ANNEX 2

Policy Assessment on
Social Policy, Education, Vocational Training and Youth:
a part of the
Health Systems Impact Assessment Tool

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Contents

Introduction

This document presents a draft policy assessment of the European Union (EU)[1] policy on 'Social Policy, Vocational Training and Youth'.[2] The policy assessment was written as a background document to help produce health system impact assessments (HSIA) on individual EU proposals as part of the Commission's impact assessment. The Commission's impact assessment includes the proposals of all its major initiatives in the Annual Policy Strategy or in the Work Programme. These may either be regulatory proposals or other proposals having an economic, social and environmental impact (Commission of the European Communities 2002a).

The draft policy assessment presented in this document is intended to support the desk officer assessing a proposal by:

- raising awareness for the mechanism by which the proposal may produce impacts on health systems;
- highlighting past impacts on health systems caused by the implementation of the policy;
- specifying the relevance and magnitude of impacts.

In order to provide this support the policy assessment shall present an overview on the interactions that the policy can have with health systems. This overview will be based both on the evidence and conceptual considerations.

The document starts by explaining in conceptual terms the indirect mechanism by which non-health EU policies have impacts on health systems. This is followed by an overview of the EU policy on 'Social Policy, Vocational Training and Youth' including the instruments for its implementation. Building on the overview, four case studies on health and safety of workers (lifting weights and asbestos), working conditions (working time), and the European Social Fund are presented. The case studies illustrate past impacts of the policy on health systems. Finally, the relevance and magnitude of these impacts will be discussed.

[1] Throughout the document European Union will be used synonymously with European Community.
[2] Treaty Establishing the European Community (Art 136-150).

This document should be read in conjunction with the 'draft tool for desk officers – health systems impact assessment'. The tool guides the desk officer through the process of HSIA. It explains the relevance of health in EU policies, clarifies on the terminology of health systems and explains their values and principles. Further to this, it discusses the differences between Health Impact Assessment (HIA) and HSIA. In practical terms, it explains how to use the tool and whom to contact for help. It is planned to publish a final version of the tool on the web.

This policy assessment addresses a mixed target group since its purpose is to facilitate exchange and dialogue between different DGs and sectors. That means that the policy assessment needs to be comprehensible for a non-health related desk officer conducting a HSIA on a given proposal. At the same time it should be comprehensible for a health related audience that is not familiar with the policy assessed. That entails, however, that some issues are explained in more detail than it would be needed for a single audience.

The policy assessment was commissioned by the Working Group on Health Systems Impact Assessment of the High Level Group on Health Services and Medical Care. It is part of the working group's activities developing an EU methodology that allows addressing prospectively and systematically the potential impacts of non-health EU policies on health systems. Technical aspects of this methodology have been discussed during an experts workshop on Health Systems Impact Assessment, taking place 31st January 2006 in Brussels.

This draft policy assessment is a pilot assessment. The topic is rather new and evidence is scarce. Much research related to this topic has focused on aspects of the Single European Market including the free movement of goods, persons, services and capital and, to a certain extend, the common rules of competition. The impacts of many other EU policies on health systems, however, are so far unknown or unreported or have been addressed only sporadically and unsystematically. This draft policy assessment is part of a new methodology developed for HSIA. Although the methodology can build on experiences with the methodology of HIA it remains to be tested in practice to demonstrate its value.

The mechanism of policy impact on health systems

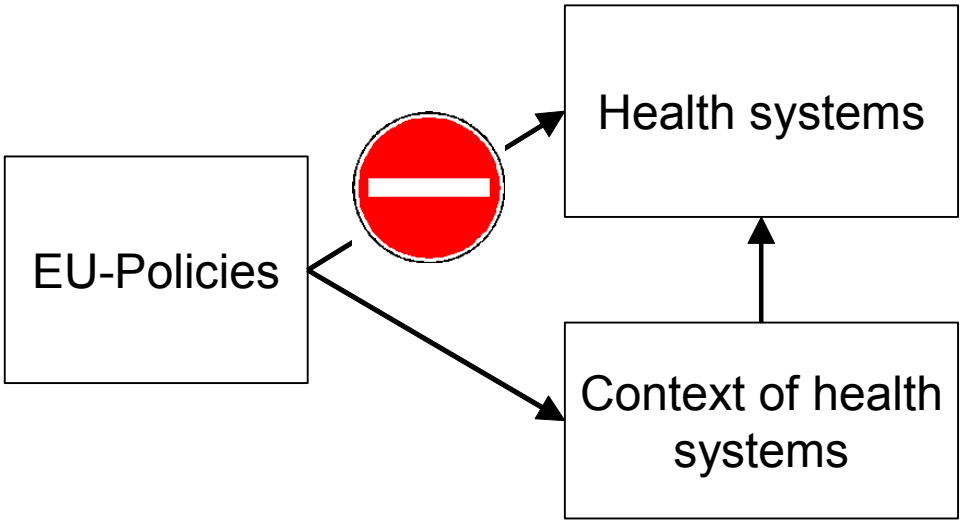
The policies of the EU may have impacts on health systems. This became most visible in the course of two seminal European Court of Justice (ECJ) cases[3] on the applicability of the free movement of goods and services to health care and specifically to cross-border patient mobility (Wismar, Busse 1998; van der Mei 1998). There are earlier examples of EU policies causing impacts on health systems (Wismar, Busse 2002). But these two court cases have unleashed an major policy and academic debate on the impacts of EU policy on health systems (Busse et al. 2002; Mossialos, McKee 2002; McKee et al. 2002; Rosenmöller et al. 2006).

