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**From:** Secretary-General of the European Commission,  
signed by Mr Jordi AYET PUIGARNAU, Director

**To:** Mr Uwe CORSEPIUS, Secretary-General of the Council of the European  
Union

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**Subject:** COMMISSION STAFF WORKING DOCUMENT IMPACT  
ASSESSMENT Accompanying the document Proposal for a Council  
Recommendation on promoting health-enhancing physical activity across  
sectors

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Delegations will find attached document SWD(2013) 311 final.

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**COMMISSION STAFF WORKING DOCUMENT**

**IMPACT ASSESSMENT**

*Accompanying the document*

**Proposal for a**

**Council Recommendation on promoting health-enhancing physical activity across sectors**

{ COM(2013) 603 final }

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## Abbreviations:

EC/COM	European Commission
DG EAC	Directorate General for Education and Culture
DG SANCO	Directorate General for Health and Consumer Affairs
EU	European Union
EUR	Euro/s
EU PA GL	EU Physical Activity Guidelines
GBP	Pound sterling
GDP	Gross domestic product
GPAQ	Global Physical Activity Questionnaire
HEPA	Health-enhancing physical activity
HEPA Europe	European network for the promotion of health-enhancing physical activity
HLG	High Level Group for Nutrition and Physical Activity
IA	Impact Assessment
IPAQ	International Physical Activity Questionnaire
MS	Member State/s
NCD	Non-communicable disease
NGO	Non-governmental organisation
NOPA	European Database on Nutrition, Obesity and Physical Activity
OMC	Open method of coordination
PA	Physical activity
PAT	Policy Audit Tool
TFEU	Treaty on the Functioning of the European Union
WG	Working Group
WHO	World Health Organization
XG SHP	Expert Group on Sport, Health and Participation

## Definitions:

Various physical activity ‘**guidelines**’ and ‘**recommendations**’ are mentioned throughout this report. In order to avoid any confusion of terms, documents which focus solely on the amount of physical activity that is necessary to achieve certain health effects on the individual level are referred to as physical activity ‘recommendations’. The term ‘guidelines’ is thus reserved for documents that advise policy makers how to take action on a certain topic.

The term ‘**monitoring**’ is used throughout the main body of this report to refer to the collection of data on physical activity and / or the implementation of policy. ‘Surveillance’ often takes this meaning in a public health context, but is not used due to the context and audience of this report. However, it is employed in many of the sources cited herein.

This IA uses the term ‘**sport**’ in line with the definition established by the Council of Europe in its 1992 European Sport Charter and used by the Commission in its 2007 White Paper on Sport: "Sport means all forms of physical activity which, through casual or organised participation, aim at expressing or improving physical fitness and mental well-being, forming social relationships or obtaining results in competition at all levels."

The term ‘**physical activity**’ is used in line with the definition established by the World Health Organization (WHO) according to which “Physical activity is defined as any bodily movement produced by skeletal muscles that requires energy expenditure. Regular moderate intensity physical activity – such as walking, cycling, or participating in sports – has significant benefits for health.”

## 1. PROCEDURAL ISSUES AND CONSULTATIONS

### 1.1. Identification

**Lead service:** DG EAC.D.2 (Sport Unit)

**Main associated service:** DG SANCO

**Other services involved:** SG, SJ, DG BUDG, DG COMM, DG EMPL, DG ENV, DG ESTAT, DG JUST, DG MOVE, DG REGIO, DG RTD

**Agenda Planning:** 2013/EAC+/013

**Subject:** Proposal for a Council Recommendation on health-enhancing physical activity (HEPA)

### 1.2. Organisation and Timing

**Table 1: Impact assessment procedural steps**

Action/Steps	Date
1 <sup>st</sup> meeting of the Inter-Service Steering Group (ISSG) - discussion of the IA Roadmap	19 July 2011
Finalisation of Roadmap	September 2011
Bilateral consultation with DG SANCO – focus on first part of the IA	3 May 2012
2 <sup>nd</sup> ISSG meeting – focus on first part of the IA and draft indicators	12 June 2012
Updated Roadmap <sup>1</sup>	September 2012
Bilateral consultation with DG SANCO – focus on monitoring framework	3 October 2012
3 <sup>rd</sup> ISSG meeting – discussion of draft final IA	24 October 2012
Submission of IA Report to Impact Assessment Board (IAB)	7 November 2012
IAB meeting	5 December 2012
IAB opinion	7 December 2012

### 1.3. Impact Assessment Board (IAB)

The IAB, in its opinion on the draft of this Impact Assessment, recommended DG EAC to provide additional explanations why the EU and the Member States had failed to increase HEPA rates and how the EU could help in that respect. To reflect the Board's comments, DG EAC has included additional information and improved the intervention logic of this IA report. In line with the Board's suggestions, an additional effort was made to better explain the policy options and to provide a realistic assessment of impacts. Moreover, an effort was made to follow the Board's advice to better reflect stakeholders' opinions.

### 1.4. Consultations

Over the past years, Member States, experts, sport stakeholders and the general public have been consulted at different levels on their views regarding the need of and scope for the promotion of physical activity in an EU context, either directly or indirectly related to

<sup>1</sup> [http://ec.europa.eu/governance/impact/planned\\_ia/roadmaps\\_2012\\_en.htm#EAC](http://ec.europa.eu/governance/impact/planned_ia/roadmaps_2012_en.htm#EAC)



the planned EU policy initiative on health-enhancing physical activity (HEPA). After the adoption of the Communication on sport in January 2011 that includes an action point to consider such a proposal, the Commission has regularly presented its plans and the work in progress for this initiative to the policy level, to stakeholders and to experts and sought feedback within different settings. The table below provides an overview of the main discussion fora and of the level of stakeholders consulted. A detailed summary of the consultations can be found in Annex I of this report to explain who was consulted and with what results relevant to this initiative, in particular also regarding the envisaged monitoring framework. The minimum consultation standards have been respected. Views from the below fora and meetings have informed all main parts of this IA, in particular the problem section but also the development of the main ideas for the initiative, including the monitoring framework, which this IA will assess in detail.

**Table 2: Overview consultations**

Actors consulted	Meetings/Fora
<p><b>Member States</b></p> <p>- Work in the Council</p>	<ul style="list-style-type: none"> <li>▪ Preparation of the Council Resolution on an EU Work Plan for Sport adopted on 11 May 2011 (Working Party on Sport / EYCS Council) and its implementation</li> <li>▪ Preparation of Council conclusions on HEPA adopted in November 2012 (Working Party on Sport / EYCS Council)</li> <li>▪ Expert Group “Sport, Health and Participation” set up by the Council (4 meetings as of autumn 2011)</li> <li>▪ Preparation of Council conclusions in the field of health (2011, 2012)</li> </ul>
<p>- Work at the informal level</p>	<ul style="list-style-type: none"> <li>▪ Meetings of EU Sport Ministers in 2011 and 2012</li> <li>▪ Meetings of EU Sport Directors in 2011 and 2012</li> <li>▪ High Level Group on "Nutrition and Physical Activity" (meetings of 3 February 2011 and 14 June 2012)</li> </ul>
<p><b>European Parliament</b></p>	<ul style="list-style-type: none"> <li>▪ Preparation of the EP Resolution on the European dimension in sport (adopted on 2 February 2012)</li> </ul>
<p><b>HEPA Experts</b></p>	<ul style="list-style-type: none"> <li>▪ Annual meetings of the HEPA Europe network 2008-2012 (incl. meetings of the HEPA Europe EU contact group as of 2010)</li> <li>▪ Workshop on indicators, 29 February 2012</li> </ul>
<p><b>Sport stakeholders and general public</b></p>	<ul style="list-style-type: none"> <li>▪ EU Sport Forum 2012 (Nicosia)</li> <li>▪ Expert meeting, 19 September 2012</li> <li>▪ Sportvision2012 – DK Presidency Conference</li> <li>▪ EU Platform for Action on Diet, Physical Activity and Health</li> <li>▪ Online consultation to implement the Lisbon Treaty in the field of sport, Feb.-April 2010</li> </ul>

### 1.5. Use of external expertise

As part of the preparations for this initiative DG EAC commissioned a study to assist it with specific elements, in particular the development of the envisaged monitoring framework including a set of indicators. The latter is proposed to form the core part of the planned Council Recommendation on HEPA. The study consortium (The Evaluation Partnership - TEP, the University of Zurich and VU University Medical Center) combines experience in evaluating EU initiatives and expertise in the field of HEPA. Work on the study started in October 2011 and was finalised a year later.

## 2. PROBLEM DEFINITION

### 2.1. Context

#### 2.1.1. *The importance of physical activity*<sup>2</sup>

Physical activity, including regular sporting practice and exercise, across the life course is one of the most effective ways of staying physically and mentally fit, combating overweight and obesity and preventing related conditions. In addition, participation in sport and physical activity is correlated with other factors such as social interaction and enjoyment<sup>3</sup>. The myriad **benefits of physical activity** are well recorded and include lowered risk of cardiovascular disease, some cancers and type-2 diabetes, improvements in musculoskeletal health and body weight control<sup>4</sup>. There is also a growing body of evidence on the positive correlation between exercise and mental health, mental development and cognitive processes<sup>5</sup>, including the fact that physical activity mitigates both the development and the effects of chronic stress. Mirroring these benefits is a requisite set of **detriments caused by the lack of physical activity**, including premature mortality<sup>6</sup>, rising overweight and obesity levels, particularly among children, as well as a number of health problems aside from obesity (e.g. breast and colon cancers, diabetes, ischaemic heart disease). Available evidence also shows that the various health problems caused by the lack of physical activity have significant **economic costs**, especially in view of the fact that most European societies are ageing rapidly. Apart from these far-reaching negative health and economic effects, physical inactivity also has environmental and social implications.

#### 2.1.2. *Policy context*

As awareness of the importance of physical activity has grown, many public authorities at the local, regional, national, European and international levels have stepped up their efforts to promote health-enhancing physical activity (HEPA). As sport and health policies are primarily national competences, it is within individual **Member States** (MS) that the most important efforts to promote HEPA are being made. As of 2010 a large majority of EU MS reported to have at least some form of guidelines or recommendations in place for physical activity<sup>7</sup> to enable and encourage their populations to become more

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<sup>2</sup> Evidence on the benefits of physical activity and costs of physical inactivity are outlined in Annex II.

