The transition, affecting the science–policy interface, has been from a situation where scientific information is produced by science and research and passed on to decision-makers with a marked separation of roles, to one where a more collaborative approach is adopted, with more direct participation and interaction between the relevant interested parties: from one where risk assessment and risk management are clearly separated to one where there is a continuum. More specifically, at the starting point a model was used where information on the health effects of given risk factors contributes to rectifying environmental policies, in a reactive fashion, in order to remediate or mitigate detrimental health consequences. This model has been and continues to be evolving into a more proactive one, where health is on the broad political agenda of the environment and other sectors at earlier stages of the policy process, in an effort to better prevent adverse health effects but also to promote good health and well-being. Health in All Policies can be seen as the ultimate goal of this transition, which should therefore be pursued further.

Health in All Policies: risk assessment and beyond

The transition or evolution we are describing has involved the development and use of risk assessment and burden of disease (BoD) methods, the essential tools to evaluate quantitatively the health consequences of environmental risk factors. The methodological advancement around risk assessment, the identification of its limitations and the development of enhanced tools illustrate the progress under way in the area, the methodological needs and the long-term strategy towards HiAP.

Risk assessment

In environmental health matters, information regarding health considerations in the policy-making setting is often provided by risk assessment, which has been described as a "bridge from science to policy".[2] Risk assessment is mainly an expert exercise, consisting of combining evidence on the existence and strength of an exposure–disease causal association with information on the frequency and intensity of exposure to derive estimates of the true risks borne by individuals in a population.[3] Risk assessment is routinely applied, is based on consolidated methodology [4,5] and has been widely used in environmental health and standard setting. Its main function is to support decisions and regulations concerning individual substances or exposures. Using risk assessment, it is possible, for example, to calculate the risk of developing lung cancer in individuals in a given population, as a function of cumulative exposure to tobacco smoke, or, separately, from ambient air pollution. Such estimation involves, apart from the need to apply appropriate algorithms, clarifying the assumptions, using the appropriate dose–response functions and coefficients, and evaluating uncertainties.

Risk assessment was originally applied to evaluate the real risk posed to people by known hazards, but also became motivated by the need to develop public policies in environment and health that are more "rational", that is they maximize returns of societal investment (in terms of money, discomfort and lack of benefits) by identifying the areas of intervention where actual rather than perceived risks can be more effectively reduced. However, there are some limitations in using risk assessment for concrete policy development. Risk assessment normally addresses one risk factor and one health outcome at a time; it can be carried out for several health outcomes associated with the same risk factors, but it may then be difficult to combine the results in a meaningful way. More importantly, since risk assessment describes the risks of current or hypothetical levels of exposure to a given risk factor it is well suited to setting protective standards, but provides a partial picture when it comes to informing policy formulation, where more complex scenarios are under scrutiny.

There are several reasons for this: first, health outcomes that are difficult to measure or for which hard quantitative evidence is not available cannot undergo risk assessment, so some health implications can be dismissed or ignored, while they may well be high in the political or public list of priorities; second, policy action does not normally affect levels of exposure directly, rather it aims at controlling activities that produce various exposures, including the ones for which risk assessment is available, for example, to control air pollution levels governments will need to act on transport, industry, energy, etc.; third, risk assessment concerns adverse health effects only, while beneficial or protective factors are invariably involved in decision-making; fourth, in situations where induction and latency times are protracted, estimated risks reflect exposures that occurred years or even decades earlier and the health benefits following reduction or removal of risk factors might be diluted or delayed. Risk assessment was developed and used to translate scientific knowledge into information more amenable to being used in the decision-making context. This approach concentrates on adverse effects, requires relatively "hard" quantitative evidence, with a high level of "proof of harm", and discards softer ones, and adopts a narrow concept of health. Because of its reactive nature, aiming at measuring the health damage of certain exposures, it tends to create opposition, friction or even conflict between the priorities and aspirations of public health and those of other sectors. Debate within this framework tends to concentrate on what level of risk is acceptable in return for other benefits, typically of an economic nature.

Despite the limitations, this approach, aiming at making effective use of the impressive progress in knowledge on health and its determinants, has been instrumental in bringing health concerns into the political agenda. It continues to provide ammunition for the health sector, especially when dealing with established, well-known risk factors. It helps identify sectors with the greatest potential to contribute to good health. Methods for risk assessment are an essential instrument and have been enhanced continuously. They have also been made more general with the introduction of BoD analysis (see section on burden of disease). It is important that these methodologies are made available and are used rigorously when feasible, while making their role and limitations explicit.[6]

Burden of disease

In an effort to overcome some of the shortcomings of risk assessment in supporting policy formulation, WHO has promoted the development of methodologies for synthesizing more comprehensively available evidence on determinants of health. In particular, methods for describing so-called BoD

Table 7.1 *Burden of disease for selected environmental factors and injuries in the European Region (52 Member States of the Regional Office for Europe of WHO)*

Risk factor (age range)	Attributable deaths		DALYs (disability-adjusted life-years)	
	No.	No. per 10 000 children	No.	No. per 10 000 children
Outdoor air pollution (0–4)	13 796	2.68	–	–
Indoor air pollution (0–14)	89 845	1.91	340 818	66.13
Inadequate water and sanitation (0–14)	13 548	0.78	549 940	31.57
Lead (0–4)	–	–	482 892	93.70
Injuries (0–19)	75 159	22.6	4 793 557	200.39

have been developed and widely used for combining different measurable health impacts including mortality and morbidity. WHO used this methodology to evaluate the global disease burden associated with 26 major health determinants.[7] Given a health determinant (for example water, sanitation and hygiene), BoD methods start by evaluating the number of deaths and the number of cases of all diseases attributable to the relevant risk factors; then mortality and morbidity are translated into a common metric. One of the most frequently used metrics is the disability-adjusted life-year (DALY) consisting of the sum of years of life lost due to excess mortality and years lived with disability.[8] DALYs summarize, in one number, the health burden attributable to a given cause or set of causes related to a sector. DALYs enable direct comparison of the magnitude of the health burden posed by different sectors, and therefore of the potential health gains achievable through policy implementation. Also, they allow better economic evaluations than risk assessment, another potentially useful instrument for identifying priorities in policy development.

The introduction of the concept of BoD and the appropriate methodology to measure it has allowed valuable progress in identifying priorities for intervention. For example, the Fourth European Ministerial Conference on Environment and Health approved a pan-European Children Environment and Health Action Plan[9], adopted by the 52 Member States of the WHO Regional Office for Europe, indicating priorities for action based on an analysis of the BoD on European children and adolescents due to environmental factors.[10] Results from this analysis are summarized in Table 7.1 and show the relative importance of outdoor and indoor air pollution, inadequate water and sanitation, exposure to lead, and injuries. Data in the table refer to all of the European Region; a breakdown by subregions is also available. Results underline the large burden of these factors, the need to take

urgent action and the potential health gains achievable through preventive policies.

These applications are highly informative, for example, for international comparison or for identifying broad priorities. However, further efforts are needed if this information is to provide more concrete support to policy-makers facing concrete political negotiation and decisions. Under ordinary circumstances in the policy-making setting at national or local level, the outcome of a BoD analysis is certainly more useful to risk managers than an overall assessment of the evidence, but it still falls short of providing direct guidance on developing protective policies, as it does not answer some of the typical questions that decision-makers face. In addition, the essential dimension of health promotion may be lost, at least partially, owing to the focus on adverse effects and negative impacts. As a result, the information provided by these analyses is not always exhaustive for effective and sustainable intersectoral action, where decisions involve a process of negotiation including the weighing of costs and benefits of various natures, including quantifiable and non-quantifiable ones (health, economic, social and cultural). Thus this kind of information is an important and probably necessary ingredient, but is only one component of a more ambitious process of effective and systematic participation of the health sector in other policies.[11]

Which way forward?

European politicians and citizens seem to be increasingly attracted by a broader concept of health than is normally used in risk assessment, including well-being and quality of life and not limited to absence of measurable disease; more and more attention is being paid to questions of unequal distribution of health status, to the needs of vulnerable subgroups, and to fairness in the social distribution of risks and benefits; it has become clearer that good health is not only an outcome of a prosperous society, but it also contributes to creating wealth;[12] and finally, the complex nature of many health determinants, their interplay with social factors and the potential of far-reaching indirect risk factors require, more and more, interdisciplinary efforts.

These facts have resulted in a demand for approaches that complement the risk assessment paradigm, by adopting a proactive stance (trying to anticipate harm rather than measuring it; making use of information, including qualitative, on hard and soft health end points); considering, besides the magnitude of the impacts, their distribution across the population, and contrasting this distribution with the allocation of the benefits; and including the potential long-term social and economic benefits deriving from a healthier and more equitable society. One natural strategy to address these challenging

requirements is to foster closer interaction and collaboration between health and other sectors, and to establish transparent and participatory approaches, for example through the framework provided by health impact assessment (HIA) (see Chapter 10). Intersectoral collaboration has indeed proved to be effective, or at least promising, in some instances, and has great potential for further development.[13] It is essential that its possible limitations and shortcomings are clarified and addressed if it has to establish itself as a viable and sustainable feature of policy-making in Europe.[14]

Strategic environmental assessment: an opportunity for Health in All Policies

Risk assessment and BoD analysis provide some of the technical resources for describing the health implication of environmental risk factors. As we have seen, these tools cannot guarantee, in isolation, that adequate, health-friendly policies are identified and adopted; rather they provide a valuable contribution to be used within a solid political framework involving the sectors concerned.

Recent developments around SEA may provide such opportunity, through a high-level policy framework. Strategic environmental assessment is the evolution of environmental impact assessment, which is firmly established in Europe and worldwide as a mandatory evaluation of new projects. Environmental impact assessment normally deals with impacts on the physical environment, such as soil, water, air, natural resources and ecosystems.

The need to expand the assessment to comprise a broader picture was recognized in the debate that lead to the concept of sustainable development, where environmental concerns are paralleled by social and economic dimensions. Strategic environmental assessment was developed because of the necessity to assess the implications of plans and policies and, to a lesser extent, projects, at the strategic level; SEA is acquiring a legal profile in Europe. EU Directive 2001/42/EC – usually referred to as the SEA Directive – was issued in 2001 and prescribes that plans prepared from July 2004 undergo an analysis that considers the likely significant effects on the environment, including on issues such as biodiversity, fauna, flora, soil, water, air, climatic factors, material assets, cultural heritage (including architectural and archaeological heritage), landscape and, importantly, population and human health. Also the interrelationships between the above factors, including secondary, cumulative, synergistic, short-, medium- and long-term, permanent and temporary, positive and negative effects must be considered, through a participatory process open to stakeholders.

Reference to human health, although made in passing, is crucial for those concerned with health protection and promotion. In fact a long debate has been taking place as to whether or not human health should be included in SEA, and if so to what extent and with what methods. In 2003, the United Nations Economic Commission for Europe (UNECE) Protocol on SEA was signed by 35 European countries, including most of the then 15 EU Member States. The Protocol further confirms the engagement of Member States to use SEA to evaluate plans and policies in all sectors. Reference to human health is explicit throughout the Protocol, which spells out several prescriptions on "environment, including health". The Protocol is currently being ratified by signatory countries (Finland was the first country to do so, in 2005) and is expected to come into force in late 2006 or 2007.

Strategic environmental assessment does not aim to contribute new methodology or tools for HiAP; rather, it represents a valuable policy mechanism to institutionalize the consideration of HiAP. It can be expected, in this respect, that current methods of risk assessment and HIA, subject to appropriate adjustments, should provide an adequate basis. However, experience is still limited in this field, and open questions remain on how to incorporate health in SEA in an effective and manageable way. There are conceptual questions (for example, what definition of health is appropriate?), methodological questions (for example, what form of HIA is suitable in SEA?) and institutional questions (for example, whose responsibility is it to assess the health implications of a proposed policy? Who bears the costs?). Work is under way to clarify these questions and identify a suitable way forward. It is clear, however, that the Protocol offers a unique opportunity to promote intersectoral work, not only with the environment sector but also with all other sectors involved in various policies. The EU Directive and the Protocol provide a strong legal basis for establishing constructive and durable mechanisms for pursuing HiAP.

Example: air quality, transport and health in Europe

Strategic environmental assessment may thus provide a policy and legislative framework for HiAP, through a "top down" mechanism requiring and supporting intersectoral collaboration among health, environment and other sectors. This important result is due, among other things, to successful experiences, such as transport, environment and health where, in a "bottom up" type of development, interest groups created and took advantage of opportunities for the promotion of instruments for supporting health-friendly policies. The political momentum created by such an initiative has been highly effective. At present, transport, environment and health represent a

paradigmatic case of intersectoral collaboration, and possibly a model for establishing HiAP as a systematic approach in Europe and elsewhere. Also, the case of transport, air pollution and health exemplifies the transition discussed earlier, from a simplified model of a separation between risk assessment and risk management to one of intersectoral collaboration.

In fact, transport and health have a strong record of intersectoral collaboration.[15] One of the driving forces of this process has been the mounting body of evidence on the health effects of ambient air pollution in urban areas. Numerous gaseous and particulate pollutants have been studied for several decades, and their effects on a variety of health end points, including mortality, morbidity and hospital admission have been documented. This process has been based on the systematic review of evidence and risk assessment-type evaluations such as the one illustrated earlier, which quantifies the mortality burden of outdoor and indoor air pollution in Member States of the WHO European Region. This type of evidence has resulted in increasingly stringent standards adopted in Europe on emissions and concentrations.[16] The focus has moved, since the 1980s, from considering and controlling concentrations, reacting to high values with ad hoc measures, to intersectoral action aimed at reducing emissions. This shift of emphasis from reactive control policies to more proactive, anticipatory policies has taken place thanks to several factors. On the one hand, such progress has been underpinned by EU legislation, through a Framework Directive and no less than four Daughter Directives and the Exchange of Information Decision, an exemplary case of evidence-based policy. In addition, in 2001 the European Commission launched the Clean Air For Europe (CAFE) Programme, with the aim of developing strategic and integrated policies for health protection.[17] This process has been instrumental in reducing the exposure of Europeans to some pollutants, notably to sulphur dioxide, nitrogen oxides and volatile organic compounds, through the implementation of cleaner energy production and industrial technology (Directive 88/609/EEC on large combustion plants, Directives 98/69/EC, 98/70/EC and 99/96/EC on automotive vehicles and fuel quality, and Directive 1999/13/EC on emissions of solvent-using industries).

However, besides the legislative response, a deeper realization of the potential of broader intersectoral action, together with the active role played by various agencies, has contributed to the change in focus we are describing. Despite good progress in terms of emission legislation and concentration standards, ambient air pollution remains responsible for a large proportion of ill health in Europe.[18] The process in the field of air quality has involved interaction between health and other sectors, based on evidence essentially in the form of

quantitative environmental HIA. A parallel process, more intrinsically intersectoral, has been taking place in transport, which is one of the main sources of air pollution.[19] It became apparent that urban transport affects other important health parameters or determinants, that is road injuries, noise, physical activity and psychosocial effects. So transport policies aimed at reducing air pollution emissions, which are generally achievable through limiting private motor vehicle transport, are likely to produce additional health benefits. These considerations led to an alliance between health, transport and the environment that resulted in the development of the Charter on Transport, Environment and Health, adopted at the Third Ministerial Conference on Environment and Health in London, 1999, which brought together representatives from the three sectors, intergovernmental and nongovernmental organizations. Aiming at placing health considerations on the agenda of transport policy-makers, the Charter included a plan of action with international and national policy development, based on the concept of sustainable transport, where all health implications are explicitly addressed. This initiative, coordinated by WHO, and a parallel one coordinated by the UNECE, were subsequently brought under a common framework with the establishment of the Transport, Health and Environment Pan-European Programme (THE PEP). The THE PEP was adopted, again by representatives of the three sectors, by 38 European countries in July 2002, and launched at the World Summit on Sustainable Development. It includes the following actions: the creation of a clearing house on information on transport, environment and health; the elaboration and implementation of urban plans for transport sustainable for health; characterization of the transport-related health impacts and their costs and benefits; and the establishment of a set of indicators to monitor the integration of health aspects into transport policies. The THE PEP was also included in the agenda of the Fourth Ministerial Conference on Environment and Health, where progress in the implementation was reviewed and further opportunities, challenges and actions were discussed.

Conclusion

The process of feeding the scientific knowledge and the available evidence into the decision-making process is fraught with difficulties.[20] More often than not, the reality of policy-making makes it difficult to reconcile science with the other needs and priorities of society. A participatory model, where the instances of health promotion and protection are represented and advocated and contribute to identifying a satisfactory course of action, seems to be a natural response to these difficulties.

Experience, trends and perspectives in intersectoral collaboration between health and other sectors (notably the environment) indicate that there is great potential for enhancing health through coordinated action in policy-making. Several lessons have been learnt in the recent past, and several workable questions have been formulated. Experience is now abundant on the possible benefits of intersectoral action, in terms of governance, quality of democratic participation, acceptability of policies and coexistence between the priorities of public health and those of a different nature, notably the economic ones. Indeed, the best outcome of intersectoral action is when policy options are identified that equally satisfy the various needs and priorities. Health in All Policies at its best may contribute to make these "win-win" opportunities more frequent. It is hoped that European Member States will take advantage of these lessons, and will support further investment in this area.

Acknowledgement

I would like to thank Francesca Racioppi for her comments on earlier drafts of this chapter.

REFERENCES

1. Kahlmeier S, Kunzli N, Braun-Fahrlander C. The first years of implementation of the Swiss National Environment and Health Action Plan (NEHAP): lessons for environmental health promotion. *Soz Praventivmed*, 2002, 47(2):67–73.
2. Hertz-Picciotto I. Epidemiology and quantitative risk assessment: a bridge from science to policy. *American Journal of Public Health*, 1995, 85(4):484–493.
3. Samet JM, Schnatter R, Gibb H. Invited commentary: epidemiology and risk assessment. *American Journal of Epidemiology*, 1998, 148(10):929–935.
4. *Risk assessment and management: framework for decision making*. US Environmental Protection Agency, 1984.
5. *Risk assessment in the Federal Government: managing the process*. US National Research Council, 1983.
6. Shore RE. Epidemiologic data in risk assessment – imperfect but valuable. *American Journal of Public Health*, 1995, 85(4):474–476 (editorial).
7. *The World Health Report 2002*. Geneva, World Health Organization, 2002.
8. Mathers CD et al. *Global burden of disease in 2002: data sources, methods and results. Report no. 54*. Geneva, World Health Organization, 2003.
9. *Declaration: fourth ministerial conference on environment and health, Budapest, Hungary, 23–25 June 2004*. Copenhagen, WHO Regional Office for Europe, 2004.

10. Valent F et al. Burden of disease attributable to selected environmental factors and injury among children and adolescents in Europe. *Lancet*, 2004, 363(9426):2032–2039.

11. Dora C. What can health impact assessment add to comparative risk assessment in decision-making? *Bulletin of the World Health Organization*, 2003, 81(6):460.

12. Commission on Macroeconomics and Health. *Macroeconomics and health: investing in health for economic development*. Geneva, World Health Organization, 2001.

13. Krieger N et al. Assessing health impact assessment: multidisciplinary and international perspectives. *Journal of Epidemiology and Community Health*, 2003, 57(9):659–662.

14. Lock K, McKee M. Health impact assessment: assessing opportunities and barriers to intersectoral health improvement in an expanded European Union. *Journal of Epidemiology and Community Health*, 2005, 59(5):356–360.

15. Dora C, Racioppi F. Including health in transport policy agendas: the role of health impact assessment analyses and procedures in the European experience. *Bulletin of the World Health Organization*, 2003, 81(6):399–403.

16. *Air quality guidelines for Europe*, 2nd edn. Copenhagen, World Health Organization Regional Office for Europe, 2000.

17. *Health aspects of air pollution – answers to follow-up questions from CAFE. 2004 Report on a WHO working group meeting, Bonn, Germany 15–16 January 2004*. Copenhagen, World Health Organization, 2004.

18. Medina S et al. Apheis: public health impact of PM10 in 19 European cities. *Journal of Epidemiology and Community Health*, 2004, 58(10):831–836.

19. Krzyzanowski M, Kuna-Dibbert B, Schneider J, eds. *Health effects of transport-related air pollution*. Copenhagen: World Health Organization, 2005.

20. Ezzati M. Complexity and rigour in assessing the health dimensions of sectoral policies and programmes. *Bulletin of the World Health Organization*, 2003, 81(6):458–459.

Part 3

Governance

Chapter 8

Opportunities and challenges for including health components in the policy-making process

Anna Ritsatakis, Jorma Järvisalo

Introduction

As already said in Chapter 1, Health in All Policies (HiAP) has been promoted under different labels for decades. This chapter outlines mechanisms and processes used in integrating health components in policies in all sectors. Prerequisites for HiAP are discussed, such as the underlying values and capacities for making alliances for health.

The processes and mechanisms for HiAP are infrequently documented and rarely evaluated for their effectiveness, but this is not a reason to ignore them. For years it has been said that HiAP is easier said than done, but across Europe serious efforts are being made to put health higher on the agenda at international, national, regional and local levels. Although we may not have the evidence at present to state clearly what works and what does not, the plethora of examples of HiAP in Europe, of which we can give only a small sample here, indicates the potential for learning from experience.

Starting with the values

All policy-making is about making choices to bring about change. It is a political process circumscribed by values and principles, whether these are explicitly stated or not.[1] Across Europe there appears to be a degree of

consensus, influenced by values permeating the establishment of the European Union (EU), promulgated by the Council of Europe, World Health Organization (WHO) and other United Nations organizations, and the history of the welfare state.

The broad definition of health and its underlying values highlighted through the WHO Health for All (HFA) policy are, in principle, widely accepted. Reviews of national health policies in Europe,[2] progress in the WHO Healthy Cities project[3] and in health impact assessment (HIA)[4] indicate that the following values and principles are generally accepted.

- Equity in health. Differences in health status and health determinants, which are considered unfair and avoidable, should be reduced, with the aim of everyone reaching their full health potential.
- Solidarity in health. A sense of collective responsibility ensuring the protection of the vulnerable.
- Participation in decision-making. By those who may be affected.
- Sustainability. Policies should be sustainable over time and not endanger the health of future generations.

Accepting these values in theory is one thing, implementing them in practice is another. Although surveys indicate that health is highly valued by individuals, their behaviour frequently belies this. Most health policy documents refer to these principles, but less is known about their implementation in practice. Similarly, although other sectors might not repudiate these values, they naturally have their own aims and objectives, which may be conflicting.

In some countries these values act as an incentive for HiAP. They are not, however, the only incentive. Fear has frequently been a prominent motivator for intersectoral action as, for example, in tackling the danger of "avian flu".

Whatever the motivation for action, it is essential to find potential allies and partners sharing common or converging values and objectives, or to find acceptable trade-offs when conflicting interests are unavoidable. In order to do this, the health sector must:

- be clear in its own health arguments
- ensure a holistic understanding of health
- clearly define its own values and their policy implications, and
- highlight the possible impact of ignoring these values.

Health for All policy documents[5] and discussion papers[6] offer accessible working definitions of these principles.

Mechanisms and processes for developing Health in All Policies

Reaching policy-makers and the public

Raising awareness of the need for Health in All Policies

For health aspects to be introduced in other sectoral policies, the critical health issues must first be recognized by health experts or advocates, with lay input where possible, and the determinants of such health challenges defined. For example, it must be explained that poor social and economic circumstances affect health throughout life[7] and that people further down the social ladder run at least twice the risk of illness and premature death as those near the top. Improving health therefore involves improving educational attainment, income security and housing standards and reducing unemployment and social exclusion. Since tobacco use is the single most important risk factor for ill-health in Europe,[8] informing people about the dangers of smoking is not enough: it requires action in many sectors to discourage smoking, create smoke-free environments and support those seeking solace in tobacco.

The Solid Facts,[7] which was prepared for the Healthy Cities Project, for example, provides the latest scientific evidence and argumentation regarding ten major social determinants of health, in a form accessible to policy-makers. A report prepared for the EU indicates there is evidence of the effectiveness of intersectoral action to promote health.[9]

There are examples where popular versions of health reports and research findings have sensitized the public to the need for HiAP. When the public health programme in Sweden was prepared, short publications, particularly on "controversial" issues, were produced by well-known journalists and politicians, creating considerable discussion in the mass media. These were free of charge and also available in Braille and as audio cassettes.[10] The Swedish National Institute of Public Health produced a document specifically for politicians and decision-makers regarding the health of older people.[11]

Ministries of health frequently retain a special relationship with journalists interested in health issues. On the whole the mass media continue to focus on acute health care, but successful collaboration, particularly with women's magazines, is credited with raising awareness of nutritional issues, for example, encouraging food producers to voluntarily reduce fat content.

Securing the information

International databases can, to some extent, provide policy-makers and the public with standards in other countries by which to judge and question their own positions. Much of these data are accessible through the Internet and frequently come with programmes allowing further processing and attractive presentation.

Many European countries are fortunate in having excellent health information systems for evidence-based policy formulation.

> Denmark has a large number of registers (often combined for analytical purposes according to a unique civil personal number), regular health surveys and a rich research programme.[12] Comparison with similar international data showing that the health of Danes was not improving as well as it might was one incentive leading to their present intersectoral public health programme.

Many countries are less fortunate. It is probably also true that much of the data collected in Europe only see the light of day in official publications read by experts, or articles written largely by researchers for researchers, having little impact on policy formulation.

Although there have been continued efforts by governments and researchers across Europe to analyse inequalities in health and determine their causes, too many countries are still far behind in providing such data. The problem is particularly pronounced at local level where responsibility for many of the policies affecting inequalities in health mainly lies. Apart from countries with a long tradition of such research, if inequalities in health are monitored at local level, this is mainly by geographic area. Only if health status is related to income, education or employment, for example, can policy-makers understand the need for HiAP.

> Rotterdam in the Netherlands has been a pioneer in this area. Starting as an off-shoot of the Healthy Cities Project, data on local health problems were collected at neighbourhood level and presented by a software program, REBUS Vision. The vast amounts of data collected led to the need to consider their relative importance and condense this into a summary figure. The *health barometer* therefore chose the 27 most important available neighbourhood indicators and divided these data into six groups leading to six scores by which a neighbourhood could be compared with the city mean, other neighbourhoods or itself over time. Later, a *health monitor* was developed that not only signals public health problems but also tries to identify determinants and offer solutions on a health policy and promotion level.[13]

Presentation and discussion of the information are vital, and increasingly health issues are being brought to the attention of policy-makers and the public in ways demanding action.

One way is the production of public health reports. WHO and the EU produce such reports providing comparable international information. Most EU countries produce national public health reports on a regular basis, as do many regions and cities. In recent years, the coverage of such reports has broadened from the traditional epidemiological and health services data (see Chapter 9).

> The regular health profile in Seixal, Portugal, covers the demographics of the city, employment, economic sectors, income, the environment and housing, education, sports and various social facilities, health and health services.

Parliament legislates in all sectors and this high-level intersectoral forum has been used effectively to discuss public health reports. Lithuania, for example, organized a parliamentary discussion of health challenges in 1995. Four ministers participated in the six-hour discussion, broadcast through the mass media.

Many European cities make similar reports to their city councils and these are available, frequently through the Internet, to their citizens.

Obviously, providing the evidence alone is not sufficient. Data on the link between health status and food and nutrition were available in Finland long before comprehensive action was taken. This is partly because the language spoken by policy-makers and health advocates can be very different[14] as can the understanding of the population.

Even in countries with a long tradition of health promotion such as Canada,[15] the public are focused on the availability and safety of health care, and to some extent on individual lifestyles, and has less appreciation of the interrelatedness of factors such as education, housing and health.

In an initial mapping of the issues, a simple matrix can be useful to indicate the relationship between health challenges and the sectors or institutions influencing their determinants. Such matrices are being widely used in HIA.

Although the links between the determinants of health and health outcomes are not easy to untangle, particularly in quantitative terms, research regarding the determinants of health and inequalities in health is growing rapidly in Europe. Steady progress has also been made over the last twenty years in assessing the effectiveness of policy-oriented health promotion,[9] but on the

whole available evidence on the effectiveness of policies in reducing socioeconomic inequalities in health is more limited.[16] Even less is known about the economic costs and effects, which are of particular interest to policy-makers.

Ensuring capacities for Health in All Policies

In addition to knowledge of the determinants of health, HiAP calls for conceptual, analytical, managerial and political skills. As shown below, establishing new partnerships calls for flexibility, negotiating skills and the ability to work with different disciplines and interest groups are particularly important.

A number of countries have made striking progress in improving such public health competences, placing public health experts in critical positions, particularly at local level. Health impact assessment training courses are already operating across Europe. Policies to promote equity in health have also led to training courses for people working outside the health sector. Orebro University in Sweden, for example, conducts long-distance courses for a number of municipalities. The joint training for teachers, architects, etc. creates intersectoral links, formalized by the setting up of intersectoral committees in the participating municipalities. The Institute of Public Health in Ireland is testing courses to support leadership without executive authority, in complex environments.[3] Most of Europe, however, still has some way to go.

Policy formulation and implementation

The importance of intersectoral work has been emphasized and establishment of intersectoral committees for formulating and implementing comprehensive HFA-type policies has been recommended by WHO for over 25 years. However, the implementation has proved to be challenging (see Chapter 1). Participants from 26 of the 32 countries invited to the policy dialogues held as part of the Finnish EU Presidency preparations reported the following obstacles for intersectoral cooperation:[17] workload; inconsistencies between health and other sectors' objectives; health not having a very high priority in other sectors; the perception that only the Ministry of Health is responsible for health; and lack of evidence of what works and does not. Driving forces for initiating or running intersectoral action identified in the policy dialogues were: incidental events (for example, in one country an accident initiated the alcohol strategy process); strong political leadership; scientific evidence; the presence of the theme on the EU agenda; shared values of health and well-being; awareness of health problems; public support; and personal contacts.

Although there is a need to develop measures for further intersectoral cooperation, there are already several mechanisms available. Participants of the policy dialogues identified the following mechanisms:[17]

- horizontal public health committees
- formal consultations on, for example, legislation
- ad hoc committees on specific initiatives
- intersectoral policies and programmes
- public health reporting (with the cooperation of other sectors)
- formal communication between sectors (for example, bilateral meetings of permanent secretaries)
- EU coordination (see Chapter 9)
- HIA
- informal contacts.

Intersectoral committees have tended to be heavily health sector dominated but attempts are being made to draw other sectors into such committees, including nongovernmental organizations (NGOs) and representatives of special groups. Lidkoping in Sweden has a public health council that also acts as a crime prevention council and is responsible for promoting safety in the community. The council meets twice a year but a subcommittee meets once a month.

Leadership of such committees in some cases by the Prime Minister, or in cities by the mayor, emphasizes overall government responsibility. In England *Saving lives: our healthier nation*[18] was signed by 12 ministers with a foreword by the Prime Minister.

Participation in intersectoral committees takes time and there are indications of lower-level substitutes being sent to meetings, thus defeating the purpose. An evaluation of the impact of intersectoral committees or councils, and what hinders or enhances their effectiveness, would be invaluable.

Parliamentary committees or city councils have been involved in formulating intersectoral policies for health in some countries. There is at least anecdotal evidence of this leading to a degree of party political consensus, conducive to long-term commitment.

In Sweden, a National Committee for Public Health[19] was established in 1997 composed of politicians from the seven political parties represented in parliament, together with experts and advisers from national authorities, universities, trade unions and NGOs. They were to define national objectives of health development and strategies to achieve them. The politicians represented and reported back to their parties, so developing a considerable degree of consensus.[11]

Attempts have been made to include the general public in this process, usually by consultation on draft policy documents. Frequently this is carried out on the Internet, opening the process, but failing to include vulnerable groups.

Consensus conferences, national, regional and city Health Forums, and traveling roadshows have been organized to spread the message and involve partners. In Wales, making use of specially prepared videos, the HiAP message was "cascaded" from a central health forum down to local level.