In parallel to these debates, the impacts of EU policies on health systems have been formally acknowledged by the Member States in the Health Council in 2002 (Health Council 2002). A high level reflection process on patient mobility was started which resulted in a report and recommendations (European Commission Health & Consumer Protection Directorate-General 2003) to which the Commission responded (Commission of the European Communities 2004b).

EU policies have impacts on health systems. But these impacts are not caused by the EU's public health policy. The public health policy, as stipulated in Art. 152 of the TEC, states explicitly that Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care. However, while a direct impact on the ground of the public health policy is excluded impacts are caused by non-health EU policies. This takes place by an indirect mechanism as depicted in figure 1.

[3] C-120/95, Nicolas Decker v. Casisse de maladie de empoyés privé; C-158/96 Raymond Kohll v. Union des casisses de maladie.

Fig. 1: The mechanism by which EU policy have impacts on health systems.



The indirect mechanism by which EU policies have impacts operates via the context of health systems. Health systems operate in the context of the economy, social systems and the physical environment. Policies and legislation may change these contexts or parts of it. These contextual changes may have consequences for the way health systems operate. There are 20 non-health EU policies in the TEC and some of them have the proven potential to change these contexts.

Table 1: The EU policies in the Treaty (in bold the policy assessed in this document)

I	Free movement of goods	VIII	Employment	XV	Trans-European networks
II	Agriculture	IX	Common commercial policy	XVI	Industry
III	Free movement of persons, services and capital	X	Customs cooperation	XVII	Economic and social cohesion
IV	Visas, asylum, immigration and other policies related to free movement of persons	**XI**	**Social policy, education, vocational training and youth**	XVIII	Research and technological development
V	Transport	XII	Culture	XIX	Environment
VI	Common rules on competition, taxation and approximation of laws	XIII	Public health	XX	Development cooperation
VII	Economic and monetary policy	XIV	Consumer protection	XXI	Economic, financial and technical cooperation with third countries

In the past, impacts of non-health EU polices have been observed in regard to the free movement of goods, persons, services and capital. The aforementioned cross-border patient mobility is an example for this impact. Impacts of other non-health EU policies were found in the regard to the implementation of the common rules on competition, taxation and approximation of laws funds (Schulz-Weidner, Felix 1997; Karl 2002; Wismar 2003), the economic and monetary policy (Urban 2003; McKee et al. 2004), social policy, education vocational training and youth (Baeten, Jorens 2006).

Impacts may differ between countries. What may affect health systems in one country may not produce any impact in another. Differences in impacts can be explained by the diversity of health systems and their contexts. The way the stewardship, financing, resource generation, and service delivery functions are organized may explain differences in the susceptibility to impacts caused by non-health EU policies. There are marked differences between health systems in the EU. Health systems in social health insurance countries vary decisively from national health services in regard to organizational make up and financing (Busse et al. 2006). With the new Member States acceding the EU in 2004, this diversity has grown (Dubois, McKee 2004).

Impacts of non-health EU policies on health systems may also differ because of differences in the context. New legislation implementing EU policy, may be drafted on the model of a specific country. When implementing the policy, the model country will be unaffected by the legislation while others may experience serious impacts on their health systems (Renck, Sundh 2002).

Impacts may differ in relevance and magnitude. Some of the impacts are negligible; some of them may even be favourable and support health systems objectives such as accessibility and quality of services and the financial sustainability of health systems. But other impacts may seriously affect these objectives.

Although the relevance of impacts on health systems is measured against a set of objectives, this assessment is not conducted from a normative point of view. It is the purpose of HSIA to inform and assist the decision.

Many of the impacts of non-health EU policies on health systems are unintended or unforeseen. They are the result of the complex interplay between the EU policies, health systems and their contexts. But some impacts are the result of conflicting policy aims. In order to avoid the unintended impacts and mitigate the consequences of policy

inconsistencies, the inclusion of HSIA into the Commission's impact assessment may be a valuable contribution to ensure complementarities between EU policies and the social dimension.

The policy

The purpose of the policy overview is to put the case studies into context and facilitate a discussion on the relevance and magnitude of past and future impacts. In order to assess the policy's potential to produce impacts, all policy sectors and instruments of the policy need to be discussed.

The overview serves solely the purpose of the assessment and is therefore very brief. It may not do justice to the intentions of the described initiatives and actions. The level of detailed description depends on the relevance for health systems.

The policy under assessment comprises a large number of diverse policy sectors and instruments for implementation. Some of these policy sectors have a long and intensive regulatory history, dating back to the inception of the Treaty Establishing the European Economic Community which came into force in 1958. This overview can only capture the current status.

The policy in the treaty

The EU policy on 'Social Policy, Education, Vocational Training and Youth' falls into three chapters. The first comprises 'Social Provisions' the second the 'European Social Fund' and the third 'Education, Vocational Training and Youth'.

Box 1: The three chapters of the policy and the specific articles[4]

Social provisions

136 objectives of social provisions

137(a) improvement in particular of the working environment to protect workers' health and safety;

137(b) working conditions;

137(c) social security and social protection of workers;

137(d) protection of workers where their employment contract is terminated;

137(e) the information and consultation of workers;

137(f) representation and collective defence of the interests of workers and employers, including co-determination,

137(g) conditions of employment for third-country nationals legally residing in Community territory;

137(h) the integration of persons excluded from the labour market;

137(i) equality between men and women with regard to labour market opportunities and treatment at work;

137(j) the combating of social exclusion;

137(k) the modernisation of social protection systems;

138-139 European Social Dialogue;

140 encourage cooperation between Member States by making studies, delivering opinions and arranging consultations;

141 equal pay;

142 equivalence between paid holiday schemes;

143 reports on the demographic situation in the Community;

144 establishing a social protection committee;

145 chapter on social developments.