<sup>3</sup> In this regard a keynote speaker at the EU Sport Directors meeting on 8/3/2013 noted: “Sport must be part of the solution. Participation in sport is ‘fun’, connected with ‘play’, and it is ‘sustainable’. The latter was demonstrated by a recent study on sport’s contribution to economic growth and employment in the EU showing the sector’s exponential growth. Sport is sustainable – it ‘won’t go away’.”

<sup>4</sup> See, inter alia: Effect of physical activity on major non-communicable disease worldwide: an analysis of burden of disease and life expectancy, *The Lancet*, Volume 380, Issue 9838, Pages 219 - 229, 21 July 2012.

<sup>5</sup> <http://www.health.gov/paguidelines/Report/pdf/CommitteeReport.pdf>.

<sup>6</sup> Physical inactivity is the 4th leading risk factor for global mortality. Increasing levels of physical inactivity are seen worldwide, including in high-income countries.

<sup>7</sup> [http://ec.europa.eu/health/nutrition\\_physical\\_activity/docs/implementation\\_report\\_a6\\_en.pdf](http://ec.europa.eu/health/nutrition_physical_activity/docs/implementation_report_a6_en.pdf).

physically active. Specific measures for this purpose have been launched in a number of policy areas or sectors, in particular sport, health, transport and education.<sup>8</sup>

At the **international level**, the World Health Organization (WHO) adopted a Global Strategy on Diet, Physical Activity and Health in May 2004 aimed at reducing risk factors for chronic diseases that stem from (...) physical inactivity.<sup>9</sup> The Action Plan for the Global Strategy for Prevention and Control of Non-communicable Diseases<sup>10</sup> (NCDs) 2008-2013 calls for the implementation of actions in line with the strategy.<sup>11</sup> The WHO has also developed Global Recommendations which recommend at least 150 minutes per week of moderate-intensity physical activity for adults.<sup>12</sup> In September 2011, a political declaration of the UN high-level meeting of the General Assembly on the Prevention and Control of NCDs recognised that the most prominent NCDs are linked to four common risk factors, including lack of physical activity, and strived at further advancing the implementation of the WHO Global Strategy, including the introduction of policies and actions aimed at increasing physical activity in the entire population.<sup>13</sup> Voluntary targets for the prevention and control of NCDs by 2025 have been agreed in the WHO global monitoring framework, including a 10% reduction in prevalence of insufficient physical activity.<sup>14</sup> In Europe, the WHO Regional Office for Europe has played a key role through HEPA Europe, a collaborative project established in 2005 with the aim of strengthening and supporting efforts to increase physical activity.<sup>15</sup> In November 2006 WHO Europe adopted the European Charter on Counteracting Obesity, which calls for a package of preventive actions relating to nutrition and physical activity. The Second European Action Plan on Food and Nutrition Policy (2007-2012) contains actions to tackle four main health challenges including physical inactivity.<sup>16</sup> The Action Plan for implementation of the European Strategy for the Prevention and Control of NCDs 2012-2016 takes account of the fact that physical activity is influenced by urban environments and transport policies and also calls for supporting interventions to promote active mobility.<sup>17</sup>

At **EU level** physical activity has been promoted through different competences and instruments. The lack of physical activity is being addressed through action in the *policy*

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<sup>8</sup> This has been confirmed in discussions in several EU level fora (EU Sport Directors; XG SHP; HLG; Platform). (See Annex I)

<sup>9</sup> [http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy\\_english\\_web.pdf](http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf)

<sup>10</sup> An NCD is a medical condition or disease which by definition is non-infectious and non-transmissible among people. NCDs include autoimmune diseases, heart disease, stroke, many cancers, asthma, diabetes, chronic kidney disease, osteoporosis, Alzheimer's disease, cataracts, and more. (Wikipedia)

<sup>11</sup> [http://whqlibdoc.who.int/publications/2009/9789241597418\\_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241597418_eng.pdf)

<sup>12</sup> WHO: Global Recommendations on Physical Activity for Health. URL: [http://www.who.int/dietphysicalactivity/factsheet\\_recommendations/en/index.html](http://www.who.int/dietphysicalactivity/factsheet_recommendations/en/index.html)

<sup>13</sup> [http://www.un.org/ga/search/view\\_doc.asp?symbol=A/66/L.1](http://www.un.org/ga/search/view_doc.asp?symbol=A/66/L.1)

<sup>14</sup> Report of the formal meeting of Member States to work on the comprehensive global monitoring framework for the control and prevention of NCDs, WHO, 21/11//2012. This global monitoring framework (GMF), including a set of 25 indicators and 9 global voluntary targets, comes after nearly a year of consultations led by WHO, and is one of the critical parts of the Global NCD Framework.

<sup>15</sup> The network carries out activities to encourage cooperation and collaboration between government bodies, research institutions, NGOs and other organisations in the field.

<sup>16</sup> [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0017/74402/E91153.pdf](http://www.euro.who.int/__data/assets/pdf_file/0017/74402/E91153.pdf)

<sup>17</sup> [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0019/170155/e96638.pdf](http://www.euro.who.int/__data/assets/pdf_file/0019/170155/e96638.pdf)

*area of sport* which inter alia has the advantage of drawing on the potential of sport stakeholders to reach large parts of the EU population, including inactive people<sup>18</sup>. An informal EU Working Group “Sport and Health”, open to all MS, was launched in the second half of 2005. The 2007 White Paper on Sport highlighted the importance of physical activity, stipulated that the COM would facilitate the exchange of information and good practice for HEPA, and set out a plan for the COM to propose physical activity guidelines by the end of 2008.<sup>19</sup> These guidelines – known as the *EU Physical Activity Guidelines* (EU PA GL) – were drafted by a group of 22 experts from around Europe representing various disciplines and broadly representative of informed scientific opinion, approved by the Working Group on Sport and Health, and endorsed by EU Sport Ministers in November 2008.<sup>20</sup> They reiterate WHO Recommendations on the minimum level of physical activity, emphasise the importance of a cross-sectoral approach and provide 41 guidelines covering the relevant sectors responsible for HEPA promotion. The 2011 Communication on sport<sup>21</sup> pointed out that “physical activity is one of the most important health determinants in modern society” and that “sport constitutes a fundamental part of any public policy approach aiming at improving physical activity”. MS and the COM were invited to “based on the EU PA GL, continue progress toward the establishment of national guidelines, including a review and coordination process”. In response to the Communication, in May 2011 the Council agreed an EU Work Plan for Sport for 2011-2014<sup>22</sup> that recognised the need to strengthen co-operation between the COM and MS in sport, defined priority themes, including HEPA, and established several Expert Groups, including an Expert Group on Sport, Health and Participation (XG SHP) that got the mandate to “explore ways to promote HEPA and participation in grassroots sport”. The Group’s first set of deliverables was presented to the Council in July 2012 and provided input to the planned initiative.<sup>23</sup>

On the *health policy side*, physical inactivity has been addressed in relation to the epidemic of overweight and obesity, based on the 2007 White Paper on a Strategy for Europe on Nutrition, Overweight and Obesity-related health issues<sup>24</sup> that aimed at encouraging co-operation between MS and supporting them in their efforts to encourage healthier eating habits as well as HEPA. This Strategy outlines key principles for action, reiterated the importance of an effective partnership approach between different levels of government as well as different sectors of society, and emphasised the need for policy coherence across various policy areas including sport and physical activity. In particular a High Level Group on Nutrition and Physical Activity (HLG), consisting of European government representatives and chaired by the COM, was set up. Its aim has been to help

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<sup>18</sup> Cavill, Richardson, Foster, BHF Health Promotion Research Group, *Improving Health through Participation in Sport*, a review of research and practice. June 2012.

<sup>19</sup> European Commission White Paper on Sport, COM(2007) 391 final.

<sup>20</sup> EU Physical Activity Guidelines - Recommended Policy Actions in Support of Health-Enhancing Physical Activity, Brussels, 10 October 2008. URL: [http://ec.europa.eu/sport/library/documents/c1/eu-physical-activity-guidelines-2008\\_en.pdf](http://ec.europa.eu/sport/library/documents/c1/eu-physical-activity-guidelines-2008_en.pdf)

<sup>21</sup> European Commission Communication “Developing the European Dimension in Sport”, COM(2011) 12.

<sup>22</sup> Council Resolution on a European Union Work Plan for Sport 2011-2014, adopted on 11 May 2011, OJ C 162 of 1.6.2011.

<sup>23</sup> The Council conclusions on promoting HEPA adopted in November 2012 give support to the EU PA GL and call on the COM to present a proposal for a Council Recommendation on HEPA., doc. 15664/12 (LIMITE), 6 November 2012.

<sup>24</sup> European Commission White Paper “A Strategy for Europe on Nutrition, Overweight and Obesity-related health issues”, COM(2007) 279 final.

share information on policies, policy ideas and practices. Among the strategy's implementation tools, there is the EU Platform for Action on Diet, Physical Activity and Health launched in March 2005 in order to create a forum for cross-sectoral co-operation between relevant private sector and non-governmental actors at European level willing to commit to tackling current trends in diet and physical activity.

As far as funding is concerned, projects promoting physical activity have been supported under various EU programmes, including the Health Programme (2008-2013), the Lifelong Learning Programme (2007-2013), the framework programmes for research<sup>25</sup> and also under the Preparatory Actions in the field of sport (2009, 2012). Regarding future programmes, it should be noted that the proposed Erasmus+ Programme 2014-2020 foresees €238 million of funding for European cooperation in sport, with HEPA being a priority area for action.<sup>26</sup>

## 2.2. Identification and analysis of the main problem(s)

In spite of the growing profile given to physical activity promotion in the political debates at MS as well as international and EU levels and available tools to promote HEPA (as described under 2.1.2), the **rates of physical inactivity in the EU remain unacceptably high**. The available EU<sup>27</sup> and national data outlined in Annex II shows that the vast majority of Europeans do not engage in sufficient HEPA (e.g. in 2010, 60% of Europeans responded that they exercise or play sport *seldom* or *never*).<sup>28</sup> It also demonstrates vast discrepancies between individual MS. This situation runs not only counter to the Europe 2020 Strategy<sup>29</sup>, which acknowledges the need to fight health inequalities as a prerequisite for growth and competitiveness, but is also incompatible with the EU's stated policy ambitions in the fields of sport and health.