More rarely, efforts are made to assess the health issues important to the public before the formulation of a draft document. In England *Choosing health* was initiated by a process for asking people what they want and how they could be helped to achieve their aims, so the public "set the agenda and identified what 'for their own good' means, not Whitehall".[20]

In partnership with one sector or limited sectors, ad hoc committees are created, their membership varying according to the sector. Different organizations and sectors compete for scarce resources and like to delineate their boundaries and dominate their territory. One way of circumventing such rivalries is to involve politicians in the mediation. This type of mixed steering group or committee has proved successful at national, regional and city levels. Involving a high proportion of community representatives has also proved effective.[21] In dealing with a restricted number of issues, countries and cities in the former Eastern Europe frequently use "Health Days", which are usually centred around an exhibition open to the general public, offering practical examples of the health issues at hand and involving local industries.

Formal consultations in drafting legislation provide an opportunity for the health sector to give its views on legislative proposals but consultation frequently takes place late in the policy process when there is little opportunity for major changes. The development of HIA increases health sectors' opportunities for earlier contributions (see Chapters 10–13). The European Commission (EC) has been active in HIA and health systems impact assessment, aiming at better practical considerations of health in the development of proposals in other policy areas, including the addition of health and health systems in the Commission Guidelines on Impact Assessment.[22]

Public referenda have resulted in changes in the law concerning nuclear power and pesticides in Italy.

Informal contacts between civil servants, particularly in small countries and at local level, can play an important role in HiAP.

Seeking partnerships and alliances

Although external players sometimes take the lead in introducing HiAP, more usually the health sector, having defined the issue, seeks collaboration with those able to influence the determinants. One of the changes slowly gaining ground is a willingness to look for common or converging objectives, and opportunities for contributing to the achievement of objectives in other sectors (see also the win-win strategy in Chapter 1).

The health sector must understand not only the objectives of potential partners but also their different types of expertise and styles of working, which vary from sector to sector.[23] A joint assessment of challenges/needs and opportunities/assets can be an effective start to such partnerships.[24]

Apart from obvious instances – such as the reduction of mortality from road accidents – "pure" health outcomes, as measured in epidemiological terms, may not be of central interest to other sectors, or appear to relate to their objectives. The long delay between an intervention and its health outcome further decreases the attraction of such objectives for other sectors. Common ground to tackle different ways of thinking, aims and objectives can, however, be found in the determinants of health managed by other sectors (see Chapter 9).

With the wider development of HIA, an old technique from the social sciences – stakeholder analysis – has been revived in order to assess which individuals, groups, institutions and NGOs are affected by or affect the relevant policy, as well as their main interests, control over resources, exertion of power, commitment to the policy in hand, and possible reaction to alternative outcomes.

For the core policy formulation, implementation and monitoring group[25] the aim is to achieve:

- shared vision and common agenda
- agreed objectives and priorities
- agreed roles and policy instruments
- openness about self-interests
- mutual respect, trust and ability for mutual learning, and
- agreed method of dealing with disagreements.

There is now considerable experience in building "healthy alliances" but it is not always sufficiently recognized that training is required in entering such partnerships.

Provisions for implementation

When a shared understanding is reached with regard to introducing health components in other policies, responsibility for implementation must be apportioned, resources designated, and processes for monitoring, evaluation and revision established from the planning stage. Unfortunately this is not always the case. A weakness of the first HFA-type policy in Finland was that overstretched civil servants were expected to monitor and evaluate progress in implementation in addition to their normal duties.[26] Only when specific staff time is designated and accountability for delivering expected actions is established can HiAP be carried out.

There is no single way of carrying out HiAP. The types of policy instruments used differ according to the issue. For example, in the housing sector regulatory measures may call for childproof windows, funds may be provided to adapt homes for the elderly and disabled, and better street lighting may reduce the fear of crime. A study[1] indicated that more than a decade after the HFA intersectoral approach was launched, attention was still focused on areas of established collaboration, and a limited range of policy instruments was being used. Notably missing were measures for research, education and training.

A survey of 40 HFA-type documents carried out for the 2005 update of the European Health For All policy framework[5] indicates that 32 included provisions for funding, infrastructure and monitoring of implementation or outcomes. Funding is a frequent obstacle to HiAP and even between the health and welfare sectors, joint-funding has not proved easy.

Planning for evaluation of progress forces better definitions of the aims and objectives of HiAP, ensuring more reasonable goals. The use of quantified targets with a time horizon, related to outcomes, intermediate risk factors and processes or action is becoming widespread. In practical terms this entails defining and adopting appropriate indicators.

Health in All Policies: examples of where and how it happens

The international level

The EU plays a central role through its mandate in areas related to determinants of health, which strongly affect policies in Members States. Chapter 2 indicates that the EU regulatory framework is (in principle) in place to extend the impact assessment of regulations and policies to health protection, but so far this has not been particularly evident.

Countries can put health on the EU agenda as Finland showed by raising the issue of mental health during its first EU Presidency in 1999. The objective was to ensure that mental health was recognized as being part of public health. The initiative was carefully prepared in several publications, clarifying the somewhat obscure concepts of mental health and ill health, and analysing the impacts of different policies on mental health. Subsequent presidencies continued to elaborate on this issue. In 2005 the Commission published a Green Paper on mental health, which stressed the relevance of policy areas other than health for the mental health of the population.

Policies in countries and at local levels are increasingly affected by European-level actions and must be formulated in the framework of those and other international obligations and regulations such as those of the World Trade Organization. Although vitally important to HiAP, these are outside the range of this chapter.

Country examples of Health in All Policies

Policies with a health component are developed at all levels of governance. In this section we consider:

- comprehensive intersectoral health policies
- overall development policies, and
- sectoral policies.

Most countries implement a combination of these approaches to HiAP.

Health for all-type comprehensive health policies

Following the launch of the Global Health for All policy, the WHO European Region defined and continuously updated a regional HFA policy and targets. Countries were actively encouraged to develop national-, regional- and city-level HFA policies and to report back on their implementation.

A survey carried out for the 2005 update[5] indicates 40 countries as having comprehensive, national health policy documents, based on HFA principles and introducing an intersectoral perspective. Although studies of target setting[27, 28] indicate that the role of the health sector is still dominant in most countries, the development of comprehensive intersectoral policies for health remains a distinct and extensive type of HiAP.

As far as we are aware, only England and Finland have tried to review the impact of such comprehensive policies, and the jury is still out on their effectiveness.[29]

England has tried to ensure that all government departments "design" health considerations into their policies, through a number of mechanisms.

- ***Choosing health***,[20] a cross-government White Paper focusing on current public health problems such as obesity, smoking and sexual health. It embeds health into the policies of other government departments. For example, it refers to Regulatory Impact Assessments (RIAs) which should be carried out for all policy changes, whether European or domestic, which could affect the public or private sectors, charities, the voluntary sector or small businesses. Health impact assessment has now been incorporated into RIA within the social element.
- **A Minister for Public Health** based within the Department of Health (DoH) and a cross-government Ministerial Public Health Committee chaired by the Deputy Prime Minister. Ministers from other government departments are represented on this committee. It has already reviewed *Choosing health* and will shortly consider the Public Service Agreement target on inequalities.
- The inequalities theme was itself the subject of a cross-government spending review led by the Treasury Department.
- **Public Service Agreement targets** are shared by the DoH and other government departments. These include a target aimed at "halting the year-on-year rise in obesity among children under 11 by 2010 (from the 2002–04 baseline) in the context of a broader strategy to tackle obesity in the population as a whole." This target is shared with the Department for Education and Skills (DfES) and the Department for Culture, Media and Sport; the DoH and DfES also share a target to reduce conception rates in those under 18 years of age.

The 2005 survey[5] identified 22 countries as having subnational HFA policies. The four nations in the United Kingdom, autonomous regions in Spain, regions in Italy and German *Länder* have a long history of developing this type of policy.

Today, many hundreds of cities are committed to the WHO Healthy Cities principles, including the development of intersectoral policies for health. Liverpool, a Healthy Cities founding member, has over 20 years' continued experience in such "joined-up" policy-making.[30] Newer members are bringing their own experiences. For example, in Turkey, Bursa's City Health Development Plan (2003–2007) inter alia provides for action in the environment, transportation, housing and safety.

Health in overall development policies

In the 1960s, when overall development planning was still in vogue, a "health

chapter" was included in overall development plans, not so much to put health in other policies but to coordinate sectoral policies in relation to factors such as investment and human resources.

This type of development planning has practically fallen out of use at national level in Europe, but the EU still calls for regional development plans. The vast financial resources shifted across Europe to disadvantaged regions are almost never assessed for their potential impact on health.

The process of sustainable development is one of the main overall horizontal policies in the EU and is increasingly taken into account across the countries. Health is one of the cornerstones of sustainable development, which therefore provides excellent possibilities for the integration of health and public health arguments in the decision-making processes of all sectors.

With the shifting of responsibilities to the local level in recent years, there are several examples of regional and city development plans where health is seen as an integral part of social and economic development.

> The Newcastle Plan aims to create a "prosperous city attracting investment and jobs, but also a safe and caring city where people want to live and work and where everyone is helped to achieve their full potential." The plan aims to improve health by "tackling poverty, deprivation and discrimination, widening access to leisure facilities, improving housing conditions, reducing crime and providing a healthy environment".[31]

There is also evidence of such action at sub-city level. The strong focus on inequalities and social exclusion in the United Kingdom was activated through plans to improve disadvantaged neighbourhoods, by lowering unemployment and crime and improving health, skills, housing and the physical environment. Strategic partnerships support "joined-up" work at local level, and a special fund has been designated to top up local area funds. Popularized documents explain the strategy.

Health in other sectoral policies

From ancient times, policies for sectors such as water supply and waste disposal have given health objectives as a reason for action. Other sectors also include health aspects among their objectives, though this is not always recognized.

Transport

The transport sector is one example, where for years policies have included a health component to reduce deaths and injuries caused by accidents.

As greater understanding has been achieved of the importance of determinants of health such as physical exercise and a sense of security, in recent years transport policies reflect these wider aims. Other common objectives pursued in transport policies include smoke-free public transport, improved access for people with disabilities, and environmentally friendly schemes such as "Park and Ride" bus and metro services.

As part of the overall vision for sustainable regeneration, the Merseyside local transport plan[32] defines as its aims:

- an integrated public transport network "putting the passenger first"
- improved access for *all* the community
- improved safety and security
- improved access to key facilities and employment opportunities
- improved pedestrian and cycling opportunities
- better freight routes, and
- improved maintenance of the road network, lighting and car parks.

The potential impact of values in this sector is indicated by the Swedish "no tolerance" attitude to death and serious injury through road accidents.

Housing

Housing is another sector with long-standing consideration of health objectives. Good sanitation and safe cooking facilities are among the normal requirements of modern housing. Insulation and the avoidance of damp housing cut down the use of energy and create warmer homes for the vulnerable. The social sector has long collaborated with the housing sector on specific home adaptations, allowing older or disabled people to remain independent.

Shepherd's Bush Housing Association, which is responsible for almost 4000 homes, began in 1999 to study the links between health and housing, with the aim of realigning its policies and practices to have a positive impact on tenants' health and contribute towards reducing inequalities among disadvantaged groups. Interviews with tenants indicated which issues they felt were a priority for their health, such as heating, space and sound insulation. A striking improvement in self-perceived health status followed the improvement of their homes.[33]

Environment and health

Environmental protection, sustainable development, risks related to environmental exposure, and environmental impact and strategic environment assessment are in a sense predecessors of HiAP and HIA, and are typically managed by the Ministry of Environment.

Environmental assessments typically concern exposure to various types of risk and conditions, not particularly those concerning human life or health. As environmental concerns are frequently regulated through standard setting, the assessments are also very much norm based. However, at political or strategic level environmental impact assessment increasingly includes health impacts, thus deviating from the more traditional risk assessment approaches.

Social insurance

Social insurance may be defined as a system for a group or community to collect funds to cover the consequences of defined risk through providing income transfers or covering service costs as necessary. In Europe, social insurance shares the health promotion values of solidarity and fairness.

Although efficient prevention can be economically justifiable, it has proved difficult for the social insurance sector to invest in prevention and health promotion. In accident insurance, investing in prevention is a common practice globally. The first steps to include prevention and health promotion in disability pension insurance are very recent. Social insurance investing in prevention and health promotion is still new and little is known about, for example, the potential for trade unions to consider balancing health and income gains.

In 1998, the Finnish Social Insurance Institution, the German Federal Association of Company Health Insurance Funds and WHO established a European Network for Social Insurance for Health composed of social insurance institutions committed to promoting health at work, including vocational rehabilitation. Members collaborate to identify, evaluate and disseminate strategies and practices of social insurance contributing to improving social insurance efficiency and thus improving public health.

Workplace

Health protection at the workplace is largely regulated or co-regulated by EU legislation (see Chapter 4). The EU and WHO have also put considerable effort into developing workplace health promotion. Compared to the United States experience, which focused on lifestyle issues and stress management as employers sought savings in insurance premiums, Europe has done better in managing labour safety.

Efforts in Europe were challenged by two factors: first, that employers saw little sense in putting effort into issues that were considered public responsibility and that employees often considered their personal business; and second, that employers and employees were relatively happy with their collaboration on safety issues, and felt that health promotion might compromise their joint efforts.

In 1997, WHO and the International Labour Organization agreed that health promotion serves as an umbrella concept for environmental health, safety at work, lifestyle and work organization issues. A European Network for Workplace Health Promotion was developed based on the EU's first public health programme. There has only been slow movement towards a common understanding on what the action should be and the development of national networks has not been successful in all countries.[34]

Education

Health education programmes have long been part of school curricula, and school health services are provided in most countries.

With the development by WHO, the Council of Europe and the European Community of a European network of health-promoting schools in 1992, school was established as a valuable setting for health promotion. Countries have since developed their own versions of this concept, linking school and community and creating supportive settings, intended to influence how young people form relationships, make decisions and develop their values and attitudes. Actions can range from ensuring that the toilets are clean to preparing children for democratic participation in the life of the community.

Some emerging challenges and opportunities

Poverty, deprivation and social exclusion/inclusion

The 1993 World Development Report clearly stated that people's decisions to shape health are constrained by their income and education, and that overall economic growth can improve those decisions if economic policies benefit the poor, expand investment in schooling and promote the rights and empowerment of women. The World Health Report for 1995[35] named extreme poverty as "the world's most ruthless killer". By 2000 the focus was more aggressively centred on tackling poverty, and the United Nations set related Development Goals.

Although the concepts of poverty, deprivation and social exclusion are frequently used interchangeably, absolute poverty relates to the absence of

resources for physical survival, relative poverty to the standards of living of a particular society at a specific time. There is a growing body of evidence that it is not the richest countries that have the best health, but the most egalitarian, and that one of the characteristics shared by egalitarian societies is a high degree of social cohesion.[36] Deprivation is a similar concept relating to a lack of both material resources and the social networks and contacts necessary for participation in standard roles and behaviour in society. Social exclusion can be the result of such poverty or deprivation. The type of analysis carried out in relation to poverty and deprivation can clarify to some extent where interventions are needed to reduce inequalities in health.

Following a meeting of the European Council in Lisbon in 2000, a set of common objectives were adopted to fight against poverty and social exclusion. All Member States agreed to develop National Action Plans (NAPs) with targets for significantly reducing the number of people at risk of poverty and social exclusion by 2010. They were also asked to emphasize the importance of gender differences and the high risk faced by some people as a result of immigration.

Countries have already submitted two two-year NAPs (new Member States submitted their first reports in 2004); action is expected at both national and local levels. In 2005 heads of state reaffirmed the importance of this approach and suggested a focus on target groups such as children in poverty. The European Regional Development Fund and the European Social Fund may both support national and local efforts in this area.

Particularly given the potential for funding, these efforts could strengthen the promotion of HiAP.

Focus on target groups

Specific target groups such as immigrants, disabled people, children, women and older people call for intersectoral cooperation and sometimes need specific policies. Examples of policies on women and older people are described below.

Women

Although women can expect to live longer than men, many of these extra years are spent in poor health and social isolation, and at a disadvantage regarding determinants of health such as income, unemployment and pressure from multiple roles.

At a health forum in 1995, delegates called for women's health issues to be put firmly on the European agenda. This resulted in the establishment of the European Institute of Women's Health and the European Advisory Council

for Women's Health. Many countries have since drafted action plans for women, with a strong health component. The Irish plan[37] includes elements directly related to women's health, their access to health care, their role as carers of the elderly and disabled, and determinants of health such as housing, income, education and employment.

Older people

For the Second World Assembly on Ageing, WHO prepared a policy framework for active ageing,[38] based on the determinants of health.

> Following a process facilitating an expression of the wishes of older people themselves, in 2003 Wales developed a strategy for older people, dealing with determinants of health such as employment, income and social exclusion, and tackling dependency through housing, health and social care.

Brno, in the Czech Republic, has made healthy ageing a top priority and is working, for example, with the education department to develop computer skills for older people, and with the transport department to facilitate their use of public transport.

Where there is a clearly understood relationship between health and other policies, as for example between the price of fuel and deaths of older people from hypothermia, there are widespread examples of preventive action. Better evidence needs to be provided where the links are less easy to determine.

Innovative mechanisms for participation, including elected Older People's Councils, are being tested.

Corporate social responsibility

For many years large enterprises have been concerned with the health of their employees. More recently this has broadened beyond health and safety at work, to cover issues such as stress, smoking, alcohol, exercise, nutrition and equal opportunities in the workplace.

Attention has also turned to the role of business organizations in society, or what has been called corporate social responsibility (CSR). In 2001, the EC issued a Green Paper to promote a European framework for CSR.[39] This noted that large companies are already recognizing the need to pay attention to the well-being of societies in which they function if they wish to flourish. In the follow-up, a strategy was presented to share knowledge about the impact of CSR on business and further encourage its adoption by small and medium-sized enterprises operating at local level.

Despite certain misgivings regarding the motivations of profit-making companies, there could be huge potential for promoting a strong health component in this voluntary movement of private and public enterprises.

Conclusion

Despite the confines of this chapter, which only allow us to highlight examples of what is happening in Europe, some conclusions can be drawn.

Value-based Health in All Policies

The health sector and prospective partners must share a common understanding of the determinants of health and values underpinning HiAP. When essential trade-offs are made between possible conflicting objectives, the implications for these values should be transparent.

Raising awareness, strengthening support

Public health reports, particularly in popular versions, can demonstrate the linkages between health and its determinants.

Reference to joint action for health already in place, particularly where linkages are clear, can strengthen the message and indicate opportunities for cooperation (that is, where comprehensive and sectoral HiAP are in place simultaneously). Examples of success need showcasing.

Health in All Policies cannot be implemented immediately. Clear presentation of the main public health issues should facilitate discussion of where health gains can best be made: which parts of the "health determinants rainbow" need urgent attention, and in which population groups.

The mass media need expert assistance for presenting an HiAP approach to high-visibility issues (such as "avian flu"). All existing channels need to be used more effectively to publicize information.

Key personalities in public and private sectors, including parliamentarians, city councillors, and leaders of private corporations and NGOs need to be convinced of the value of HiAP. Celebrities – for example "celebrity chefs" representing the food industry and racing drivers representing transport – could become advocates for HiAP.

Information and research

In many countries the basic data for formulating and evaluating HiAP need to reflect possible inequalities in health, particularly at local levels.

Cross-sectoral partnerships for multisectoral research could strengthen potential HiAP partnerships and use resources more efficiently, for example, common population profiles.

Much more effort is needed to evaluate the effectiveness of HiAP and, where possible, to provide more information about costs and benefits. Urgent attention needs to be given to evaluating processes, structures, mechanisms and incentives for HiAP to show what works and what does not; the innumerable examples of HiAP in Europe should facilitate this. Greater attention needs to be given to evaluating the possible impact of European-level policies on HiAP in Member State.

Scenarios of the implications of not acting to introduce health components in some sectors could trigger a valuable discussion of a desirable future.

Structures and mechanisms

Structures and mechanisms for cross-sectoral working exist in all countries and at all levels of governance. To avoid overlap and pressure on staff, existing structures could be examined as potential channels for HiAP. European, national, regional and local mechanisms need to be working synergistically.

Leadership for HiAP does not necessarily need to come from the health sector, but leadership in a complex situation, with no executive authority, requires training.

Case studies of what works and what does not could help disseminate information on the vast European experience.

Seeking partnerships

In developing HiAP it is important to look for win-win situations. This entails a greater understanding of potential partners' objectives and styles of working, and respect for differing perspectives, particularly from the public.

The rules of engagement and of dealing with conflicting interests must be agreed, and compromises, such as pilot trials, attempted. Continuous feedback of results is essential, including through the mass media.

The pressure of public opinion, the "naming and shaming" of policies detrimental to health and the celebration of health advocates, could bring partners to the table. At European level an investigation of the carrots and sticks effectively used could be valuable.

Training and skills

Public health experts need training in consultation, negotiation and management skills for working with multiple sectors. Short courses, particularly with intersectoral participation, for key people in important sectors and institutions have proved effective. If the public are to participate effectively, they also need support in terms of information and skills.

Existing training packages available in Europe could be examined for local adaptation.

Resources

Perhaps the most important resource for HiAP is the designation of staff time for alliance building, including training. Provision for new funds or the reallocation of existing funds must be clearly made.

Targeting for Health in All Policies

The use of quantified targets in many countries and sectors seems to facilitate testing the feasibility of objectives, and encourages the monitoring and evaluation of progress in both implementation and outcomes.

Finally, just as the economy is assessed in terms of indicators such as gross national product and the public debt, and mindful of the 1986 World Health Assembly Resolution,[40] *the changes over time in the health status of disadvantaged groups should be used as an indicator of the quality of development in countries.*

REFERENCES

1. Ritsatakis A et al., eds. *Exploring health policy development in Europe*. European Series, No. 86. Copenhagen, WHO Regional Office for Europe, 2000.
2. Judge K et al. *Health inequalities: a challenge for Europe*. Produced by COI for the UK Presidency of the EU, 2005.
3. Tsouros A, Farrington J, eds. *WHO Healthy Cities in Europe: a compilation of papers on progress and achievements*. Copenhagen, WHO Regional Office for Europe, 2003.
4. Breeze C. *Health Impact Assessment and Government Policymaking in European countries: a position report*. Cardiff, Welsh Assembly Government, 2003.
5. *The HFA policy framework for the WHO European Region. 2005 Update*. European HFA series No. 7. Copenhagen, WHO Regional Office for Europe, 2005.
6. Whitehead M. *The concepts and principles of equity and health*. Copenhagen, WHO Regional Office for Europe, 1990.

7. Wilkinson R, Marmot M, eds. *The solid facts*, 2nd edn. Copenhagen, WHO Regional Office for Europe, 2003.

8. *Health 21: health for all in the 21st century*. European HFA series No. 6. Copenhagen, WHO Regional Office for Europe, 1999.

9. *The evidence of health promotion effectiveness. Part Two. A report for the EC by the International Union for Health Promotion and Education*. Brussels–Luxembourg, ECSC-EC-EAEC, 1999.

10. Ostlin, P, Diderichsen F. *Equity-oriented national strategy for public health in Sweden*. Policy Learning Curve Series No. 1. Brussels, WHO Regional Office for Europe, European Centre for Health Policy, 2000.

11. Berleen G. *A healthier elderly population in Sweden*. Stockholm, National Institute of Public Health, 2004.

12. Kamper-Jorgensen F. *The Danish Government Programme on Public Health and Health Promotion 1999–2008*. Policy Learning Curve Series No. 5. Brussels, WHO Regional Office for Europe, European Centre for Health Policy, 2001.

13. Swart W, Bleeker J, De Haes W. The Rotterdam Local Health Information System 1987–2000 from Rebus and the Health Barometer to the Health Monitor. *Scandinavian Journal of Public Health* (suppl.), 2002, 59:63–71.

14. *The evidence of health promotion effectiveness. Part One. A report for the EC by the International Union for Health Promotion and Education*. Brussels–Luxembourg, ECSC-EC-EAEC, 1999.

15. *Saskatchewan Heart Health Program, Annual Report, Year 1* (www.usak.ca/healthsci/che/hhdis/ar1999.html, accessed 21 March 2006).

16. Mackenback J, Bakker M, eds. *Reducing inequalities in health: a European perspective*. London, Routledge, 2002.

17. Ståhl T, Lahtinen E, Wismar M. *Report of the policy dialogues. The Finnish EU Presidency project on "Europe for Health and Wealth 2006"*. Unpublished report. Helsinki, 2006.

18. Secretary of State for Health. *Saving lives: our healthier nation*. London, The Stationery Office, 1999.

19. *Health on equal terms: national goals for public health* (in English). Final report, Swedish National Committee for Public Health, Government Official Reports 2000:91. Stockholm, Ministry of Health and Social Affairs, 2000.

20. Department of Health. *Choosing health. Making healthy choices easier*. London, The Stationery Office, 2004.

21. *City planning for health and sustainable development*. European Sustainable Development and Health Series 2. Copenhagen, WHO Regional Office for Europe, 1997.

22. SEC (2005) 791. *Impact Assessment Guidelines*, 15 June 2005. European Commission.

23. Winsemius P. Intersectoral negotiation. In: Taket AR, ed. *Making partners. Intersectoral action for health proceedings and outcome of a working group*, Utrecht, 30 November to 2 December 1988. Copenhagen, WHO, 1989.

24. *Community participation in local health and sustainable development. Approaches and techniques*. European Sustainable Development and Health Series 4. Copenhagen, WHO Regional Office for Europe, 2002.

25. *Working together for better health*. London, Department of Health, 1993.

26. *Health for all policy in Finland*. WHO policy review. Copenhagen, WHO Regional Office for Europe, 1991.

27. Allin S et al. *Making decisions on public health: a review of eight countries*, 2004 (http://www.euro.who.int/Document/E84884.pdf, 2004, accessed 1 Feb. 2006).

28. Marinker M, ed. *Health targets in Europe: polity, progress and promise*. London, BMJ Books, 2002.

29. *UK Health Watch 2005*. London, Politics of Health Group, 2005.

30. *A 21st-century approach, Liverpool Healthy City*. Liverpool, Liverpool Partnership Group, (no date).

31. *The Newcastle plan summary*. Newcastle, The Newcastle Partnership, 2002.

32. Merseyside Local Transport Plan 2001/2–2005/6. *Opportunities for all. Summary report*. Liverpool, Merseyside Information Services, 2000.

33. Barnes R. *Shepherd's Bush Housing Association. Investigating the links between health and housing. Second Annual Report: 2000/2001*. London, Shepherd's Bush Housing Association, 2001.

34. Breucker G, ed. *Towards Better Health at Work. Successful European Strategies*. Essen, Federal Association of Company Health Insurance Funds, 2000.

35. *The World Health Report 1995. Bridging the gaps*. Geneva, WHO, 1995.

36. Wilkinson R. *Unhealthy societies. The afflictions of inequality*. London, Routledge, 1996.

37. *Plan of action for women*. Dublin, The Stationery Office, 2002.

38. *Active Ageing. A policy framework*. Geneva, WHO, Noncommunicable Disease Prevention and Health Promotion Department, 2002.

39. *Promoting a European framework for corporate social responsibility. Green Paper*. Directorate-General for Employment and Social Affairs, Luxembourg, 2001.

40. WHA Resolution 39.22 adopted by the Thirty-ninth WHA, May 1986.

Chapter 9

Towards closer intersectoral cooperation: the preparation of the Finnish national health report

Timo Ståhl, Eero Lahtinen

Introduction

Intersectoral cooperation is a fundamental task of modern public health. The origins nowadays of burden of disease are complex and relate to lifestyle factors, such as smoking, excessive alcohol consumption, physical inactivity and unhealthy diet. These lifestyle factors are determined by broader social and community influences, living and working conditions, and general socioeconomic, cultural and environmental conditions. Changing the behaviour of individuals requires amending the broad determinants in addition to the individual ones. Thus, the health sector needs to cooperate with the other sectors, such as transport, agriculture, community planning, education and law enforcement. Action is needed at all levels, from local to global. The prerequisite of effective public health actions is, as far as possible, complete political commitment across all sectors of government. A recent review of eight countries* showed that many countries try to strengthen the collaboration between health and other sectors to meet the challenges posed by the complex intersectoral and multilevel nature of population health. However, the practices and practicalities of how this should be done are not yet well established.[1] In other words, all means and entry points that enable the development of intersectoral cooperation are highly welcome.

* Australia, Canada, Denmark, Finland, France, Germany, the Netherlands and Sweden.

The preparation of health reports can be an entry point serving as a natural way to cooperate with other sectors. Although monitoring the health of the population has been a fundamental task of public health for a long time, only since the 1990s has it become more popular to present this information systematically in national health reports, thus reviewing policy processes and linking them with health outcomes. Health reporting has thus become an indispensable element in formulating and guiding national health policy in many countries. Although most national health reports recognize that the main determinants of the population's health are located outside the health care system, links between the development of socioeconomic health determinants and other sectors' activities are not usually emphasized.[2, 3] This may be due the fact that people with a medical or epidemiological background write many of the reports and that other sectors are not directly involved in the preparation of the report.[2] From the perspective of the determination of population health, this can be seen as a major deficit with reference to the essential role other sectors play in health. Incorporating other sectors in the preparation of health reports could increase intersectoral dialogue, help other sectors in recognizing the health relevance of their actions and, consequently, taking health overtly into account in their decision-making.

The focus of this chapter is on intersectoral cooperation and the role of the national health report in policy-making as an enabling link for such cooperation.

First, the chapter describes the current state of affairs of national public health reports in Europe from a policy-making perspective.

Second, the Commission's previous reporting system on the integration of health protection requirements in Community policies and recent developments are described.

Third, the preparation of the Finnish national public health report concerning health in other policies is described with the focus on the preparations in the autumn of 2005. In this section of this chapter, the ways in which other government ministries were involved in new ways in the preparation are presented and the arguments for doing so are discussed.

Fourth, the views of other sectors on their most important population health-relevant activities are described and discussed, as well as the existing intersectoral mechanisms, especially those that were found to be most useful.

Finally, the relevance of other sectors' participation, above all the importance of the bilateral discussions conducted, with regard to increasing the mutual understanding of the concepts of health and health determinants as pertinent for the respective ministry in its own field, and strengthening future

intersectoral policy development, is discussed. Overall results are presented with emphasis on the methodology and experiences of the undertaking.

The preparation of the social and health report of 2006 showed that other ministries have many activities relevant for health and social well-being. Bilateral dialogues – a new way of preparing the report – were experienced as useful for several reasons: they were a participatory and efficient way of working; they promoted a common understanding of the ways in which health is perceived; they revealed relevant themes to further strengthen the cooperation; and they committed other ministries to preparation more extensively than previously. The advantage of this method compared to other intersectoral mechanisms was that it emphasized the activities from the respective ministry's own perspective, framework and way of thinking. Thus it shed light on the determinants of health from other sectors' points of view. The common, shared values of the Nordic welfare society were seen as an important factor that enabled both relatively good intersectoral cooperation and integration of health into the activities of other sectors.

The scope and policy relevance of national health reports in the European Union

The roots of health reporting in Europe go back to 1662 when John Graunt in the United Kingdom presented his "Bills of Mortality" to the "Privie Council" of Charles II. Since 1848 public health reports have been produced on a regular basis in the United Kingdom. The tradition in most European countries starts in the 1970s.[4] A recent analysis shows that national health reporting is characterized by a great heterogeneity and discrepancy with expectations of decision-makers in health policy.[4] Typically the reports are commissioned by the Ministry of Health and are usually prepared by a governmental office or an independent research institute, people with a medical or epidemiological background, with a rather technical style as a result. Most reports recognize that the main determinants of the population's health lie outside the health care system. A range of social and economic indicators and their changes over time are given, but coverage is largely descriptive. Some reports try to discuss the complex relationship between socioeconomic conditions and health, but others simply provide descriptive data, for example even data on unemployment are rarely given.[2] Many of the reports do not show any link between the development of the socioeconomic health determinants and government policies.[3]

Most of the national health reports are based on available surveys and other data. Their approach is to describe and present the data and to provide options for their epidemiological interpretation. Policy relevance is modest in the greater part of the reports. This concerns, for example, a lack of linkage of information on health status and health determinants with the provision of health care and its financing, a lack of evaluation of programmes and activities, and no views concerning future health trends.[4] However, there are good examples, too, for example the Dutch national report *Health on Course?* (2002) and the new Swedish *Public health policy report* (2005). The Dutch report is based on a conceptual model structured according to the determinants of health, also stressing health inequalities.[5] The Swedish report aims to assess to what extent the objectives of the latest intersectoral public health policy that were adopted by the parliament in 2003 have been met in government policies.[6] However, neither of these reports has integrated other sectors' active participation in producing information for the report. Interestingly, the Dutch report comments on the role of other sectors': "We concentrate on life style factors and personal risk factors in this report because these are the determinants on which health policy is able to exercise a direct influence. The task of influencing social and physical environmental factors belongs largely to other departments."