European Social Fund

146-148 objectives and administration of the social fund

Education, Vocational Training and Youth

149 objectives of education

150 objectives of vocational training

The policy included under 'Social provision' was introduced by the Single European Act, adopted in 1985 and coming into force in 1987. It introduced a policy mandate for harmonizing aspects of the 'working environment' in regard to 'health and safety of workers'. Since then the policy has constantly evolved, first by the agreement on social policy, annexed to the Treaty on European Union. With the Treaty of Amsterdam, the social agreement was

[4] Lengthy articles (136, 138-150 abbrivated) in the overview.

incorporated into the TEC and again modified with the Treaty of Nice. However, some legislation related to this policy has preceded the introduction of a policy mandate in regard to health and safety of works and was based on other policies in the Treaty. The European Social Fund (ESF) has been introduced in 1957 with the creation of the European Economic Community. Early initiatives of vocational training started in 1975, a programme was adopted in 1994. A programme for youth exchange started in 1988.

In some cases, policies that seem to belong to 'Social Policy, Education, Vocational Training and Youth' are based on other policies in the Treaty. For example, the coordination of social protection (Art. 42) and mutual recognition of diplomas (Art. 47) is part of the policy on the Free Movement of Persons, Services and Capital'.

The specific directions of the regulation and the action programmes depend on the policy context set by the Member States and the EU institutions. The Lisbon Council conclusions of 2000, better known as the Lisbon Agenda provide an important part of the policy context, since creating better and more jobs is one of the key objectives of the Lisbon Agenda. Health and safety issues are considered essential elements in terms of quality of work (The Council of the European Communities 2000). This is picked up in the Community's strategy on health and safety at work 2002-2006 (Commission of the European Communities 2002b). The objective of the Community's policy on health and safety at work is defined to bring about a continuing improvement in well-being at work. There are other, important documents which serve as a frame of reference, such as the European Union's Charter of Fundamental Rights[5], which incorporates the earlier Community Charter of Fundamental Rights of workers from 1989. The European Social Charter of 1961 signed by the members of the Council of Europe provides another point of reverence.

The instruments for policy implementation

The EU has different instruments for policy implementation at its disposal: legislation, financial instruments (the European Social Fund, action programmes) social dialogue, the 'open method of coordination' (Commission of the European Communities 2005) and various other supportive instruments.

[5] The Charter is a political declaration and did not receive a formal legal status.

Legislation regulating policy sectors

A broad range sectors of social provision are regulated by EU law: Health and safety of workers (Art. 137a), working conditions (137b), social security and social protection of workers (137c), protection of workers when their employment contract is terminated (137d), the information and consultation of workers (137e), and the representation and collective defence of the interests of workers and employers, including co-determination (137f), conditions of employment for third-country nationals legally residing in Community territory (137g), the integration of persons excluded from the labour market (137h) and equality between men and women with regard to labour market opportunities and treatment at work (137i). Equal pay (art. 141) constitutes another policy sector under social provisions. For 137a-i the EU may adopt legislation on minimum requirements by means of legislation.

For Art. 141 the EU shall also adopt the appropriate measures.[6] It should be noted that the provisions laid out in the chapters of the TEC concerning the ESF and 'Education, Vocational Training and Youth' exclude any harmonization of laws and regulations in the Member States.

Health and safety of workers (Art. 137a) constitutes one of the EU's most concentrated and most important policy sectors (Gerlinger 2000). The regulatory framework is set by a large number of directives. A framework directive[7] specifies the objectives of the regulatory measures, defines the key terminology and specifies the obligations of employers and employees. Eight directives specify various aspects of the workplaces and work equipment.[8] Another set of directives focuses on sectors of activities such as mobile construction sites, miners extracting industries and surface and underground mineral extracting industries.[9] This is followed by directives on specific risk such as manual handling of heavy loads[10], visual display units[11], carcinogens[12], chemical agents[13], biological agents[14], physical agents (noise, vibrations and electromagnetic fields)[15] and asbestos[16]. In addition, two directives are

[6] Decisions on 137c-d and f-g require an unanioums decision by the Council.
[7] Directive 89/391/EEC.
[8] Directive 89/654/EEC; Directive 89/655/EEC; Directive 89/656/EEC; Directive 1999/92/EC; Directive 92/58/EEC; Directive 93/103/EC.
[9] Directive 92/57/EEC; Directive 92/91/EEC; Directive 92/104/EEC.
[10] Directive 90/269/EEC.
[11] Directive 90/270/.
[12] Directive 90/394/. Directive 97/42/EC. Directive 1999/38/EC.
[13] Directive 98/24/EC; Directive 91/322/EEC; Directive 2000/39/EC; Directive 98/24/EC.
[14] Directive 2000/54/EC.
[15] Directive 86/188/EEC; Directive 2003/10/EC; Directive 2002/44/EC;.

specifically aimed at health and safety of pregnant women and mothers with babies and young workers.[17]

Working conditions (137b) covers issues of employer insolvency[18], fixed term work[19], health and safety in fixed term and temporary employment[20], information on individual employment conditions[21], part time work[22], posting of workers[23], working time[24] and young people at work[25].

Articles 137d-f constitutes another policy sector referring to collective rights and representation of workers. This comprises the legislation on collective redundancies[26], European work councils[27], the European company statute[28], European co-operative society[29], information and consultation of employees[30], and the transfer of undertakings[31].

The chapter on social provisions also links to the general anti-discrimination policy of the EU with articles 137g and 137i. Racial or ethnic discrimination[32] or discrimination on the grounds of religion or belief, disability, age or sexual orientation[33] is the focus of the directives. The directives cover a broad scope of employment and work related issues such as conditions of access to employment or self-employed activities, including selection criteria, recruitment conditions and promotion, vocational training, working conditions including dismissals and pay, and membership of and involvement in organisations of workers or professional organisations.