HEPA promotion depends primarily on efforts within MS at national, regional and local levels. However, most MS have not achieved the principal policy objective in this area, namely to increase the proportion of citizens who reach the HEPA levels recommended by the WHO, and reiterated in the EU PA GL. The main problem to be addressed by the initiative therefore is that in general, **the HEPA promotion policies of EU MS have not been effective** (although there are notable exceptions<sup>30</sup>).

The often disappointing results in the evolution of HEPA participation rates raises the question of **why the HEPA promotion policies adopted by most MS have so far not**

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<sup>25</sup> E.g. a recent call for proposals under the 'Cooperation' work programme within FP7 (FP7-HEALTH-2013-INNOVATION-1).

<sup>26</sup> Already in 2009, transnational HEPA projects received funding under the first Preparatory Action in the field of sport. In 2012, the Preparatory Action European Partnership on Sports provides funding to transnational projects in the field of physical activity supporting active ageing: [http://ec.europa.eu/sport/preparatory\\_actions/introduction\\_en.htm](http://ec.europa.eu/sport/preparatory_actions/introduction_en.htm)

<sup>27</sup> European Commission: Special Eurobarometer 183-6 (December 2003), 213 The citizens of the European Union and Sport (November 2004), 246 Health and Food (November 2006), 329 Health determinants (January 2010) and 334 Sport and Physical Activity (March 2010).

<sup>28</sup> The 2010 Impact Assessment for the 2011 Communication on sport identified the lack of physical activity as a main challenge in connecting with sport's health-enhancing, social and educational function.

<sup>29</sup> COM(2010) 2020 final.

<sup>30</sup> Some MS, e.g. FI, have seen a positive development with regard to their national physical activity levels.

**delivered the desired results.**<sup>31</sup> The reasons for the low effectiveness of MS policy are above all shortcomings in the way HEPA promotion policies are developed and implemented within individual MS.

To determine the main shortcomings, it is first useful to outline what is meant by ‘effective’ HEPA policy. At European level, the **criteria to define effective HEPA policy** are laid out in the EU PA GL.<sup>32</sup>

***EU Physical Activity Guidelines***

*“It is only possible to reach the set targets through inter-ministerial, inter-agency and inter-professional collaboration, including all levels of government (national, regional, local), and in collaboration with the private and voluntary sectors.”*

*“Increasing the levels of physical activity falls within the remit of several important sectors, most with a major public sector component:*

- Sport
- Health
- Education
- Transport, environment, urban planning and public safety
- Working environment
- Services for senior citizens”

Most importantly, these GL emphasise that a cross-sectoral approach to HEPA policy is an absolute necessity, that “Targets and objectives are not enough to ensure effective implementation of national Physical Activity Guidelines”, and that national HEPA policies should be based on “the following quality criteria that have shown to increase the potential for effective policy implementation:”

- Developing and communicating concrete goals, objectives and target groups;
- Planning concrete steps, timeframes and milestones for implementation;
- Defining clear responsibilities for implementation;
- Allocating sufficient financial and human resources at all relevant levels;

<sup>31</sup> Comprehensive evaluation data linking policies to the evolution of physical activity rates in the EU are not available for all MS, but looking at the countries for which data exist allows this link to be drawn. In addition, the existence of the shortcomings in MS policy is further demonstrated through examining more widely available data on policy development and implementation and comparing it with international quality standards. These two methods serve to identify the main shortcomings in this section (i.e. aspects where national policies fall short of established good practice).

<sup>32</sup> The importance of the EU PA GL as a reference framework for shaping national strategies was regularly underlined by the policy level (e.g. EU Sport Directors, HLG) and lately by the Council (draft conclusions on HEPA; draft conclusions on healthy ageing across the lifecycle). Experts also underlined that HEPA as a problem "is complex and it is highly interdependent. Adequate policy instruments therefore have to be (...) inter-sectoral. The EU PA GL reflect these needs". (See Annex I). Recent years have seen several other efforts to develop such criteria, including the publicly funded international inventories and comparative studies such as the WHO Europe HEPA Policy Audit Tool (PAT).  
[http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0006/151395/e95785.pdf](http://www.euro.who.int/__data/assets/pdf_file/0006/151395/e95785.pdf)

- Creating a supportive policy environment with support from key actors across all relevant sectors and at all levels;
- Increasing support from the public and specific target groups through effective communication;
- Monitoring and evaluating the implementation and outcomes of the policy in a robust and systematic way.

Hereafter those criteria for effective HEPA policy are examined which the MS have evidently had the least success in implementing on a wider scale (several exceptions notwithstanding). The available evidence<sup>33</sup> confirms the existence of **shortcomings in at least three aspects of HEPA policy** that are interconnected: the **cross-sectoral approach** and collaboration among different ministries and bodies responsible for HEPA promotion; **objective setting**; and **monitoring** and evaluation.

### 2.2.1. *Approach to HEPA not sufficiently cross-sectoral*

The lack of a sufficiently cross-sectoral approach is the most clearly identifiable problem in the national HEPA policy of a large number of MS, a tendency that is evident in the findings of several recent studies (e.g. the 2012 Lancet series, see fn4) and was confirmed in the consultations with national policy makers, experts and other relevant stakeholders.

One study consisted of an in-depth examination of 27 policy documents from 14 countries including 11 EU MS.<sup>34</sup> It confirms that each individual Ministry tends to have its own agenda when it comes to taking action to promote physical activity. The assessment revealed a lack of cross-sectoral collaboration at both the policy development and implementation stages. For example, the paper cites only ‘limited evidence for intersectoral collaboration in the preparation of the policies between ministries and in most cases the **documents had been prepared by a single ministry alone.**<sup>35</sup> Moreover, while some policy documents involved authorities or bodies besides the lead ministry, one third were prepared without any form of collaboration at all. This lack of collaboration extended to plans for implementation. Nearly one third of the documents involved only one ministry or authority in policy implementation, while the majority required collaboration between a maximum of two actors.<sup>36</sup> Clearly, “the mere existence of a national physical activity policy or action plan does not secure its functionality or implementation”.<sup>37</sup>

A tool for collecting comprehensive data on HEPA policy, the HEPA Policy Audit Tool (HEPA PAT), coordinated by WHO Europe, also demonstrates the insufficiently cross-sectoral approach to physical activity promotion taken by countries. Crucially, the HEPA

<sup>33</sup> To do so, this IA draws on data from various studies and research papers (many of them carried out under the auspices of WHO Europe), consultation outcomes, large scale survey results and the outputs of the WG on Sport and Health, the XG SHP and the HLG – also referred to in Annex I.

<sup>34</sup> Daugbjerg et al: Promotion of Physical Activity in the European Region: Content Analysis of 27 National Policy Documents. *Journal of Physical Activity and Health*, 2009, 6, 805-817.

<sup>35</sup> Ibid.

<sup>36</sup> Ibid.

<sup>37</sup> The Lancet PA Series Working Group (see above).

PAT allows a distinction to be drawn between ‘theory’ and ‘practice’. All seven countries that completed the HEPA PAT (FI, IT, NL, NO, PT, SI and CH) reported **some degree of formal consultation** in the formulation of government policy.<sup>38</sup> Examining the completed HEPA PATs collectively, it is clear that, despite good-practice exceptions (e.g. Finland and the Netherlands), **active collaboration and coordination between all relevant and responsible ministries and other authorities / organisations are rare** and often not sustained. The HEPA PAT data also shows that government officials in fields that have only recently taken on some responsibilities to promote HEPA, such as transport and education, have not fully benefited from the expertise of other sectors, such as public health, where the importance of HEPA is more firmly established.

#### ***Finland’s cross-sectoral approach***

*Many national-level ministries and agencies in addition to local authorities and rural communities all share responsibility for physical activity promotion and the funding of HEPA programmes. In order to ensure collaboration and cooperation among these different actors, Finland has:*

- *Issued a political resolution on HEPA and diet to consolidate existing documents, define the political direction and over-arching goals across sectors;*
- *Set up advisory committees consisting of members from national ministries, local authorities, NGOs and research institutes;*
- *Consulted relevant organisations during the development of policies.*

*While cross-sectoral collaboration is still considered a challenge, this approach has succeeded in securing wide participation in the policy-making process and incorporating HEPA across all the sectors concerned.*

Relevant governmental and non-governmental stakeholders consulted for this IA, echoed these findings: **lacking cross-sectoral cooperation was cited as the key obstacle** to effective physical activity promotion.<sup>39</sup>

A recent large-scale study of policy documents from all EU MS<sup>40</sup> serves to add weight to this argument. The study compiled and examined **policy documents** related to HEPA promotion from 26 MS, and categorised them according to the sectors concerned. The data indicates that while nearly all countries (25) have *public health* policies in place which promote HEPA, and 16 promote HEPA through *sport* policy, only ten countries

<sup>38</sup> For example, while FI has successfully institutionalised the use of advisory committees for physical activity including members from national ministries of health, education, culture, environment, labour and transport, local authorities and NGOs, in NO the mandate for a similar steering committee system was not renewed after it expired in 2010. In NL the Ministry of Health, Welfare and Sport coordinates at a policy level while implementation is coordinated by an NGO, the Netherlands Institute for Sport and Physical Activity, whereas in CH responsibilities are divided among national, cantonal and community-level actors. In PT and IT, despite formal structures for collaboration and coordination, physical activity is addressed separately by a number of ministries and other organisations, leading to potential omissions and duplications.

<sup>39</sup> XG SHP (meetings on 21/3 and 27/6/2012), EU Sport Directors (meeting on 30/5-1/6/2012), HLG (meeting on 14/6 and written submissions), work in the Council Working Party on Sport (Cypriot Presidency), HEPA seminar with stakeholders (19/9, Nicosia). (See Annex I)

<sup>40</sup> Review of physical activity promotion policy development and legislation in EU MS, study jointly funded by the European Commission and the WHO in 2010: [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0015/146220/e95150.pdf](http://www.euro.who.int/__data/assets/pdf_file/0015/146220/e95150.pdf).



have *transport* policies that explicitly refer to HEPA. Few MS pursue HEPA through other policy areas: only five countries had specific *education* policies with goals relating to HEPA,<sup>41</sup> while four countries have produced documents making the link between physical activity and the *environment*. The analysis shows that in the vast majority of countries HEPA is included in policy documents covering a maximum of three policy areas, while **hardly any MS approach HEPA policy from four or five policy areas**.