Although Member States seem not have been active, at least at national level, in integrating other sectors into health reporting, the Commission ran a reporting system on Health in All Policies (HiAP) during the years 1993–1999, the early years of specific EU policies in the field of health. This reporting system was an innovative measure for integrating health into all Community policies.

Commission reports on the integration of health protection requirements in Community policies

In 1993 health had been included in Article 129 of the Maastricht Treaty. In the same year the Commission made a decision to submit annual reports on health aspects of other Commission policies. This was a means to integrate health across the European Community following this first inscription into the treaty base. The future reports were planned "to report on new initiatives in the different areas of Community policy involved, review the progress made, and consider the possibilities and issues that lie ahead".[7]

The commission's public health directorate produced the first report in 1995. It was compiled from information obtained from the 23 other directorates. The directorates had been written to and asked to submit their assessments of how they were taking health into consideration in their policy areas.[8] The first

report was extensive, but the following were shorter, of about seven pages, complemented by a separate Commission services working document containing a detailed overview of Community activities with a health impact. In 1999 the reports were discontinued. It was felt that they were not leading to useful outcomes to justify the resources used in producing them. The reports were extensive and descriptive, but tended to contain too little analysis on how the integration of health could be improved and what could be performed better.

Instead, the Commission saw more benefit in focusing on specific policy areas where most progress could be made. Thus, the latest, fourth report in 1999 suggested that the system with annual descriptive overviews of all health-related Community activities should be replaced by more specific work on health requirements. This more clearly defined and narrowed approach was also recommended by the European Parliament and the Council.[9]

Since then, the Commission has focused on concrete action to mainstream health concerns into a number of key Community policies with the greatest potential to improve health, rather than on reporting about such action. The achievements of this successful amended strategy are seen in the inclusion of health in many key EU policies, such as the Lisbon Agenda and the Sustainable Development Strategy, the Regional Development Policy, and a wide range of work encompassing research, environment, demographic change, pharmaceuticals, e-health, etc. In addition, the Commission has been active in health impact assessment (HIA) and health systems impact assessment, working towards better practical considerations of health in the development of proposals in other policy areas, including the addition of health and health systems into the Commission's *Impact Assessment Guidelines*.[10] Currently, other policies are reviewed through the Commission's planning cycle, and those relevant to health are followed up on a case-by-case basis.

Scope and policy relevance of the Finnish national health reporting system

Public health reporting started in Finland in 1985 and a legal basis was created ten years later.[11] The Ministry of Social Affairs and Health (MSAH) must give out a report on the state and development of public health and social security at four-year intervals to be used as an attachment to the government's annual report.[12] The purpose of the report is to assess to what extent the activities have supported the realization of the government programme. Specific to the Finnish health reporting has been the involvement of other sectors in the preparation of the report. All ministries have a legal obligation to give

sufficient information for the preparation of the report. Another particular characteristic of the Finnish national health policy has been its transparency, which is strongly supported by the reporting practice. In addition to the national public health reports, Finland has consistently submitted its health policy and the work of the agencies that support and implement the policy, to both international and national evaluations.[13–15]

The preparation of the Finnish social and health report is closely tied up in the policy process of the government's life-cycle. At the moment when the report is given out the government will have been active for over three years with less than one year to go. Thus the report is on the one hand reviewing the successfulness of the government's action and on the other hand serves as a basis for planning future work at government level. Since the report is being discussed in the parliament, there are good opportunities for the politicians to raise important health and social issues to be taken into account when drafting the next government's programme. The upcoming election of the parliament (one year after the report has been given to parliament) further strengthens the political relevance of the report. Accordingly, the report is an essential part of the long-term strategic health policy.

Preparation of the Finnish national public health report of 2006

Until the year 2002, all ministries were asked to provide a brief document of their most important policies and actions which they considered to have had an impact on health.[16] The information ministries provided was usually relevant from a social affairs perspective but less so with regard to health. Therefore, a new method – bilateral dialogues complemented by filling in a form – was introduced as the preparations for the 2006 report. An underlying argument for the change was the desire to strengthen the visibility and role of other sectors. This was seen as important in order to clarify the role of other sectors in the determination of population health and to approach an "operationalization" of the means the other sectors have for promoting health.

In addition to the collection of health-relevant information, in particular from the perspective of the different government sectors themselves, for the social and health report, bilateral dialogues are expected to strengthen intersectoral links, to increase the mutual understanding of the concepts of health and health determinants as pertinent to the respective ministry in its own field.

How other ministries participated in the preparation of the report

When bilateral dialogues between the MSAH and other ministries were chosen as a starting point for collecting the information needed for the report, the ministries were approached via an official letter and asked to nominate a contact person for the undertaking. Furthermore, advance information was given to the ministries in regular bilateral meetings between the permanent secretaries. A time for the dialogue was agreed upon by e-mail, based on a list of alternative options. After the bilateral dialogues, the ministries were asked to fill in a form, which helped to review their most important activities for population health. Based on the forms – completed by the respective ministry – and other relevant policy documents the ministries provided, a short report was produced on each of the ministry's activities and a summary was produced (see Table 9.1). The results were sent to the ministries for comments and possible additions. The civil servant in charge of the issue was also expected to contact other people to guarantee the relevance of the information provided.

Themes of the dialogues

The dialogues were structured around five broad themes:

1. activities of the respective ministry that are associated with population health and social well-being;
2. the role of the health and social issues in the process of decision-making and policy-making;
3. methods used for the assessment of the social or health impact of the policies;
4. availability of health-related knowledge; and
5. partners in the health and social issues, and the role of the MSAH.

With the aim of facilitating the preparations of the dialogues, ministries were informed of the main themes to be discussed in the invitation letter.

Duration of and participants in the dialogues

A dialogue was planned to last about one-and-a-half hours. It was up to the ministries themselves to decide who would participate. The number of participants of the other government sectors was not limited and varied from one to three. One or two civil servants from the MSAH, one senior researcher and a secretary (taking notes) from the National Research and Development Centre for Welfare and Health (STAKES) and, with regard to the themes to

be covered in each dialogue, an expert from the National Public Health Institute and/or the Finnish Institute of Occupational Health represented the organizers of the dialogue. In all around five to seven people attended the dialogues. All the other ministries (11) participated in the dialogues.

Screening of the most essential activities

To get the ministries' views of their most essential activities with regard to the health and social well-being of the population, they were asked to prioritize up to five strategies, legislative measures, or programmes during the years 2002 and 2005 and fill in a form on each of the prioritized issues. The form contained the objectives of the National Health for All Strategy, complemented with objectives that are expressed in other government social and health policy documents. The ministries were asked to define how their activities had contributed to these objectives. The identification of target groups, regionality and rationales behind action/expected impacts were asked for. Although the national-level health and social policy objectives were the starting point, the respondents could also refer to the ministries' own objectives which did not fit within the scale of the MSAH.

The number of the completed forms varied from one to five per ministry. One ministry found it difficult to complete the form as it was difficult to identify links between the sector-specific and the health and social objectives. According to this ministry its sectorial actions did not fit with the MSAH's objectives. A modified form, without the health and social objective, was provided for this ministry.

Outcomes of the preparation

Presence of health-related activities in other sectors

The review confirmed the basic assumption and argument for intersectoral action: there are plenty of activities with health and well-being relevance outside the health sector. All the 11 ministries provided information on specific activities relating to health and social issues. Even the ministries that did not have any health expertise (health care professionals or public health specialists) of their own, for example the Ministry of the Environment, had a very strong "health consciousness" in their everyday work. There seemed to be a shared value basis across the sectors, highlighting the importance of health and social welfare expressed by representatives of all ministries. A person from the Ministry of Agriculture and Forestry put this message: "It's good that we can address these [health] issues in practice although we are not that good on paper."

An analysis of the annual reports of the Ministry of Agriculture and Forestry makes the message clear: there are very few references to human health. In 2004 the word "health" was used eight times* but only twice did this refer directly to human health (others were related to animal health, phytosanitary issues, organization or research programmes). The respective figures for the year 2003 were 18 and 2; and in 2002, 19 and 1. It seems that the ministries do not all have "health" explicitly expressed in their documents but rather they have an implicit agreement on the value of health.

A summary of the most important areas and activities where the ministries had contributed to the health and social well-being of the population is presented in Table 9.1. In a concrete way, the expressed areas and activities indicate how the ministries see the concept of health and how health is related to their everyday work. The defined activities are not comprehensive, or at least not from all ministries' points of view. The listed activities are those that were found especially important for population health during the years 2002–2005.

Intersectoral mechanisms identified

In addition to the commonly used intersectoral mechanisms – such as the bilateral meetings of permanent secretaries, formal written procedures, informal contacts at desk level, and interdepartmental ad hoc working groups (legislation, intersectoral programmes, etc.) – one mechanism was expressed to be most useful by several ministries: the Advisory Board for Public Health. Also, the dialogues provided evidence that the systematic procedures for the preparation of Finland's positions on EU matters had been useful in increasing informal intersectoral contacts, but also in bringing closer views when the positions of different ministries had originally been very divergent.

Advisory Board for Public Health

The advisory board monitors the development of public health and the cross-sectoral implementation of health policy. It develops national health policy and promotes intersectoral cooperation between government departments, nongovernmental organizations and other bodies. The Council of State sets the advisory board for three years at a time according to the recommendation of the MSAH. In addition to the chairman and deputy chairman, there are 15 members and 4 permanent experts. The board has a permanent secretary. The existence of the advisory board is stipulated by an act and the tasks, composition and appointment by a decree.

* All health-related words were searched. Irrelevant words – such as those only concerning layout – were omitted from the analysis.

Table 9.1 *Priority-setting of policies and activities (from 2002 to 2005) as defined by respective ministries for the promotion of health and welfare of the population*

Ministry	Areas of activity or responsibilities relevant to health
Agriculture and Forestry	• Safety of food products • Enhancing the living environment in rural areas • Secure clean water for the economy of domestic animals and the food production industry • Prevention of infectious diseases, such as zoonoses • Announcement of the Finnish Nutrition Recommendations (2005)
Defence	• Equality and a discrimination-free environment among conscripts and personnel • Prevent the exclusion of conscription-aged men • Developing the physical examination system of conscripts for reducing the number of drop outs • Alcohol programme for personnel and conscripts • Prevention of overweight problems of conscripts
Education	• Health education was introduced as a new, compulsory subject for comprehensive schools in 2001 • Development of special education in comprehensive schools for promoting integration • Regulation of the national curriculum according to which each school has to make a plan for the pupils' social and health services in cooperation with the social and health sectors of the municipality • Workshop activities for the young and unemployed who have completed comprehensive school • Youth alcohol and drugs prevention • Welfare studies of university, polytechnic and vocational education students and programmes based on the results of studies • An Open University for the elderly • Supporting the prerequisites of physical activity for the young and children, and promoting health-enhancing physical activities • Promotion of accessible and equal library, art, and culture services
Environment	• Act on the assessment of the impact of authorities' plans, programmes and policies on the environment or environmental impacts including human health • Proposal for a national noise reduction programme • Preparation of a chemical programme (effects of chemicals on human health) • Implementation and monitoring of the air protection programme (2010) • Preparation of a living environment development programme • Act on the organization of water handling: regional water-handling plans must be prepared in cooperation with the relevant participants • Protect the healthiness of housing, for example, by subsidizing the repair of health hazards in housing
Finance	• Adapt the alcohol duty in situations where the restriction of passengers' import of alcohol was abolished • Prevent the illegal passenger import of alcohol and tobacco products • Prevent the smuggling of drugs and doping substances • Monitor the safety of imported foodstuffs and products

cont.

Table 9.1 *cont.*

Ministry	Areas of activity/responsibilities relevant to health
Foreign Affairs	• To develop a readiness for crisis • Prevention of international child kidnapping • Taking health into account in foreign trade agreements – all members of the World Trade Organization have a right to set standards at the level they wish for the protection of human, animal and environmental health – promotion of developing countries' imports into the EU and Finland by improving the developing countries' possibilities of following the Sanitary and Phytosanitary Measures rules of the EU – accepting the reform of the TRIPS agreement (Agreement on Trade-Related Aspects of Intellectual Property Rights), which allows the export of pharmaceutical products made under force licence in those developing countries that cannot produce medicine in sufficient quantities
Interior	• To develop fire safety, such as the prevention of fires caused by children • To ensure the housing security of people with a low functional capacity • Promotion of school security and a sense of belonging to the school • Local area police action to prevent the use of intoxicants among adolescents • Prevention programme for domestic violence • Developing programme for municipal democracy • The new Foreign Act emphasizes the consideration of the good of the child • Centralization of health and social care emergency phone calls on the government emergency exchanges
Justice	• Reforms of the custody acts aiming particularly at enhancing young people's integration into society and reducing the repetition of crimes • Development of the health care of convicts • Programme against violence • Development of economic and debt counselling aimed at policy administering debt problems, which prevents social and economic exclusion and resists "grey economy" • Citizen participation policy programme aimed at strengthening possibilities for participation and influence
Labour	• Development of the occupational rehabilitation of the disabled unemployed • Creation of standards for the social enterprise in order to employ disabled and long-term unemployed people • Individual plan for searching for jobs is guaranteed to all unemployed 15 to 24-year-olds before being unemployed for three months • Reform of the employment services to motivate unemployed people who have serious problems finding employment • Research and development programmes on working life in order to maintain and promote the well-being of workers
Trade and Industry	• Technology programmes for health and well-being • Financial support and services of the Employment and Economic Development Centre for health care and social welfare enterprises • Consumer policy programme for protecting the status of the citizen • Recommendation for the appropriate marketing of children's food products • Investment grant for village shops
Transport and Communications	• Prevention of noise and pollution • Development of traffic safety • Promotion of walking and cycling • Developing accessible transport systems • Developing accessible and safe communications and societal information services (such as digital television and broadband internet connections)

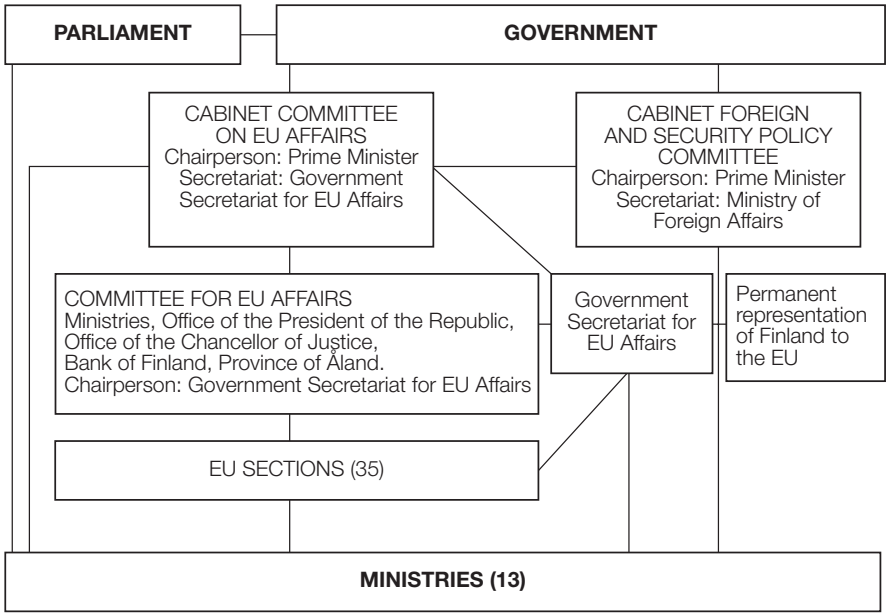


Figure 9.1 *Coordination of EU affairs within the Finnish Government.*

The Advisory Board for Public Health has three divisions, one of which focuses on intersectoral cooperation. The main task of the Division for National Intersectoral Cooperation is to support the implementation of the Government Resolution on the Health 2015 Public Health Programme in other sectors than health and social sectors. It can write motions and prepare comments for the Advisory Board for Public Health; 8 ministries out of 12 are represented in this division.

Preparation of Finland's positions on EU matters

When Finland joined the EU, effective coordination of EU affairs was considered to be very important and a special structure for that purpose was created (see Figure 9.1). Positions on EU matters are currently discussed in 35 sectorial preparatory subcommittees. The MSAH is in charge of six subcommittees (namely insurance, social affairs, health protection, social security coordination with regard to workers' mobility, health and drugs), and the chairman comes from the responsible ministry. Subcommittees have two different compositions. In the smaller composition arrangement, all relevant ministries participate. A broad composition of the committee, with social partners' and professional organizations' participation, convenes in particular before the Council or other important meetings. Discussions are based on a memorandum written by the civil servant(s) in charge of the relevant matters,

which after its adoption becomes the draft position of the government. If unanimity is not reached, the matter will be sent to the EU Affairs Committee. All positions are finally adopted in the Cabinet EU Affairs Committee and the Grand Committee of the Parliament. The Parliament is also actively connected to the adoption of positions on EU legislative proposals via other mechanisms.

The experiences from 10 years of EU membership are good, as the processes are participatory and provide equal possibilities for all interested parties to become involved in decision-making processes. Obviously, quite a number of informal horizontal, practical links have been created "at desk level" between government sectors by this collaboration. However, one of the most interesting results is the increased understanding of other sectors' thinking, processes and issues. Perhaps even more importantly, there are examples of how positions, which were originally very divergent, have become increasingly convergent. One example is the field of illegal drugs. In the process of the formulation of the drug strategy in 1997, the different strands of the MSAH and the Ministry of the Interior (especially on harm reduction) were brought together. However, the government's first resolution on drug policy (in 1998) and the drug policy action programmes ever since have been based on general drug prohibition on the one hand, and on harm reduction policy on the other. The social and health authorities have been able to launch low-threshold activities for drug users, and the police have new powers to act against drug trafficking. The national drug strategy and coordination that have been started, also due to EU coordination, have brought the two ministries closer to each other in questions related to drug policy.

Conclusion

The Finnish public health report of 2006 was first produced in close collaboration with other sectors than that of health and social affairs. The aim was to strengthen intersectoral cooperation, achieve a more comprehensive picture of health and how it is promoted through other sectors' activities, and to increase the understanding of health and its determination. As a main strategy bilateral dialogues with all ministries were conducted. Although the participants of the ministries represented only one or two units, they consulted their colleagues when filling in the forms and commenting on the ministry-based reports. Thus the way of working was to a great extent participatory, committing the ministry as a whole more widely to the preparations of the report than previously. The information provided can also be seen as representing the whole ministry and its administrative sector institutes. The way the report was

produced, that is ministry-based reports were provided by a researcher, was considered to be efficient and economic. It also produced structurally coherent reports, which was considered important. Many of the participants were impressed with the diversity and amount of the activities that other ministries provided. This was expressed by a participant as follows: "This new way of preparing the report has been a good exercise. Hopefully in coming years the concept of health and factors influencing health are seen comprehensively, not only from the [health] services perspective. Health is determined by many things but still we only look at resource allocation on services."

The policy dialogues were found to be useful for strengthening intersectoral cooperation. A participant said, spontaneously, that the discussion was a step forward for the Advisory Board for Public Health's work. This may be due to the perspective of the dialogues. The discussions were started from an "empty table", that is they were based on the respective ministry's own premise and understanding of the issue. The MSAH was interested in what other ministries do for the health of the population, what their strengths are and how they could help other ministries in their work. In many cases the cooperation focuses on issues of what other sectors could do for the MSAH. Other sectors are not asked what they are doing or what they would like to do for the health of the population.

If the policy dialogues and interactive working methods for producing the ministry-based reports were institutionalized, they would function as a fourth permanent intersectoral mechanism in the MSAH, others being the Advisory Board for Public Health, the bilateral meetings of permanent secretaries and the preparation of Finland's positions on EU issues. Although the national public health report is only prepared every four years, it can be considered an important mechanism since the preparation requires about one year of interactive cooperation. The question is now: how it could be institutionalized? Compared to previous preparations this procedure is more resource intensive. In addition to the extra time the civil servants have to spend in the policy dialogues, a researcher's input is needed for producing the ministry-based reports in collaboration with the ministries. The question here is: is it worth it? Other ministries felt that this way of working is less time consuming for them. That is maybe true for the contact person who, previously, had written the ministry-based report very much alone. This new method "forced" the writer to contact other units of the ministry that produced information directly for the researcher. It can be assessed that in fact the ministries were using more time for the preparation but that the workload was distributed across units and that is why it was felt to be more efficient and less time consuming.

It must be remembered that the method used for the preparation does not give a comprehensive picture of the activities that the ministries are doing for the promotion of population health, but rather the most important activities within a specific time frame. The method is neither exploring if the ministries could do more for health nor if their other activities are harmful for health. This would need a more sophisticated and detailed analysis and, for example, for future activities, the use of HIA procedures.

Could the same kind of procedure be integrated in other EU countries? A basic question is: are the other sectors willing to participate in the preparations? In Finland all ministries have a legal obligation to provide sufficient information for the report. However, they are not obliged to participate in policy dialogues or filling in the forms. Despite the legal basis, there were some difficulties with some ministries participating in the process, mainly owing to a subjective feeling that there is nothing to say due to a lack of expertise in health or no obvious activities related to health. It was considered to be somewhat frightening to participate in discussions with the representatives and experts from the MSAH and its agencies. In one case the personal contacts of the Director-General were used for persuading the ministry to participate in the process. After the process all ministries declared the process as useful. Only one ministry was not convinced about the benefits of this working method, as it is active in health issues and, accordingly, used to have more space in the report.

The European Commission's reporting system, from 1993 to 1999, paved the way towards more effective intersectoral work and taking health into account across the EU sectors in their decision-making. While the Commission is currently making progress by focusing on key policy issues and major EU policy developments (rather than by producing an annual report), Finland finds that a report that is not given with too-short intervals fits well within its national structures. The Finnish reporting system is closely tied to the policy-making process and life-cycle of the government's programmes. The report of 2006 also serves as an intermediate evaluation report indicating how the Government Resolution on the Health 2015 Public Health Programme has been implemented so far. The close link between the report, policy processes and participatory intersectoral work seems to be crucial for a national health reporting system that reaches all sectors and can be seen as one of the elements of the successful horizontal health policy of Finland. Looking ahead, the work of the Commission and the Finnish Government in this area forms a foundation of experience, which can now inform other national governments that may be considering a similar approach to HiAP.

With a view to the obligation and mandate expressed in Article 152 of the Treaty of the European Community, one could ask whether a corresponding treaty obligation to report, at regular intervals, how health has been integrated into policies across the EU sectors, with an obligation to the other Commission sectors to contribute, would in the end benefit EU citizens and their health and, after all, improve the competitiveness of the Community.

Acknowledgement

The advice of Jarkko Eskola has helped us enormously in writing and revising this chapter. Thanks also to the Directorate-General for Health and Consumer Affairs (DG SANCO) for providing the history of HiAP in the Commission.

REFERENCES

1. Allin S et al. *Making decisions on public health: a review of eight countries*. Copenhagen, World Health Organization European Observatory on Health Systems and Policies, 2004.
2. Allebeck P. Public health reporting: for what and in what form? *European Journal of Public Health*, 1998, 8:272–273.
3 Lindberg G. Comparing European public health reports. In: Achterberg PW, Kramers PGN, eds. *Health reporting in the European Union. Summary and proceedings of a workshop organised by the RIVM in Bilthoven, 19–20 February 1998*. RINM Report No. 432504 004, Bilthoven, the Netherlands, 1998.
4. Evaluation of National and Regional Public Health Reports (EvaPHR). Final report to the European Commission. Bielefeld, Germany, LÖGD, 2003.
5. Van Oers JAM, ed. *Health on course? The Dutch public health status and forecasts report.* Bilthoven, the Netherlands, National Institute for Public Health and Environment, 2002.
6. Folkhälsopolitisk rapport. Rapport 43. Statens Folkhälsoinstitut, 2005.
7. COM (95) 196 final. *Report from the Commission to the Council, the European Parliament and the Economic and Social Committee on the integration of health protection requirements in Community policies*. Brussels, Commission of the European Communities, 1995.
8. Rayner M. European Union policy and health. *British Medical Journal*, 1995, 311: 1180–1181.
9. COM (1999) 587 final. *Fourth report on the integration of health protection requirements in Community policies*. Brussels, Commission of the European Communities, 1999.
10. SEC (2005) 791. *Impact Assessment Guidelines, 15 June 2005*. European Commission, 2005.
11. Act on public health reporting 1238/1995.
12. Act on public health reporting 879/2002.

13. *Health for All policy in Finland. WHO health policy review*. Copenhagen, WHO, 1991.

14. *Review of national Finnish health promotion policies and recommendations for the future*. Copenhagen, WHO Regional Office for Europe, 2002.

15. *Third Evaluation of Progress Towards Health for All – Finland*. Helsinki, Reports of the Ministry of Social Affairs and Health, 2, 1998.

16. Piha T. Public health reports in Finland as policy tools. In: Achterberg PW, Kramers PGN, eds. *Health reporting in the European Union. Summary and proceedings of a workshop organised by the RIVM in Bilthoven, 19–20 February 1998*. RINM Report No. 432504 004, Bilthoven, the Netherlands, 1998.

Part 4

Health impact assessment

Chapter 10

Health impact assessment and Health in All Policies

John Kemm

Introduction

A fundamental tenet of Health in All Policies is that it is possible to predict the health consequences of policies. If this were not true the aim of ensuring that health implications of all policies are considered would be no more than a pious wish for the impossible. Health impact assessment (HIA) could be a tool that helps policy-makers foresee how different options will affect health and so take the health consequences into account when choosing between options. By following a systematic series of processes (see Figure 10.1) it aims to reduce the likelihood of surprises, to avoid the occurrence of unexpected negative health impacts when a policy is implemented, and to allow positive health impacts to be maximized.

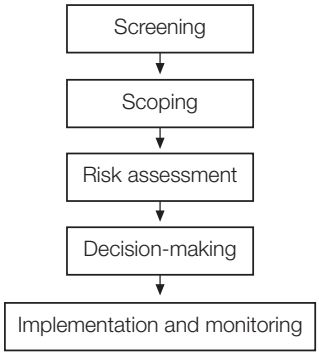


Figure 10.1 *The sequence of processes in health impact assessment*

The first part of this chapter explores the conceptual origins of HIA paying particular attention to the logical bases for prediction of impacts. The second part considers the benefits for health, economy and other policy goals that might arise if HIA were more widely used in policy-making. The third section examines what HIA can contribute to the overarching policy aims of reducing health inequities and increasing participation in policy-making. The final section considers some practical issues of incorporating HIA into policy-making processes.

The conceptual basis for HIA

The name "health impact assessment" may suggest that it is simply an adaptation of environmental impact assessment (EIA) but this is misleading. Much of the practice and theory of HIA owes more to notions taken from healthy public policy and policy science than to EIA.

An activity directed at prediction involves radically different modes of reasoning to most science. Most scientific activities involve making observations and then drawing conclusions from them. Health impact assessment, in contrast, starts with a series of theories about how the world works and the causal connections between events. It then assumes these theories to be correct and deduces from them the predicted consequences of implementing various options. The place of observation in this process is limited to describing the baseline conditions, which the policy is expected to modify, and possibly assessing the accuracy of the prediction after the chosen policy option has been implemented. The theories used in this process are usually referred to as the "evidence base" for HIA and this evidence base has largely been built and tested by observational studies.

HIA: a decision support tool

Health impact assessment is an approach, which supports policy-makers by predicting the consequences and clarifying the various trade-offs that have to be made. It is not some sort of complicated calculus, which identifies the best policy option. It does not make the decision for the policy-makers or remove the need for judgement.

Health impact assessment aspires to describe all health impacts. For example, an HIA might include death, admissions to hospital, loss of sleep, anxiety and self-esteem among the outcomes predicted. However, HIA does not attempt to make value judgements about the relative importance of these different outcomes, since such judgements are properly the preserve of the policy-maker.

In avoiding any attempt to combine the different outcomes into a single measure HIA differs from comprehensive risk assessment[1] and cost–benefit analysis. These approaches attempt to reduce all outcomes to the same type of measure (a single metric). For example, all predicted outcomes may be expressed as disability-adjusted life-years (DALYs), a measure that takes account of both loss of life by fatal illness and loss of quality of life by non-fatal illness. Different policy options can then be simply compared by seeing which produces the most additional DALYs.[2] These approaches introduce major practical and theoretical problems and it may be argued that HIA is better suited to the needs of policy-makers because it more clearly separates the technical and value judgements.

The basis for prediction

In HIA, prediction is based on a set of causal or logic models, linking each policy option through a series of intermediate factors to health outcomes. For each intermediate factor (for example, employment, income, traffic density, law breaking, etc.) ideally one would predict the nature of the health impacts (for example, death, non-fatal illness, mental health, social cohesion), the direction of change (will it increase or decrease?) and the magnitude of the change. Magnitude of impacts has at least two dimensions: the number of people affected and how severely they are affected.

Figure 10.2 illustrates a possible causal chain for changes in alcohol policy. Similar models could be constructed for any other policy option. This diagram illustrates the complexity of the world that one is trying to predict, but it is undoubtedly still a gross simplification of the real situation. This approach has been described as the policy risk assessment model[3] and is extremely helpful in forcing clarity about the assumptions which underlie any prediction. There are many uncertainties about causal paths and in very few cases can one state the precise scope of the effect that would result from changing a supposed causal factor.

The presumed causal relationships used in prediction should be based on evidence.[4, 5] For some things – such as the relationship between smoking and disease – there is a wealth of evidence on causal mechanisms and the relationship is well understood. For others – such as the relationship between employment and health – there is considerable observational evidence but the nature of the relationship is imperfectly known and much more needs to be discovered about the scope of effects and the importance of various modifiers.[6–8] For some factors, such as the components of social capital and housing quality, one can only roughly describe the possible causal relationships.

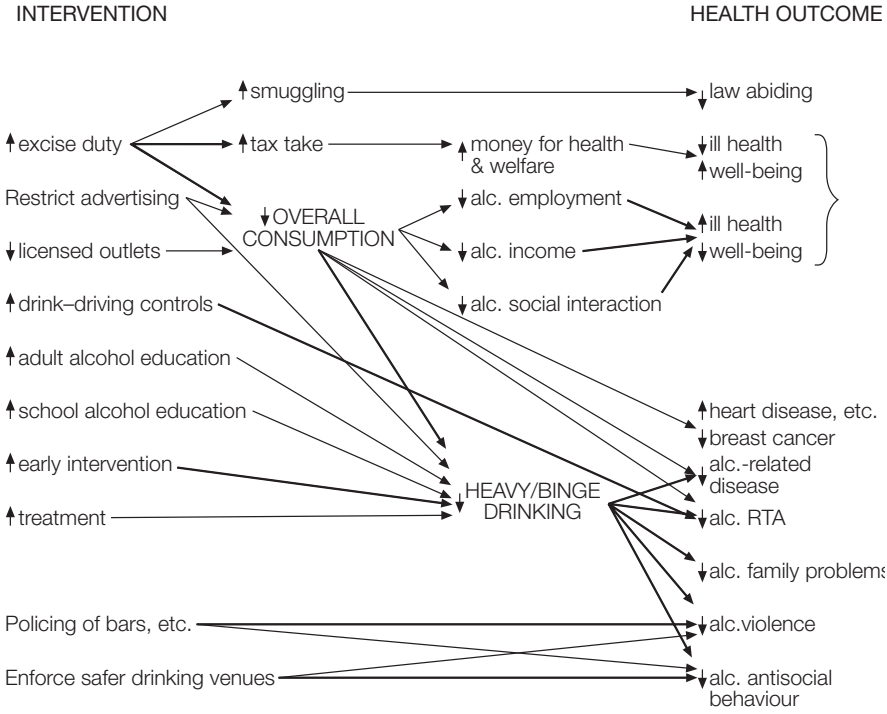


Figure 10.2 *Causal links in alcohol policy. (The thick lines indicate those causal pathways that are believed to be more important.) (Reproduced by permission of Oxford University Press from Kemm JR. HIA and the National Alcohol Strategy for England. In: Kemm JR, Parry J, Palmer S.* Health impact assessment*. Oxford, Oxford University Press, 2004:399, Fig. 34.3)*

Health impact assessment, especially at project level, often pays particular attention in making predictions to lay knowledge[9] as opposed to the views of technical experts. Typically a small number of affected residents will be asked to discuss possible consequences of a proposal; their views form the basis of the assessment. It is not unreasonable to argue that those who know most about living in a particular area and best understand the consequences of changes to that area are the people who live there. Furthermore, impacts are often mediated or modified by behavioural changes. For example, studies of road safety suggest that people may react to a safer environment by increased risk taking.[10] It is often the people who will be affected who can best predict how they will modify their behaviour in response to any change. Lay knowledge is often presented as stories, which have meaning and when appropriately analysed contribute to prediction. However, there is a need for much more work to build a robust theory to underpin the use of lay knowledge in prediction.