There are a substantial number of interventions by the EU into matters concerned with pay. The best known and most highly developed is the explicit commitment to equal pay for

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[16] Directive 83/477/EEC; Directive 91/382/EEC; Directive 2003/18/EC.
[17] Directive 92/85/EEC; Directive 94/33/EC.
[18] Council 80/987/EEC; Directive 2002/74/EC.
[19] Directive 1999/70/EC.
[20] Directive 91/383/EEC.
[21] Directive 91/533/EEC.
[22] Directive 97/81/EC; Directive 98/23/EC.
[23] Directive 96/71/EC.
[24] Directive 2003/88/EC; Directive 93/104/EC; Directive 1999/63/EC; Directive 2000/34/EC; Directive 2000/79/EC;.
[25] Directive 94/33/EC.
[26] Directive 75/129/EEC. Directive 92/56/EEC. Directive 98/59/EC (This Directive consolidates Directives 75/129/EEC and 92/56/EEC above).
[27] Directive 94/45/EC; Directive 97/74/EC.
[28] Directive 2001/86/EC; Council Regulation (EC) No. 2157/2001.
[29] Directive 2003/72/EC; Council Regulation (EC) No. 1435/2003.
[30] Directive 2002/14/EC.
[31] Directive 2001/23/EC.
[32] Directive 2000/43/EC.
[33] Directive 2000/78/EC.

women and men in Article 141 EC. The clear commitment by the EU to enforceable regulation with regard to the principle of equal pay between women and men was perceived as critical to the common market objective of fair competition, ensuring that employers in some Member States did not benefit from a competitive advantage due to higher regulatory wage standards (in this case, prohibiting discrimination in pay on grounds of sex) in others. For the same reason, the EC Treaty also included a provision that, 'Member States shall endeavour to maintain the existing equivalence between paid holiday schemes' (Article 142 EC).

Financial instruments

The key financial instruments are the European Social Fund and the various action programmes. The action programmes in the area of social policy are planned to be merged into a single financial instrument, called PROGRESS (Commission of the European Communities 2006). The action programmes in the area of vocational training and education are planned to merge into a new EU Action programme in the field of lifelong learning 2007-2013.

There are various Community action programmes and budget lines under the social provisions chapter of the TEC. Examples for action programmes are the Community action programmes on combating social exclusion[34] **(**2002-2006) (173 j), combating discrimination[35] (2001-2005) and promoting gender equality[36] (2001-2006). The original budgets of the programmes amount to €75 million, €98.4 million and €50 million over the whole period.

Created in 1957, the European Social Fund (Art. 146-148) is the EU's main tool for the development of human resources and the improvement of the workings of the labour market. It supports measures to prevent and combat unemployment and to develop human resources. The ESF aims to promote a high level of employment, equality between men and women, sustainable development and economic and social cohesion. Through the ESF, the EU is providing almost €70 billion over the seven year period 2000-2006. This money works alongside public and private funding within Member States to tackle the specific problems of each area of the EU. The EQUAL initiative, funded by the ESF for over €3 billion for the

[34] Decision No 50/2002/EC.
[35] Council Decision of 27 November 2001, establishing a Community Action Programme to combat discrimination (2001-2006).
[36] Decision 2001/51/EC of 20 December 2000 establishing a Programme relating to the Community framework strategy on gender equality (2001-2005)

2000-2006 period, has been testing new ways of tackling the discrimination and inequality experienced by many people both at work and when looking for a job. The EQUAL initiative places an emphasis on transnational cooperation and the principle of "mainstreaming" - integrating new approaches into policy and practice.

There are various programmes under the chapter on 'Education, Vocational Training, and Youth'. In regard to education (Art. 149), the SOCRATES programme is the most important. It supports and encourages exchanges of students and teachers, the launching of joint study programmes or intensive courses, pan-European thematic networks and other measures aimed at the development of a European dimension in higher education. The second phase of the Socrates Programme will end in 2006.

Vocational training (Art. 150) comprises several action programmes and activities. The most important is the Leonardo Programme. Its aim is to contribute to the implementation of an EU vocational training policy. The programme has been progressively opened to participation in 31 countries.

The new Integrated Action Programme in the field of lifelong learning comprises sectoral programmes on school education, higher education, vocational training and adult education, and is completed by transversal measures and an additional Jean Monnet programme focusing on European integration. The proposed budget is €13.62 billion for the total period 2007-2013.

Youth Community action programme (Art. 149-150) offers young people opportunities for mobility and active participation in the construction of the Europe and contributes to the development of youth policy, based on non-formal education. It aims to promote exchanges and discussion meetings between young people, voluntary work, participation and active citizenship, and the innovation and improvement of international training and cooperation skills in the youth field.

European social dialogue

European social dialogue (Art. 138-139) allows for the joint involvement of the organisations of the social partners in European policymaking. The European social dialogue may result in a

European collective agreement.[37] Examples include the framework agreements on parental leave, part-time work and fixed-term work, which were transformed into directives, and the more recent agreement on telework.

Open method of coordination

The Open method of coordination (OMC) has been introduced based on various legal provisions in the policy such as the modernisation of social protection systems (Art. 137k), the social protection committee[38] (Art. 144) and provisions in regard to specific policy sectors, i.e. the integration of persons excluded from the labour market (137h).