The lack of effective collaboration and coordination even extends to **individual policy sectors**. The sport sector, one of the key players in any successful effort to promote HEPA, has in some cases been singled out for **prioritising elite sport at the expense of grassroots sport** and sport for all, despite the benefits of the latter in terms of promoting physical activity. This was highlighted, for instance, at the last meeting of the EU WG on Sport and Health.<sup>42</sup> Although the organisation of sport in Europe (as described in the White Paper on Sport) demonstrates the complementary relationship between elite and grassroots sport, representatives from the sport for all movement have regularly expressed concerns<sup>43</sup> that the sport sector does not make the link strongly enough. This, *inter alia*, prevents the sport sector, and policies targeting elite sport, from achieving their potential impact in terms of increasing physical activity among the wider citizenry and contributing to health – a potential outreach which cannot be replicated in other policy sectors. It was suggested, e.g. at the abovementioned meeting, that the coordination between the different parts of the sport sector needed to be reinforced.

A **recent public consultation**<sup>44</sup> demonstrates that concerns about lacking cross-sectoral collaboration on HEPA resonate with a broad cross-section of interested stakeholders. Asked to express the extent of their agreement with several statements relating to physical activity promotion by public authorities and sport organisations, a strong majority of respondents felt that public authorities do not give enough support to physical activity, and that there is not enough physical activity in education.

### 2.2.2. *Objectives and goals not concrete and clear enough*

The available evidence also suggests that many MS do not define the **objectives** of their HEPA policies clearly and concretely enough, and tend not to develop sufficiently measurable indicators to track progress (see also the sub-chapter on monitoring and evaluation below). The study of 27 policy documents cited above shows that very often, objectives listed were vague (e.g. ‘to stimulate the practice of regular physical activity in the population’). Quantifiable targets to achieve stated goals only existed for 22% of the documents analysed, and examples of good practice (e.g. by 2010, at least 65% of the adult population will meet the exercise standard) were rare. Hardly any policies made specific provisions for targeting groups with particularly low levels of physical activity, such as individuals of low levels of education and / or income.

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<sup>41</sup> The majority of countries did, however, include education elements in sport policies.

<sup>42</sup> [http://ec.europa.eu/sport/library/documents/b23/wg\\_sh\\_170311\\_meeting\\_report.pdf](http://ec.europa.eu/sport/library/documents/b23/wg_sh_170311_meeting_report.pdf).

<sup>43</sup> For example in plenary sessions of the EU Sport Forum, organised by the European Commission.

<sup>44</sup> The public online consultation, ‘Strategic Choices for the Implementation of the New EU Competence in the Field of Sport’, was completed in 2010 by 1,326 stakeholders and other interested individuals. (See Annex I)

A recent analysis of national sport strategies and policies undertaken as part of the COM-funded Net-Sport-Health project<sup>45</sup> paid particular attention to **targets and indicators**, and unearthed similar results. All 25 of the documents<sup>46</sup> examined, which covered the national and sub-national level for 15 MS, contained (at the least) **broad goals** which made the link between physical activity and health for the wider population. However, hardly any countries (i.e. three) identified quantifiable targets relating specifically to physical activity and health, while only **one policy document was described as ‘fully adhering to the requirements of Specific, Measurable, Attainable, Relevant and Timely (SMART) targets’**.

### 2.2.3. *Insufficient provisions for monitoring and evaluation*

Collecting, recording and publicising comprehensive data on physical activity are crucial features for the effective monitoring of HEPA and evaluation of policies aimed at promoting physical activity. However, an examination of current practice reveals significant shortcomings in the majority of MS. This is at least partly due to the lack of cross-sectoral coordination, as various actors collect similar but incomparable data and / or fail to share data while precluding the critical mass (both in terms of expertise and budgetary capacity) necessary to employ suitable methodologies.

Regarding **monitoring** of HEPA participation rates, there is no data that is comprehensive and comparable across countries. Although the WHO has issued concrete recommendations for the effective monitoring of physical activity on the basis of the standardised IPAQ and GPAQ questionnaires,<sup>47</sup> the data collected for the NOPA database<sup>48</sup> indicates that **only eight EU MS have included the IPAQ in national surveys**, while just one has made use of the more exhaustive GPAQ. Moreover, hardly any of these MS repeat the exercise at regularly defined intervals, making it difficult to ascertain trends and gauge progress and / or the success of HEPA promotion policies **over time**. Some countries had systems in place to produce comparable data on changes to physical activity, while others altered survey questions and methodologies year on year or did not have any such systems in place. While there are a number of MS (most notably the United Kingdom, Finland and the Baltic countries) which carry out extensive and periodic surveys of physical activity outside the IPAQ, variations in methodology render statistical comparison between countries impossible.

<sup>45</sup> NET-SPORT-HEALTH was one of 9 HEPA projects funded under the 2009 Preparatory Action in the field of sport. [http://www.euro.who.int/\\_data/assets/pdf\\_file/0006/147237/e95168.pdf](http://www.euro.who.int/_data/assets/pdf_file/0006/147237/e95168.pdf).

<sup>46</sup> Various types of document were included in the selection, including legislation, policies, strategies and action plans as well as other documents on health and physical activity.

<sup>47</sup> In order to facilitate the systematic collection of comparable, timely data on physical activity, the WHO recommends administering on a regular basis the questions from one of two available standardised surveys: the International Physical Activity Questionnaire (IPAQ) or the Global Physical Activity Questionnaire (GPAQ). Both questionnaires allow comprehensive and comparable data to be recorded across a range of relevant factors of physical activity, including the frequency, duration and level of intensity both in general and in relation to specific activities. For more information, see [http://www.euro.who.int/\\_data/assets/pdf\\_file/0015/146220/e95150.pdf](http://www.euro.who.int/_data/assets/pdf_file/0015/146220/e95150.pdf)

<sup>48</sup> A first overview on HEPA policy-related aspects is available from the joint WHO/DG SANCO project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union” (NOPA), which was carried out from 2008 to 2010. Additional information on NOPA is provided in Annex III. [http://www.euro.who.int/\\_data/assets/pdf\\_file/0015/146220/e95150.pdf](http://www.euro.who.int/_data/assets/pdf_file/0015/146220/e95150.pdf).

With regard to policy **evaluation**, the above-mentioned Net-Sport-Health project found that although about two-thirds of the national strategies did set out requirements for evaluation, many of these **lacked detail**. For example, only a small number of national strategies called specifically for periodic reports on progress, while measurable outcome indicators were not provided in the majority of cases. The detailed analysis of national policies in a few countries demonstrates a similar set of issues.<sup>49</sup> Generally, concrete goals and performance indicators, and specific plans for measuring the success of specific policies, were vague or non-existent.

MS representatives and experts have expressed similar views regarding data availability, describing current monitoring and evaluation practices as inadequate for gauging progress or making comparisons across countries.<sup>50</sup>

### 2.3. Underlying reasons for the main shortcomings

There is a clear gap between the available evidence (benefits of physical activity; cost burden posed by present levels of inactivity; effective interventions) on the one hand, and subsequent policy action to address physical inactivity, on the other.<sup>51</sup> The question arises what has prevented MS to develop more effective HEPA promotion policies or why the role of physical activity has been undervalued.

The underlying reasons are likely to relate to the fact that HEPA is **only starting to become a focused policy field** on its own and to get recognition as a complex policy area that requires multi-sectoral interventions, such as those provided for in the EU PA GL. Physical activity has so far **not enjoyed advocacy power** comparable with e.g. the mobilisation of tobacco control to ensure that it receives the appropriate political recognition.<sup>52</sup> ‘Integrated approaches’ at the international level have helped to bring physical activity on the policy agenda. For instance, physical activity has been **coupled with ‘diet’ to address obesity**<sup>53</sup> or treated as a risk factor among others in the **debate on NCDs**<sup>54</sup> (see sub-chapter 2.1.2). However, physical activity has not been considered as a stand-alone topic requiring specific approaches, despite evidence for many independent

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<sup>49</sup> Completed HEPA PATs for FI, IT, NL and PT: While FI evaluates physical activity policy inter alia through the use of a yearly postal survey, plans for evaluation in IT and PT are fragmented and incomplete. The HEPA PAT for NL, which cites plans for evaluation in its National Action Plan for Physical Activity, also notes that processes, results and effects of policies are not evaluated in uniform and comparable ways.

<sup>50</sup> EU Sport Directors meeting, 31/5-1/6/2012; HLG meeting on 14/6/2012; Expert Seminar on HEPA, 19/9/2012. (See Annex I)

<sup>51</sup> Ibid.

<sup>52</sup> The Lancet PA Series Working Group (see above). This lack of advocacy and mobilisation is starting to change: an important player in this regard can be the sporting goods industry, which is putting efforts in promoting HEPA, e.g. via large ‘healthy lifestyle’ campaigns, such as, in 2012, “Designed to move”.

<sup>53</sup> "One problem is that physical activity is often perceived only in the context of controlling obesity, and therefore physical inactivity is regarded as a minor or secondary risk factor for NCDs" P. Das, R. Horton, Rethinking our approach to physical activity (The Lancet, Vol 380, Issue 9838, p. 189-190; 12 July 2012).