The size of impacts

Policy-makers need to know not only that there will be health impacts but also how big the impacts will be. For example, an impact of one extra death in every hundred years in a population of 100 000 has very different significance for a policy-maker than 10 extra deaths every year. In considering the advisability of allowing a waste incineration plant, policy-makers would be less concerned by a predicted increase in mortality when they learnt that the predicted size of increase was 0.03 deaths per year in a population of 3.5 million.[11] However, usually one has to be content with describing the size of impacts with crude ordinal scales (for example, trivial, small, moderate and large). As knowledge develops it may become possible to describe the magnitude of impacts more precisely with numeric units of measurement.

In some cases formal numerical models have been developed to aid prediction (see Chapter 7). All predictions of catastrophic events – such as an explosion in a nuclear reactor or an aeroplane crash in a built-up area – rely on such modelling. Other examples have been the use of models to predict the consequences of different policies on greenhouse gas emissions[12] or fluorocarbon emissions.[13] Recently formal modelling has been used to explore the consequences of waste incinerator construction,[14] of health insurance benefits,[15] and of taxation and benefit policy.[16] Such formal modelling has attractions but it is important not to be beguiled by the apparent precision of a model. Inevitably the model will be an inadequate representation of the real world and its predictions may well be erroneous.[17]

Prediction is inevitably associated with uncertainty and HIA will not help Health in All Policies unless it communicates this uncertainty to the policy-maker. It will sometimes be possible to quantify the uncertainty around quantitative predictions with confidence limits but usually the lack of knowledge is so extensive that it is not even possible to set bounds to the uncertainty. In every case it is important that the assessors make clear to the policy-makers what assumptions they have made and give some indication of how well founded those assumptions are believed to be.

The relation of HIA to other impact assessments

Considered as policy analysis HIA is not a new process but merely an existing practice with an increased emphasis on health outcomes. It is a form of cost–utility analysis, which pays particular attention to health costs and health utilities. Since EIA considers impacts on flora and fauna one might expect that human communities, being an important part of the fauna, would be covered but in practice this rarely happens.[18, 19] However, there is a strong case for

including health within EIA. Social impact assessment (SIA) explicitly considers the well-being of human communities and thus differs in no important respect from HIA.[20] Much of the apparent lack of HIA activity in the United States may be explained by it being described as SIA activity, which in Europe would be called HIA.[21] The European directive on strategic environmental assessment also makes clear that health should be covered in this process.[22]

HIA is beneficial for health

Health impact assessment has the potential to benefit health in three ways. First, it describes the consequences of the various policy options and so allows the policy-maker to choose that which is most favourable to health. Second, it includes recommendations as to how positive impacts can be maximized and negative ones avoided or minimized. Third, it may inform and shape the policy-making environment and so influence future policies. For example, an HIA of a proposal to relax controls on gambling, which highlighted the associated health risks, might not influence the immediate decision but would ensure that future policy in this area was not made in ignorance of the risks.

Many examples can be given of where policies would not have been adopted if their negative impacts had been foreseen. As examples one could cite changes in rendering processes for carcasses in the United Kingdom (leading to "mad cow disease") or wholesale slum clearance (leading to community disruption). If an HIA had been able to predict such consequences, and if policy-makers had accepted the predictions, then these harmful impacts might have been avoided.

Most guides to HIA place considerable emphasis on the recommendations. In the context of Health in All Policies the proper role of HIA may well be to prompt others to develop the necessary modifications rather than to make specific recommendations as to how the policy should be modified. The policy-makers probably have far greater understanding of the complexities of their policy area than the health impact assessors and so may be better placed to develop policy modifications, which maximize positive and avoid or minimize negative impacts. The case for any recommendation must arise from the analysis of potential impacts, which precedes them, and should be soundly evidence based. Health impact assessment therefore becomes the tool that prompts policy improvement rather than a detailed instruction on how to modify the policy.

Communication with policy-makers

A beneficial effect for health is most likely to be achieved where the HIA and the policy-making process are closely linked and there is continual communication between the policy-maker and the assessor. In this situation the policy is likely to be adjusted and refined in the light of HIA thinking before any HIA report is produced. This is probably the optimal outcome but it means that no recommendation will appear in the final HIA report and makes it very difficult to demonstrate the benefit that the HIA has produced.[23]

The HIA of the Welsh Home Energy Efficiency Scheme provides an example. During the HIA several possible negative impacts were identified but because the policy was immediately modified to remove these, no trace of these can be found in the published HIA of the finalized policy.[24]

The direct health benefits of an HIA depend on the policy-makers' response. If they choose to ignore it, then the HIA will not have any beneficial effect on the consequences of that policy. This has tempted some HIA practitioners to move beyond the role of impartial advisers, who give equal consideration to the merits of all options. Instead they become advocates of the option that they consider most beneficial and risk overstating the case for that option and understating the case for other options. When this happens the relation between the HIA practitioner and the policy-maker changes and the HIA becomes no more than yet another lobbying tool. This author would argue that HIA is most influential and most useful when it is impartial and remains inside the policy tent "speaking truth unto power".[25]

Health impact assessment does more than influence the particular policy question to which it is directly applied. It also influences future policy-making through an enlightenment process.[26, 27] Even if it has little or no influence on the formulation of the current policy it has still entered the policy discourse and may have increased the policy-makers' awareness of health issues. An HIA may thus produce health benefits by influencing the attention paid to health issues in future policy-making.

HIA is beneficial to non-health sectors

Very few policy-makers intentionally damage health. Even with those policies which cause considerable health damage – for example, the subsidizing of tobacco growth[28] – the policy-maker will persuade himself or herself that the benefits, such as increased income for growers, outweigh the health damage. Before they are committed to a policy every policy-maker wants to know the likely impacts, good and bad, and would like, so far as it is compatible with

other policy aims, to avoid any negative impacts. Where health problems (or problems for any other sector) are identified after a policy is implemented this will reflect badly on the policy-maker concerned and there may be a need for "retrofit" solutions, which are far more expensive to put in place than if they had been installed when the policy was first instigated. Thus HIA and other impact assessments are beneficial in all sectors and contribute to the goal of "joined-up" policy-making to which policy-makers aspire.[29] After a policy-maker is committed to a policy, the situation is different and he or she will probably welcome assessments and evaluations which support the policy, and disapprove of ones that reveal problems with the policy. It follows that HIA is only useful while policy options remain open.

The economic consequences of using HIA

The economic consequences of HIA need to be considered at two levels. First, how does it affect the cost of implementing the policy and, second, how does it affect the cost of making the policy?

Policy-making requires the trade-off of multiple policy outcomes. The policy-maker will seek to obtain an optimal mix of economic, social, health and environmental outcomes. The policy-maker may well decide that a lesser economic benefit is justified by a greater health or social benefit, thereby choosing to invest in health. Even considered in narrow financial terms bad health is damaging to the economy, reducing productivity and incurring health care costs. However, economists are increasingly thinking more widely and recognizing the importance of human and environmental capital alongside financial capital. Improving health should be recognized as an economic gain just as much as increased financial wealth. The effect of HIA on implementing a policy should, therefore, not be looked on as a cost but as a redistribution of benefit between the different types of capital.

The evaluation of HIA

Assessing the benefits that arise from HIA requires evaluation. The evaluation of HIA must be clearly distinguished from evaluation of the policy decision it is intended to inform. The question is not "Did implementation of this policy benefit health?" but "Did the HIA contribute to a better decision?" The criteria for evaluating an HIA are thus: how effective was it in informing policy-makers, how accurate were its predictions and did it make the policy-making process more open and involve stakeholders? Additional outcomes might be: raising policy-makers' awareness of health, building partnerships between

different sectors of the policy-making community (for example, different ministries) and raising awareness of health in the general population. Outcome and process evaluation can then be attempted in relation to each of these outcomes.[30] A better evaluation of HIA should allow its benefits to be more adequately described but a great deal more work will be needed before it is possible to put a monetary value on these benefits.

The cost of doing HIA

Health impact assessment is not, however, a cost-free process. It requires investment of time, skills and money and it is proper to ask whether the improvement in the decision-making process is sufficient to justify the costs. The evidence to answer this question is still being gathered. Until recently there was very little information on the costs of HIA, which was usually free to the decision-makers, while costs were frequently "hidden" in the accounts of the organization performing the HIA. More recently estimates of the cost of doing an HIA have been made[31, 32] but they are almost certainly underestimates. The fees charged by commercial organizations undertaking EIA are probably a better guide to the true cost of HIA.

At the moment information on costs is limited and benefits are poorly evaluated. Until the discipline has progressed much further it is unlikely that a cost–benefit analysis of HIA will be possible but cost–utility analysis may make a reasonable case that investment in an HIA is a wise use of policy-makers' resources.

HIA addresses inequities

Health impact assessment has the potential to assist policy-makers greatly in reducing health inequities. Equity figures prominently in the list of HIA values[33] but if the purpose of HIA is to inform rather than to decide, the question must be "Does HIA predict the effect of different policy options on health inequalities?" Virtually every policy has "winners" (people who gain from the policy) and "losers" (people who lose or gain less from the policy). Health impact assessment would assist policy-makers by describing the distribution of impacts and predicting how different segments of the population would experience health impacts if the different options were implemented. Some have urged that there should be separate health inequality impact assessment[34] but most have concluded that this would do no more than a properly conducted HIA.[35]

While the aspiration to predict the distribution of impacts is clear, the delivery has been less impressive.[36] Many HIA reports describe the differences between various sectors of the population but there is a need to go further in the subsequent discussion and give a clear description of how these sectors will be differentially affected. Several HIAs describe how individuals with certain characteristics (such as a single parent, a person on low income or a member of an ethnic minority) will be affected by a policy[37] but this falls short of a proper analysis of distribution of impacts detailing how the various impacts would fall on different groups within the population.

Recommendations relating to equity may suggest how the inequalities described might be redistributed so that any negative impacts fall on the least deprived, and the most deprived obtain the greatest positive impacts. Alternatively recommendations may discuss ways in which those who will experience negative impacts could be compensated with other benefits. Again, in preparing such recommendations, the health impact assessor would be wise to do so in close communication with the policy-makers, who have a democratic mandate to consider issues of distribution of benefits.

HIA and participation

Openness is listed as one of the key values of HIA.[33] Practitioners have placed a high value on participation, sometimes valuing it more than scientific rigour. Participation improves decision-making in many ways. First, as mentioned earlier, people are an important source of information, and participation is a method by which this information is made available to the HIA.[38] Second, participation allows the people affected by a decision to know how a decision is being made and what considerations are being taken into account. Third, participation allows people to take part in the decision-making (as opposed to merely being able to know what is happening) in what Lehto has termed "little democracy". The Aarhus Convention affirms that for decision-making on environmental issues this participation is a right.[39] Attempts to organize participation prompt the question: how does participative democracy relate to representative democracy? There can be a tension between elected decision-makers and self-appointed groups undertaking HIA, whose mandate and legitimacy are unclear. Attempts to use HIA to allow people to participate in decision-making raise difficult issues of which people contribute and how and which voices will be heard, since it is usually logistically impossible to involve all those affected by a decision.

Much of the discussion on participation is more directly applicable to HIA of projects rather than to HIA of policies. Policies necessarily affect larger

numbers of people and, therefore, have more stakeholders. For many policies at national level the legitimate stakeholders are the entire population of the country or even wider than that. In such cases it is extremely difficult to think how participation could amount to more than the consultative processes widely used in democratic countries.

A further difficulty with participation is that it fails to accept that it would be difficult to operate a government without some secrecy. All governments consider options before consulting upon them and the process of finally choosing one option takes place behind closed doors. It is difficult to imagine how a cabinet could operate if all its proceedings were continuously recorded and broadcast. Governments need to be able to think and say the unthinkable before arriving at their public position. In the United Kingdom and most other national civil services there is a well-established tradition that advice to ministers is confidential. For all these reasons the consequences of participation need to be carefully explored before deciding its place in HIA as applied to Health in All Policies. Is there a need to develop a confidential HIA?

Community development

In many circumstances HIA takes place in contexts where there is conflict between groups in favour of and opposed to a particular proposal. For example, one group may favour construction of a road, factory or leisure facility while another may oppose it. Often in these situations there are clear winners and losers, the losers are those who live close to the proposed development while the winners are the more widely distributed general population. Health impact assessment claims to be able to assist in these situations by spreading understanding of the issues involved, promoting rational debate and arriving at a situation where both sides – even if they do not like the final decision – understand how it was made and feel that their arguments have been taken into account. In practice the HIA often ends up being seen as the tool of one faction[40] and there is a danger that it may merely inflame the situation. However, skilfully used HIA could be a tool to resolve social conflict and promote social cohesion.

A final reason for participation in HIA is that it fosters social learning.[41] The process of undertaking the HIA encourages people to think about the factors that influence their health and how they can increase their control over these factors. It gives them an opportunity to share their knowledge and experience with their neighbours, to construct their own causal diagrams, to challenge accepted interpretations and to build alliances and action groups. After the issue with which it was concerned is resolved, an HIA leaves a

stronger, more empowered community. Health impact assessment has the potential to be a very powerful community development process.[42]

Factors that hinder the use of HIA

The process of HIA can vary widely and the resources required will depend on the approach taken. At one end of the range is a quick desktop exercise involving a few people for a few hours and at the other end an exercise involving many people for many months with detailed examination of routine data and extensive literature searching.[43] The investment in HIA for Health in All Policies should be proportional to the importance of the policy decision. Major policies such as the European Union Common Agricultural Policy, policies on waste disposal, or energy policy and the relative places of nuclear, fossil fuel and renewable energy have great resource implications and far-reaching ramifications for health and other matters. It is unrealistic to suggest that such policies can be adequately assessed in a few hours and they are likely to deserve more intensive HIA methods.

Responsibility for undertaking HIA

One factor that has hindered the use of HIA in policy formulation is uncertainty as to who should do it. To date, HIA has largely been undertaken by people in public health organizations. This has three disadvantages from the point of view of influencing policy-making. First, there is insufficient capacity to undertake HIA of more than a tiny fraction of policies. Second, the HIA is disconnected from the policy-making process. Third, it is too easy to disown the HIA if its findings are not to the policy-makers' liking.

In some administrations there has been more progress in linking HIA to the policy-making process. In British Columbia HIA was for a time embedded in government procedures[44] but this has now been discontinued. In the Netherlands an HIA unit was established to survey all government activity and an impressive number of HIAs have been undertaken.[45, 46] In London a procedure for applying HIA to all mayoral strategies has been established.[47] The Swedish regional councils have also set up a procedure for applying HIA to their policy-making.

In all these examples capacity to undertake the HIAs proved to be a problem.

Capacity for HIA

Lack of capacity and people with the time, ability or willingness to undertake HIA is a barrier to its use in most places. One solution to this lack of capacity would be for the policy-makers to take responsibility for undertaking HIA of their own policies. The objection that policy-makers do not have the necessary health knowledge and skills could be met by training them in the necessary skills. Sharing of skills and cooperation between different sectors could overcome many of the difficulties. The provision of a support unit that would not do the HIAs but would offer assistance with those aspects that required particular health expertise is another way to help policy-makers undertake HIA. It must be remembered that nearly every HIA requires knowledge of some topic in which public health has no expertise (predicting traffic flow, town planning, crime prevention, etc.) and this has not deterred public health from engaging in HIA.

Objectivity and HIA

A more fundamental objection to policy-makers undertaking HIA of their own policies is the view that only public health people can be trusted to value health sufficiently. There is a fear that policy-makers will not be impartial but biased towards the policy options that fit their political preconceptions. This argument amounts to a claim that the partialities of public health should take precedence over the partialities of other sectors and its incoherence is clear. The case that HIA should not simply be a form of advocacy has already been made. A requirement to publish the HIA of policy options at the same time as the policy is published should ensure that it has been performed fairly and impartially.

Another barrier to using HIA is uncertainty about at which stage of the policy-making process it should be used. The discussion in this section discusses policy as if it were a discrete and fixed entity, which it is not. Policy consists of a general intention and direction and may be implemented by action with the introduction of regulations and programmes, or by inaction.[48] It is constantly changing, being shaped and revised by the evolution of events. Health impact assessment can only be applied to the more clear-cut expressions of policy. For example, it is not possible to do an HIA on the general policy that women's welfare should be promoted but it may be possible to do an HIA on a proposal to pay a specific benefit to women. The continually evolving nature of policy makes it difficult to identify when an HIA should be done. It is not helpful to undertake an HIA before the policy options to be considered are clear, nor is it helpful to undertake an HIA after all important decisions have been made.

Policy-making is an iterative process and HIA works best if it too can be iterative alongside the process it seeks to inform.[49]

Integrated impact assessment and consideration of health impacts

A further factor hindering the use of HIA is that policy-makers and governments are very busy. They are also subject to a host of demands for impact assessment. For the United Kingdom, parliament legislators are required to undertake EIA, regulatory impact assessment (how will business be affected?) and rural proofing (effect on the countryside) as well as to consider the effect on families, law and order and a host of other cross-cutting issues. It is not surprising that a demand for yet another impact assessment is not greeted with enthusiasm. Other barriers to undertaking HIA are a tendency for each government department to give precedence to their own concerns over all other concerns, a feeling that they do not have the necessary knowledge to deal with health issues and a view that health should be the business of the Department of Health. One solution to overcoming these barriers is to roll all the various impact assessments into a single integrated impact assessment procedure. This has the further advantage that it allows the limited health expertise to be focused on those cases, where health impacts appear to be most problematic. Asking for several different assessments involves considerable duplication of effort since many of the issues to be investigated are common to several impact assessments. For example, in order to do an HIA one has to consider environment, employment, community cohesion and fear of crime, issues which also figure in several other impact assessments.

Some object to integrated impact assessment on the grounds that insufficient attention will be paid to health, and assessment may degenerate into a tokenistic "tick box" procedure. On the other hand inclusion of health as an element in an integrated impact assessment would be much better than no HIA at all.

Governance of HIA

If HIA is to be a part of the policy-making process then all stakeholders must have confidence that it is being carried out to the highest ethical and technical standards. All need to be assured that in performing the HIA there has been "ethical use of evidence" and that the assessors have been impartial. Evaluation of the HIA should give confidence that the predictions have been competently made. In other words HIA for policy-making needs to be quality assured.

In some situations and some jurisdictions particular HIAs may also become subject to review in the courts (judicial review).

Guidelines are frequently suggested as a method of ensuring the quality of HIA. Certainly guidelines can be useful in spreading good HIA practice. In using guidelines it is important to accept that there are many shortcomings in current HIA practice and that HIA is an evolving art. The assessor's aim must be to produce an HIA that is not as good as previous HIAs but better than them. Guidelines must not have the effect of freezing development at current practice. HIA methods always need to be adapted to the context and circumstances of each particular policy question. Guidelines are helpful if they are used as guides for practice and very unhelpful if they are treated as rules.

Others have suggested accreditation of health impact assessors. However, as with guidelines, if an accreditation process is introduced it must make allowances for the rapidly evolving state of the process and encourage improvements on current practice rather than mere imitation. The best evidence of competence in HIA comes not from the number of courses attended or certificates obtained but from the number of HIAs completed and the reports of those HIAs.

It is already standard practice in many legislatures to require evidence that the various impacts of new legislation have been assessed. In England legislators have to complete a regulatory impact assessment, which covers many possible impacts including health.[50] A document describing this must be deposited in the House of Commons library and so made available to all. Similar arrangements operate in other countries. This requirement to produce documents open to peer and public scrutiny provides the key to quality assurance of HIA in the context of Health in All Policies. Documents reporting an HIA should contain a description of the processes followed, the assumptions and reasoning underlying the predictions, and a justification of the conclusions. Review of their reports will distinguish robust from unsatisfactory HIAs. Openness will provide the best assurance of the quality of HIA and the competence and trustworthiness of the assessors.

Conclusion

Health impact assessment has already made a considerable contribution to better public decision-making, and with further development it has the potential to make an even greater contribution. In order for HIA to become even more useful there is a need to strengthen the logic used for predicting consequences of decisions, to improve estimates made of the magnitude of outcomes and to develop forms of participation that meet the needs of both HIA and policy-making.

Future progress requires that policy-makers should become more acquainted with HIA and that health impact assessors should develop better understanding of the policy-making process. Health impact assessment will have to change from something done by public health enthusiasts to something done by all competent policy-makers. While consideration of health need not rigidly follow the procedures currently used in HIA, the processes developed in HIA for systematically exploring the probable health consequences of different policy options are very powerful tools for policy-makers. It is difficult to see how Health in All Policies could become a reality without HIA or some similar approach.

Acknowledgement

The advice and constructive criticism of Jayne Parry and Timo Ståhl have helped me enormously in writing and revising this chapter.

REFERENCES

1. Murray CJ et al., eds. *Summary measures of population health. Concepts, ethics, measurement and applications*. Geneva, World Health Organization, 2002.
2. Kjellstrom T et al. Comparative assessment of transport risks – how it can contribute to health impact assessment of transport policies. *Bulletin of the World Health Organization*, 2003, 81:451–457.
3. Joffe M, Mindell J. A framework for the evidence base to support Health Impact Assessment. *Journal of Epidemiology and Community Health*, 2002, 56:132–138.
4. Mindell J et al. Enhancing the evidence base for Health Impact Assessment. *Journal of Epidemiology and Community Health*, 2004, 58:546–551.
5. Mindell J et al. *A guide to reviewing evidence for use in Health Impact Assessment*. London, London Health Observatory, 2005 (www.lho.org.uk).
6. Smith R. *Unemployment and health: a disaster and a challenge*. Oxford, Oxford University Press, 1987.
7. Morris JK, Cook DG, Shaper AG. Loss of employment and mortality. *British Medical Journal*, 1994, 308:1135–1139.
8. Bartley M, Sacker A, Clarke P. Employment status, employment conditions and limiting illness: prospective evidence from the British household panel survey 1991–2001. *Journal of Epidemiology and Community Health*, 2004; 58:501–506.
9. Popay J et al. Theorising inequalities in health: the place of lay knowledge. *Sociology of Health and Illness*, 1998, 20:619–644.
10. Adams J. *Risk*. London, University College London Press, 1995.

11. Mindell J, Barrowcliffe R. Linking environmental effects to health impacts: a computer modelling approach for air pollution. *Journal of Epidemiology and Community Medicine*, 2005, 59:1092–1098.

12. Martens P. *Health and climate change: modelling the impact of global warming and ozone depletion*. London, Earthscan Publications, 1998.

13. Slaper H et al. Estimates of ozone depletion and skin cancer incidence to examine the Vienna Convention achievements. *Nature*, 1996, 384:256–258.

14. McCarthy M et al. A health impact model for environmental changes attributable to development projects. *Journal of Epidemiology and Community Health*, 2002, 56:611–616.

15. Cole BL et al. Projected health impact of the Los Angeles City living wage ordinance. *Journal of Epidemiology and Community Health*, 2005, 59:645–650.

16. Mitchell R, Dorling D, Shaw M. *Inequalities in life and death: what if Britain were more equal?* Bristol, Policy Press, 2000.

17. Box G. Robustness in the strategy of scientific model building. In: Launer RL, Wilkinson GN, eds. *Robustness in statistics*. New York, Academic Press, 1979:201–236.

18. Joffe M, Sutcliffe J. *Developing policies for a healthy environment*. Health Promotion International, 1997, 12:169–173.

19. Mindell J, Joffe M. Health impact assessment in relation to other forms of impact assessment. *Journal of Public Health Medicine*, 2003, 25:107–112.

20. Hendley J et al. *What is HIA and how can it be applied to regeneration programmes?* Working paper series No 1. Liverpool Departments of Civic Design and Public Health, University of Liverpool, undated.

21. Wright J, Parry J, Scully E. Institutionalizing policy-level impact assessment in Europe: is coupling health impact assessment with strategic environmental assessment the next step forward? *Bulletin of the World Health Organization*, 2005, 83:472–477.

22. Breeze CH, Lock K. *Health impact assessment as part of Strategic Impact Assessment*. Rome, WHO Regional Office for Europe, 2001.

23. Burney P. Evaluating health impact assessments. In: *Health impact assessment: report of a methodological seminar*. London, Department of Health, 1999.

24. Kemm J, Ballard S, Harmer M. *Health impact assessment of the New Home Energy Efficiency Scheme*, 2000 (www.phel.gov.uk/hiadocs/home_energy_efficiency.pdf).

25. Hoppe R. Policy analysis, science and politics: from speaking truth to power to making sense together. *Science and Public Policy*, 1999, 26:201–210.

26. Davis P, Howden-Chapman P. Translating research findings into health policy. *Social Sciences and Medicine*, 1996, 43:865–872.

27. Innvaer S et al. Health policy makers' perceptions of their use of evidence: a systematic review. *Journal of Health Services Research and Policy*, 2002, 7:239–244.

28. Dahlgren G, Nordgren P, Whitehead M. *Health impact assessment of the EU Common Agricultural Policy*. Stockholm, National Institute of Public Health, 1996.

29. Bullock H, Mountford J, Stanley R. *Better policy making*. London, Centre for Management and Policy Studies, 2001; available at www.policyhub.gov.uk/docs/betterpolicymaking.pdf.

30. Parry JM, Kemm JR. Criteria for use in the evaluation of health impact assessments. *Public Health*, 2005, 119:1122–1129.

31. Fleeman N. *Estimated time and costs of health impact assessments*. Liverpool, Public Health Observatory, 1998.

32. Atkinson P, Cooke A. Developing a framework to assess the costs and benefits of health impact assessment. *Environmental Impact Assessment Review*, 2005, 25:791–798.

33. WHO Regional Office for Europe. *Gothenburg Consensus Paper: health impact assessment. Main concepts and suggested approach*. Brussels, European Centre for Health Policy, 1999.

34. Acheson D. *Independent inquiry into inequalities in health*. London, The Stationery Office, 1998.

35. Douglas M, Scott-Samuel A. Addressing health inequalities in health impact assessment. *Journal of Epidemiology and Community Health*, 2001, 55:450–451.

36. Parry J, Scully E. Health impact assessment and the consideration of health inequalities. *Journal of Public Health Medicine*, 2003, 25:243–245.

37. Scottish Needs Assessment Programme. *HIA of the city of Edinburgh council's urban transport strategy*. Glasgow, Scottish Needs Assessment Programme, 2000.

38. Kemm JR. The future challenges for HIA. *Environmental Impact Assessment Review*, 2005, 25:799–807.

39. Aarhus Convention; see http://www.europa.eu.int/comm/environment/aarhus.

40. Cook A, Kemm J. Health Impact Assessment of proposal to burn tyres in a cement plant. *Environmental Impact Assessment Review*, 2004, 24:207–216.

41. Webler T, Kastenholz H, Renn O. Public participation in impact assessment: a social learning perspective. *Environmental Impact Assessment Review*, 1995, 15:443–463.

42. Mittelmark MB, Gillis DE, Hsu-Hage B. Community development: the role of HIA. In: Kemm J, Parry J, Palmer S, eds. *Health Impact Assessment: concepts, theory, techniques and applications*. Oxford, Oxford University Press, 2004:143–152.

43. Parry J, Stephens A. Prospective HIA: pitfalls, problems and possible ways forward. *British Medical Journal*, 2001, 323:1177–1182.

44. Banken R. HIA of policy in Canada. In: Kemm J, Parry J, Palmer S, eds. *Health Impact Assessment: concepts, theory, techniques and applications*. Oxford, Oxford University Press, 2004:165–176.

45. Roscam Abbing EW. HIA and national policy in the Netherlands. In: Kemm J, Parry J, Palmer S, eds. *Health Impact Assessment: concepts, theory, techniques and applications*. Oxford, Oxford University Press, 2004:177–190.

46. Bowen C. HIA and policy development in London: using HIA as a tool to integrate health considerations into strategy. In: Kemm J, Parry J, Palmer S, eds. *Health Impact Assessment: concepts, theory, techniques and applications*. Oxford, Oxford University Press, 2004:235–242.

47. Mindell J et al. Health impact assessment as an agent of policy change: improving the health impacts of London's draft transport strategy. *Journal of Epidemiology and Community Health*, 2004, 58:169–174.

48. Walt G. *Health policy: an introduction to process and power*. London, Zed Books, 1994.

49. Putters K. HIA, the next step: defining models and roles. *Environmental Impact Assessment Review*, 2005, 25:693–701.

50. Cabinet Office Better Regulation Unit. *Regulatory impact assessment: what's new*, 2006 (www.cabinetoffice.gov.uk/regulation/ria/whats_new.asp).

Chapter 11

The use of health impact assessment across Europe

*Julia Blau, Kelly Ernst, Matthias Wismar, Franz Baro, Mojca Gabrijelčič Blenkuš, Konrade von Bremen, Rainer Fehr, Gabriel Gulis, Tapani Kauppinen, Odile Mekel, Kirsi Nelimarkka, Kerttu Perttilä, Nina Scagnetti, Martin Sprenger, Ingrid Stegeman, Rudolf Welteke**

Introduction

This chapter presents the results of a mapping exercise on the use of health impact assessment (HIA) in European countries.† Health impact assessment aims at informing decision-makers, stakeholders and the affected population on possible health-related consequences of pending decisions. In this regard, HIA is prospective and geared towards the decision-making process.

Health impact assessment has been endorsed by the WHO Regional Office for Europe[1], the European Union (EU)[2], and national[3] and subnational governments.[4, 5] It has attracted a lot of attention since it is assumed to have the potential to address all determinants of health, tackle inequities and provide a new impetus for participation and empowerment in health.[6, 7] This almost universal potential makes it highly relevant for Health in All Policies (HiAP). As pointed out in Chapter 10, HiAP requires some form of prospective assessment of strategies and policies, and HIA may be an appropriate tool for it.

But what do we actually know about the use of HIA in Europe? Much of the current literature is based on conceptual frameworks and case studies, or focuses on selected aspects of HIA. Most publications in the international literature refer to a limited number of countries. There is a lack of cross-

* Secondary contributors to this chapter are listed at the end of the chapter.

† The research presented in this chapter was produced by the partners of the "Effectiveness of HIA project". The project was conducted with the financial assistance of the European Community in the framework of the Public Health Work Programme (Grant Agreement 2003101). The views expressed herein are those of the authors and can therefore in no way be taken to reflect the official opinion of the EC.

country comparison applying a common conceptual and methodological framework. If HIA is discussed as a tool for HiAP and, in general, for health promotion in Europe, then it is necessary to gain a better understanding on the actual use of HIA across Europe. There might be substantial variations in the use of HIA given the differences between European countries in terms of political, socioeconomic and institutional settings.

Key questions addressed in this chapter are:

- How frequently is HIA used in Europe and are there variations between countries?
- Are HIA terminology and definitions uniform throughout Europe?
- Are HIA policy documents driven by the same aims and values?
- Does HIA, when implemented, incorporate equity and participation?
- At what levels are HIAs implemented?
- In what sectors are HIAs found to be utilized?
- Is HIA prospective in practice?
- What are the stages and types utilized in HIA?

This chapter can be read in conjunction with Chapter 12 (on the implementation and institutionalization of HIA in Europe) as both draw on the same data and are complementary. While this chapter focuses on the use of HIA, Chapter 12 analyses selected aspects of stewardship, funding, capacity building and HIA delivery in a comparative manner.