The OMC is a form of EU soft law, a process of policymaking which does not lead to binding EU legislative measures nor require Member States to change their law. The OMC aims to spread best practices and achieve greater convergence towards the main EU goals. Accessibility, quality and financial sustainability are the joint objectives for developing care systems (Commission of the European Communities 2004a). Preliminary national policy statements on health care and long term care were submitted by most Member States.[39]

Other supporting instruments

There is a large number of other instrument by which the Community may implement its policy. Among these are studies, opinion and consultations, monitoring and reporting, supporting intergovernmental activities, and establishing European agencies.

The Commission can make studies, deliver opinions and arrange consultations (Art. 140) in order to encourage cooperation between Member States and facilitate the coordination of their action in all social policy fields.

On the basis of the monitoring and reporting (Art. 143-145) requirements, the Commission is requested to draw up a report each year on the progress towards the objectives of Article 136, including analysis of the demographic situation and social developments in the Community. In addition, the European Commission publishes an annual report on the social situation in the EU, which deals with the quality of life of people living in Europe and provides a holistic

[37] Web-site European Foundation for the Improvement of Living and Working Conditions: http://www.eurofound.eu.int/areas/industrialrelations/dictionary/definitions/EUROPEANCOLLECTIVEAGREEMENTS.htm

[38] Council Decision 2000/436/EC. Council Decision 2004/689/EC.

[39] http://ec.europa.eu/employment_social/social_protection/health_en.htm.

view of the European population and its social conditions as a background to social policy development.

The EU policy on 'Social policy, Education, Vocational Training and Youth' is supported by various agencies. The European Centre for the Development of Vocational Training (Cedefop) was established in 1975.[40] The European Foundation for the Improvement of the Living and Working Conditions, based in Dublin, Ireland, was set to contribute to the planning and design of better living and working conditions in Europe.[41] The European Training Foundation based in Turin, Italy, was established in 1990 and became operational in 1994. The European Agency for Safety and Health at Work, based in Bilbao, Spain, was set up in 1996.[42] All the agencies support the EU and Member States by carrying out research and development projects, providing data and analysis, informing and supporting the formulation of EU policy. The EU subsidy of these foundations varies between €10.7 and €19.5 million.[43]

There are also inter-governmental processes such as the Bologna process under the Education chapter (Art. 149). Thus, the aim of the process is to make the higher education systems in Europe converge towards a more transparent system which whereby the different national systems would use a common framework based on three cycles - Degree/Bachelor, Master and Doctorate.

[40] Regulation (EEC) No 337/75.
[41] Regulation (EEC) No 1365/75.
[42] Council Regulation No 2062/94.
[43] Last available budget figures.

Case studies on past impacts

The policy includes a large number of diverse policy sectors and instruments for implementation. Since it is impossible to cover all of them comprehensively, case studies were produced that can well illustrate the impacts of non-health EU policies on health systems.

The case studies should have the capacities to further illustrate and specify the mechanism by which the policy impacts on health systems, their functions and objectives. In addition, the case studies should demonstrate the relevance and magnitude of impacts.

Two case studies based on the policy sector of health and safety of workers (Art. 137a) were chosen because this policy sector counts, as already mentioned, as the most concentrated and most important policy sector. A case study on the manual handling of heavy loads in health care organizations seems to be very timely too, since the Commission announced in its Community strategy plans (Commission of the European Communities 2002b) to renew legislation in this area. This case study is complemented by a case study on EU policies and Asbestos in Hospitals. A third case study focusing on working time and human resource management was produced since the debate around the impacts of the working time directive has presented this as a highly relevant case for HSIA.

In order to cover policy sectors and instruments from all chapters of the policy a case study on the ESF was written. The ESF is one of the four structural funds and a major instrument for financing various programmes from different chapters of the policy.

An original planned case study falling under the chapter of Education, Vocational Training and Youth was dropped after expert consultation. It seemed unlikely that such a case study could present impacts worthwhile discussing in the context of the policy assessment.

Manual handling of heavy loads in health care organizations[44]

The work environment in health services is dominated by heavy physical workload, such as heavy lifting and working in awkward positions, and often combined with time pressure. All these conditions are well known to cause musculoskeletal disorders in Finland. In the Finnish

[44] This case study was written by Leena Tamminen-Peter, PhD (Finnish Institute of Occupational Health)

health services, the self reported rate of musculoskeletal disorders among health and social workers was 75% which was higher than in the general population (Piirainen et al. 2003).

The Finnish Ministry of Social Affairs and Health, the Department for Occupational Safety and Health, published guidelines for application of the legislation on "Manual handling of loads", based on the European Directive 90/269/EEC. It came into force on 1 January 1994.

The Finnish Occupational Safety and Health Act (738/2002) has several sections which relate to patient handling ergonomics: analysis and assessment of the risks at work, design of the working environment, providing auxiliary and other technical devices, as well as a special section on ergonomics of the workstation, work postures and work motions.

As a result of the Directive 90/269/EEC, the Finnish Institute of Occupational Health has stated that hospitals and other health care service organizations were obliged to increase their acquisition and use of handling devices and hoists for their employees to minimize direct manual handling and lifting. The purchase of such aids has obvious financial implications as well impacts on resource generation in terms of the initial purchase as well as providing the required training in order for them to be optimally utilized.

Nurses generally become aware of the advantages of using this equipment after experiencing relief from physical strain involved in the positioning and moving of patients. A survey by Siukola et al. (2004), which examined nursing staff experiences of working conditions, practices and ergonomic arrangements during the years 1992-2003 in Finland, found that nurses' physical working environment and work practices had improved during that period.

Hoists, however, are not yet available in all institutions where they would be needed (Siukola et al. 2004), and on average only 35 % of the nurses use hoists, though the frequency of usage varies a lot in the different institutions (Körkkö 2004).