<sup>54</sup> While the global NCD approach is considered important, according to WHO experts, regarding physical activity that approach is too limited; it does for instance not include ‘urban design’.

health effects and other effects beyond health.<sup>55</sup> Today, scientists therefore call for a ‘**specific policy focus** on physical activity to tackle physical inactivity’ and to act now.<sup>56</sup>

While HEPA as a policy field is a rather **new topic on the agenda** of governments (if at all), understanding of the determinants of HEPA, which is essential for designing interventions to change physical activity levels, is even younger.<sup>57</sup> As a consequence, **intersectoral capacities<sup>58</sup>, improved understanding and institutional structures are still lacking** in most MS to promote HEPA, in particular in those with the highest inactivity rates, in contrast with e.g. nutrition where most countries even have special academic curricula. This was confirmed in the discussions with public authorities and is consistent with the observation that on the occasion of international consultations related to obesity, nutrition and physical activity most MS participated with much stronger expertise related to nutrition (a field scientifically “mature” and historically well established in the institutional infrastructure of MS) than to physical activity (a discipline under rapid scientific development, and a relatively new area of interest for public health).<sup>59</sup> It is furthermore confirmed by the fact that whenever international institutions have called upon MS to appoint counterparts on physical activity, appointees were generally not experts in HEPA promotion but rather in nutrition or other related fields.<sup>60</sup> Evidence shows that countries with institutional capacity to promote HEPA (e.g. FI or NL) are doing better than those without it (e.g. CY or HU).

Another underlying reason for ineffective HEPA policies relates to budgetary constraints in the **crisis context**. Despite the urgent need for action, policy makers might have been tempted to give **low priority to HEPA** policy development and implementation. The current economic situation could have led MS to allocate insufficient financial and human resources to effective HEPA promotion – such cuts have, for instance, been reported for national sport departments<sup>61</sup>. HEPA promotion requires investments in the

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<sup>55</sup> Physical Activity Guidelines Advisory Committee, Report, 2008, Washington, DC: US Department of Health and Human Services, 2008.

<sup>56</sup> The Lancet PA Series Working Group (see above).

<sup>57</sup> Ibid: “For physical activity the science of how to change individual behaviours has overshadowed efforts to understand true population change. Because of this unbalanced focus, the structural and systemic changes necessary to promote physical activity in populations (...) across various sectors have not yet been addressed systematically. (...) A similar experience occurred in tobacco control, where initially the burden of responsibility was put solely on individuals. Once that view expanded to include recognition of societal responsibility as well, population-level action and changes in smoking prevalence followed.”

<sup>58</sup> This is not only reflected by expert opinion, but also by EU-funded projects like PASEO that analysed the policy capacity for PA promotion among older people in 15 EU MS, or MOVE that looked into the capacities of sport for all organisations to reach socially disadvantaged groups through HEPA.

<sup>59</sup> This is also shown by the review of 27 national policy documents for physical activity promotion, which suggested that, with a few notable exceptions, the development of national policy documents on physical activity in Europe has only started in recent years. See Daugbjerg et al: Promotion of Physical Activity in the European Region: Content Analysis of 27 National Policy Documents. *Journal of Physical Activity and Health*, 2009, 6, 805-817.

<sup>60</sup> E.g. for the 2006 Istanbul conference on obesity or for the 2009 NET-SPORT-HEALTH project focal points

<sup>61</sup> For instance, in the margins of the EU Sport Directors meeting on 8 March 2013 certain MS representatives confirmed the impact of the crisis on activities relating to HEPA promotion, e.g. the French Ministry in charge of sport does not support anymore the promotion campaign “Santé vous sport”. Or statement at a conference on the financing of sport on 16/2/2010 in Brussels,

short term that only deliver health and economic benefits to the MS in the medium to long term. It could well be that a majority of EU MS has not been sufficiently aware of the need to design and make well-targeted multi-sectoral investments today to benefit from positive longer-term effects in the future, or, as outlined above, **lacked the capacity or the available data** to do so. Only some MS have taken full advantage of the ‘low-hanging fruit’ (e.g. FI).

The above situation is partly also reflected in the **EU’s activities and structures** dealing with physical activity. While physical activity has been promoted in different policy fields and helped give attention to the HEPA topic (see chapter 2.1.2), **no single coordinated approach** on HEPA exists that would encompass the relevant policy sectors and take into account the multiple effects of physical activity in the field of health and beyond. It is an achievement that physical activity could be brought on the EU agenda in the context of the Strategy on Nutrition, Overweight and Obesity-related health issues. However, due to the fact that physical activity was **coupled with another public health issue** (diet/nutrition) to which MS have attached great(er) importance, a focused approach to tackling physical inactivity has not yet been developed.<sup>62</sup> Moreover, the important prevention and rehabilitation effects of physical activity tend to be neglected in other policy initiatives, for instance those aiming to address the wider economic and social challenges for the EU, such as the ageing population, where the focus has rather been on medical treatment and IT solutions instead of "smart investment" in physical activity.<sup>63</sup> No consistent approach exists either in the EU's cohesion policy that would reflect the importance of investing in physical activity and that could help address the regional dimension of low HEPA rates and corresponding investment levels in the MS. With the development of the EU PA GL, an effort was made to give a specific policy focus to the promotion of HEPA. While some progress could be achieved at the EU policy level in promoting the GL further (e.g. in policy discussions and recent Council conclusions) they have not yet been implemented effectively at national level.<sup>64</sup> Partly linked to the lack of a focused approach to HEPA at EU level involving coordination between different policy sectors (e.g. sport, health, education, transport) and their working structures, opportunities for promoting the GL within relevant policies beyond sport have been missed out. There is considerable scope in EU policy making to encourage the implementation of the GL as a means for effective HEPA promotion and to improve existing forms of policy cooperation between the MS at EU level to help reverse the trend regarding physical inactivity. Indeed, to date, **no policy coordination, neither within**

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according to which “Public budget austerity is under way in the EU-27 and sport budgets cannot escape budgetary stagnation or cuts”.

<sup>62</sup> This disparity is confirmed in the final Evaluation of that strategy (p. 162): [http://ec.europa.eu/health/nutrition\\_physical\\_activity/docs/pheiac\\_nutrition\\_strategy\\_evaluation\\_en.pdf](http://ec.europa.eu/health/nutrition_physical_activity/docs/pheiac_nutrition_strategy_evaluation_en.pdf)

<sup>63</sup> E.g. Physical activity has stayed outside the European Innovation Partnership on Active Ageing or the Social Investment Package (Commission Communication (COM(2013) 83final) and related Staff Working Documents ("Long-term care" and "Investing in health"). The latter develops on health as an investment in human capital and highlights the importance of devoting resources to health promotion and disease prevention which should make use of different settings. Physical activity is not being considered.

<sup>64</sup> According to a recent review of the implementation of the GL carried out by the XG SHP in 2012, 16 MS were able to provide information demonstrating how national guidelines and/or policies reflected the provisions of (at least some of) the GL. Source: Information in the "Implementation table" (see Annex I)

**the EU's approach nor between MS at EU level, exists that would sufficiently reflect the complexity of the HEPA topic as a differentiated (focused) policy area.**<sup>65</sup>

A continuation of the current situation would not address the ineffectiveness of MS' HEPA policies since the main problem drivers (missing advocacy power behind HEPA, lack of intersectoral capacities and understanding in MS, no focused policy approach on physical activity and no coordinated policies at EU and MS level) would only marginally be addressed which means that the aspects of HEPA policy identified above (relating to cross-sectoral approach, objective setting, monitoring) would continue to be problematic.

## **2.4. Affected groups and regions**

The planned initiative will first and foremost target **public authorities in EU MS** responsible for HEPA promotion and more specifically the thematic areas covered by the EU PA GL, including those key areas for which the initiative will propose specific monitoring activities. Accordingly, the initiative should help improve capacity to promote HEPA more effectively across sectors and will at least concern authorities in charge of the following areas: sport, health, education, transport environment, urban planning, public safety, working environment and services for senior citizens. It will in particular focus on those MS that have been less successful in raising HEPA levels of their citizens (generally these are countries in southern and eastern Europe) and thereby address regional disparities within the EU-28.

The implementation of the proposed Council Recommendation will have a direct impact on **certain sectors of society**, such as the sport or the health care sectors that will be encouraged to follow the Guidelines to promote physical activity within the sphere of their activities and competences. The initiative will also rely on mobilising stakeholders, including the ones most directly related to physical activity and with strong assets to reach out to citizens with targeted offers, i.e. the sport movement.

Ultimately, the proposed initiative aims at reaching out to **EU citizens at large** (e.g. children, working population, seniors) by providing new opportunities to engage in physical activity in accordance with WHO recommendations. Since the lack of physical activity is particularly pronounced among **specific at-risk-groups** of the population (socio-economically disadvantaged groups, women, children and the elderly), the benefits of the initiative would accrue to these groups to a greater degree than to Europeans as a whole.

## **2.5. Justification for EU action**

### *2.5.1. The EU's right to act*

The EU has the right to act in the field of HEPA based on two Articles of the Treaty on the Functioning of the EU (TFEU), both of which assign a supporting competence to the EU. **Article 165** stipulates that the Union shall 'contribute to the promotion of European sporting issues' and that action shall be aimed at 'developing the European dimension in

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<sup>65</sup> The view that 'the EU should do better in promoting the public health dimension of sport' was also the main conclusion in a keynote address at the EU Sport Directors meeting, on 8/3/2013 in Dublin.

sport’. **Article 168** stipulates that ‘Union action [...] shall be directed towards improving public health [...] and obviating sources of danger to physical and mental health’. This covers inter alia health information and education and monitoring. The Article also stipulates that the EU shall ‘encourage co-operation between the MS and, if necessary, lend support to their action’. By doing so, in line with the Treaty, the EU has to respect the responsibility of the Member States for the definition of their health policies.

In both areas (sport and public health), the TFEU states that in pursuit of these objectives, the European Parliament and Council may adopt **incentive measures**, and that the Council (on a proposal from the COM) may adopt **recommendations**. In addition, the Treaty explicitly authorises the COM to take ‘any useful initiative’ to **promote policy co-ordination** among the MS in the area of public health, in particular ‘initiatives aimed at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation’.

### 2.5.2. *Added value of EU action*

As regards the application of the **subsidiarity principle**, there can be no doubt that the main responsibility for promoting HEPA lies with the MS. Thus, the question is whether the EU action can add significant value, over and above what MS would be able to achieve on their own.

This question should be answered in the affirmative. On a very general level, EU support for more effective HEPA promotion policies can help reduce the significant social and economic costs of physical inactivity for all MS, and thus strengthen their ability to achieve the growth objectives set in the **Europe 2020 Strategy**.