Since the mapping exercise presented here provides an overview on the use of HIA in Europe, conclusions on the effectiveness or quality of the HIA cannot be drawn. There are case studies that point to various dimensions of effectiveness of HIA. For example, a case study on an HIA of urban regeneration in England demonstrated that decision-makers acted on the recommendations of the HIA.[8] Another case study on an HIA in Wales pointed to the indirect effects of an HIA on the decision-making process such as the establishment of a dialogue between stakeholders which assisted decision-making and implementation.[9] Currently a cost–benefit analysis commissioned by the United Kingdom's Department of Health is being conducted by the York Health Economics Consortium.* By the end of 2006, case studies on the effectiveness of HIA in terms of its capacity to influence the decision-making process will have been published.

* http://www.york.ac.uk/inst/yhec/client_doh.shtml.

The chapter is divided into seven parts. The first presents the conceptual framework, methodologies, limitations of the research and an overview of the data. The second compares the use of HIA definitions and terminologies across Europe. The third points to differences in the aims and values of HIA in the policy documents. The fourth explores the issues of equity and participation in practice. The fifth provides an overview of the settings of HIA by focusing on the use of HIA at different levels and in different sectors. The sixth deals with three key elements of HIA. It focuses on the timing of HIA, the stages (screening, scoping, assessing, reporting and evaluating) and the types of HIA used across Europe. Finally, a discussion draws together the different aspects of the mapping exercise.

Mapping the use of HIA in Europe

The conceptual framework, the methodologies and the research were developed, refined and conducted by the partners of The Effectiveness of HIA Project.

Conceptual framework

The research was conceptualized as an explorative mapping exercise.* The key question was: how is HIA utilized in Europe? This was preferred to a more hypothesis-driven design for the following two reasons.

First, since the research was starting from the assumption that the use of HIA and its implementation and institutionalization may differ from country to country, the conceptual framework had to take these variations into account. Therefore, the selection of a single definition of HIA from the literature or the defining of a new one was avoided. Instead, the framework allowed for countries to report their own domestic definitions, interpretation and practice of HIA.

Second, it was assumed that many countries are underrepresented in the scientific literature. Therefore, deriving hypothesis from this literature could entail distortions in the result in terms of missing the relevant issues in the countries.

The conceptual framework also included research at the subnational levels. Many decisions that have consequences on the health of the population and individuals are made on all levels in a given country. However, conceptualizing comparison at the subnational level is especially difficult. An example is the United Kingdom. The research shows 21 national entities,† since three of the

* The conceptual framework and the methodology and limitations explained here apply equally to chapters 11 and 12.

† Austria, Belgium, Denmark, Finland, Germany, Hungary, Ireland, Italy, Sweden, Lithuania, Malta, the Netherlands, Poland, Portugal, Slovakia, Slovenia, Spain, Switzerland and the United Kingdom (meaning Wales and England; Northern Ireland is covered by the Irish contribution).

four constituent parts of the United Kingdom (England, Scotland and Wales) were considered as national entities. Indeed, health is among the devolved competencies. Only England does not have a devolved parliament and its health policy is determined by the United Kingdom parliament.*

Furthermore, the conceptual framework was shaped by an analysis of 16 documents (consensus papers, glossaries and key publications) in order to identify key dimensions on the use of HIA and its implementation and institutionalization. The analysis of the documents was also used to clarify the terminology used in the research. In addition, concepts from health systems research such as stewardship, financing, resource generation and delivery inspired the development of the conceptual framework.

Methodology and limitations

The conceptual framework was operationalized by domestic literature searches facilitated by a semi-standardized questionnaire and search strategy. The questionnaire, based on the conceptual framework, was organized along four topics: terminology and general issues; HIA systems differentiated by national, regional and local levels; fact sheets on individual HIAs; and health in other assessments. The questionnaire was discussed with the partners, revised, externally reviewed, revised again and pre-tested.† Final revisions were reviewed by the project's steering group.

The research was conducted by 22 research teams in 19 countries. More than half of the researchers are experts in the field of HIA in their countries or regions, while the remainder are public health experts. The research took place between January and July 2005. The research teams were asked to complete the questionnaire by providing data on all existing HIAs at national level and from a selected reference region and reference locality. For each HIA identified, a separate fact sheet was filled in. The research covers a period of 15 years ranging from 1 January 1990 to 31 June 2005. Detailed instructions on research strategies including database research, internet research and "snowballing" were provided. Furthermore, in addition to the standard literature, a wide range of "grey literature" was specified to be included in the research. For some of the items in the questionnaire, an analysis of policy documents, regulations and other official documents was required. The data were consolidated by using triangulation methods. The answers in the questionnaire were checked with respect to completeness and adequacy. It was sent back to the researchers for completion, modifications and verification,

* Home rule of the Northern Ireland Assembly was suspended in October 2002.

† The project partners gratefully acknowledge the input provided by Marco Martuzzi, Louise Nilunger and Jayne Parry.

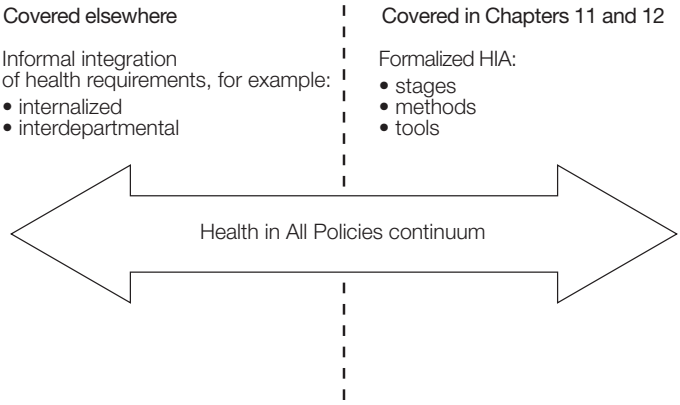


Figure 11.1 *The focus of health impact assessment presentation*

and subsequently established in a Microsoft Access database. A large portion of the data was published on the Internet to allow discussion between the partners on the validity of the results.*

Although this research has rigorously applied conceptual frameworks and methodologies, various limitations have to be addressed especially with regard to the representativeness of the results. First, there are variations with regard to what has been included in the mapping exercise. The inclusion of an HIA was based on the dominant domestic definition of HIA. These differences in domestic definitions may result in variations with respect to the types of HIA included. These variations can be justified since the purpose of the research was to be explorative and to identify the use of HIA in different countries, and this use may differ due to contextual circumstances reflected in the domestic definitions.

Excluded from the research were informal prospective assessments of possible health consequences which take place in many countries. These assessments may be based on personal contacts, political ties or other networks. In this regard, HIA is one side of a Health in All Policies continuum, while the more informal activities constitute the other side (as shown in Figure 11.1). The informal activities, although partly included in the research, are not presented here or in Chapter 12. Also excluded were all other forms of impact assessment if they did not embody a particularly strong health component that integrated HIA into these assessments.

A second restriction has to be made with regard to the number of HIAs identified. Owing to the large number of HIAs found in England and the

* http://www.euro.who.int/observatory/Studies/20050713_1.

Netherlands, only a sample of HIAs were included. For the Netherlands, HIAs were selected based on the date of completion, the information provided and the ease of availability. England decided to select 30 prospective case studies which were representative of the total sample in terms of type, level and sector. Moreover, as only a single reference region and reference locality were selected at subnational level, the data cannot be representative. Two research teams did not report on any individual HIAs in their countries. Despite employing comprehensive search methodologies, some HIAs may not have been identified. For example, if an HIA is fully integrated in the routines of an administrative structure they may not have a separate report or a publication.

In addition, the results for regional and local levels have to be interpreted with great care. In order to describe the use of HIA at regional and local level in depth, the research was restricted to one reference region and locality per country. Therefore, results for local and regional levels may not be assumed to be representative of all regions and localities of a given country. Comparisons between levels have to be made cautiously as responsibilities for policies and public health functions sit at different levels in different countries. Some countries have decision-making bodies on three levels while others only have two levels. Also, owing to ongoing federalization, devolution, delegation and privatization, this distribution of responsibilities is a dynamic process. Subdivisions of countries are sometimes complex, multilayered or non-uniform and vary greatly across Europe. More than two-thirds of the reported HIAs' results come from England, Finland, the Netherlands and Wales. However, this does not necessarily mean that HIAs are not being conducted in other European countries, but could rather be attributed to a lack of reporting mechanisms.

Apart from all these limitations, it should be noted that this mapping exercise is the most current and the most comprehensive. A previous mapping exercise, covering 22 European countries in 2001, reported 42 HIAs either completed or in progress.[10]

Overview of the results

Given the limitation, mentioned above, it is impossible to determine the number of HIAs conducted in the countries. The research teams have abstracted 158 HIAs for analysis. However, adding the number of HIAs not abstracted for England and the Netherlands and the numbers provided in some domestic overviews, the overall number of documented HIAs for the countries included in the research is 470. In any case, the actual number of existing HIAs is probably much higher than the number of documented HIAs, as overviews on HIA activities were only available for nine countries.

Table 11.1 *Health impact assessments as reported in the fact sheets*[a]

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005[b]	On-going	Yr n/a	Total
Austria						2							3		5
Belgium								1			1	1			3
Denmark									1	1					2
England					1		3	7	5	4	4	1		3	28
Finland		1		2	2	2	5	3	3	11	5				34
Germany		1		2						1	2	1			7
Hungary															0
Ireland											3				3
Italy										2	2				4
Lithuania											1				1
Malta												1			1
Netherlands			2	4	3	6	1	1	1						18
N. Ireland									2		3				5
Poland						1									1
Portugal															0
Slovakia									1						1
Slovenia	2			1	1					1	1				6
Spain								1		5		1			7
Sweden										1	4				5
Switzerland												1		2	3
Wales				1		2	5	4	3	3	6				24
Total	**2**	**2**	**2**	**10**	**7**	**13**	**14**	**17**	**16**	**29**	**32**	**6**	**3**	**5**	**158**

[a] Only HIAs reported in the fact sheets corresponding to the study were recorded in the table.

[b] The mapping exercise was completed in 2005. All HIAs completed by this time were included in 2005 and those still in progress were included under "ongoing".

Table 11.1 shows that England, Wales, Finland and the Netherlands have the highest number of HIAs reported.*

The results reported in Table 11.1 look surprising in regard to HIA developments in Sweden especially since it has been reported that HIA has been widely employed at regional, and especially at local, level.[11]

The low number of HIAs found in Sweden in the context of this study may be attributed to the fact that while gender and equity are included within the strict definition of HIA in the Swedish public health policy, HIAs that are part of an environmental impact assessment (EIA) are not included and were not reported. Therefore many EIAs, including one with a health component conducted by the Swedish Road Administration and other public authorities, were not incorporated in the research.

* As mentioned earlier, the number of HIAs in England and the Netherlands is higher than presented in Table 11.1.

Common use of HIA definitions and terminology across Europe

A widely used definition, the so-called "Gothenburg Consensus", describes HIA as "any combination of procedures or methods by which a proposed policy or program may be judged as to the effects it may have on the health of a population".[12] There are many other definitions of HIA.[6,13] Still, most researchers would agree on two central features of HIA as suggested by Kemm and Parry:[6]

- It attempts to predict the health consequences of different options.
- It is intended to influence and assist decision-makers.

According to the data collected, the Gothenburg Consensus still provides a general framework of orientation for HIA according to the analysis of policy documents, legal acts and other key supportive documents for many countries. In seven countries, the Gothenburg Consensus plays an explicit role in the description or definition of HIA.

The use of the English term "health impact assessment" is widespread; it is used in 16 countries. Among these countries, 11 also translate the term into the national language. The remaining five countries use the term exclusively in their own language. However, as the German and Swiss case study shows (see Box 11.1), translations may have strategic connotations, and these connotations may have consequences on the use of HIA. Additionally, the Danish case study (see Box 11.2) provides an example of a translation that may cover activities not considered as HIA in other countries.

Differences in aims and values of HIA in the documents

While there is a lot of uniformity in the use and definitions of HIA, there are marked differences in the aims and values. The influential Merseyside Guidelines have strongly emphasized the case for explicit values and equity:[14]

> The aims of public policy dictate that HIA should openly declare its values and that social, material, and environmental equity should feature strongly among them. This is because public policy impacts disproportionately on the already disadvantaged. Consistent with the adoption of an equity-focused approach are the use of participatory methods which fully involve those affected by the public policy at every stage of assessment, and openness of all stages of the HIA process to public scrutiny.

The Gothenburg Consensus stresses the importance of values as well, focusing on democracy, equity, sustainable development and ethical use of evidence.

Box 11.1 *Case study of the terminology and definition of health impact assessment in Germany and Switzerland*

In German, *Gesundheitsverträglichkeitsprüfung* (GVP) is often used for the translation of HIA and roughly means "examination of acceptability from a health perspective". The term was created in analogy to *Umweltverträglichkeitsprüfung* (UVP). UVP is a widely accepted and officially used translation of EIA, which is a legal obligation in the Member States of the European Union. The analogy was strategically intended to suggest that GVP is similar to or part of UVP and therefore holds comparable importance and legal implications. It is clear that both German terms are far from being "literal" translations, and the term GVP met with a lot of criticism. First, it evokes bureaucratic and "red-tape" associations. Second, sometimes the very existence of GVP is questioned since there is no legal basis. Still others claim that nearly every UVP already constitutes a GVP, simply because it considers noise and pollution levels relevant to human health. In short, GVP is a problematic term. Therefore, in the scientific debate, one often uses the English term HIA. In practical applications, a variety of alternative terms exist, for example *Mitwirkung in Planung*, which looks at the entire planning process but has a more legal and administrative context. Switzerland has adopted the German GVP for its German-speaking regions. It is considered as a translation of HIA, despite the fact that HIA is translated into the three regional languages.

Box 11.2 *Case study of the terminology and definition of health impact assessment in Denmark*

In Denmark, the definition of HIA often comes from the Gothenburg Consensus Paper and is translated into Danish. The official translation is *sundhedskonsekvensvurdering*. In addition, the term *sundhedsmaessige konsekvenser*, which means health-related consequences, is often used. However, it tends to be applied more in relation to economic evaluation. The term "health impact assessment" can be found in literature and database searches that focus more on economic and environmental areas than on health. The terminology restricts the scope of HIA and therefore the broader social determinants of health are not addressed.

For the analysis of aims and values, a synopsis of five objectives was drawn from the literature[6, 15] as presented in the row headings of Table 11.2. However, not all countries, reference regions and reference localities have relevant documents such as governmental policies, strategy documents or delivery plans, so it was not always possible to identify the objectives of HIA in a given country. Also, in some countries, either the regional or the local level is not concerned with decision-making, while in other countries decision-making bodies exist at all three levels.

Table 11.2 *The objectives of health impact assessment as reported in the analysed sample of documents*

	National level	Reference region	Reference locality
Countries with relevant documents included in the analysis	16	8	11
Objectives in documents			
To maximize health gain or minimize loss	9	3	6
To tackle health inequalities and inequities	8	4	3
To raise awareness among decision-makers of the relationship between health and the physical, social and economic environment, thereby ensuring that they always include a consideration of health consequences in their deliberations	11	6	8
To help decision-makers identify and assess possible health consequences and optimize overall outcome of a decision	12	6	4
To help those affected by policies to participate in policy formulation and contribute to decision-making	5	2	2

The small number of documents available makes it difficult to provide numerical comparisons of objectives. However, it can be seen from the available data that objectives that related to the decision-makers (to raise awareness among decision-makers and to help decision-makers) ranked particularly high at all levels. This is important as it stresses the objective of HIA to influence the decision-making process. However, other objectives such as equity and participation are less frequently mentioned.

The practice of HIA values

Equity and participation are issues that have attracted a lot of attention in the debate on HIA. In the policy documents, regulations and other supporting documents analysed, equity and participation ranked surprisingly low. The purpose of the analysis of the individual 158 HIAs was to clarify the role of equity and participation in the practice of HIA.

Equity

Equity is a highly debated issue in the literature on HIA. However, the analysis of objectives of HIA has revealed that not all policy documents, regulations and other HIA documents place equity equally high on the agenda. It has been

Table 11.3 *Factors to stratify health impact assessment in order to take health inequalities into account*

	Stratified by conventional factors	Stratified by specific factors
National level	4	24
Reference region	6	9
Reference locality	17	17

argued that analysing the distribution of health impacts over various groups is a complex, scientifically demanding and time- and resource-consuming task. It is assumed that the equity claim often falls short in the execution of HIA.

In contrast to the analysis of the objectives of HIA, most of the HIAs identified by the project had an equity concern. The identified 158 HIAs were analysed to see if they were stratified by group in order to take inequalities into account. Stratifying the population is a condition for assessing the distribution of health impacts over a given population. Conventional factors for stratification are, for example, gender, age and socioeconomic group. However, specific interventions may require specific stratification. A policy that may increase exposure to pollution may have severe health impacts for those who already suffer from a respiratory condition, while the health impact for others may be negligible. A total of 71 HIAs reported the stratification of the population either into conventional or special categories highlighting the general concern for equity. In six cases, both conventional and special categories were employed (see Table 11.3).

The Welsh case study (see Box 11.3) provides an example of a health inequality impact assessment (HIIA).

Participation

Participation is also a highly debated issue in HIA and one that can be addressed from different angles. There is a strong emphasis on democracy as a value in itself. Whenever possible, citizens should have a say in the decision. From a more technical point of view, it is argued that the affected population is an important source of information. Learning about the concerns of the affected population and stakeholders may help to get a better understanding of the consequences of the pending decision. This is especially helpful in identifying vulnerable groups in the affected population and assessing the distribution of impacts on the population. A third approach discusses the value of community development. The involvement of stakeholders and the affected community has positive secondary effects. Strengthening communities

Box 11.3 *Case study of health inequality impact assessment in a road construction project in Wales*

Reducing health inequalities is one of the priorities of the Welsh Assembly Government. HIAs that focus on the health equity impact of specific measures are an important way of achieving this. An HIIA was applied to analyse the impact of a road construction project that would link the motorway between Cardiff and London. The road would be located very close to a housing area that consisted primarily of rental units, leased out on the basis of social criteria. The area suffered from high levels of unemployment and very low incomes. A rapid HIIA, initiated by the local residents' association, was carried out, using the Bro Taf method. This was devised in the former Bro Taf health authority area of Wales, and has been somewhat expanded and revised to become a useful source of information alongside Wales' national guidance on HIA.[16] One of the main tasks of the HIIA was to discuss and document health impacts on the already vulnerable. The HIIA took into account issues such as the health impacts of pollution, and noise and physical activity levels. The evidence collected led to the conclusion that the road construction project would have negative health impacts on the local population. The outcome of the HIIA was positive in that it empowered a vulnerable group to raise their concerns, while making planners aware of the impact of their activities. The road has not been built, although it is uncertain to what extent the results of the HIIA influenced this decision.[17, 18]

by including them in the decision-making process may raise awareness of health issues and strengthen the community's capacity to tackle these issues. Related to this is the assumed capability of participation in an HIA that may help to resolve conflicts within a given community. The project shows the majority of the HIAs reported were participatory: 102 out of 158; 29 were not participatory and in 27 cases it was unclear, or data were insufficient to assess the participatory nature of the HIA.

While participation does not feature highly on the policy documents identified, it is indeed an important feature of HIA in practice as seen from the project data. Participation seems particularly strong at local level, as seen in Figure 11.2, where it appears that HIA at the reference localities tended to use a more participatory approach than at the reference regions.

In the analysis, three forms of participation were distinguished: the right to be informed, the right to be heard and the right to decide. According to the data the right to be informed goes hand in hand with the right to be heard. This implies a rather active involvement of stakeholders and the affected populations. In most cases, after the completion of the HIA, the report was made available to the public. In 70 cases, both rights were exerted stressing the importance of community-based involvement in strengthening the HIAs'

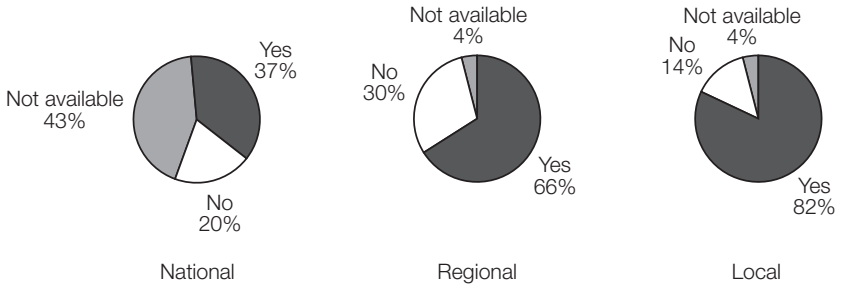


Figure 11.2 *Community and stakeholder participation in health impact assessment as reported in the fact sheets*

recommendations to allow them to be tailored closely to the needs of the current population. The right to decide was identified in only 11 cases implying that this is a more difficult area to address. It is clear that participation and transparency are closely connected and the project results highlight this with 138 out of 158 HIA reports being made available to the public.

HIA settings: levels and sectors

The relevance attached to HIA is at least partly owed to its assumed capacity to be used as a universal mechanism that can be applied equally to all sectors. Case studies in the literature range from supranational,[19, 20] national[21] and regional to local HIAs. They deal with issues such as the common agricultural policies,[22] accession to the EU,[23] extension of airports,[24] urban reconstruction schemes[25] or the proposed burning of old tyres in a cement plant.[26] This raises the question: are these exceptional cases or does this reflect common practice with respect to HIAs?

Levels

Among the 158 HIAs included in the mapping exercise, 54 were conducted at national level, 23 at regional level and 81 at local level. While the results need to be carefully interpreted in the context of the methodologies employed, it was expected that at national level HIA would be more prominent, as this level was searched comprehensively. Since only one reference region and one reference locality were selected per country, it is not possible to extrapolate this information within countries and/or between countries. However, it is interesting to note that relatively more HIAs were taking place at these levels. There are differences in institutional settings in some countries, where decision-making and HIA only take place at two levels, meaning that in

Box 11.4 *Case study of national and regional levels of health impact assessment in Slovenia*

Slovenia has a long tradition of assessing impacts on health. Procedures are, however, embedded in the legislation and are only partially comparable with HIA methodology. The Ministry of Health of Slovenia has started to implement HIA as a method at national level. A model of HIA on food and agricultural policies related to accession to the EU has been developed. The process resulted in better cooperation between the agricultural and health sectors. The outcome of this cooperation was the inclusion of the food security pillar as an important part of the resolution on the national food and nutrition action plan. Similar to the national level, comparable procedures for accessing impacts on health have been used at regional level, where Slovenia came the closest to HIA in the area of environmental issues. In some regions, long-term measures were put in place to access the impact of environmental policies such as waste management, air pollution and drinking water management. In these cases, efforts to reduce environmentally related harm were at the forefront of the country's attention with the aim of preventing direct negative impacts on the health of the exposed population. In these activities, regional development agencies with their intersectoral potential have been recognized as an important partner for future structural capacity building in support of HIA.

addition to the national level, HIA is only taking place either at regional or local level, as the Slovenian case study shows (see Box 11.4).

In general, the data obtained from the analysis of the 158 HIAs suggest that HIA is in fact taking place at all levels but that HIAs at national level are rather scarce. There could be a variety of reasons for this, including the possibility of a lack of support for HIA at national level or the fact that many countries are still in the infancy stages of implementing HIA.

Sectors

Health impact assessment is viewed as a key mechanism for intersectoral health. Does HIA keep its intersectoral promise? Is it really applicable to a large variety of sectors? From the project data, HIA is found to be fulfilling its intersectoral promise and is conducted in a variety of sectors. Overall, HIA is most commonly found in the transport, housing and urban planning, environmental and multisectoral sectors. Most of the HIAs reported were carried out outside of the health and social sectors (see Table 11.4).

Depending on the level, some sectors are more prominent than others. At national level, the four main sectors are transport, housing, finance, and health. At regional level, employment is the most common sector, followed by transport, social

Table 11.4 *Sectors of health impact assessment*

Sector		Transport	Housing/ urban planning	Environment	Multisectoral	Health/other	Employment	Social care	Finance	Energy	Agriculture	Industry	Eduction	Tourism
Number of HIAs	27	23	18	17	14	10	10	8	8	7	7	4	3	2

care and environment.* At local level, housing is the most common sector, followed by multisectoral, transport and the environment. However, all these data have to be interpreted with great care owing to the small number of cases and the aforementioned methodological limitations. Still, the analysis provides evidence that it is possible to conduct HIA in a large variety of sectors.

Transport can be found at all levels, which shows that there are health concerns at all levels when transport issues are involved. The Austrian (see Box 11.5) and Belgian (see Box 11.6) case studies illustrate this.

Box 11.5 *Case study of the transport sector in Austria and five other European countries*

Austria is extensively affected by transit and transport policies and most of the HIAs are aimed at this sector. However, the lack of consistent methods to assess the overall health impacts of transport policies has led to a conglomeration of different concepts, ranging from narrow mono-disciplinary expertise to comprehensive interdisciplinary assessments. A transnational project (Austria, France, Malta, the Netherlands, Sweden and Switzerland), coordinated by Austria, started in 2003. The aim of the project was to provide a review on transport-related health impacts, costs and benefits and to make a set of evidence-based recommendations on political implementation strategies with a particular focus on children. Along with the review of the scientific literature, the project facilitated a series of four two-day workshops in which the participants were experts and stakeholders on health, transport, environment, economy, children's affairs, scientists, governmental and nongovernmental representatives, and representatives from the Organisation for Economic Co-operation and Development (OECD), United Nations Economic Commission for Europe (UNECE) and World Health Organization (WHO). A comprehensive brochure covers the main outcome, conclusions and recommendations. The results were presented at the Fourth WHO Ministerial Conference on Environment and Health in 2004.

* An extended HIA is sometimes conducted in the framework of environmental impact assessment.

Box 11.6 *Case study of the transport sector in Belgium: Brussels Airport*

In the area around Brussels Airport, nightly air traffic has economic advantages due to employment. The negative health and economic impacts have not been directly investigated. A health economics impact model was developed in order to assess the burden related to sleep disturbance due to noise from airplanes. Data were based on observed noise levels in the area around Brussels Airport and published relationships between noise levels and the probability of sleep disturbance. Hence, per town or village in the area, the incremental percentage of the population suffering from sleep disturbance was calculated. Based on literature, a causal relationship was found between sleep disturbance and alcohol abuse, heart disease, diabetes, depression and overall mortality. Hence, owing to the excess in sleep disturbance, 2644 more alcohol abuse patients, 758 more patients with heart disease, 580 more cases of diabetes, 5492 more incidents of depression and 215 more deaths occurred in the area. As these diseases are associated with direct medical costs and with productivity-related costs, the total societal impact was estimated at €149 991 730. The health impact was found to be higher than originally expected, and the negative economic consequences of the health impact were taken into account when looking at the positive employment effect.

Differences in timing, stages and types of HIA

This section reviews the timing of HIA, the use of stages (screening, scoping, assessing, reporting, evaluating) and the use of different types of assessment.

Prospective timing

There has been a long conceptual debate on the timing of HIA. While it is generally accepted that HIA is prospective, it has been argued that there may be the need for concurrent or retrospective HIA. Concurrent HIA is conducted during implementation to identify changes as they occur and allow for action to be taken. Retrospective HIA is carried out after the proposal has been implemented; this may be more of an evaluation exercise which can, in turn, influence similar future decisions. Although HIA can be defined differently in a multitude of countries, the Gothenburg Consensus is seen to be widely accepted. The project results indicate that most countries do indeed conduct HIA prospectively in order to influence decision-makers. Based on the 158 fact sheets, HIA timing is predominantly prospective (65%). However, in some countries – such as Austria, Belgium, the Netherlands, Slovakia, Slovenia and Switzerland – the HIAs tend to be conducted concurrently or retrospectively. Countries that report concurrent or

retrospective HIAs may see HIA as a form of evaluation rather than a tool to influence current decision-making. Alternatively, they may have planned to start – or may have started – the HIA prospectively, but owing to time constraints or other factors the project carried on and the HIA was therefore conducted concurrently or retrospectively. An example of this can be seen in an HIA conducted on traffic and transport in the Republic of Ireland. While it was intended to conduct the HIA prospectively, by the time an agreement was reached by the different stakeholders, the project had gone ahead, but it was decided it was still worth pursuing retrospectively.

Stages

According to the Gothenburg Consensus, HIA is conducted in five stages. The first stage – screening – primarily filters out proposals that do not require HIA, so that scarce resources are used efficiently. Screening encompasses identifying the elements or aspects of the proposal to be assessed such as the aims and objectives of the HIA, the values underpinning the HIA, etc. The second stage – scoping – serves to determine the methods that need to be used. The third stage – appraisal or assessment – identifies and calculates the health impacts of a proposal. The fourth stage – reporting – focuses on preparing and submitting the report with its recommendations integrating the information obtained from stakeholders during appraisal. For the submission, it is necessary for the report to be submitted within the schedule set for the relevant decision-making process. Submission of the report to decision-makers is the primary mechanism by which the outputs from appraisal influence proposal development and/or implementation. The fifth stage – monitoring and evaluation – has several components: process evaluation assesses how successful the process was in practice; impact evaluation monitors the acceptance and implementation of recommendations; and outcome evaluation monitors indicators and health outcomes after the proposal has been implemented.[15]

Table 11.5 shows that scoping, appraisal and reporting are the most widely used stages of HIA. The evaluations of HIAs (both process and outcome evaluations) are minimal, most likely due to limited financial and personnel resources remaining once the HIAs are completed. Not all HIAs followed all the stages. In only 39 cases, four stages of the HIA were completed, and all five stages were completed in only 29 cases.

Types of HIA

According to the conceptual framework based on a review of key documents, three types of HIA were distinguished in the research.

Table 11.5 *Stages of health impact assessment as reported in the fact sheets*

Stage completed	Screening	Scoping	Appraisal	Reporting	Evaluation
Yes	84	102	122	138	49
No	69	51	31	13	95
Not available	5	5	5	7	14

The first type is a mini or desktop HIA. It can be defined as "a brief investigation of the health impacts of a proposal" and usually involves an exchange of existing knowledge and expertise, and research from previous HIAs. This process usually takes a few days to complete.

The second type is a standard or intermediate HIA. It can be defined as "a more detailed investigation of health impacts" and usually involves a review of the available evidence, exploration of opinions, experiences and expectations, and sometimes the production and analysis of new information. This more lengthy investigation can take weeks to complete.

The third type is a maxi or comprehensive HIA. It can be defined as "an intensive investigation of health impacts undertaken over an extended period" and usually involves a review of the available evidence base along with the other elements mentioned under the second type. In addition, it also involves the production and analysis of new information and may take months to complete.

In the HIAs reported (see Figure 11.3), the most commonly used type of HIA at national level and in the reference localities was the standard or intermediate (22 HIAs out of 54 at national level and 35 out of 81 at local level). At regional level, however, the mini or desktop HIA was used most frequently (13 out of 23). The full-scale HIA known as maxi or comprehensive was used less frequently than other types. This may be a result of the maxi HIA taking a considerable amount of time, and being seen as a possible drain on staff and financial resources. From the project data, Italy, England and Spain (HIAs in the sample) were the three countries that exceptionally undertook most of their HIAs as maxi or comprehensive. Not all countries are able to allocate the necessary resources for such an exercise, therefore the limitations of the HIA must be taken into account.

The Finnish case study (see Box 11.7) provides an example of a mini HIA at national level.

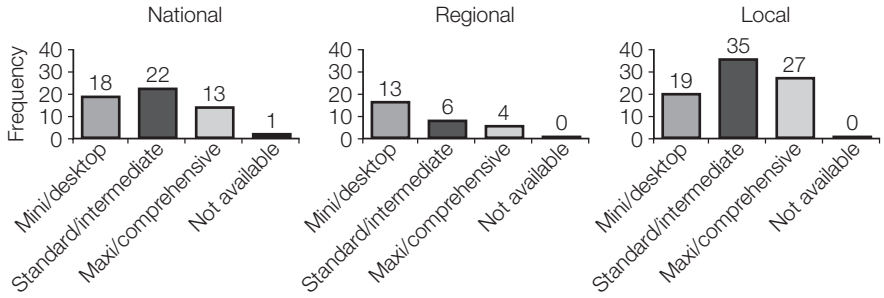


Figure 11.3 *Types of health impact assessment by level as reported in the fact sheets*

Box 11.7 *Case study of a mini health impact assessment at national level in Finland*

In Finland, it is a common practice that a (mini) HIA is a part of the more comprehensive assessment process (EIA, Strategic environmental assessment [SEA]). The assessment is also usually integrated into the preparation of the proposal and report as in this example of the "housing policy programme approved by the government for 2004–2006". The Ministry of the Environment commissioned the assessment of the housing policy programme. It established a special working group for conducting the HIA. The Ministry consisted of experts from various sectors and institutions like the Ministry of the Environment, Ministry of Social Affairs and Health, an association of residential property managers, etc. The working group developed both the programme and its assessment. The group functioned as an expert panel and prepared the programme in six months. An assessment expert from the Ministry of the Environment made the appraisal of economic, environmental and human impacts by himself in one day. The appraisal was discussed and approved by the working group during one meeting and they submitted the programme to the government. The working group identified impacts on regional policy as well as socio-political impacts (that is, impacts on housing of different population groups and equitable housing policy). The assessment paid attention to housing of low-income people and specific groups. The impacts on health and living conditions were also assessed.