Worker's exposure to Asbestos in Hospitals[45]

Directive 83/477/EEC (most recently amended by Directive 2003/18/EC) calls for the protection of workers from the risks related to exposure of asbestos at work. Asbestos, which has been proven to cause cancer, especially mesothelioma and lung cancer, has been used for decades in building materials to give them strength, color or make them fire retardant.

[45] We gratfully acknowledge comments on the draft cases study by Prof. Makropoulos, Greece.

Hospitals which were built with asbestos products can lead to exposure to both patients and hospital staff.

Greece implemented national legislation, namely the presidential decree 70a/88 "Protection of workers exposed to asbestos at work" in compliance with the community directive 83/477/EEC as amended by the presidential decree 175/97 in compliance with community Directive 92/92/EEC. However, Greece, being both producer (7th largest asbestos producer in the 1990's) and user of asbestos might explain why it was one of one two European Union Member States not to have banned asbestos prior to the EU 2005 asbestos deadline of 1 January 2005 (Kazan-Allen, L. 2002). The transposition of the Directive 2003/18/EC into national law will be completed in Greece in the following 3 months (November 2006) as it is currently in the final stage of signatures. It is expected that the national asbestos situation will improve following the application of this law.

Asbestos was still being used in construction in Greece as late as 1996. Construction began in 1992 and was completed in 1996 on one of Greece's newest state hospitals, Thriasio Hospital. The hospital was built using large quantities of asbestos and the decision for removal was signed by the Minister of Health prior to February 2005. The removal, which is estimated to cost more than €2.7 million is being undertaken to protect the health and safety of both staff and patients.[46] Thriasio is not the only hospital to have been found with asbestos products. The Deputy Minister of Health, Mr. Athanasios Giannopoulos, reported on The Hellenic Radio in February 2005 that Grevena General Hospital and Kastoria General Hospital have both been found to contain asbestos sheets while six additional hospitals have been earmarked for removal of external undulate material containing asbestos. This clean up process will undoubtedly by very costly for Greece.

Working time and human resource management in hospitals[47]

The 1993 Working Time Directive (WTD) on aspects of the organization of working time aims at improving employment conditions by protecting workers from adverse health and

[46] MesoLink.org. [website]. Greek hospital full of asbestos. December 22, 2004. (http://www.mesolink.org/mesothelioma-news/12-22-04.html, accessed 4 August 2006. The Hellenic Radio [website]. Reconstruction will cost Euro 2.7 million asbestos removed from Thriasio. 2 February 2005. (http://www.hri.org/news/greek/eraen/2005/05-02-02.eraen.html#09, accessed 3 August 2006.

[47] This case study has been written by Rita Baeten (Observatoire Social Européen, Belgium).

safety risks.[48] Directive 93/104/EC lays down provisions for a maximum 48 hour working week (including overtime), daily and weekly rest periods and breaks as well as a minimum of four weeks paid leave per year. A number of areas, including doctors in training, were brought under its scope in an amendment in 2000.[49] A number of categories of workers such as persons with autonomous decision making powers are still excluded from the Directive.

In the healthcare sector, the concept of working time led to interpretation problems mainly because of the unclear status of on-call work and the periods of rest at the workplace. A series of judgements of the ECJ clarified that if the healthcare worker is required to be physically present at the workplace, time spent on-call must be regarded as working time, even though the person concerned is permitted to rest. For healthcare workers who are on-call by being reachable without having to be present at the health centre, only the time spent actually providing health care services is regarded as working time.[50] Prior to these ECJ rulings, periods of inactivity during time spent on-call were generally not defined as working time.

Furthermore, the progressive implementation of the Directive to doctors in training means that their maximum weekly working time would in principle decrease from 58 hours in 2004 to 48 hours from mid 2009. In specific circumstances this transitional period can be extended to 2012

The ECJ rulings might have substantial (financial) consequences for national health care systems. The rulings may require the recruitment of more health care staff in order to avoid exceeding the maximum daily and weekly working time and ensure sufficient breaks for personnel. This, combined with the progressive implementation of the Directive to doctors in training, would potentially have even more far reaching consequences. In many countries, considerable front-line care is provided by doctors in training. Furthermore, as the working

[48] Directive 93/104/EC.

[49] Directive 2000/34/EC.

[50] Judgement of the Court of 3 October 2000 in Case C-303/98, Sindicato de Medicaos de Asistencia Publica (SIMAP) v Conselleria de Sanidad y Consumo de la Generalidad Valenciana, European Court reprots 2000, p. I-07963
Judgement of the Court of 9 October 2003 in Case C-151/02, request to the Court by the Landesarbeitsgericht Schleswig-Holstein (Germany) in the proceedings pending before that court between the Landeshauptstadt Kiel and Norber Jaeger
Judgement of the Court of 5 October 2004 in Case C-397/01 tot C-403/01, Pfeiffer and others versus Deutsches Rotes Kreuz.
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patterns of doctors in training would change to comply with the WTD, the training authorities must find new ways of delivering the training.

Following the judgements, several Member States made use of the opt-out arrangement provided for in the WTD, as a means to alleviate some of the problems created by the case law, but did so for the health sector only (Commission of the European Communities 2003).

European Social Fund

Regulation (EC) No. 1784/1999 redefined the framework and political priorities of the European Social Fund (ESF) for the period 2000-06. The ESF was established to help people improve their skills and, consequently, their job prospects. Created in 1957, the ESF is the EU's main source of financial support for efforts to develop employability and human resources. It helps Member States combat unemployment, prevent people from dropping out of the labour market, and promote training to make Europe's workforce and companies better equipped to face new, global challenges.[51]

In Finland[52], the ESF is being used to provide vocational training to the Romany population in a variety of areas including practical nursing and massage therapy. The Romanies, which have lived in Finland since the sixteenth century, and are entitled to the same educational opportunities as the majority population, however, in reality this has not been the case.