EU action has the potential to render MS efforts to promote HEPA both **more effective and more cost effective** than would be possible otherwise. In line with the international framework and actions to promote physical activity, the EU can provide renewed political momentum to focused action on HEPA in the EU-27 and raise awareness of the need to act now.<sup>66</sup> The EU can, in line with its supporting and coordinating competences in the fields of sport and of health, **facilitate and strengthen policy co-ordination** by helping MS to share information and experience, engage in peer learning, disseminate good practice and work together to develop common approaches, and thereby contribute to **improving capacity** to promote HEPA across sectors and to shape policies that ensure better interventions.<sup>67</sup> In particular in the current crisis context, the EU could help the MS in developing and implementing effective policies for HEPA promotion, e.g. by enabling

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<sup>66</sup> Unlike the WHO which is mandated to support governments and health authorities through a regional director who has primary allegiance to Ministries of Health, the EU offers much broader scope for cooperation among the governments of the MS, which is particularly important to promote a multi-sectoral approach to HEPA.

<sup>67</sup> As expressed, for instance, by EU Sport Directors (see Annex I) and in the 2011 Evaluation of the Preparatory Actions in the field of sport, which found that ‘while data on the ultimate impacts of the activities carried out so far is lacking, tackling these transnational issues [incl. physical inactivity] at European level provides policy makers with the information needed to develop effective and coherent policies. Bringing stakeholders from around Europe together also reinforces the European dimension of the issues at hand.’

them to make well-targeted interventions in the shorter term designed to avoid future harmful economic and social consequences resulting from physical inactivity. A number of MS consider such co-ordination in the area of HEPA particularly useful given the vast differences that currently exist between them in terms of the amount of priority afforded to HEPA to date, the approaches chosen, the national policy co-ordination mechanisms and the cultural and economic differences and similarities between MS that have an effect on HEPA rates and point to measures that may be most promising.<sup>68</sup>

Moreover, exchange of best practices is significantly strengthened when there is actual evidence as to the effectiveness of different measures and policies. The EU is well situated to enhance provisions for **monitoring and evaluation** of HEPA and HEPA policies and thereby help the MS to track developments over time. As pointed out previously, robust data is seldom available, despite its value for formulating and refining policy.<sup>69</sup> Through the proposed monitoring framework, EU coordination will deliver the evidence to MS to justify more focused and multi-sectoral approaches to HEPA promotion. Ultimately, a ‘joint monitoring’ will help MS to save costs since it will serve to improve investment of scarce resources. This is particularly relevant in the current economic context.

The view that the EU has a role to play in contributing to promoting HEPA is shared not only by the EU institutions, existing EU level cooperation structures for sport and for health as well as at expert level, but also by a large segment of stakeholders (e.g. sport for all organisations or the sporting goods industry) and EU citizens.<sup>70</sup> **By approaching HEPA promotion from a sport policy perspective, the EU can make a real difference**, boosting its effort by drawing on the huge potential of the sport movement to reach large parts of the EU population, inter alia through membership in a sport club. Citizens usually like sport and its connotations are unmistakably positive. The results of the 2010 public consultation referred to above confirm the **widespread support for EU action to promote HEPA**. Asked to identify priorities for future EU action, respondents (which included individual citizens as well as nearly 400 stakeholder organisations, most of which were sport organisations, NGOs, and public authorities from across the EU) were overwhelmingly in favour of an EU role in promoting physical activity.

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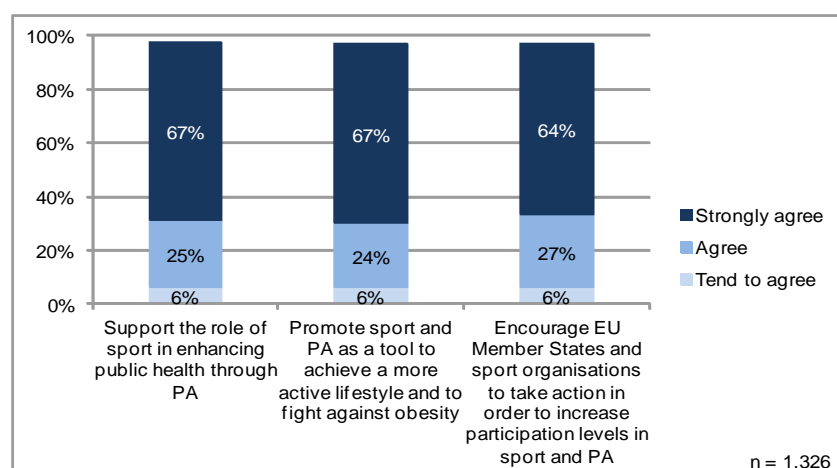
<sup>68</sup> As confirmed by several MS in the political debates at EU level (see Annex I).

<sup>69</sup> Ibid.

<sup>70</sup> Details can be found in Annex I.



Figure 1: Future priorities for EU action in the field of HEPA



Source: EU-wide public consultation (2010): Strategic Choices for the Implementation of the New EU Competence in the Field of Sport

## 2.6. Baseline scenario

The continuation of current arrangements building on existing structures and tools at MS, international and EU level - as described in sub-chapter 2.1.2 - would lead to the following elements that would **continue to work unsatisfactorily** in combating the problem described.

Firstly, regarding advocacy power, recent intensified calls from experts worldwide and stakeholders (e.g. ‘Designed to move’ campaign) on the policy level “to act now” will help raise awareness on the importance of physical activity. Such **initiatives are valuable** in that they point to shortcomings and help to make the case for additional policy action. It is however highly unlikely that they alone could lead to real change towards more effective HEPA policy making in the EU. In addition, such initiatives are **often built on an evidence base that describes the global problem, but does not contain data covering several or all EU MS.**

Secondly, on the lack of capacity in the MS, a continuation of current arrangements will only marginally improve the understanding and intersectoral capacity to develop, design and implement effective HEPA policies. In the EU context, the conditions for cooperation in the field of sport (i.e. Council mandate for the XG SHP) and of health (mandate of the HLG) are expected to continue also after their current lifespan (i.e. after 2013/2014). Given the priority of HEPA in the current EU Work Plan for Sport and considering that the XG SHP has helped to foster the exchange of information, it is expected that a similar Expert Group will be set up to continue work in the field of HEPA promotion after the mandate of this group in the context of the next EU Work Plan as of 2014. Likewise, in the field of health, the HLG has provided a forum for engaging in coordinated activities as well as exchanging and raising awareness of key issues among public authorities over the past several years, and its work is likely to continue. While the **achievements of the existing structures should be recognised**, the continuation of these forms of cooperation consisting essentially of a mere exchange of best practices, sharing of policy ideas and discussion of 'HEPA promotion' between the MS is, **however, not**

**likely to solve the problem of ineffective national HEPA policies** and, ultimately, to increase physical activity levels in the EU. Moreover, although nutrition and physical activity are stated core areas of action in the Strategy on Nutrition, Obesity and Overweight-related Health issues, the HLG combines expertise mainly in the field of nutrition<sup>71</sup> There are different reasons for this, one stemming from the expertise and priorities of those involved: many of the Ministry of Health officials participating in the HLG are responsible for nutrition policy but not for physical activity.<sup>72</sup> MS specialised capacity on physical activity would remain weak.

Thirdly, the focused policy approach to physical activity, which forms the basis for effective HEPA promotion, will continue to be inexistent in most MS and in the EU without additional EU action. For instance, recent deliberations of the Council in the form of conclusions that call for more concerted action to promote physical activity confirm the existence of the problem from the policy side, but do not foresee measures that are likely to have sufficient leverage to convince many MS to reconsider their national approaches to HEPA across sectors. There is also no reason to believe that the political statements to which European countries have signed up in broad international strategies and voluntary action plans<sup>73</sup> would suddenly become more effective tools than in the past to lead to a stronger policy focus on HEPA in national and EU policy making. Current arrangements are rather conducive to continued progress in those MS that are already pursuing relatively effective approaches to physical activity promotion. Thereby the noted discrepancies between MS who make progress in developing and implementing effective HEPA policies and those who do not would continue if not increase. It appears that **HEPA would very likely continue to be undervalued in national and EU policy making and not get the recognition as a focused discipline requiring a multisectoral policy approach.**

Fourthly, related to the above arrangements and the lack of a focused policy is the policy coordination at EU level and between the MS more particularly, which would remain weak. As a consequence the development and **implementation of effective policies in the MS, such as provided for by the EU PA GL** would continue to advance at a low pace and, considering developments since 2008, **would leave out a number of MS, especially those that face the greatest challenges** with regard to their national physical activity levels. This progress, in addition, would continue to depend on efforts by

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<sup>71</sup> For example, the major achievement of the HLG since its inception in 2007 is the Common Framework for salt reduction, while new initiatives are currently being explored in the areas of sugar and fat reduction. Minutes from the 15 HLG meetings held until mid-2012 demonstrate that nutrition issues play a far larger role in the discussions than physical activity. According to the Evaluation of the Strategy "nearly all HLG members agreed that physical activity played only a small role in the discussions" (p. 33) – see fn 62.

<sup>72</sup> The Evaluation of the Strategy concluded that "Physical activity was perceived as playing only a small role in HLG discussions despite its importance for reducing overweight and obesity; a considerable proportion of HLG members saw this as a pragmatic choice that reflected the expertise and competences of participants, many of whom do not have responsibility for physical activity promotion" (p. 36) – see fn 62.