Conclusion

The mapping exercise presented in this chapter provides an overview on the use of HIA in Europe. The data have to be interpreted with great care, especially since only one reference region and one reference locality were investigated per country. Furthermore, HIAs that are fully integrated in administrative procedures may not leave any trace in terms of a report or a publication and can therefore not be included in the analysis.

However, despite these limitations, two conclusions regarding the current use of HIA can be drawn. First, HIA has proven its capacity to be used in various

countries at various levels and in various sectors. Equity and participation, two values which are widely discussed in the debate on HIA, play a substantial role in the practice of HIA. The evidence also provides insight into the timing, stages and types of HIA. Despite all the variations reported, HIA can, in principle, be used prospectively, cover all stages and use different types of HIA.

Given the long period covered by the research, it is surprising that only a few countries have used HIA extensively. This uneven development may have different reasons. In some countries, HIA development started much earlier than in others. Some have a long track record in using HIA while others are just about to develop HIA. These differences may be due to a lack of government support, funding, capacity building and establishing mechanisms for delivery. However, they may also reflect the difficulty HIA has in proving its usefulness to other sectors and to therefore become a systematic part of the policy-making process, rather than a tool that is employed on an ad hoc basis for pilot studies.

But is HIA a tool for HiAP? In many countries key policies are formulated at national level. Little HIA activity has been reported at national level although this level was researched comprehensively. Policy-making also takes place at subnational level. Owing to federalization, decentralization and devolution, important political accountabilities and competencies can be found at regional level. It is not possible to extrapolate the results from the reference regions to all other regions but the information provided raises some scepticism of the current use of HIA as a tool for HiAP. In fact, most HIAs identified were conducted in the reference localities.

Secondary contributors to this chapter

Elisabet Aldenberg, Swedish National Institute of Public Health, Sweden; Francisco Barroso Martin, Técnicas de Salud S. A., Spain; Ceri Breeze, Welsh Assembly Government, Wales, United Kingdom; Edit Eke, Semmelweis University, Hungary; Alison Golby, Cardiff University, Wales, United Kingdom; Loes M van Herten, TNO Quality of Life, The Netherlands; Jarmila Korcova, Trnava University, Slovakia; Owen Metcalfe, The Institute of Public Health in Ireland; Ewa Nowak, CM Jagiellonian University, Poland; José Pereira-Miguel, University of Lisbon, Portugal; Roberta Siliquini, University of Turin, Italy; Marius Strička, Kaunas University of Medicine, Lithuania; Lorraine Taylor, Former Health Development Agency, United Kingdom.

REFERENCES

1. WHO Regional Office for Europe. *Health21: the health for all policy framework for the WHO European Region*. Copenhagen, WHO, 1999.
2. Commission of the European Communities. *Communication from the Commission on Impact Assessment*. COM(2002) 276 final, 2002.
3. Secretary of State for Health. *Saving lives: our healthier nation*. Vol. Cm 4386. London, The Stationery Office, 1999.
4. Fehr R, Mekel O, Welteke R. HIA: the German perspective. In: Kemm J, Parry J, Palmer S, eds. *Health impact assessment*. Oxford, Oxford University Press, 2004:253–264.
5. Thriene B. GVP in Sachsen-Anhalt. In: Fehr R, Welteke R, eds. *Workshop Gesundheitsverträglichkeitsprüfung – Health Impact Assessment*. Bielefeld, Landesinstitut für den Öffentlichen Gesundheitsdienst NRW, 2003:83–88.
6. Kemm J, Parry J. What is HIA? Introduction and overview. In: Kemm J, Parry J, Palmer S, eds. *Health impact assessment*. Oxford, Oxford University Press, 2004:1–13.
7. Wismar M. The effectiveness of health impact assessment. *Eurohealth*, 2005, 10(3–4): 41–43.
8. Kemm J, Parry J. HIA and urban regeneration: the Ferrier estate, England. In: Kemm J, Parry J, Palmer S, eds. *Health impact assessment*. Oxford, Oxford University Press, 2004: 299–308.
9. Elliott E, Francis S. Making effective links to decision-making: key challenges for health impact assessment. *Environmental Impact Assessment Review*, 2005, 25(7–8):747–757.
10. EuroHealthNet. *Health impact assessment and government policymaking in European countries: a position report*. Cardiff, Public Health Strategy Division, Office of the Chief Medical Officer, Welsh Assembly Government, 2003.
11. Nilunger L, Schäfer Elinder L, Pettersson B. Health impact assessment: screening of Swedish governmental inquiries. *Eurohealth*, 2003, 8(5):30–33.
12. Health impact assessment: main concepts and suggested approach. Gothenburg consensus paper, December 1999. In: Diwan V et al., eds. *Health impact assessment: from theory to practice*. Göteborg, Nordic School of Public Health, 2001:89–103.
13. Krieger N et al. Assessing health impact assessment: multidisciplinary and international perspectives. *Journal of Epidemiology and Community Health*, 2003, 57:659–662.
14. Scott-Samuel A, Birley M, Ardern K. Merseyside guidelines for health impact assessment. Liverpool, Merseyside Health Impact Assessment Steering Group/Liverpool Public Health Observatory, 1998.
15. Mindell J, Ison E, Joffe M. A glossary for health impact assessment. *Journal of Epidemiology and Community Health*, 2003, 57:647–651.
16. *Improving health and reducing health inequalities: a practical guide to health impact assessment*. Cardiff, Welsh Assembly Government, 2004 (http://www.cmo.wales.gov.uk/content/work/health-impact/improving-health-e.pdf).

17. Fosse E. *Social inequality in health as a theme of health impact assessments. Tools and experiences in some European countries*. Report to the Norwegian Directorate of Health and Social Affairs, 2005.

18. Lester C, Temple M. Rapid collaborative health impact assessment: a three-meeting process. *Public Health*, 2004, 118(3):218–224.

19. Hübel M, Hedin A. Developing health impact assessment in the European Union. *Bulletin of the World Health Organization*, 2003, 81(6):463–464.

20. Mekel O et al. *Policy health impact assessment for the European Union: pilot health impact assessment of the European Employment Strategy in Germany*. Liverpool, UK, IMPACT, University of Liverpool, 2004.

21. Roscam Abbing EW. HIA and national policy in the Netherlands. In: Kemm J, Parry J, Palmer S, eds. *Health impact assessment*. Oxford, Oxford University Press, 2004:177–190.

22. Dahlgren G, Nordgren P, Whitehead M. *Health impact assessment of the EU Common Agricultural Policy*. Stockholm, National Institute of Public Health, 1996.

23. Lock K et al. Conducting an HIA of the effect of accession to the European Union on national agriculture and food policy in Slovenia. *Environmental Impact Assessment Review*, 2004, 24(2):177–188.

24. Abdel Aziz MI, Radford J, McCabe J. The Finningley Airport HIA: a case study. In: Kemm J, Parry J, Palmer S, eds. *Health impact assessment*. Oxford, Oxford University Press, 2004:285–298.

25. Bekker MPM, Putters K, van der Grinten TED. Evaluating the impact of HIA on urban reconstruction decision-making. Who manages whose risks? *Environmental Impact Assessment Review*, 2005, 25(7–8):758–771.

26. Cook A, Kemm J. Health impact assessment of proposal to burn tyres in a cement plant. *Environmental Impact Assessment Review*, 2004, 24(2):207–216.

Chapter 12

Implementing and institutionalizing health impact assessment in Europe

*Matthias Wismar, Julia Blau, Kelly Ernst, Eva Elliott, Alison Golby, Loes van Herten, Teresa Lavin, Marius Strička, Gareth Williams**

Introduction

The purpose of this chapter is to analyse implementation and institutionalization of health impact assessment (HIA) in Europe.† It will support the debate on how to advance with HIA developments in the countries concerned and how HIA can contribute to Health in All Policies (HiAP). The chapter will also raise the question as to whether institutionalization is really a tenable option for all countries included in the research, given the differences in current developments (as highlighted in Chapter 11).

The debate on implementation has centred on the issue of institutionalizing HIA. Institutionalizing is a multifaceted concept defined in various ways by disciplines such as sociology, political sciences and organizational theory.[1] In the context of the debate on HIA, institutionalizing means the systematic integration of HIA into the decision-making process. Health impact assessment would have to become part of the rules and procedures normally followed by the different decision-making bodies involved in order to realize its potential to catalyse intersectoral action for health.[2]

Institutionalization as an approach is not unchallenged. It has been argued that it may restrict the scope for political advocacy since it requires an impartial role of the HIA practitioner (see Chapter 10). It has also been

* Secondary contributors to this chapter are listed at the end of the chapter.

† The research presented in this chapter has received funding from the European Community under the Public Health Work Programme (grant agreement 2003101). The sole responsibility lies with the authors.

stressed that prior to institutionalization, methodological standardization is required. However, many methodological issues are still the subject of scientific debate. Among these are the quality of prediction, the quantification of impacts, the analysis of distribution of impacts over a given population, the role of the practitioner and participation.[3, 4] Moreover, it has been stressed that each country will need to find its own approach to institutionalizing HIA according to the specific domestic contextual circumstances.[2] While these arguments are all valid, institutionalization remains an important if not key perspective for HIA. First, if conducted on an ad hoc basis there is the danger of opportunistic HIAs. Health impact assessments may only be initialized if the outcome is expected to support a preferred policy decision. This reduces the potential of HIA substantially. Second, it is doubtful if criteria-based priorities can be addressed by HIAs conducted on an ad hoc basis. Even the undertaking of a large number of HIAs in a given country does not necessarily mean that those policies and decisions, which matter most in terms of health consequences and should therefore be prioritized, are subject to an HIA. Third, if not institutionalized, HIAs will depend on proactive political leadership, administration and communities, but these circumstances cannot be expected everywhere. Fourth, if not institutionalized, positive developments may become easily subject to political volatilities and be reversed quickly. Fifth – and this is probably the experience many HIA practitioners can relate to – if not institutionalized there is little leverage for the results of the HIA predicting serious negative health consequences of a pending decision being taken into consideration by the decision-makers. All of this does not mean that HIAs conducted on an ad hoc basis have no value. The point is that ad hoc HIAs have their limits.

The key message of the chapter is that it is possible to institutionalize HIA. There is evidence that some countries have at least partially institutionalized HIA. However, despite these promising examples, it remains doubtful if institutionalization of HIA is currently an option for all countries. Institutionalization requires firm political commitment and strong stewardship. It also requires investment into HIA and resource generation. Institutionalization does not come about without effort and does require constant support. It should also be taken into consideration that some countries have a stronger public health culture and capacity in support of institutionalization than others.

Summing up the evidence presented later in this chapter, HIA implementation and institutionalization are incomplete in all countries. None of the countries have strengthened and developed all the stewardship, funding, resource generation and delivery in full. This is an important limiting factor

for HIA activities. The variations in implementing HIA explain the uneven distribution of HIA activities across Europe as reported in Chapter 11. However, despite the incompleteness, there is evidence that some countries have made progress in implementing and institutionalizing HIA. Stewardship for HIA has been strengthened in many countries by national, regional and local governments. However, HIA is not always endorsed at subnational levels. In some cases, policy has not resulted in regulation and in other cases, regulation seems to come without vision and policy. Apart from some notable exceptions, the provision of HIA-related basic health intelligence is currently underdeveloped. Financing remains a key issue and limiting factor to the implementation of HIA. So far, only a handful of countries have invested in HIA in terms of securing and providing dedicated and substantial budgets both for generating resources and conducting HIA. Moreover, solid information on the costs of different types of HIA is still scarce. Resource generation and capacity building are supported by a multitude of organizations and institutions. In some cases, there is evidence of complementary or coordinated activities. According to the data from the sample, the delivery of HIA is relatively strongly developed. The evidence shows that most countries have established "lead agencies" which can act as focal points exerting technical leadership and providing support regarding conducting, organizing, managing, commissioning and supervising the HIA. For the choice of assessors, a multitude of different options were reported. These options, depending on the type and topic of HIA, include administrators, state institutes, universities, private research companies and freelance scientists. Some countries have managed to establish a close link between the pending decision and the triggering of the HIA process. However, in most countries, this link is less solidly institutionalized and makes HIA dependent on proactive initiatives. Similar to the link between a pending decision and triggering the HIA process, some countries have managed to establish a close link between the assessment and the reporting of the HIA to the decision-makers.

This introduction is followed by a brief mention of the data and methodology and a section on comparing HIA implementation and institutionalization. The results are presented in four subsections on selected aspects of stewardship, funding, capacity building and delivery of HIA. Finally, the results will be discussed in regard to HiAP and further developments of HIA.

Data and methodology

The results and analysis presented in this chapter are based on an explorative mapping exercise conducted in 2005. The methodology is explained in detail

in Chapter 11. The limitations to this mapping exercise, as pointed out in Chapter 11, apply equally to both chapters. To avoid misunderstandings, three limitations in regard to the representativeness of the results have to be highlighted.

First, while the national level has been researched comprehensively, research at subnational levels focused on a single reference region and reference locality. Therefore, variations within countries at subnational level cannot be analysed.

Second, starting from the assumption that the implementation and institutionalization of HIA may assume different forms in different countries and at different levels, the imposing of a single HIA definition was avoided. Research teams were asked to include HIAs according to their domestic definition. Indeed, HIA is integrated in some countries in environmental HIA, human impact assessment or other forms of integrated impact assessment. Therefore HIAs included in the sample may show substantial variations. Since the exact purpose of this research was to gain a better understanding of the various forms of implementing and institutionalizing HIA, it is important to report and analyse these variations.*

Third, not all countries have completed the questionnaire. For Hungary, information was only researched at national level and the information on Portugal is incomplete. Despite all aforementioned limitations, it should be noted that this is the most comprehensive and detailed mapping exercise dealing with implementation and institutionalization of HIA in Europe.

Comparing implementation and institutionalization of HIA

There is currently no established conceptual framework for analysing implementation and institutionalization of HIA. In order to facilitate analysis and comparison, this chapter draws on concepts developed in health systems research.[5] In health systems research, it is assumed that systems work to achieve specific goals such as the health of the population, the nonmedical expectations of patients and citizens or the fair distribution of the financial burden of health systems expenditure. Achievement of these goals will depend on the development of four functions. These four functions are: stewardship, sometimes used interchangeably with good governance; financing; resource generation; and delivery. These functions can be subdivided into many detailed tasks. The research has focused on a selection of key tasks and aspects of these

* Employing the domestic definition of HIA as an inclusion criterion has important consequences. According to the strict definition of HIA in Swedish public health policy, issues of gender and equity shall be included in the assessment. Therefore many of the environmental impact assessments (EIAs) including a health component conducted by the Swedish Road Administration and other public authorities were not included in the research.

functions, while some of the case studies presented in the chapter provide a broader picture on the functions.

One of the reasons for using this conceptual framework is the degree of abstraction. It allows comparison between diverse forms of implementation and institutionalization. This is important given the institutional, social and economic diversity of Europe. It is also important to use abstract categories for the analytical framework to avoid imposing strict definitions of HIA. This would not allow for identifying and analysing the assumed diversity of institutionalizing and implementing HIA.

Selected aspects of stewardship for HIA

Stewardship is a function which is primarily, but not exclusively, conducted by the government. In broad terms, it is concerned with the welfare of the population. In this regard, stewardship shall provide the framework, support and supervision for integrating HiAP. Stewardship can be divided into three tasks: policy formulation (vision, values, policies, evaluation, etc.), exerting influence (promoting the issue, paralleling political processes, involving stakeholders, consensus building, setting incentives and sanctions, etc.) and gathering and providing health intelligence.[5–7] The following two subsections focus on selected aspects of stewardship. In the first subsection, the existence of policies, regulations and other means of endorsement for HIA are reviewed. This is followed by a second subsection which provides an overview on selected aspects of health intelligence for HIA.

Policies, regulations and other means of endorsement

To understand how governments and ministries fulfil their stewardship roles, an analysis of the means of HIA endorsement was conducted. Do governments support the development of HIA by some kind of official document and if so are they employing policies, regulations* or other means of endorsement in order to provide a framework and basis for action for HIA.

As presented in Table 12.1, almost all of the countries included in the research had at least a policy, regulation or other means of endorsement either at national level or at the level of the reference region or reference locality.

A well-known example of a policy that includes HIA is *Saving lives: our healthier nations*,[8] policy in England from 1999. This policy has been superseded by a more recent public health policy, which is suggesting that

* Regulation was interpreted in the broader sense as a legal instrument.

Table 12.1 *Policy, regulation or other means of endorsement to provide a framework and basis for action for health impact assessment*

	Austria	Belgium	Denmark	England	Finland	Germany	Hungary	Ireland	Italy	Lithuania	Malta	Netherlands	Northern Ireland	Poland	Portugal	Slovakia	Slovenia	Spain	Sweden	Switzerland	Wales
National	O	O		P	P	O	P	O		O	R	O	P	R	O	P	R		P		P
Reference region		R	O	O		R								R		R			P	R	
Reference locality		P	P			R			O	O		R	O	R		P			P		O

P, policy; R, regulation; O, other means of endorsement.

non-health sector impacts on health should be more routinely considered before implementation through HIA, for example. However, detailed provisions have not been made.[9] In Wales, HIA has been in policy documents since 1998 (see Box 12.1).

An example of a regulation at regional level is the Public Health Service Act of the reference region North Rhine Westphalia in Germany. It provides, in principle, a legal basis for HIA by stating that public health services shall contribute to all planning processes. A similar provision is made in the German state of Saxony-Anhalt.

Selected aspects of health information and intelligence for HIA

Requirements on health information and intelligence can be quite demanding. They may entail availability of information on population health status and health determinants, and if the HIA is conducted at regional and local levels, this information must be available for these levels too.

Apart from data on population health and determinants, health information and intelligence for HIA provide information on the planning and delivery of HIAs including, concepts, methods, tools and evidence. Across all countries, dedicated HIA web sites, HIA databases and HIA reviews or overviews were searched. No distinction was made between levels since it was assumed that health intelligence is a general task which can equally be used at national, regional and local levels (see Table 12.2).

Clearly, in many countries, HIA practitioners have received little support in regard to HIA-related health intelligence. They must rely on their personal experiences and their own networks when planning and conducting HIAs, or they have to use intelligence provided in other countries. However, this may involve problems of transferability.

Box 12.1 *Health impact assessment and governance in Wales*

The National Assembly for Wales was established in July 1999. It provides Wales with more control over its own affairs and enables it to set policies to meet its specific needs on a wide range of issues including health. The need to improve health and to reduce health inequalities has been one of its priorities from the outset. Several policy and strategy documents have emphasized the role of all sectors, all levels of government and all parts of society in improving health. Action to support people to take steps to improve their lifestyles is accompanied by wider action across policy areas to tackle social, economic and environmental health determinants. The Welsh Assembly is committed to developing more integrated policies and programmes and, as part of this, to the use of HIA.

Health impact assessment is seen as a practical and flexible approach that recognizes the realities and constraints of the planning and decision-making processes involved in the development of policies, programmes and other actions. The initial national guidance document, *Developing Health Impact Assessment in Wales*,[10] led to the implementation of a development programme. This included the creation of the Welsh Health Impact Assessment Support Unit. The use of HIA is promoted strongly in national and local policy documents and has a recognized importance within key national and local government bodies. At national level, the Welsh Local Government Association and the National Public Health Service for Wales support the use of HIA and work closely with the support unit. At local level, the 22 local authorities and their corresponding local health boards have a joint statutory duty to develop, implement and evaluate local health, social care and well-being strategies. Guidance issued for the strategies highlighted the role that HIA could play. In support of this, *Improving health and reducing inequalities: a practical guide to health impact assessment*[11] was written by the unit and published by the Welsh Assembly Government in November 2004.

The Welsh Health Impact Assessment Support Unit was set up to help organizations and groups outside the Welsh Assembly to understand and use the approach throughout Wales. It has a multifaceted capacity building programme. The Welsh Assembly funds the unit through the Wales Centre for Health, a new independent public body that focuses on addressing inequalities, providing information and advice to the public, developing networks and partnerships, undertaking and commissioning research, and contributing to public health training and education. Funding for the unit covers the costs of two development workers and provides resources for communication and dissemination, including a web site. The unit itself is based in the Cardiff Institute of Society, Health and Ethics in Cardiff University's School of Social Sciences. This maximizes the opportunities for, and links to, academic research alongside the need to develop a practical approach.

Table 12.2 *Selected aspects of health intelligence for health impact assessment*

	Austria	Belgium	Denmark	England	Finland	Germany	Hungary	Ireland	Italy	Lithuania	Malta	Netherlands	Northern Ireland	Poland	Portugal	Slovakia	Slovenia	Spain	Sweden	Switzerland	Wales
HIA web site				✓	✓			✓			✓	✓	✓						✓		✓
HIA database				✓	✓							✓									✓
HIA review/ overview	✓	✓	✓	✓	✓	✓						✓									✓

Funding and costs of HIA

The following subsection reviews funding arrangements for HIA in the countries included in the research. Information collected on the costs of the HIAs is also presented.

Funding

Health impact assessment budgets for sustained funding of support units, centres, institutes and other facilities are scarce, although England, Ireland, Northern Ireland, the Netherlands and Wales are exceptions. In some instances, a budget for HIA is reserved within the general budget of national or regional institutes. Money to conduct HIAs often comes from the regular budget of institutes or local administrations.

Budgets for HIAs were reported for eight countries at national level (see Table 12.3). Some reference regions and reference localities have reported budgets. However, they were not included in the table since, for these levels, it was assumed that there were hidden budgets that could not be identified. In most cases, quantification of the budgets was impossible.

Table 12.3 *Budgets for health impact assessment at national level*

	Austria	Belgium	Denmark	England	Finland	Germany	Hungary	Ireland	Italy	Lithuania	Malta	Netherlands	Northern Ireland	Poland	Portugal	Slovakia	Slovenia	Spain	Sweden	Switzerland	Wales
National				✓				✓				✓	✓	✓			✓			✓	✓

There is hardly a common approach between the countries regarding budgets for HIA as the following examples show. The Institute of Public Health in Ireland, which provides services for Ireland and Northern Ireland, receives funds for the development of HIA from the Irish Department of Health and Children and from the Northern Ireland Department of Health Social Services and Public Safety. There is a budget for funding the Welsh Health Impact Assessment Support Unit, which is provided by the Welsh Assembly Government. The budget holder is the Wales Centre for Health, a new national body whose main functions are to provide public health information, coordinate the surveillance of health trends and carry out risk assessments of threats to health and well-being, and to train and develop a multidisciplinary public health workforce. In Poland, the Ministry of Health provides funding in the framework of overall political accountability. The budget is held by the chief sanitary inspector. In Slovenia, at national level, the Ministry of Health provides a small budget for HIA for the National Institute of Public Health, defined according to working hours of the staff. However, this budget is not a regular budget but dedicated for special cases.

In England, the Public Health Development Fund provides finances for HIA. For the financial year 1999–2000, £9 million were allocated to support the public health strategy as a whole in areas such as HIA, the development of nine regional Public Health Observatories and the improvement of infection control.[8] Examples of Public Health Observatories' involvement in HIA include the London Health Observatory, which developed a programme of work and had a dedicated HIA facilitator attached to it, and the Yorkshire and Humber Public Health Observatory, which has recently secured funding for a post on health/integrated impact assessment.[12]

Budgets for HIA were also reported at national and local levels. In the German reference region North Rhine Westphalia, work on HIA is funded as part of the budget of the State Institute of Public Health, which is acting as the state health authority and participating in the financial budget of the State Health Ministry. In Switzerland, a budget comes from the Department of Health and Social Affairs and is managed within the public health office.

At local level in Belgium, the nongovernmental organization (NGO) Leuven Local Agenda 21 was reported as a budget holder for HIA. The budget comes from the City Council, which in turn receives its funds from different sources, such as the Flemish Government, the Government of the Province of Vlaams-Brabant and from the funds of cities and communities. For municipalities in Germany, the local health authority's budget is responsible for funding. In Finland, the city of Jyväskylä held the project budget.

Box 12.2 *Financing health impact assessment: the Netherlands*

The attention to HIA in the Netherlands can be separated into two periods. The first is from 1996 to 2003. In 1996, the Ministry of Health, Welfare and Sports installed an Intersectoral Policy Office at the National School of Public Health. This office was the governmental agency that was responsible for commissioning experimental HIAs on national policy proposals and developing HIA methodology, including building a network of relevant organizations for HIA. The Ministry of Health allocates a part of its budget to the Intersectoral Policy Office. The annual budget increased from €230 000 in 1996 to €340 000 in 2001.

The second period started in 2003 when the Ministry of Health decided to stop the funding to the Intersectoral Policy Office and to start funding a number of connected research projects together with the funding of projects to support municipalities. As a result, a part of the function of the Intersectoral Policy Office was taken over by the National Institute of Public Health and the Environment, including research and the networking function, e.g. organizing meetings in which health impact screening and related topics are discussed. Until 2006, a budget is available for maintaining intersectoral policy in the work of the National Institute of Public Health and the Environment. In addition, money is available for two PhD studies on HIA. One focuses on the development of instruments for analysing and influencing administrative processes in the interests of public health and the other focuses on the development of instruments for analysing and quantifying the impact of policy on public health.

Costs of an HIA

It has been argued that the costs of an HIA can be very high and this might constitute a problem, especially in a situation when it is unclear who will bear the burden.[13] Furthermore, the costs of an HIA must be proportional to the decision at hand.[14] Different types of HIA require different analytical methods, and provision for participation costs can vary considerably between individual HIAs. A mini or desktop HIA will certainly consume far less resources than a maxi or comprehensive HIA. Therefore, a differentiated picture of the type of HIA and the costs incurred would be welcome. Unfortunately, despite the growing interest in evaluation of HIA, very little information on the costs of HIAs is available.

Among the few examples currently available are those presented in the "Merseyside Guidelines". On the basis of three projects, the calculated average cost of an HIA was €18 000,* of which €15 000 represented the actual costs of

* All figures in this paragraph were converted into € and rounded off.

Table 12.4 *Costs of a health impact assessment*[a]

Country	Year	Level	Type	Sector	Topic	Costs (€)
Belgium	2001	Regional	Maxi/comprehensive	Transport	Noise, pollution, stress	€25 000
	2004	Regional	Standard/intermediate	Environment	Pollution	€20 000
Lithuania	2004	Local	Standard/intermediate	Multisectoral	Noise, pollution, waste, stress, working environment	€4600
Northern Ireland	2002	Regional	Standard/intermediate	Social care	Access to information and services	€29000
Ireland	2004	Local	Maxi/comprehensive	Transport	Traffic	€63000 available[b]
	2004	Local	Standard/intermediate	Housing/urban planning	Local area plan	€10000
Slovenia	1994	Local	Standard/intermediate	Energy	Pollution	€10000
	1994	Local	Mini/desktop	Housing/urban planning	Other pollution, contamination, infestation	€1000
	1998	Local	Mini/desktop	Tourism	Other bathing water pollution	€2000
	1997	Local	Mini/desktop	Industry	Other noise pollution, air and water pollution	€2000
	2004	Local	Mini/desktop	Industry	Pollution	€5500
Wales	2000	Local	Maxi/comprehensive	Employment	Housing, economic	€33000[c]
	1999	Local	Maxi/comprehensive	Transport	Pollution	€81000[d]
	2002	Local	Maxi/comprehensive	Housing/urban planning	Noise, stress, living conditions	€7000
	2001	Local	Maxi/comprehensive	Housing/urban planning	Community change, health, well-being, housing, indoor air quality, environment	€145000[e]

[a] It should be noted that for England only a selection of HIAs was included. Domestic currencies were converted into euros and sums were rounded.
[b] Part of the HIA was the production of 65 000 two-page summary leaflets for distribution to local households. €10 000 is allocated to evaluation.
[c] A social and health impact assessment involved questionnaires to be completed by all households.
[d] The money was spend over a three-year period. Methods included questionnaires, diaries, lung function tests and measurement of air pollutant levels.
[e] The high costs of the Welsh Impact Assessment may relate to the methodology. Apart from the use of routine data, detailed health data was collected from 300 households one year prior to the renovation, shortly before the renovation and after the renovation. The modelling of the community used a sophisticated geographical information system.

assessor/support staff time.[15]* The costs of the Finningley Airport HIA, which was concluded in 2000, were calculated at €76 000 to €101 000 in actual staff costs and €25 000 for commissioning and disseminating.[16] The costs of the HIA of Dulwich Healthy Living Centre, which was concluded in 2003, were calculated at €36 000.[14]

Among the 158 HIAs identified and analysed in the project, information on the costs incurred was only available in 15 cases (see Table 12.4).

Capacity building

Capacity building provides specific input for the HIA system. Key aspects are the production and training of HIA practitioners, and the establishment of support units. There can be a close link between capacity building and health intelligence, since support units may provide health intelligence required for conducting HIA. Box 12.3 provides a detailed example for Ireland.

Table 12.5 presents aggregated data on the organizations and institutions involved in resource generation. The row total exceeds the number of countries included in the research, since in some countries a multitude of organizations and institutions are involved in capacity building. The absence of resource generation and capacity building was only reported from one country at national, two countries at regional and one country at local level.* The table demonstrates the multitude of organizations and institutions involved. The involvement of governments, government agencies and universities were frequently reported.

Table 12.5 *Resource generation and capacity building: organizations and institutions involved*

	Government	Government agency	NGO	Public health association	University	Other	None
National levels	4	5	6	1	12	8	1
Reference regions	13	14	7	7	6	7	2
Reference localities	5	7	6	1	8	4	1

* The calculation was based on i) actual costs of the person-hours input of assessors and of administrative/secretarial staff; ii) notional costs of the person-hours input of academic staff, Steering Group Members and key informants; and iii) notional travel expenses.

Again, the data at subnational level need to be interpreted with great care, since only a single reference region and a single reference locality were included in the research.

Sweden serves as an example for the complementary roles of different institutions in resource generation and capacity building. The Swedish National Institute for Public Health is developing the methodology for conducting HIAs at local, regional and national levels using the Gothenburg Consensus framework as a model. Ongoing projects include:

- supporting governmental agencies within different sectors to implement HIA in their work;
- health impact assessment as a methodology for social sustainable regional development;
- developing HIA methodology for municipalities;
- conducting case studies on road projects, 3G and climate change.

General education on HIA is a subject of public health courses given at different universities, for example Karolinska Institute and Malmö University College. The Swedish Association of Local Authorities and Regions has developed an instrument "Focusing on Health", which can be found on the web site of WHO Regional Office for Europe.

The roles may vary in scope. An example is the government's involvement in Malta. The Office of the Director General of Health took responsibility for introducing the concept of HIA during the period of accession by introducing training both in Malta and abroad. However, according to the data presented in Chapter 11, this has not yet led to a large number of HIAs.*

Delivering

Four aspects of the delivery function of HIA systems were analysed. First, "lead agencies" for HIA were identified. A lead agency is defined as the focal point that may also exert technical leadership. This could entail conducting, organizing, managing, commissioning or supervising the HIA. Second, who actually conducted the assessment was analysed. Third, the link between the owners of a pending decision and the triggering of the HIA process were explored. Finally, the link between the assessment and the reporting of the results were analysed. The latter two issues already refer to institutionalization of HIA since they imply the integration of the HIA in the decision-making process.

* However, in some countries one of the levels was not applicable due to the institutional setting.