To combat this problem, a trial training programme, especially for Romanies, known as Romako, was run from 1996-1998. Following the success of the programme, upon Finland's accession into the EU, it extended the programme nation-wide and is now know as Suomen Romako. The programme targets Romanies that are either long-term unemployed or have been displaced from the job market. The funding, 40% from the ESF and 60% from Finland's Labour Administration, has so far helped 195 Romany students gain a profession that enhances their identity both as individuals and as a group.

The training of Romany students in health care fields has implications on financing and resource generation as well as service provision. The cost of the staff, training materials and allocation of the training sites will have to be provided for through the funding and will

[51] Employment, Social Affairs and Equal Opportunities [web site]. European Social Fund. (http://ec.europa.eu/employment_social/esf2000/introduction_en.html, accessed 9 August 2006).
[52] The following paragraphs are based on a web-page of the Finnish National Board of Education 5 July 2006: www.edu.fi/english/SubPage.asp?path=500,4699,6276

impact on the finances and resource generation. The training of health care workers from the Romany population helps in service delivery by providing trained Romany nurses. These nurses can take into account the Romanies' own needs and special features of their culture.

Relevance and Magnitude of impacts

The case studies have shown that regulating the context of health systems by the EU policy on 'Social Policy, Vocational Training and Youth' can cause impacts on health systems. The following paragraphs shall clarify on the relevance of impacts, further specify the mechanism by which this policy produces impacts, raise some issues around assessing the magnitude of impacts and discuss the likelihood of further impacts.

Impacts and health systems objectives

The policy's capacity to produce relevant impacts affecting health systems objectives is clearly given. The WTD provides an example of a policy that has the potential to threaten the financial sustainability of health systems in several countries. While this example is very illustrative in terms of the relevance and magnitude of the impact it should be noted that it focuses mainly on a single health system objectives. Other objectives of health systems such as accessibility and quality have not been affected in the context of the case studies. [53]

The Netherlands estimated that applying the ECJ rulings would require to recruit 10,000 additional workers at an extra cost of €400 million. The UK believed it would require about 1,250 additional health care staff other than doctors and between 6,250 and 12,550 additional doctors, at an estimated £380 to £780 million. (Commission of the European Communities 2003) Malta would require double the number of specialists in the highest training grade and would need up to a third more doctors-in-training.[54]

In the UK, several assessments found a decrease in the number of weekly training lists for trainee anaesthetists (Sim et al. 2004; White et al. 2005). Other studies indicated however that new organisation schemes might allow compliance with the WTD whilst improving the quality of patient care, including reducing waiting time, staff training and reducing the risk to patients from errors (Jones et al. 2004; NHS Modernisation Agency 2005; Department of Health 2005). Several other authors conclude that reduction of junior doctors' working hours in the UK and Ireland requires changes be made to roles, processes and practices (Cass et al. 2003; Department of Health and Children 2004; Murray et al. 2005).

[53] The following paragraphs have been compiled and written by Rita Baeten.
[54] Azzopardi Muscat, N. and Grech, N. (2004) Malta Case Study (unpublished)

The mechanism by which the policy produces impacts

In the case of the WTD the impacts of the policy is transmitted via the resource generation function of health systems. And the potential impact of this was so impact was estimated to be so substantial that the financial sustainability of health systems would have been affected. In fact, all of the case studies presented have had their major impacts on the resource generation function. It is unclear if that means that the policy in general transmits its impact via this function. Only a full assessment of all policy sectors could clarify this.

The primary target of the impacts have been in all case studies resource generation. Resource generation encompasses both human resources such as the production and employment of health professionals and the purchase, upgrade or maintenance of infrastructure and equipment (Murray, Frenk 2000; World Health Organization 2000). The example of the asbestos decontamination of hospitals provided an example for the investment into the existing infrastructure required by EU-legislation. Investment in equipment was required for the purchase of hoists as illustrated by the example on lifting weights. The case study on the working time directive focused on expanding staffing levels. The case study on the ESF provided an example of investment in the production of health professionals.

The impact on resource generation had obvious consequences for other health systems functions, in particular financing. The most drastic consequence for financing were described by the case study on the working time directive. But the working time directive seemed to have impacts on stewardship too. The options to regulate hospital working hours were restricted by the working time directive. Around the WTD, industrial conflicts were reported too. In Catalonia and Slovenia, the non-implementation of the WTD (both countries opted-out) was at stake in doctors strikes. These strikes finally ended with negotiations on financial compensations for overwork.[55]

[55] *Eiroline*, European industrial relations observatory on-line, "Doctors strike over pay and working time in Catalonia" http://www.eiro.eurofound.eu.int/2006/05/articles/es0605029i.html,
Eiroline "Government rejects proposed revision of Working Time Directive"
http://www.eiro.eurofound.eu.int/2005/07/feature/si0507301f.html

Difficulties assessing the magnitude of impacts

The case studies presented in this assessment have implications for the assessment of the magnitude of impacts. Many impacts are only visible in some countries but not in others and often they are not visible at once. In other cases incremental legislation on a specific policy sector may lead to an underestimation of impacts if not put in the context of earlier legislation.