<sup>73</sup> E.g. Global Strategy on Diet, Physical Activity and Health (WHO, 2004); Action Plan for the Global strategy for prevention and control of NCDs 2008-2013 (WHO), Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of NCDs (UN, 2011), Parma Declaration on Environment and Health (WHO Europe, 2010), Action Plan for implementation of the European Strategy for the Prevention and Control of NCDs 2012-2016 (WHO Europe).

individuals in single HEPA sectors (e.g. sport, health, transport) in view of the lack of a coordinated and focused policy approach driven by the impetus from an EU initiative that is designed to reach out to all relevant sectors. Ensuring the cross-sectoral cooperation between relevant actors and Ministries in the MS, to be achieved through the implementation of the GL, would continue to be the key challenge for individual countries that often lack the necessary capacity – this can be barely changed by general policy statements or discussions on the GLs' implementation in the way it has been done until now in meetings between MS at EU level. **Without stronger political support most MS are not likely to step up efforts across sectors.**<sup>74</sup>

Finally, considering the continuation of the current situation, **monitoring of physical activity aimed at achieving sound and reliable data on national HEPA levels and HEPA policies would remain difficult** if the current weaknesses of collecting, validating and processing national physical activity data, reported by experts and policy makers<sup>75</sup>, were not addressed. Further collection of information on progress in establishing national guidelines on physical activity and related actions in line with the EU PA GL, as it has been done by the XG SHP, would only serve as a general overview, but could not be considered a systematic collection of data for monitoring progress in policy development and implementation and that has value in guiding future policy. Regarding the implementation of the 'EU Strategy', information on nutrition, physical activity and obesity prevention would continue to be collated and processed within the current EC/WHO monitoring project (NOPA II) until mid-2014; this means a national coordinator in a MS would collate the information in all fields of the 'Strategy' which would then be made available and updated in the WHO information system (NOPA database). Although the WHO issued concrete recommendations for the effective monitoring of physical activity on the basis of the standardised IPAQ and GPAQ questionnaires (referred to in sub-chapter 2.2.3), the physical activity data so far collected for the NOPA database points to important methodological shortcomings regarding the data received from a number of MS. In the WHO context, independent sustainable physical activity counterparts, similar to those existing for nutrition, are considered desirable to improve monitoring on physical activity in the European Region. Within the current EU monitoring arrangements, specific coordinators on physical activity that could be expected to deliver more complete and comprehensive data in the field of physical activity would not be established. **The unsatisfactory situation of fragmented or lacking data on HEPA** (as repeatedly criticised by the expert and the policy levels and confirmed by the WHO)<sup>76</sup> **is therefore likely to continue**, making it difficult to track progress in individual countries over time, compare developments between them and identify trends in the EU. Not improving current monitoring arrangements would amount to a missed opportunity for informed future policy decisions.

To conclude, regarding how the problem would evolve all things being equal, it can be assumed that physical activity rates would continue to be unacceptably low in the EU. Despite the initiatives in the MS as well as at EU and international levels aimed at addressing the problem, there are currently no indications that the general trend towards

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<sup>74</sup> It is telling that the majority of MS representatives and experts consulted for this initiative have identified as a key problem the lack of a cross-sectoral approach and called for additional action.

<sup>75</sup> This in turn confirms that the status quo does not work in a satisfactory way (see also Annex I).

<sup>76</sup> E.g. by the XG SHP, EU Sport Directors, the HLG, experts (see also Annex I).

See Annex I.

stagnating or declining physical activity levels in the EU as a whole is about to be reversed. Instead, very **high rates of physical inactivity can be expected to continue**, leading to the described economic and social detriments.

### **3. DEFINITION OF POLICY OBJECTIVES**

The EU has been addressing HEPA through a number of policies and instruments. It is important to note that the proposed new initiative is not intended to fundamentally alter the course of policy, but to reinforce a focused approach on HEPA by facilitating a more widespread, consistent implementation of what already exists, in particular the principles contained in the EU PA GL. The following objectives have been defined with this in mind.

#### **3.1. General objective**

The general objective can be expressed as follows:

Contribute to a healthier and more productive society through increased levels of health-enhancing physical activity in the EU.

#### **3.2. Specific objective**

The initiative would seek to increase the effectiveness of MS' HEPA policies by enabling MS to develop and implement HEPA policies based on the EU PA GL, which would help them address the main shortcomings (lack of cross-sectoral approach, unclear objectives, insufficient monitoring). The development of policies and their implementation would take place at MS, rather than EU, level. Therefore, the single specific objective is expressed as:

Ensure the EU Member States develop and implement effective policies for HEPA by improving the uptake and implementation of the EU PA GL.

#### **3.3. Operational objectives**

Operational objectives should fulfil the specific objective and will be linked directly to underlying policy drivers and the parameters of the future initiative. They relate to areas where the EU could be expected to add value in light of the justification for EU action and baseline scenario, and consist of:

- (1) Enhance policy co-ordination between the EU Member States in the field of HEPA, based on a focused approach to HEPA promotion, to improve Member States' capacity to design and implement effective HEPA policy.
- (2) Facilitate the collection of comparable and comprehensive data on HEPA and HEPA policies in the EU Member States.

#### **3.4. Consistency of objectives with EU strategic objectives**

Action to promote HEPA is desirable from the perspective of the EU as it contributes to wider EU policy objectives, in particular those defined in the **Europe 2020 Strategy** – as

described in sub-chapter 2.5.2. The strategy highlights that, in order to reach the overarching objective of inclusive growth, the EU has to be able “to meet the challenge of promoting a healthy and active ageing population to allow for social cohesion and higher productivity”. By promoting HEPA along the EU PA GL, the EU would address one of the key factors that can contribute significantly not only to healthy and active ageing (i.e. with regard to older people in employment, their social participation and independent living), but in particular also to a healthy workforce and ultimately higher productivity.<sup>77</sup>

### 3.5. Coherence of objectives with those of other policies

The proposed initiative is also fully coherent with EU policies in a number of other fields, in particular:

- **Health:** The EU Health Strategy commits the EU to tackling health inequality, and to promote health and prevent disease throughout the lifespan by tackling key issues / health determinants including physical activity. It notes that: “Improving the health of children, adults of working age and older people will help create a healthy, productive population and support healthy ageing now and in the future.”<sup>78</sup> The importance of encouraging HEPA is also emphasised in the Strategy for Europe on Nutrition, Overweight and Obesity related Health issues.<sup>79</sup> At the end of 2011, the Council expressed its commitment to “accelerate progress on combating unhealthy lifestyle behaviours, such as (...) lack of physical activity, leading to increased incidence of non-communicable diseases (...).”<sup>80</sup> It inter alia called on the MS and the COM to reinforce and continue action to support healthy lifestyle behaviours, including encouraging the development of urban and social environment policy conducive to physical activity for all.
- **Transport:** The EU Action Plan for Urban Mobility<sup>81</sup> stresses the need to promote integrated urban transport policies, and notes that sustainable urban transport (including active commuting) can play a role in creating healthy environments and contribute to reducing non-communicable diseases.
- **Social inclusion:** Sport and physical activity are increasingly recognised as an instrument for social inclusion. Women and disadvantaged groups, including lower socio-economic groups, immigrants, and people with a disability generally tend to have lower HEPA participation rates, even though their participation has been shown to have a potential positive impact on integration and equal

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<sup>77</sup> This is also reflected in the recent Council conclusions on closing health gaps that invited the MS to “promote policies and actions that sustain the health of working age people leading to a healthy workforce, as a prerequisite for productivity and growth”. (See Annex I)

<sup>78</sup> European Commission White Paper “Together for Health: A Strategic Approach for the EU 2008-2013”, COM(2007) 630 final.

<sup>79</sup> European Commission White Paper “A Strategy for Europe on Nutrition, Overweight and Obesity related health issues”, COM(2007) 279 final.

<sup>80</sup> Council Conclusions on closing health gaps within the EU through concerted action to promote healthy lifestyle behaviours, 1-2 December 2011.

<sup>81</sup> European Commission Communication “Action Plan on Urban Mobility”, COM(2009) 490 final.

opportunities. This link has been recognised inter alia in the EU Disability Strategy<sup>82</sup> (in particular with regard to accessibility).

- **Research:** EU research policy<sup>83</sup> includes actions to identify, develop and apply innovative approaches and “good practices” to reduce sedentary behaviour and enhance the level of physical activity in the population, combined with dietary or other interventions. The relevant research, using the concept of social innovation, may cover various areas affecting lifestyle and should identify more effective and efficient evidence-based strategies for reducing sedentary behaviour and increasing physical activity, as well as facilitating multi-disciplinary policy environments and collaboration between different public and private stakeholders, including Small and Medium Enterprises (SMEs). The aim is a greater uptake of innovative approaches by policy makers and to make it more appealing to citizens to choose a healthy lifestyle.

#### 4. POLICY OPTIONS

In view of the concrete objectives defined in the previous section, a range of options to support MS in their endeavours to develop and implement effective policies for HEPA promotion is being considered hereafter. The options have been elaborated with a focus on their content. Regarding the policy instruments at the COM's disposal, the implementation of these options requires either a COM Communication or a COM proposal for a Council Recommendation.

The options that have been discarded are:

- A complete cessation of EU policy coordination on HEPA, since this would contradict the EU's stated wider policy goals and run counter to the objectives of this as well as other initiatives;
- A policy option that would put the main focus on a revision of the content of the EU PA GL. The GL represent the current state of scientific knowledge and have been confirmed again by the Council in its conclusions on HEPA (Nov. 2012). It is suggested that adaptations to include possible new scientific findings on HEPA promotion and to reflect possible new developments in HEPA policies can be made in the context of the full evaluation of the implementation of the proposed Recommendation.
- To address the problems identified, a policy option that focuses solely on the adoption of new incentive measures in the area of HEPA, such as foreseen in the

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<sup>82</sup> European Commission Communication “European Disability Strategy 2010-2020: A Renewed Commitment to a Barrier-Free Europe”, COM(2010) 636 final.

<sup>83</sup> FP7 Cooperation Work Programme Health 2013 (Social innovation for health promotion): <http://ec.europa.eu/research/participants/portal/page/cooperation?callIdentifier=FP7-HEALTH-2013-INNOVATION-1> as well as FP7 research projects from the diabetes/obesity area, such as DEXLIFE (<http://www.delife.eu>) and METAPREDICT (<http://metapredict.eu>). The FP 7 ENERGY project inter alia noted that parents' physical activity is an important predictor of physical activity in children. It is however not considered politically feasible to address parenting behaviour within the context of the present initiative, which is, moreover, based on the EU PA GL that do not have a specific focus on parents.