Box 12.3 *Capacity building for health impact assessment in Ireland and Northern Ireland*

The Institute of Public Health was established in 1999 to promote cooperation for public health in Northern Ireland and the Republic of Ireland. It aims to improve health across the whole island by working to combat health inequalities and influence public policies in favour of health. A substantial work programme on HIA has been developed in response to needs identified by the Health Departments and health practitioners in both jurisdictions.

The aim is to promote the implementation of HIA across the island and act as a resource to support government departments, health services and other agencies involved with HIA.

The institute is currently the only organization on the island providing comprehensive training in HIA. The three-day course furnishes participants with the practical skills necessary to conduct HIA and provides networking opportunities for organizations working within different structures in Northern Ireland and the Republic of Ireland. Shorter "awareness raising" and "taster" sessions are also held for those who wish to increase their knowledge of HIA.

A number of resources for HIA in Ireland have been developed by the institute, including a practical guidance manual and reviews of the links between transport and health, and employment and health. A dedicated HIA web site provides information on the concept and practice of HIA across the island as well as links to international developments in HIA and other useful sites. The institute coordinates an HIA network and members receive a quarterly newsletter.

The institute collaborates with organizations throughout the island as well as international partners in building capacity for HIA.

Lead agencies are established in most countries

On the basis of the project data, four major observations regarding the lead agency can be made.

First, with Austria and Portugal as the only exception (data for Portugal are incomplete), each country identified lead agencies. This is in itself unsurprising, since almost all countries in the sample have a policy, a regulation or other means of endorsement in place establishing the case for HIA.

Second, for most countries and their reference regions and reference localities, lead agencies have been identified on all relevant levels. In only five countries no lead agency was identified for more than one of the relevant levels. It was taken into account that due to the differences in political, administrative and institutional settings some countries have only two relevant levels.

Third, in nine countries the function of the lead agency was shared on the same level between different entities. The data were not detailed enough to determine if these lead agencies were conducting their tasks in a complementary, overlapping or conflicting manner.

Fourth, there are a multitude of different bodies and entities serving the function as a lead agency; however, a key role is played by governments and the public sector administration or institutes. Governments as lead agencies were specifically identified at national and local levels. This was the case with 11 countries. In six of them, both national and local governments were identified as lead agencies and frequently the public sector administration or institutes were identified as the lead agency. However, they were exclusively located at national and local levels. Public health associations were identified in six countries as lead agencies, universities or their respective units in six cases, and NGOs in three countries. Other lead agencies were identified in four cases, exclusively located at local level.

Conducting the HIA

The analysis of who conducted the assessment of the HIA has produced a multitude of assessors. Variations are considerable. Quite often assessment is conducted by a combination of assessors, or the assessors are supported by other organizations, groups and individuals. A case study for Lithuania is provided in Box 12.4.

Examples from the local level in Finland have shown that variations regarding the choice of assessors may be found at the same level. In one exceptional case, the HIA was performed by students of Turku Polytechnic. In many other cases, the assessment was conducted by the responsible planner from the city administration itself, with the support of the National Research and Development Centre for Welfare and Health (STAKES). In two cases, it was the local Energy and Waste Management Corporation. These assessments were conducted by external consultants.

For England, data on who has conducted HIA are only available for nine of the selected 28 HIAs. It was either the entity that triggered the HIA process or independent consultants; 19 local HIAs were reported for Wales. A multitude of groups, organizations and institutions have been involved in triggering and conducting the HIAs in Wales. Historically, local health authorities supported HIAs. More recently, the Welsh Assembly, local authorities and local health boards, with the support of the Welsh Health Impact Assessment Support Unit in some cases, have taken on this role. Many of the HIAs have been collaborative undertakings, with local health alliances playing an important part.

Box 12.4 *Organizations and agencies conducting health impact assessment in Lithuania*

In Lithuania, HIA started in 2004, when two legal acts, foreseen in the Law on Public Health Care (2003) as the supplements for environmental impact assessment (EIA), were approved by the Ministry of Health. In EU Member States belonging to the EU before May 2004, HIA is used for the comprehensive assessment of projects, strategies and policies which may have an effect on health at local, regional or national level, and is described as "strategic" HIA. Meanwhile in Lithuania there are a few "strategic" HIAs, and strongly enforced environmental HIA for planned economic activities.

Eighteen institutions (ten public agencies and eight private businesses) were licensed to provide environmental HIA at the State Public Health Service under the Ministry of Health and starting from July 2004 no EIA could be accomplished without a more comprehensive environmental HIA.

From 2001 to 2004, the number of EIAs provided increased from 150 to 422 cases. Most private companies working in the EIA sector tried to get their licences for environmental HIA because they saw advantages in this joint action. Furthermore, there is a tendency for public health professionals to shift their positions from governmental public health agencies to private consultancy companies as this is an easier way to coordinate projects and reports with public health institutions.

For Belgium, for one of the HIAs reported, the policy was owned by Leuven City Council. The HIA was triggered by a partnership of 25 institutions, business organizations and citizens' groups and the HIA was conducted jointly by the University of Leuven and the Groep T. Leuven Engineering School.

The Italian assessment on the Brenner motorway was conducted by EURAC (European Academy, Bolzano), a private institute. In Spain, five of the seven HIAs identified were part of an EIA and followed the legal requirements. However, a fifth was identified which was initiated by the Public Health Agency of Barcelona. It was conducted by L. Agència de Salut Pública de Barcelona and Mutual Cyclops, Barcelona. In the Netherlands, some of the HIAs were conducted by the Intersectoral Policy Office. Others were conducted by universities or institutes such as SCO Kohnstamm-Institute, the Trimbos-Instituut and TNO, while liaising with the Intersectoral Policy Office.

The link between the pending decision and the HIA

Health impact assessments conducted on an ad hoc basis may sometimes be affected by suspect opportunistic politics. It may be argued that the HIA was only initiated because the expected outcome would support the pending decision.

Table 12.6 *Ministries whose policies were the subject of health impact assessments in the Netherlands and Finland*

Netherlands[a]	Finland
Government	
• Ministry of Finance; Ministry of Health, Welfare and Sports • Ministry of Housing and Spatial Planning • Ministry of Social Affairs and Employment • Ministry of Transport, Public Works and Water Management • Interdepartmental Commission for Economic and Structural Reinforcement	• Ministry of Agriculture and Forestry • Ministry of the Environment • Ministry of Trade and Industry • Ministry of Transport and Communication; Prime Minister's Office
Others	
• Political parties	• Finnish Rail Administration • Finnish Road Administration

[a] *In one case there was not sufficient information to determine who had initiated the HIA.*

A systematic link between the pending decision and the HIA process may avoid this. The analysis of this link at national level comprised 54 HIAs from 13 countries. Among these HIAs, 18 were from Finland and another 18 from the Netherlands. For the reported cases from Finland, the link was very close. The HIAs, with one exception, were initiated by government departments or government agencies. In the Netherlands, all HIAs were initiated by the Intersectoral Policy Office. They screened the policies of the Ministry of Finance, Health, Welfare and Sports, Economic Affairs and the Ministry of Housing and Spatial Planning. For all the other countries in the sample, the number of HIAs at national level was too small to report on a pattern.

In the Netherlands, all HIA processes were initiated by the Ministry of Health, Welfare and Sports and the Intersectoral Policy Office. They screen the policies of other ministries for those who might have an impact on health. In practice, the Intersectoral Policy Office plays a major role in this. In Finland, the pattern differs. In general, it is the owner of the policy, programme or project that initiates the HIA process. However, in some cases, working groups were set up that included other ministries or organizations (see Table 12.6).

The link between the pending decision – or the "decision owner" – on the one hand and the initializing of the HIA process on the other was also analysed at regional and local levels. However, the data were less conclusive.

In the selected cases for England there was a close link reported between the owner of the policies, programmes and projects, and the initiation of the HIA.

The London Health Commission (LHC) played a key role. It worked in partnership with agencies across the capital to reduce health inequalities and improve the health and well-being of all Londoners. The LHC used HIA to support the development of various Mayor of London strategies: Air Quality, Biodiversity, Children and Young People, Culture, Economic Development, Energy, Noise, Transport, Spatial Development and the London Plan on Waste.[17]

A similarly close link at national level is visible for Wales where five HIAs were reported. As a policy owner, the Public Health Strategy Division in the Welsh Assembly plays an important role in triggering the HIA process and, to a certain degree, is involved in conducting the HIA.

Strategic HIAs may constitute a slightly different case, since they are not linked to a decision. Health impact assessments reported from Germany focused on the health impact of the privatization of drinking water management. In this regard, it was not a reaction to a concrete policy proposal. The lead role in terms of initiating, triggering and conducting the HIA was with the State Institute of Public Health of North Rhine Westphalia in cooperation with the University of Bielefeld.[18, 19]

The link between assessing and reporting

Delivery, as a function of HIA systems, contributes to the achievement of specific HIA objectives. However, if the HIA is not reported adequately to the decision-makers it can neither be taken into consideration nor can it influence the pending decision. In this event, the whole delivery function does not contribute to the objectives of the HIA. This does not exclude other secondary positive effects of an inadequately reported HIA.

As an expansion of the analysis of the stages presented in Chapter 11, the data were analysed in regard to the actual submission of results to the decision-makers.

According to the analysis presented in Table 12.7, reporting back to the policy-makers takes place. However, the data have to be interpreted with great care given the limited availability of data for HIAs at national level and for the reference locality. And, of course, the subnational level was included in the research with only one reference region and one reference locality per country.

The patterns and means of reporting to the decision-makers vary a great deal. According to the data, two major patterns can be distinguished. One is following the formal model of the HIA stages in which the assessment is an activity clearly distinguished from the reporting. Reporting takes place after the assessment has been formally finalized. The other pattern refers to a steady

Table 12.7 *Reporting to the decision-makers (based on a sample of 158 health impact assessments)*

	Yes		No		N/a	
	No. of HIAs	%	No. of HIAs	%	No. of HIAs	%
National level	27	50.0	11	20.4	16	29.6
Reference region	14	65.2	7	30.4	2	4.3
Reference locality	31	38.3	26	32.1	24	29.6

involvement of the decision-makers or their responsible staff. That means that when agreement on the assessment has been achieved no separate or formal reporting is necessary, although written reports may be produced. The means by which the assessment is reported to the decision-makers vary a great deal too. In some cases, submission of the report is the key means of communicating the results. In other cases, individual briefings took place. In several cases, workshops for the decision-maker were organized to inform on the results of the assessment and discuss possible consequences and options. Some HIAs have used a combination of means for reporting to the decision-makers.

As Table 12.7 suggests, in a fair of number cases within the sample of HIAs analysed, the results of the assessment were not directly reported to the decision-makers. There are a variety of reasons for this. First, some of the HIAs in this category resembled strategic HIAs. Decision-makers were involved in them and they were linked to the broader policy process but not to a specific pending decision. The explicit role of the HIA was to prepare a public debate on future directions in a specific policy field. However, there are other cases in which there was no link with the decision-makers. One reason for this was that the assessment was not finalized on time. Interrelating the HIA stages and the policy cycle was unsuccessful. A second reason for not reporting directly to the decision-makers was an obvious disinterest of the decision-makers in the HIA. A third reason was that some of the HIAs were conducted as a scientific project which was eventually published in a scientific journal but was never intended to be reported to the decision-makers.

Conclusion

This mapping exercise has provided evidence that most countries have been implementing HIA at least on a project basis. Implementation takes a variety of forms and varies considerably from country to country. Although governments and government agencies play an important role in the implementation and delivery of HIA, there is a large variety of other

institutions and organizations involved in capacity building and the delivery of HIA including local authorities, public health institutes, health observatories and special HIA units, universities and private companies.

A small number of countries have been able to institutionalize HIA at least partially. The examples from England, Finland, the Netherlands and Wales should be mentioned in this context. Important elements of this institutionalization are comparable strong governance support as illustrated by the Welsh case study, the establishment of dedicated support units or explicitly integrating responsibilities for HIA in existing institutions, developing the health intelligence for HIA and regular funding for HIA activities. The analysis of the link between the pending proposal, the HIA and the decision-making process has provided examples that HIA can be conducted systematically in collaboration with different sectors and departments. However, most countries in the mapping exercise are lacking many of these conditions. Government support is half-hearted, the HIA-related health intelligence is insufficient and funding is provided either on a project basis or from existing resources.

The progress made both in terms of implementation and institutionalization does not necessarily continue. Developments and policy support may vary in the future. This was demonstrated at national level by the case study on the Netherlands. Support for implementation or institutionalization of HIA may dwindle due to changes in governments.[20] Doubts have also been raised in Germany by the governmental Advisory Council of the Assessments of Developments in Health Care regarding the current knowledge gap and methodological uncertainties and the implementation of HIA.[21] On the other hand it was recently reported that the public health administration of the Swiss Canton Ticino had announced its intention to assess all future political decisions by carrying out an HIA.[22]

Drawing conclusions regarding the role of HIA as a tool for HiAP is difficult due to the limited activities at national level and the small number of HIAs identified at regional level. The evidence suggests that, currently, the strongest developments in HIA are to be observed at local level. Still, the analysis of the link between the pending decision, the HIA and the decision-making process has provided insights that this is possible in principle. It demonstrated the involvement of various government departments in HIA. It is questionable if such involvement is likely to take place for most other countries in the near future.

Secondary contributors to this chapter

Elisabet Aldenberg, Swedish National Institute of Public Health, Sweden; Franz Baro, WHO Collaborating Centre on Health and Psychosocial Factors in Belgium; Francisco Barroso Martin, Técnicas de Salud S. A., Spain; Ceri Breeze, Welsh Assembly Government, Wales, UK; Konrade von Bremen, Institute of Health Economics and Management, Switzerland; Edit Eke, Semmelweis University, Hungary; Rainer Fehr, LÖGD (Landesinstitut für den Öffentlichen Gesundheitsdienst) NRW, Germany; Mojca Gabrijelčič Blenkuš, Institute of Public Health of the Republic of Slovenia; Gabriel Gulis, University of Southern Denmark, Denmark; Tapani Kauppinen, National Research and Development Centre for Welfare and Health (STAKES), Finland; Jarmila Korcova, Trnava University, Slovakia; Odile Mekel, LÖGD, Germany; Owen Metcalfe, The Institute of Public Health in Ireland; Kirsi Nelimarkka, STAKES, Finland; José Pereira-Miguel, University of Lisbon, Portugal; Kerttu Perttilä, STAKES, Finland; Walter Riccardi, Institute of Hygiene, Catholic University of the Sacred Heart, Rome, Italy; Martin Sprenger, Medical University of Graz, Austria; Ingrid Stegeman, EuroHealthNet, Belgium; Lorraine Taylor, Former Health Development Agency, UK; Rudolf Welteke, LÖGD, Germany; Cezary Włodarczyk, CM Jagiellonian University, Poland.

REFERENCES

1. Banken R. *Strategies for institutionalizing HIA*. Brussels, World Health Organization Regional Office for Europe, 2001.
2. Banken R. Health impact assessment – how to start the process and make it last. *Bulletin of the World Health Organization*, 2003, 81(6):389.
3. Kemm J. HIA – growth and prospects. *Environmental Impact Assessment Review*, 2005, 25(7–8):691–692.
4. Kemm J. The future challenges for HIA. *Environmental Impact Assessment Review*, 2005, 25(7–8):799–807.
5. *The World Health Report 2000. Health systems: improving performance*. Geneva, World Health Organization, 2000.
6. Saltman RB, Ferrousier-Davis O. The concept of stewardship in health policy. *Bulletin of the World Health Organization*, 2000, 78(6):732–739.
7. Travis P et al. Towards better stewardship: concepts and critical issues. In: Murray CJL, Evans DB, eds. *Health systems performance assessment: methods, debate and empiricism*. Geneva, World Health Organization, 2003:289–300.
8. Secretary of State for Health. *Saving lives: our healthier nation*. Vol. Cm 4386, London, Stationery Office, 1999.

9. *Choosing health: making healthy choices easier. Executive summary*. London, Department of Health, 2004.

10. *Developing health impact assessment in Wales: better health better Wales*. Cardiff, National Assembly for Wales, 2000.

11. Welsh Health Impact Assessment Support Unit. *Improving health and reducing inequalities: a practical guide to health impact assessment*. Cardiff, Welsh Assembly Government, 2004.

12. Hill A et al. Building public health skills and capacity in the English regions. *Public Health*, 2005, 119(4):235–238.

13. Krieger N et al. Assessing health impact assessment: multidisciplinary and international perspectives. *Journal of Epidemiology and Community Health*, 2003, 57:659–662.

14. Atkinson P, Cooke A. Developing a framework to assess costs and benefits of health impact assessment. *Environmental Impact Assessment Review*, 2005, 25(7–8):791–798.

15. Scott-Samuel A, Birley M, Ardern K. *Merseyside guidelines for health impact assessment*. Liverpool, Merseyside Health Impact Assessment Steering Group/Liverpool Public Health Observatory, 1998.

16. Abdel Aziz MI, Radford J, McCabe J. The Finningley Airport HIA: a case study. In: Kemm J, Parry J, Palmer S, eds. *Health impact assessment*. Oxford, Oxford University Press, 2004:285–298.

17. *What is the London Health Commission?* London Health Commission, 2005: (http://www.londonshealth.gov.uk/pdf/whatisthelhc.pdf, accessed 24 April 2006).

18. Fehr R et al. Towards health impact assessment of drinking-water privatization– the example of waterborne carcinogens in North Rhine-Westphalia (Germany). *Bulletin of the World Health Organization*, 2003, 81(6):408–414.

19. Fehr R, Mekl O, Welteke R. HIA: the German perspective. In: Kemm J, Parry J, Palmer S, eds. *Health impact assessment*. Oxford, Oxford University Press, 2004:253–264.

20. Broeder LD, Penris M, Varela Put G. Soft data, hard effects. Strategies for effective policy on health impact assessment – an assessment analysis and procedures in the European experience. *Bulletin of the World Health Organization*, 2003, 81(6):404–407.

21. Sachverständigenrat für die Begutachtung der Entwicklung im Gesundheitswesen. Koordination und Qualität im Gesundheitswesen, 2005 Bd I: *Kooperative Koordination und Wettbewerb, Sozioökonomischer Status und Gesundheit, Strategien der Primärprävention*. [*Cooperative coordination and competition, socio-economic status and health, strategies for prevention*] Stuttgart, Nomos, 2006.

22. Schweiz: Politik überprüft sich selbst [Switzerland: Government reviews policies]. *EUREPORT social*, 2006, 14(3):17.

Chapter 13

A case study of the role of health impact assessment in implementing welfare strategy at local level

Tapani Kauppinen, Kirsi Nelimarkka, Kerttu Perttilä

There are many international and national programmes concerning health promotion. There are new methods for evaluating the effectiveness of medical treatments and calculating risks or costs of health care services, but few tools for future-oriented health-promotion policy and work. It is difficult for politicians to understand the health effects of decisions, and presenting officials have trouble illustrating why one decision is better than another from the point of view of health. Health impact assessment (HIA) has often been applied as a method for helping local-level decision-makers take health aspects into account in strategic planning and the decision-making process.

This chapter first describes the factors in an HIA process which help to benefit decision-making at local level. This is done by analysing experiences based on one case study from the city of Kajaani in Finland. In Kajaani, the use of HIA was part of the implementation of a city welfare strategy. Three factors involved in the HIA process were considered to be especially important for a successful HIA: participation; a description of alternatives; and an assessment matrix.

This chapter then analyses the possible benefits and risks of using HIA in the implementation of local welfare strategy. Among the benefits that emerged were support in choosing the alternative for strategy implementation, a better acknowledgment of the views of the local health authorities and vulnerable groups compared with earlier practices, and the strengthening of a common understanding of strategic goals.

The experiences of Kajaani showed that more attention should be paid to methodological, procedural and cultural challenges. One methodological challenge for HIA arises from being used in extensive activities. Dividing the activity into smaller parts for the HIA would be practical. One of HIA's procedural challenges is to link HIA to the decision-making in order to ensure the effectiveness of HIA. HIA also faces cultural challenges. The lack of a forward-looking culture in municipalities can impede the use of HIA.

HIA as a tool in the implementation of the welfare strategy in Kajaani

Kajaani is a medium-sized city in the eastern part of Finland (35 700 inhabitants). The city has worked actively in health promotion for about 10 years. Kajaani is one of the founder members of the Finnish Healthy City Network and it has tried to put health promotion issues on the decision-making agendas of top management groups. A city welfare strategy was prepared in 2001 by a health promotion working group in coordination with different administrative fields. The strategy was prepared within a balance score card frame and the objectives were balanced with staff, cost and process plans. The strategy did not involve any implementation plan; the execution of the strategy had been left open, and the responsibility for follow-up was also not made clear. Shortcomings in executing welfare strategies and the lack of a follow-up to the implementation are also common to other cities in Finland.[1]

When the National Healthy City Network decided to take HIA as its development objective, Kajaani wanted to pilot it as a tool for implementing the welfare strategy. The aim of this implementation was to find new possibilities and alternatives for organizing welfare services in Kajaani so as to support the strategy. The other reason to choose implementation as the focus of the HIA pilot was that Kajaani wanted to make its voice heard in the Kainuu regional pilot. The pilot project involved targeting nine municipalities in the region (Kajaani being one) to organize their health, social and basic school services jointly at regional level. These services would be offered by the region, and the responsibility of the basic municipalities would only be for producing locally based services. As this large organizational renewal was forthcoming, the thoughts in Kajaani were directed to how to arrange the regional services.

The implementation of HIA in Kajaani

Kajaani had formed a health promotion working group (hereafter referred to as "working group" or "group") in 1996 as a result of its involvement in the Healthy City Network. The working group was under the supervision of the

city management group. The HIA pilot was carried out by the working group, with its members coming from different administrative fields and from other organizations besides the city organization.

The group members included a director of Social and Health Services, a health promotion planner, a planner for the technical sector and a labour protection delegate, with representatives from Education and Cultural Services, the Sports Council, the Council for the Elderly, the Advisory Council for Children and Youth Affairs, the Kajaani Polytechnic and the Research and Development Centre of Kajaani.

The group started its work with HIA in March 2003 and had meetings approximately once a month. The secretary of the health promotion group (who also worked as a health promotion planner in the city) organized and prepared the meetings and wrote memos and summaries for the group. HIA consultants from STAKES (the National Research and Development Centre for Welfare and Health) were twice involved at the start of the process and after hearing of the problems and needs, gave advice on possible ways of working.

Three different models were created for the implementation of the welfare strategy.

- Model 0 – a sectored legislation-based model, in which services required by law are offered in sectors divided into areas of expertise.
- Model 1 – a sector-based combination model in which services required by law are offered mainly in areas of expertise or on the basis of the community's needs.
- Model 2 – a client-based model in which special services required by law are offered on the basis of the community's needs.

The assessment considered the impact of different models, focusing differently on age groups, costs of producing services, staff and the actions of other sectors.

The experts of the working group discussed the alternatives and impacts and made a draft assessment. After that they brought the draft into their own background organizations. Officials, politicians and representatives of nongovernmental organizations, such as members of seniors' clubs in the Council for the Elderly, attended the meetings in the background organizations. The health promotion planner also participated in the meetings. The organizations revised the draft and made their own suggestions when needed (see Figure 13.1).

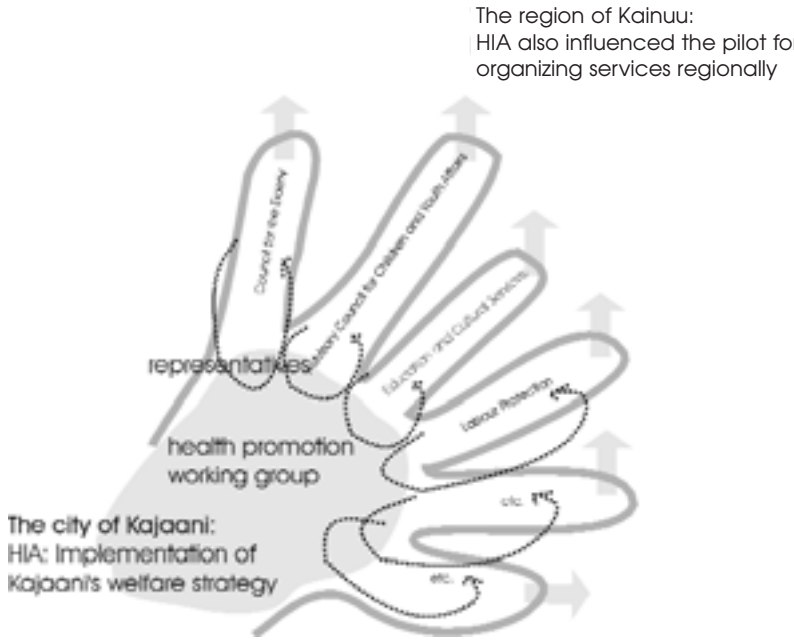


Figure 13.1 *The health impact assessment in the city of Kajaani as organized according to a "hand model". The palm depicts the working group that was responsible for conducting the HIA. Fingers symbolize the background organizations that helped in the HIA. The focus of the HIA was the implementation of Kajaani's welfare strategy, but the HIA also influenced the work of the Kainuu regional pilot*

After six meetings the group delivered a summary of the HIA process and its outcomes to the Kajaani management group. The summary pointed out how health promotion could be carried out in Kajaani according to different models for organizing services. The working group recommended the client-based model for implementation of the welfare strategy. The group also presented the results of HIA to the steering group of the Kainuu regional pilot. It decided to adapt the same model as Kajaani for organizing its regional health and social services. Afterwards the city of Kajaani joined the Kainuu regional pilot and the services were organized jointly at regional level.

The STAKES consultants later evaluated the HIA process by interviewing working group members. The evaluation highlighted three important aspects that play an important role in the HIA process: participation; assessment of alternatives; and the use of an assessment matrix. Experiences of HIA processes within other Finnish Healthy Cities are very similar.[2]

Figure 13.2 *Who is right? Health impact assessment helps to collect and structure participants' knowledge and information on health issues*

HIA process-strengthening factors in Kajaani

Participation

One of the basic values of HIA is democracy: the Gothenburg Consensus Paper emphasizes the right of people to participate in processes that affects their lives.[3] Participation helps to collect and identify different kinds of values, objectives, impacts and alternatives. Our experience shows that listening to others' arguments and systematically processing them using an assessment matrix, for instance, has contributed to understanding different kinds of justifications, reducing misunderstandings and conflicts, and increasing the acceptability of a decision made jointly by the community (see Figure 13.2).[2]

Participation can be divided into expert and public participation. Expert participation consists of officials, authorities and employees (from different sectors) whose work is connected to the decision and its impacts. Usually HIA needs more than one expert or discipline to succeed.[4] If the aim is to influence the work of other sectors, these sectors must be involved from the start.

Public participation means that those who are affected by the decision (citizens, patients, clients, etc.) can participate in the assessment directly or through representatives. Local knowledge and experiences are taken into consideration and the expertise of the whole community is harnessed. As delegates of the people, the politicians should also have an active role in HIA.[5] The public

participation approach to HIA draws heavily on the field of community-based health promotion.[6]

In practice there has been an inability to take forward public participation as originally envisaged. Because of the constraints of time and resources, there is tension between the HIA's participatory and knowledge-gathering dimensions. It has shifted more to participation by experts.[7] The information generated by participation has also been undervalued compared to quantitative "scientific" data.[6] Fundamentally it is a question of values: what kind of information is appreciated and who is able to produce it? [8, 9]

In Kajaani, participation was expert-centred. The working group that conducted the HIA had a broad representation of experts from various sectors. The participation was also expanded as the group members discussed the impacts of models in their own organizations (the Council for the Elderly, the Advisory Council for Children and Youth Affairs, etc.).

There was no existing process for how the views of local people could have been involved in Kajaani. On the other hand, the working group considered direct participation to be unnecessary in this case, as the subject of the HIA was difficult even for experts. Even if there was no direct participation, the views of children, working-age people and the elderly were taken into account in the background organizations. In Kajaani, participation did bring the knowledge of different sectors into the HIA process. Participation also committed the members of the working group to the results of the HIA.

Description of alternatives

Alternatives make it easier to compare health impacts and the advantages of different solutions. When participation has brought out a variety of opinions that as a consequence have given rise to conflicts, a description of the available alternatives for action can help.

Introducing alternatives and assessing them is not a particularly familiar practice in HIA even if the formulation of alternatives has been used widely in strategic environmental assessment (SEA) and social impact assessment (SIA).[10–12] Developing and comparing alternatives allows the decision-makers to determine which alternative is the best possible solution.[13] Methods for creating alternatives are discussed in more detail elsewhere.[14]

There was no open conflict in Kajaani. Alternatives for implementing the welfare strategy were created by identifying threats and possibilities. The members of the working group possibly feared that if a model for organizing social and health services in the Kainuu regional pilot were chosen without

discussions, they might find the chosen model inappropriate. It was believed that by conducting an HIA in the strategy implementation it would be possible to submit to the Kainuu pilot a proposal concerning the organization of regional services. This was what happened as it was decided in the regional pilot that the social and health services would be organized largely in accordance with the client-based approach described in the HIA of Kajaani. In that city, describing alternatives thus gave an opportunity to take participants' fears and solutions into consideration on an equal basis. As a result, three different models were created. All the opinions presented were included in the models, even if the views were opposing. This meant that everybody involved could find their own opinion in one of the alternatives.

Assessment matrix

Matrices are usually used as a tool for identifying impacts.[15] A matrix is valuable for the presentation of results because it can be used to present the pattern of impacts systematically and clearly.[10] It is also a good way to visualize the appraisal and its results (see, for example, the Swedish health matrix in the references listed as 16 and 17 at the end of this chapter).

In other forms of impact assessment – like the SIA and SEA – a matrix is also used as a tool for comparing alternatives, with the alternatives on one axis and impacts on the other.[10, 11, 13, 15] The same matrix can simultaneously deal with impacts, determinants of health or objectives. The idea is to answer the question "What happens if…?" The purpose of the matrix is not necessarily to find out the undisputed best solution but to describe health inequalities and the positive and negative impacts of different alternatives.

In Kajaani the impacts that different models have on children, working-age people and the elderly were assessed. The labour protection delegate, the representatives of the Advisory Council for Children and Youth Affairs and the Council for the Elderly discussed the impacts with their background organizations, thus adding expert opinions to the matrix. When the impacts were written into the matrix, it became apparent that there was actually no difference between population groups. The discussions that the working group members conducted with their own background organizations brought up very similar impacts, regardless of whether those affected were children, working-age people or the elderly. So the rows in the matrix were combined and named "Impacts on the inhabitants of Kajaani" (see Table 13.1).

The HIA aimed to introduce equity aspects in the planning process. However, the work done by the working group members in their own background organizations showed that there were no differences in impacts on different

Table 13.1 *Which model is the best possible? In the city of Kajaani, the effects of the implementation of the welfare strategy were analysed by health impact assessment. A working group formed three models for organizing health promotion and services in the municipality. This table is an extract from the draft assessment matrix*

	Model 0 (no action): a model sectored according to the law	**Model 1: a sector-based combination model**	**Model 2: a client-based model**
Impacts on the inhabitants of Kajaani	Services are divided according to a sector-based approach; services are spread throughout the system Care guarantee difficult to implement; services more difficult to access More specialist expertise A small-scale network A chain-like organization system; different levels of services are governed by the special areas of expertise Does not encourage preventive actions Does not encourage actions that support coping	Services are divided into a "one-stop principle" and a sector-based, broad approach Care guarantee probably easier to implement; services easier to access A little less specialist expertise; a few special experts less than in model 0 Networking is the basic working model Some chain-like quality in the organization system; some specialist fields are governed by a field of expertise and on the basis of the community's needs; a low, broad organization Encourages preventive actions and actions that support coping to some degree	Services follow a "one-stop principle", broad approach; the client is seen from a holistic viewpoint Care guarantee probably easier to implement; client can decide where to get the services needed Fewer specialist experts Networking is more "real" Special expertise is organized on the basis of the community's needs; a low, broad organization Encourages preventive actions Encourages actions that support coping
Impacts on staff: • depth of management • well-being of staff	Line manager plays an important role in terms of inner development/ the reconstruction and work capability of staff Clients move, staff does not Appreciates strong expertise of staff Staff is dependent on management "Hard" management is emphasized more than "soft" leadership	Organization is important in the reconstruction and work capability of staff Clients or staff move; depending on the choices, clients and staff move (or do not move) Staff is either dependent on the management or works on its own, depending on the organization Both "hard" management and creating suitable working conditions are emphasized	Organization is important in the reconstruction and work capability of staff Clients and staff move depending on the situation Appreciates broader expertise of staff Staff is independent in its work The most important task of the manager is to create suitable working conditions Network management (vulnerable)
Cost effects	Costs increase due to lack of linear expertise Less expensive in the short run if support is provided within the basic services Supports prevention	Supports prevention Supports well-being of people better Less expensive in the long run	Supports prevention Supports well-being of people better Less expensive in the long run
Impacts on other fields			

groups of people. The HIA and the description of alternatives took place at a fairly general level, so differences in health impacts are more likely to be identified in the more detailed planning of the services in the future. Impacts on equity would be easier to identify if the municipalities collected basic data which are broken down according to population groups.[18] There can be a risk that some population groups are excluded from HIA if there are not enough data on them. Impacts on gender were not seen as relevant in the Kajaani case and so were not assessed. Assessors thought that gender impacts would come up in more detailed planning and in sector programmes.