While estimates on the impacts of the WTD suggested serious impacts on the financial sustainability of health systems in many countries, some authors argued that adoption to the WTD could be possible. This raises the issue of variations in regard to the impacts of non-health EU policies. For the HSIA it is important to take these variations into account because the predicted negligible impacts in one country may not hold true for another. The case study on worker's exposure to asbestos in Hospitals also provides evidence on the variations of impacts. Countries that have banned earlier asbestos may have started with decontamination earlier. In those countries more recent hospital building or extensions may not face the problems of the Greek hospital sector. These Variations of impacts may depend on the regulation of the Health systems context. This has been shown by previous studies on other EU-policies. The adoption of the EU policy on data exchange and protection in the process of accession to the EU had impacts on the Swedish Health System. Although the country had the oldest health protection law in Europe, the new legislation enforced changes in the handling of patient records and the conduct of medical trials. In addition new accountabilities and responsibilities in regard to data protection were assigned (Renck, Sundh 2002).

In many cases impacts have a long latency before they become visible. The estimates in the case study on the working time directive were based on a 'big-bang-scenario'. The introduction would have taken place instantly and the consequence of the policy implementation on human resource generation, stewardship and eventually on the financial sustainability would have been visible without much delay. However, as the case study on the manual handling of heavy loads has shown, changes enforced by EU legislation may take place in a much slower manner, distributing the costs of implementation over several years. Delayed implementation or insufficient implementation may also account for a slow realisation of the impacts of non-health EU policies on health systems.

Another challenge for HSIA is incremental legislation. Art. 137 provides a policy mandate to introduce minimal standards for a range of policy sectors defined in the TEC. Over the year incremental legislation has stepwise expanded the scope of the policy, has tightened the

regulation of the individual policy sectors or has raised the minimum standards. Incremental legislation may produce impacts which seem to be negligible if looked at them individual. But in terms of the accumulated impact, they may constitute relevant impacts. This incremental legislation is difficult to identify when assessing a single regulatory proposal. Identifying incremental legislation is a task which refers to the strategic proposals that are subject to a HSIA.

The likelihood of future impacts

In terms of policy sectors health and safety of workers and working conditions have raised much attention. These are the policy sectors with a comparatively long and intense regulatory history. However, future impact of other policy sectors such as e.g. on equal opportunities and equal pay remain unclear last but not least due to a lack of case studies on the impact of EU policy on health systems..

A further extension of the policy or an attempt to rise already established standards can be expected. The Community strategy on health and safety at work 2002-2006 aims at a continuing reduction in occupational accidents and illnesses, mainstreaming the gender dimension, prevention of social risks, enhanced prevention of occupational illnesses including asbestos, hearing loss and musculo-skeletal problems (Commission of the European Communities 2002b). Some of these issues have been addressed by EU-law as demonstrated in the policy overview and the case studies. Others such as musculo-skeletal problems may lead to legislation in the near future.

In terms of Instruments, it is quite clear that legislation regulating policy sectors has the largest capacity to cause impacts. The financial instruments are less likely to have impact. Even the ESF with its enormous budget will produce at its best only mild impacts. And in the case of the training of Romanies the impact is more likely to be negligible and rather positive regarding the functions and objectives of health systems.

The European dialogue itself does not affect health systems. However, agreements and legislation based on this instrument may have effects in the future.

As the OMC in the area of health and long-term care aims at the accessibility, quality and sustainability of health systems and services, it is unlikely that it will have negative impacts. Moreover, the European Union has no mandate take actions legal actions as a result of the OMC. The other supporting instruments seem to be negligible.

Limits to Health Systems Impact Assessment

This policy assessment is intended to support the implementation of a HSIA. The purpose of this document is to support the desk officer in making assumptions about what the impact of a proposal will be on health systems. Therefore, the document explained in conceptual terms the mechanisms by which non-health EU policies have impacts on health systems. An overview on the policy including policy sectors and instrument for policy implementation was provided. Case studies illustrated past impacts of the policy on health systems. The relevance and magnitude of these impacts was discussed.

However, a couple of limitations need to be addressed. First, not all policy sectors have been addressed equally. The policy assessment has identified certain areas and certain policy instruments which have a very high potential to produce impacts in the future. The policy assessment has also identified a number of instruments which are unlikely to produce substantial impacts. But given the limitations of secondary research methodology and the restrictions in time and space, the potential of some policy sectors to produce impacts has not been addressed sufficiently. This limits the value of the document for the desk officer in charge of the impact assessment when assessing a proposal relating to one of these policy sectors.

In particular the aspects of the anti-discrimination legislation (Art. 137g and 137h), of equal pay and equal opportunities between male and female workers (Art. 141), and the outcomes of the social dialogue, such as agreements on parental leave and telework have remained unclear.

Equal pay, e.g., is a long established policy, which was already introduced with the Treaty Establishing the European Economic Community coming into force in 1958. It is rather implausible that this policy had no impact on health systems given that two thirds of hospital expenditure is spend on salaries and wages and bearing in mind the high proportion of women working in hospitals it seems implausible that the policy had no impacts in the past.

A second limitation relates to the specific mechanism by which the policies impact on health systems. In the case studies presented the policy impacts via the health systems function resource generation, either in terms of having consequences on human resource management or in terms of enforcing investment into facilities and devices. The major impacts were reported in regard to the health system objective financial sustainability. It may very well be the case that this is the specific profile of this policy's impact. However, without examples of

impacts on other health systems functions and health systems objectives the desk officer in charges may lack some background information when assessing a proposal.

A third limitation relates to the HSIA in general. HSIA is a viable approach to all regulatory and non-regulatory proposals. HSIA may help to avoid unintended consequences and mediate conflicts of policy aims. It may contribute to avoid interference of EU policy with the health system objective of access to and quality of services and the sustainability of health systems. However, the capacity of HSIA to contribute to consistency of policies depends on the status of health systems in Europe. It is hoped that this policy assessment contributes to facilitate dialogue among different DGs and sectors regarding the interaction of their policies.

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