More resources should have been made available for gathering cost data in the HIA. Further, no attempts were made to identify impacts on other fields. This was not considered necessary at the final stage of HIA and there was not enough time to initiate discussions with experts in other sectors.

The assessment matrix was a useful tool in Kajaani. It brought all significant (qualitative, quantitative and economic) impacts to the same table and helped to compare the positive and negative aspects of the alternatives. A comparison between alternatives, impacts and goals gave the decision-makers information about the best possible solution for the current situation. The problem in using the matrix was that descriptions of alternatives and assessments of impacts were mixed together (see Table 13.1).

Benefits and risks of HIA: local-level strategy implementation

In the case of Kajaani, using HIA was an attempt to apply a method of policy-making and strategy implementation at local level. Several benefits and risks relating to the use of HIA in policy assessment at local level could be recognized in the Kajaani pilot project. Benefits and risks could be classified as political, social and economic.

Political benefits and risks

The HIA made the planning process in Kajaani more structured, helping in reaching a common understanding and finding suitable alternatives efficiently. It also provided information and arguments for choosing the solution (a client-based model) in the regional pilot of Kainuu. The Director of Social and Health Services of Kajaani participated both in the Kajaani HIA process and in the preparation of the regional administration model of Kainuu. During the HIA process he became acquainted with the different alternatives and their pros and cons. He felt that taking part in the HIA helped with the preparation of the Kainuu regional pilot.

The HIA also made the health issues apparent in planning and increased the awareness of participants, authorities and politicians about the health impacts of decisions. The HIA also made apparent the need for co-operation between different sectors.[19, 20] The visibility of health promotion actions greatly increased, and the working group members became more conscious of their role. A planner for the technical sector applied HIA in his work on key technical planning. In discussions with politicians on the regional models for Kainuu, health promotion issues were used to support argumentation.

It was at first difficult to discuss the values, alternatives and negative impacts in Kajaani. The HIA was a tool for processing the differences of opinion through exploring alternative solutions. Alternatives usually make it possible to incorporate different models and views into the planning process even if there is no unanimity in their acceptability. There is of course a risk that an HIA can be used for manipulative purposes. It can be conducted to advance a certain opinion or speak about one's favourite alternative.[21] This can be avoided by ensuring that the HIA is carried out as fairly and accurately as possible.

In Kajaani the working group members believed that HIA provided an opportunity to bring up and justify a new way of providing health-promoting services. People thought that, without HIA, it might have been difficult to oppose the traditional sector-based methods. However, efforts were made to describe the effects of the traditional methods of action as fairly as possible so as to avoid manipulation.

Social benefits and risks

The HIA empowered the local health authorities and helped take account of the views of vulnerable groups (children, the elderly) in Kajaani. The HIA created a channel for the local health authorities to bring their "silent knowledge" into play. They could also influence how developments would evolve. In Kajaani the HIA provided the courage to decide on the new action model. In addition, the results of the HIA empowered the officials of the city to advocate a specific alternative in the planning related to the regional pilot of Kainuu. The HIA was presented to the regional pilot steering group, and the resulting views and arguments were used in planning the regional pilot.

The HIA was also a tool for creating a common understanding of strategic goals. The participants from various administrative branches were able to learn from each others' opinions and further develop their own viewpoints. Integrating a new tool (HIA) into the prevailing system is itself a learning process.[5, 21, 22]

Economic benefits and risks

In the HIA of Kajaani, as in many other HIAs in Finland, economic impacts were difficult to assess. The participants in Kajaani emphasized that it is important to pay attention to the total benefits of the HIA. Even though the cost factors were identified, calculating the exact economic impacts was too difficult. There was not enough time to gather data about the expenses and gains. Reasons include the inadequacy of the available data, the difficulty in assessing the cost-effectiveness of interventions and, above all, the fact that not all benefits were calculable.

The HIA did not incur any direct expenses because it was conducted by officials during working hours. The officials did not keep a record of the time used for the HIA. Therefore it was also difficult to calculate its indirect costs.

Conclusion

In Kajaani, the HIA provided the officials with material and grounds for planning. The HIA served to voice the professional community's and inhabitants' views on the future organization of services in Kajaani. The results of the HIA were presented to the steering group of the Kainuu regional pilot so that the group could use the issues and arguments raised in the HIA in its own planning work. One of the most important achievements in the context of the HIA was that it strengthened the officials' own views and empowered them. In situations of this type, where the results of the HIA directly impact the preparatory work, it is not necessary to draw up a separate assessment report.[2]

The HIA proved its usefulness in several ways in the implementation of the welfare strategy in Kajaani. The most evident advantages were that the HIA helped in finding a model for the implementation of the strategy. Moreover, the local health authorities and vulnerable groups were better heard compared with earlier practices, and the common understanding of strategic goals was strengthened. From the point of view of political decision-makers, the HIA increased the transparency and alternatives available in the planning process. Usually officials only prepare one draft resolution but with the HIA alternative resolutions emerged. The decision-makers became conscious of the alternative solutions and their benefits and drawbacks.

This chapter describes three elements that are regarded as important for HIA to be successful. Participation contributes to the identification of impacts and increases cohesion in the community. Alternatives allow the benefits of different solutions to be compared. The assessment matrix allows the assessment to be carried out and the impacts to be described systematically.

The HIA is itself a learning process for its participants. The experiences of Kajaani showed that more attention should be paid to methodological, procedural and cultural challenges.

A methodological challenge for HIA arises from being used in such an extensive activity as the implementation of a welfare strategy. As a result, alternatives may be described in a fairly general way and the identification of impacts can become difficult. Dividing the activity into smaller parts for the HIA would have been practical.

The HIA's procedural challenge arises in trying to link it directly to the decision-making so as to ensure the effectiveness of the HIA. In Kajaani this connection was not as strong as it could have been. The connection functioned more at the personal level than at the formal level, with some members of the working group also belonging to the Kainuu steering group. This made it possible to use the results of the HIA in the work of the steering group. The influence of the HIA on the Kainuu regional pilot could have been greater if the HIA was assigned by the Kainuu steering group. The working group on welfare and health promotion in Kajaani conducted an HIA with the explicit aim of identifying a model for implementing the welfare strategy of the city. A future organizational renewal as a result of the regional pilot was, however, bound to have an influence on the work of the working group. In other words, the HIA also had another implicit aim of identifying a new model for organizing regional welfare services. The end result was a number of alternative models for organizing services in Kajaani, which were equally applicable in the regional pilot. Finally, the type of service organization preferred in Kajaani was also chosen to serve as a basis for the regional model of action. Although it is not possible to distinguish the effect of the HIA on the process accurately, the HIA at least empowered the group members so that they were able to communicate the results of the HIA to the regional pilot.

Health impact assessment also raises cultural challenges. The lack of a forward-looking culture impedes the use of HIA. For example, the culture of health promotion is very weak in the municipalities. During a recession, the focus shifted from preventive work to health care. Since then, health care has dominated and health promotion is to some extent only mentioned in visions and strategies. Mainstreaming HIA requires changes in ways of thinking and in the planning structures of municipalities.

REFERENCES

1. Uusitalo M, Perttilä K, Kurenniemi M. *Hyvinvointi ja terveyden edistäminen kuntien asiakirjoissa. Asiakirja-analyysi TEJO-pilottikunnissa* [Welfare and health promotion in municipalities' documents. Document analysis from pilot municipalities of the TEJO project]. Työpapereita 8, Helsinki, STAKES, 2005.
2. Kauppinen T, Nelimarkka K. *Ihmisiin kohdistuvien vaikutusten arviointi Terve Kunta -verkoston kunnissa* [Human impact assessment in the Healthy Cities Network]. Aiheita 18, Helsinki, STAKES, 2004.
3. European Centre for Health Policy. *Health Impact Assessment. Main concepts and suggested approach*. Brussels, World Health Organization Regional Office for Europe, 1999.
4. *Health Impact Assessment Toolkit for Cities. Document 3*. (Brochure on how health impact assessment can support decision-making.) Copenhagen WHO Regional Office for Europe, World Health Organization, 2005.
5. Deelstra Y et al. Using knowledge for decision-making purposes in the context of large projects in The Netherlands. *Environmental Impact Assessment Review*, 2003, 23(5): 517–541.
6. Cole BL et al. Methodologies for realizing the potential of health impact assessment. *American Journal of Preventive Medicine*, 2005, 28(4):382–389.
7. Wright J, Parry J, Mathers J. Participation in health impact assessment: objectives, methods and core values. *Bulletin of the World Health Organization*, 2005, 83(1):58–63.
8. Nylander O, Ståhle P, Nenonen M. *Informaatio-ohjauksesta tietointensiiviseen vuorovaikutukseen terveydenhuollon kehittämisessä. kehittämisessä* [Developing health care: from information control to knowledge-intensive interaction.] Yhteiskuntapolitiikka, 2003, 68(1):3–16.
9. Soneryd L, Weldon S. Noise and newts: public engagement in the UK and Sweden. *Environmental Impact Assessment Review*, 2003, 23(1):17–37.
10. Barrow CJ. *Social Impact Assessment: an introduction*. Edward Arnold, London, 2000.
11. Becker HA. Social impact assessment: method and experience in Europe, North America and the Developing World. *Social Research Today, Vol. 10*. London, UCL Press, 1997.
12. Vanclay F. International principles for social impact assessment. *Impact Assessment and Project Appraisal*, 2003, 21(1):5–11.
13. Thérivel R. SEA Methodology in practice. In: Thérivel R, Partidário MR, eds. *The practice of Strategic Environmental Assessment*. London, Earthscan Publications Ltd, 1999:30–44.
14. *Impact Assessment Guidelines*, SEC(2005)791, European Commission, 2005.
15. Thérivel R et al. *Strategic Environmental Assessment*. London, Earthscan Publications Ltd, 1999.
16. Svenska kommunförbundet, Landstingsförbundet [web site]. Focusing on health. 1998: (http://www.who.int/hia/about/en/HIA_sweden.pdf, accessed 7 October 2005).
17. Berensson K. HIA at the local level in Sweden. In: Kemm J, Parry J, Palmer S, eds. *Health impact assessment*. Oxford, Oxford University Press, 2004:213–222.

18. Simpson S et al. Equity-focused health impact assessment: a tool to assist policy makers in addressing health inequalities. *Environmental Impact Assessment Review*, 2005, 25(7–8):772–782.

19. France C. Health contribution to local government planning. *Environmental Impact Assessment Review*, 2004, 24(2):189–198.

20. Hay L, Kitcher C. An analysis of the benefits of a cross-sectoral approach to a prospective health impact assessment of a container port development. *Environmental Impact Assessment Review*, 2004, 24(2):199–206.

21. Wilkins H. The need for subjectivity in EIA: discourse as a tool for sustainable development. *Environmental Impact Assessment Review*, 2003, 23(4):401–414.

22. Saarikoski H. Environmental impact assessment (EIA) as collaborative learning process. *Environmental Impact Assessment Review*, 2000, 20(6):681–700.

Part 5

Conclusions and the way forward

Chapter 14

Towards a healthier future

Eeva Ollila, Eero Lahtinen, Tapani Melkas, Matthias Wismar, Timo Ståhl, Kimmo Leppo

Health is both a value and an asset

Health is an important value in its own right. In all European Union (EU) countries, this is recognized through a major investment in health security by way of universal health care services and public health measures. There is also an increasing awareness that a population's health is an important asset for society and that health can contribute crucially to the economy, productivity and overall development of society. Therefore there is a growing interest in strengthening this asset systematically. This book aims to contribute to an improved understanding of the opportunities and challenges in improving population health through other policies in the European Community (EC) and its Member States.

Policies have an effect on health

The fact that health is not solely dependent on health sector activities but is, indeed, largely constructed in areas outside the health sector has been known for decades. Therefore most countries have made efforts to integrate health considerations into societal policy-making.

In the EC there is an explicit policy mandate to integrate health into all other Community policies through Article 152 of the Treaty Establishing the European Community. This mandate is unique. In order to implement it, a variety of strategies, processes, mechanisms and instruments have been used in the various sectors of policy-making at Community level and in the Member States.

Nevertheless, there is still much scope, at all levels of decision-making, for elaboration in terms of the processes and means of integrating health consideration in policy-making so as to strengthen evidence-informed policy-making.

A failure to take health concerns into account in policy-making may be costly. It may result in increased suffering, decreased well-being and even loss of life. The costs ultimately fall on individuals, their families and on the health sector in terms of increasing health care costs, but also on the whole of society in terms of lost well-being and productivity as well as increased absenteeism from work in the form of sick leave and early retirement.

Health determinants as the mediators between policies and health outcomes

Factors that are found to have the most significant influence on health are called determinants of health. Health is an outcome of a multitude of determinants, including those relating to individual genetic and biological factors, individual lifestyles, the environment, culture, and societal structures and policies. It is notable that even changing individual lifestyles is, at times, beyond the ability of the individuals themselves; a change often needs supporting policies that make healthy lifestyles a viable option. The same determinants typically influence a multitude of health issues and, for example, all major diseases.

While the health sector's curative activities are mainly planned and implemented through health outcomes, health promotion and prevention need to be planned from the determinants' points of view because the health impacts of the policies, activities and interventions of other sectors are mediated through the determinants. Health determinants can be directly and at times quickly influenced through policies and interventions in the various arenas of policy-making, as well as in the various settings in which people live and work. Usually changes in determinants can be observed much earlier than those in health outcomes.

Policies can change health and health determinants positively or negatively

Health in All Policies (HiAP) is a horizontal, policy-related strategy with a high potential for contributing to improved population health. It is complementary to the more commonly known approaches of public health and health care services. The HiAP approach is to take into account the health

impacts of other policies when planning policies, deciding between various policy options and implementing policies in other sectors. The ultimate aim is to create evidence-based policy-making by assessing and discussing the possible health impacts of existing policies as well as proposed policy alternatives.

The core of HiAP is to examine determinants of health that can be affected to improve health but are mainly controlled by policies of sectors other than health. Health in All Policies as an approach aims to clarify the links between policies and interventions, health determinants and the consequent health outcomes for decision-makers.

Great advances in health have indeed been acquired through policies in sectors such as education, the environment, water and sanitation, planning, labour, housing, traffic, agriculture and nutrition. Chapter 7 highlights some of these advances and opportunities in the area of environment and health. It shows that scientific information has been a very important driving force for the integration of health aspects into the environment and transport sectors, and discusses the ways in which solid scientific knowledge can be disseminated to inform decision-making.

Nowadays health aspects are an inherent part of policy-making in many sectors. As an example of a successful effort to integrate health considerations into other policies, Chapter 3 describes the major determinants for heart health and the ways in which heart health has been amenable to policies of other sectors. The determinants include – in addition to genetic factors – the quality of food, smoking and level of physical activity, which can all be affected by policies, legislation and regulations, as well as the other actions of various sectors that make healthy choices known, easy and affordable. Chapter 4 describes policies, societal changes and demographic factors that affect the relationship between health, work and productivity. It emphasizes that health is a prerequisite for the two latter.

In addition to advances and opportunities, there are emerging challenges and risks. Sectors have their own priorities, and these are not always easily compatible with the aims of advancing health and health equity through health determinants. Examples of the further need to consider health implications are given from agricultural and food and alcohol policies (see Chapters 5 and 6, respectively). While the Common Agricultural Policy has been successful in acquiring improved food security in terms of chemical and microbiological food safety, and has recently decided to remove the subsidies on tobacco, Chapter 5 shows that there is still room for strengthening the analyses of health impacts, as well as in considering the impacts on policy-making.

Lastly, what has received less attention is the impact of other policies on health care and its functioning. While the mandate and responsibility of organizing health services is still at national or even local level, the framework in which it can be done is increasingly determined at levels beyond the national. For example, policies on international trade, internal markets, competition, trade and industry, and linked policy objectives on taxation and the size of the public sector and its services, may all have important direct consequences for the health sector and its costs.

Equity is a core value in health

Equity in health is one of the core values and objectives of European health policy. Health and the determinants of health are unevenly distributed across population groups. Inequities in health – that is, differences in health status and health determinants that are considered unfair and avoidable – between different socioeconomic groups have either grown or remain the same. At the same time, processes linked to globalization have resulted in increased socioeconomic differences both between countries and within countries, hence posing a further challenge in combating inequities in health.

It is crucial to note that policies aimed at amending health determinants are not necessarily neutral in terms of their effectiveness in the various subgroups of the population (see Chapter 1). An explicit focus on the social determinants of inequalities in health is necessary in order to ensure improved equity in health (see Chapters 1 and 8). When considering the health impact of other policies, special attention should be paid to the distribution of these impacts across populations. For example, changes in alcohol policy in Finland have had the most detrimental effect on the health of the lowest socioeconomic group (see Chapter 6). It is also noteworthy that in the course of time the distribution of health determinants across a population may change. For example, cardiovascular health has become increasingly a concern of the lower socioeconomic groups, having previously affected the higher groups more (see Chapter 3).

Policies are increasingly intertwined

Because of the globalization and European integration processes many policy decisions, such as those concerning aspects of trade and industry, internal markets and agriculture, have been, to a large extent, lifted to European or even global level in the context of the World Trade Organization. At the same time, the implementation of many decisions, as well as the responsibilities for the outcomes, may be delegated to local level. For example, health policy responsibilities generally still remain in practice at national and local levels.

As societal challenges today are inseparably intertwined, sectoral policies at the various levels increasingly impact on each other, and the need for policy coherence is ever more important. As shown in Chapter 1, the tools for healthy public policies at local level can be too weak in cases in which the international and national level contexts are not conducive to such policies. Nevertheless, integrating health considerations into local-level policies is essential and a case study on that is presented in Chapter 13.

Not only have policies shifted in terms of the level of policy-making from national to international or to local level, but the main domain in which policy is made can also change simultaneously with this shift. Chapter 6 highlights the different contexts in which alcohol policies have been made in Europe. In Finland and Sweden alcohol policies have been strongly influenced by social and health aspects of alcohol consumption. These countries have a strong temperance tradition, restricting alcohol production and sale. In the EU, alcohol policies have traditionally been part of agricultural policies with the aim of strengthening the production and sale of alcoholic beverages. As a result there has been unavoidable friction between the aims and objectives of the former national alcohol policies in Finland and Sweden and those of the EU, having serious results in the raising of alcohol-related morbidity and mortality. While the tools have become more limited at national level, efforts to alleviate the consequences of increased alcohol consumption are increasingly made at local level and the costs are increasingly being borne by local-level health and social budgets.

The Maastricht and Amsterdam Treaties have paved the way for assessing health impacts in other policies, but health policy priorities still remain to become part of the hard core of EU priorities (see Chapter 2). Increasing emphases on internal markets, competition and economic policies more generally, poses a challenge to keeping health and health equity aims high on the agenda, as health may easily shrink into a means of acquiring economic growth rather than being an important aim or right on its own with consequent positive effects on the economy. The task for the near future is to establish processes by which health implications can be considered and taken into account in all policies.

Two strategies for Health in All Policies: health 'in' or 'on' other policies

With the ultimate aim of increasing informed policy-making and policy coherence, health considerations should be incorporated in all policy development and implementation processes at the various levels of policy-making. Since the

early 1980s World Health Organization has advocated intersectoral action for health as an important strategy for achieving improved health. Even if not all policies are sectoral policies, the term "intersectoral action" has been used as a generic term to describe a coordinated action explicitly aiming at improving people's health through influencing the determinants of health. "Intersectoral action" has been used to refer to both various sectoral ministries as well as, more recently, to sectors in terms of public and private organizations, and other NGOs (see Chapter 1).

Two main pathways or strategies of policy building can be identified. First, in cases in which mutual gains between health policy aims and other policy aims can be found, integrating health policy aims and objectives with others is likely to be relatively easy. This strategy can be called a "mutual gains strategy" or a "win-win strategy". Second, when health objectives are kept as the main objective of the cooperative exercise, the effort can be called a "single health strategy." In cases in which this strategy does not compromise the primary objectives of the other actors, this may be a viable strategy (see Chapter 1).

In some instances, however, the values and objectives of the various policy intentions can be incompatible. In these cases, aims and objectives need to be negotiated and compromises will need to be sought (see Chapter 8). In order to keep health high on the agenda, the health objectives and implications of various policy options for health need to gain recognition in the process. The prerequisites for doing that include sufficient openness and transparency of the policy processes, including reasonable time frames for assessing and commenting on policy proposals and a good dialogue with other policy actors, timely identification of the potential problems for health and health policy, the availability of a sound knowledge and argumentation base as well as identification of available alternative policy options. In the following some of the instruments used in gaining and maintaining this dialogue are described.

Mechanisms and instruments for Health in All Policies

Public and political support is essential for health implications to be taken into serious consideration in policy-making. Health is highly valued by most people. Democracy, people's participation and transparency of policy-making are important prerequisites for the high value put on health to be channeled into health-friendly policy-making.

There is a need for good-quality public information on health outcomes, trends in health outcomes, and health determinants and trends in those determinants, as well as on ways in which health determinants can be affected, not only by individual action but also by policies. A good information base on

health and health determinants, and proper analyses of the data, are prerequisites for the monitoring, assessment and evaluation of health policies, including HiAP. It is important that essential population health data remain under public domain so that evidence-based policy-making remains a viable option.

Legal mandates for the assessment of health implications of policies, as well as legal responsibilities to follow up and report population health trends and policies affecting them, are important instruments in institutionalizing health in other policies. Chapter 7 describes the methods used to assess environmental health risks. While pointing out that not all risks can be quantified and that the reality of policy-making often makes it difficult to reconcile science with other needs and priorities of society, the contributor also points to the opportunities that were offered by making a Strategic Environmental Assessment mandatory.

Understanding health implications in national-level policy-making and political support for the proper consideration of those implications can be enhanced by, for example, parliamentary public health and public health policy reporting (see Chapter 9). Similar reporting has been carried out at local level.

Partnership and alliance building is essential for integrating HiAP. Many countries have chosen to use permanent intersectoral committees to prepare, implement and follow up HiAP. In Sweden, for example, a comprehensive intersectoral policy was prepared by the National Public Health Committee, which consisted of representatives of all parliamentary political parties, the local administration, the Ministry of Health and its institutions, as well as experts from academia, education and health sectors, working life institutions, trade unions, and patient and pension organizations.

More contemporary intersectoral bodies have also been formed on specific problems, issues or policy proposals. Other intersectoral mechanisms include formal consultation in the form of, for example, requests for formal statements over policy proposals, as well as more informal mechanisms and contacts (see Chapter 8).

As a result of the increasingly multidimensional nature of policy-making there is, in general, an increasing need for consultation so as to increase policy coherence both between the various sectors and the various levels of policy-making. At European level, there has already been positive development in the European Council as several presidencies have increasingly brought issues from other policy areas with health implications to the Council Working Party on Public Health. Also, as regards the European Parliament, in the spring of 2006, it finalized its first reading of the future Public Health Programme,

clearly moving from a disease-based perspective towards that of health determinants and broad action for health across sectors.

Formulating stands for the EU-level policies at national level in intersectoral and political arenas is extremely important as the policy mandates and perspectives may differ between the various sectors at Community level on the one hand and at national level on the other. As regards HiAP at EU level, it is not least at national level that the health perspectives need to be integrated in terms of the national stands on the various policy proposals. Chapter 9 describes the Finnish way of formulating its EU stands. It has been characterized as a systematic, intersectoral and participatory working method.

Health impact assessment (HIA) has been used as an instrument for not only assessing health implications but also for helping in the process of making health implications visible and taken into serious consideration in the policy-making processes. As Chapter 10 describes, HIA has its bases not only in other impact assessments, but also in healthy public policy and policy science. The scope of HIA varies from a small desk assessment of the directions of likely health impacts of the policy options to assessments aiming at good estimates of the size of impact. The investment in HIA should be proportional to the importance of the policy decision. According to a survey on the use of HIA in a variety of European countries, as presented in Chapters 11 and 12, the extent of the use of HIA varies by country but is strongest in the United Kingdom. Chapter 13 describes a case study on the use of HIA at local level in Finland.

The health sector's role in Health in All Policies

The role of the health care sector in the vigilance of HiAP varies from country to country. Without clear responsibilities, health sector professionals may tend to consider their role to be mainly in the curative services, or at best in disease prevention and health promotion activities within the premises of the health services.

In order to have a significant role in identifying policies and policy proposals with potential impacts on health, the health sector needs to have sufficient capacity in terms of public health personnel at the various levels of administration and this personnel needs to have adequate public health training and sufficient mandates and responsibilities allotted to them. Even if health considerations have become an intrinsic part of policy-making in some sectors, such as that of environmental policies, in general other sectors need input from the health sector in order to be able to take health implications into account. This is the case especially in areas without a strong tradition of considering health implications and in the cases of new or emerging issues or potential problems.

Taking Health in All Policies seriously: policy implications

Constitutional and legal bases

Through the Amsterdam Treaty the Community assumes a responsibility to promote as well as protect the health of EC citizens, and thus – one could argue – to ensure that health is enhanced or at least not harmed through its policies. This forms the legal base for strengthening HiAP in European-level policy-making. It is important to stress that while health care responsibilities remain at the national and local levels of the Member States, public health responsibilities regarding health in those other policies in which mandates have been delegated to the Community are largely at European level.

While the legal obligation to ensure that health considerations are included in all policy-making is clear at treaty level, it would be beneficial to review possibilities for strengthening the implementation of this obligation. This might include legal obligations to report on the health implications of Community policies. It would also be important to identify current barriers for full implementation of the treaty obligation and to make necessary amendments to overcome identified barriers, so as to ensure that health is lifted higher in policy- and decision-making, interventions and actions of the various bodies of the Community. In the Member States the legislative bases are more variable and the Member States may wish to explore the legislative needs at national and local levels so as to ensure that the legal bases for implementing HiAP are in place.

Aims, values and policy coherence

In any political entity the aim is to achieve coherent policies in which the various policies lead towards the commonly agreed aims and are based on the fundamental values of the system. The ultimate aim of HiAP is also to aid informed policy-making so that health implications can be considered when making policy decisions and implementing them.

Health is currently a component of major strategies and policies of the Community, including the Lisbon Strategy, sustainable development and competitiveness. However, the argumentation for health could be strengthened, in particular with regard to economic factors. It is also important to recognize health as an aim and intrinsic value in its own right and to lift such pure health policy objectives onto the central agendas that go beyond those concerning competitiveness, effectiveness and productivity. Such objectives include, for example, those relating to distributional aspects of health and well-being, as well as the role of alleviating suffering and providing health security and care.

For increased policy coherence there is a need to overcome many sectoral and organizational barriers, both within the European level at the Commission, the Council and the Parliament, in the Member States, including their governments and sectoral administrations, as well as at local level.

Member States may wish to consider reviewing their intersectoral structures, such as intersectoral committees and other forms of consultation, to ensure that health is discussed and considered in overall policy-making. For example, in the division of labour between the Community and the Member States, health care has mainly remained in the national domain. This means that assessing implications of European-level policies on the national health care system should be done through national-level intersectoral bodies or processes, so that the national stands are not formulated without considering these implications. However, even regarding HiAP at European level, health considerations should at best also be integrated into the national stands regarding Community policies.

Ownership: public support, participation, democracy and political leadership

Health is highly valued by most people and therefore putting health higher on political agendas has solid support. Nevertheless, public information and knowledge on health implications of various policies could be improved so as to enhance proper public discussions and open decision-making. Policies should remain under democratic control without undue emphasis put on organizations and associations of mediation.

While curative and disease-based approaches are most visible in public discourse and media and among, for example, patient organizations, health promotion and the implications of other policies are not always as well established in lay knowledge and information. Special attention should also be paid to ensure that public health NGOs are involved as part of the appropriate civil society consultations, since their own funding base may not be as strong as that of some other lobbying groups.

For the HiAP approach to move up the political agendas, it needs political ownership at all levels, not least at the highest level. In order for HiAP to be widely owned, there needs to be a clear understanding of the basic concepts, the linkages of major health determinants with health on the one hand, and with other policies on the other. It is also important that the responsibilities of and mandates in implementation and monitoring of HiAP are clarified between the general administration and the health sector, at all levels of governance. Furthermore, it is important to recognize that there is still some

diversity in the HiAP perspective and premises even among the health experts of the various Member States, and therefore, to be successful, the general discourse and theoretical premises still need some discussion even among those experts.

Capacities and resources

Assessing health impacts of policies and policy initiatives, as well as formulating healthy policy options, need resources in terms of a knowledge base, public health training, personnel, structures and financing. The bodies with decision-making powers on policies and policy measures should be served with appropriate knowledge on and analyses of population health status and its major determinants stratified by population groups, as well as trends in the status and the determinants on regular bases. In addition, decision-makers should be provided with analyses of health implications of major existing horizontal policies, as well as of policy proposals and alternatives with potentially remarkable influences on health and health determinants.

Countries wishing to strengthen their HiAP approach should ensure that there exists a sound information base for the trends in population health and the underlying health determinants and that there are appropriate resources for processing and analysing the population health and determinants data for the use of policy-makers.

Structures, mechanisms and instruments for Health in All Policies

For increased policy coherence, as well as more specifically health to be considered in policy-making and development, a forum for interchanging knowledge and ideas including policy-makers and civil servants from various sectors has proven helpful. For substantiating health implications of other policies a variety of instruments has been established. For using any of them, one prerequisite is transparent: policy-making with sufficient time frames for analyses and reaction. In the search for good strategies, structures, mechanisms and instruments for considering health implications of other policies, the Commission, as well as the Member States, should learn from the best practices. This book describes a number of them, but there is still scope for further learning from each other by exploring and analysing existing good practice.

eu2006.fi

Health is largely determined by factors outside the health care domain. Efforts to integrate health considerations into societal policy-making with the aim to improve population health are being made almost everywhere, both at the Community level as well as at the national, regional and local levels.

This volume, published in the context of the Finnish Presidency of the European Union (EU), aims to highlight how and why the health dimension can and should be taken into account across all government sectors. Particular emphasis is placed on the unique mandate and obligation of the EU to protect health in all its policies. The topic is explored from the perspectives of available methods and different levels of policy-making, and examples are included from specific policy areas and health issues.

Contents include: Principles and challenges of Health in All Policies • Moving health higher up the European agenda • The promotion of heart health • Health in the world of work • Public health, food and agriculture policy in the European Union • Health in alcohol policies • Environment and health • Opportunities and challenges for including health components in the policy-making process • Towards closer intersectoral cooperation • Health impact assessment and Health in All Policies • The use of health impact assessment across Europe • Implementing and institutionalizing health impact assessment in Europe • A case study of the role of health impact assessment in implementing welfare strategy at local level • Towards a healthier future

The editors
Timo Ståhl is Senior Researcher, STAKES, Helsinki, Finland. **Matthias Wismar** is Health Policy Analyst, European Observatory on Health Systems and Policies. **Eeva Ollila** is Senior Researcher, STAKES, Helsinki, Finland. **Eero Lahtinen** is Ministerial Adviser, Ministry of Social Affairs and Health, Helsinki, Finland. **Kimmo Leppo** is Director-General, Ministry of Social Affairs and Health, Helsinki, Finland.

Finnish Institute of Occupational Health
KTL
STAKES knowledge for welfare and health
ISBN 952-00-1964-2
9 789520 019648