Sport Chapter of the Erasmus+ Programme, cannot be a solution for a policy initiative either. Recent analysis<sup>84</sup> has shown such an option to be relevant for the implementation of grassroots level activities, such as support for HEPA cooperation projects involving sport organisations, rather than the development and implementation of sport policies. Accordingly, the main operational objective of the Sport Chapter in the proposed Erasmus+ Programme in the field of HEPA is proposed to be support for the implementation of the EU PA GL.<sup>85</sup>

**Table 3: Policy options to be assessed**

Option		Brief description
A	Baseline scenario (continuation of status quo)	<ul style="list-style-type: none"> <li>▪ Continued policy coordination with the involvement of the Expert Group on Sport, Health and Participation (XG SHP), and the High Level Group (HLG), underpinned by the EU Physical Activity Guidelines (EU PA GL), but no new policy initiative.</li> </ul>
B	Push for increased policy coordination  (Tool: Commission Communication)	<ul style="list-style-type: none"> <li>▪ Policy document (with no mandatory authority) setting out a strategic approach for focused HEPA promotion across sectors;</li> <li>▪ Enhanced policy coordination at EU level with the involvement of the XG SHP, and the HLG, facilitated by the COM;</li> <li>▪ Actions to encourage MS to commit themselves to the principles embodied in the EU PA GL;</li> <li>▪ Call on MS to report on progress in implementing the EU PA GL taking account of existing reporting tools and structures.</li> </ul>
C	Push for increased policy coordination and monitoring, based on a limited set of indicators on the implementation of the EU PA GL  (Tool: Proposal for a Council Recommendation)	<ul style="list-style-type: none"> <li>▪ Policy document with legal effect (establishing non-binding rules) recommending focused HEPA promotion across sectors;</li> <li>▪ Enhanced policy coordination at EU level with the involvement of the XG SHP, and the HLG, facilitated by the COM;</li> <li>▪ MS (meeting in the Council) reaffirm and commit themselves to the principles embodied in the EU PA GL;</li> <li>▪ MS agree to monitor HEPA policy development and implementation using a limited set of high-level and aggregate indicators relating to the EU PA GL and to report back to the EU level;</li> <li>▪ COM supports the monitoring framework and assists MS in their implementation efforts.</li> </ul>
D	Push for increased policy coordination and monitoring, based on a comprehensive set of indicators covering each of the 41 EU PA GL and evaluation against targets/benchmarks.  (Tool: Proposal for a Council Recommendation)	<ul style="list-style-type: none"> <li>▪ Policy document with legal effect (establishing non-binding rules) recommending focused HEPA promotion across sectors;</li> <li>▪ Enhanced policy coordination at EU level with the involvement of the XG SHP, and the HLG, facilitated by the COM;</li> <li>▪ MS (meeting in the Council) reaffirm and commit themselves to the implementation of all 41 EU PA GL;</li> <li>▪ MS agree to monitor HEPA policy development and implementation by using a comprehensive set of quantitative and qualitative indicators relating to the EU PA GL and to report back to the EU level;</li> <li>▪ MS agree on benchmarks and targets for the implementation of the GL;</li> <li>▪ COM supports the monitoring framework, assists MS in their implementation efforts and evaluates MS' performances against benchmarks and in achieving targets.</li> </ul>

**Option A (baseline scenario)** would entail a continuation of the status quo, including all of the EU policies and initiatives described under policy context (sub-chapter 2.1.2) and baseline scenario (chapter 2.6).

<sup>84</sup> Impact assessment on the Proposal for a Regulation establishing "ERASMUS FOR ALL", The Union Programme for Education, Training, Youth and Sport. SEC(2011) 1402

<sup>85</sup> A recent evaluation of Preparatory Actions in the field of sport also confirms the role of projects to support policy development and to inform and shape policy-making, however not to replace it. Final report: Framework contract EAC/50/2009.

**Option B** would introduce a renewed strategic vision for the EU towards a focused approach to HEPA promotion across sectors and coordinated policies in the MS in form of a policy document with no legal effect (i.e. a COM Communication). Building on the already existing policy documents in the field of HEPA, including the EU PA GL, such an initiative would express a renewed political commitment to HEPA in line with the EU PA GL, and would in addition outline key actions involving the MS, the COM and other relevant actors. Under this option, MS would be invited a) to develop a national strategy and corresponding action plan for promoting HEPA across sectors, in line with the EU PA GL, and b) to regularly report progress against the action plan and exchange best practices within relevant EU-level structures. The proposed initiative would call for enhanced policy coordination on HEPA between MS at EU level within relevant existing structures. The XG SHP (which is supposed to continue under a new mandate from mid-2014) and the HLG (with regard to EU activities in the field of nutrition, overweight and obesity-related health issues) would remain the principal fora for this.

**Options C and D** would add to this political commitment to a focused approach on HEPA and enhanced policy coordination within relevant structures (i.e. the XG SHP and the HLG) another element, namely provisions for establishing a monitoring mechanism to record, measure and compare the progress made by MS, with a view to implementing the EU PA GL. The GL contain specific “guidelines for action” aimed at a number of sectors. The intention is that a reaffirmation of the GL coupled with a specific mechanism to monitor their implementation would lead to a more systematic and constructive form of coordination and peer learning, and as a consequence, a greater focus on effective HEPA policies at the national and sub-national levels. Principally, an initiative under these options would invite the MS a) to develop a national strategy and action plan for promoting HEPA across sectors, in line with the EU PA GL; b) to monitor the implementation of the EU PA GL at national level, based on an agreed set of indicators to measure changes in physical activity and in HEPA policy; and c) to report back at regular intervals on progress made. To support these activities MS would be asked to set up "national focal points for physical activity" charged with collecting data for the monitoring framework and with providing country-specific information on relevant national policies and action plans.<sup>86</sup>

The COM would facilitate this process in two ways: a) by providing support for the set up and running of the monitoring mechanism (e.g. support for training of focal points, developing a system for recording and managing the monitoring data making use of and complementing existing initiatives, including the WHO's NOPA database<sup>87</sup>) and b) by supporting MS in the development and implementation of policies consistent with the EU PA GL and thereby enhancing MS' capacity (e.g. support for capacity building provided

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<sup>86</sup> These focal points have a coordinating role and could possibly function as a subgroup within the currently existing WHO-led national focal points which so far have mostly focused on nutrition aspects. EU monitoring arrangements currently supported within a two-year WHO/COM project might continue in some form also after mid-2014; they would take into account the new PA monitoring framework and new reporting structures.

<sup>87</sup> For instance, regular surveys would be carried out using standardised questionnaires and reporting tools. Such information would be verified and abstracted into the WHO NOPA database. A system would be established to allow ad-hoc snapshots of country implementation levels, using the EU PA GL monitoring framework. Such reports would be delivered to the Commission at regular intervals.



by HEPA experts). Options C and D would apply to all MS; those who have made less progress addressing physical inactivity can learn from the progress made in other MS that have had more success in raising the physical activity levels of their citizens. Support would be targeted first and foremost at MS most in need, the choice of which would be based on a combination of HEPA expert views, information stemming from prevalence data, analysis of existing policies (incl. further work on "HEPA PAT") and the willingness of MS to develop and implement more effective HEPA policies.<sup>88</sup>

The HEPA monitoring framework would thereby develop further existing forms of monitoring and data collection in this field currently established under the Strategy for Europe on Nutrition, Overweight and Obesity-related health issues with the involvement of WHO Europe. It is expected that WHO Europe would prepare country-specific overviews on HEPA ('country snapshots') and analysis about HEPA developments and trends, building on and improving the existing NOPA database. The snapshots would be submitted to the COM and, together with other relevant information about HEPA policy development and implementation provided by the national PA focal points to be established under the strengthened mechanism, form the basis for discussion at the relevant EU level fora (e.g. XG SHP). All these elements would form the basis for periodic reports from the COM to the XG SHP and the HLG respectively to provide updates on progress and demonstrate the initiative's contribution to the EU's strategic approaches and activities in the field of physical activity and healthy lifestyles more generally. The diagram in Annex IV illustrates the main actions and activities of the monitoring framework.

All these elements, i.e. endorsement of the EU PA GL, recommended value-adding activities in the MS (e.g. the adoption of a national strategy and a related action plan responding to countries' specific needs and conditions) and the participation in the monitoring mechanism would become part of the non-binding document stressing the need for more policy coordination, which is proposed to take the form of a Council Recommendation<sup>89</sup>, i.e. an instrument with legal effect establishing non-binding rules.

The key difference between Options C and D relate to the comprehensiveness of the monitoring mechanism:

- **Option C** would focus on a limited set of indicators related to high-level information and more general aspects of the EU PA GL. Annex III gives an overview of the exact nature of the 23 indicators which are proposed to be included in such a monitoring mechanism.
- **Option D** would provide a more comprehensive mechanism for monitoring the implementation of the EU PA GL, as well as for the setting of benchmarks and targets against which MS' performance would be evaluated. In addition, this

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<sup>88</sup> Pilot testing of such support is provided under the 2013 Preparatory Action in the field of sport, based on a direct agreement between the COM (EAC) and WHO Europe, involving the HEPA Europe expert network.

<sup>89</sup> In their recent discussions in the Working Party on Sport, a number of MS representatives have been supportive to the idea a Council Recommendation. (See Annex I)

option would entail a larger set of both quantitative and qualitative indicators, covering each of the 41 EU PA GL in detail.

For options C and D all MS are supposed to participate in the monitoring framework and make the necessary structural arrangements at national level (e.g. set up physical activity focal point). For a country like e.g. FI that already has a well-established cross-sectoral approach to HEPA policy making the participation in monitoring is expected to be a more comfortable and undemanding exercise as opposed to MS where effective HEPA promotion does not yet exist.

## **5. ANALYSIS OF IMPACTS AND OF EFFECTIVENESS**

This chapter analyses the types of impacts that could be expected from a new EU initiative in the field of HEPA, i.e. direct social and indirect (but significant) economic benefits, in addition to environmental benefits from increased reliance on active forms of transport (cycling and walking). Impacts are quantified where possible and indications of their scale are provided.<sup>90</sup> These are similar for all policy options, but are likely to vary in scale as a function of each option's effectiveness. Given that the detailed assessment of effectiveness of policy options (i.e. their outputs and outcomes) is a prerequisite for assessing the impacts of the initiative (options), it is merged with this chapter on assessment of impacts. In doing so, the outcomes of policy options are defined in terms of more effective national HEPA promotion policies (specific objective) while the impacts per option are defined in terms of physical activity levels (general objective) and summarised in chapter 5.5. In all cases, the effectiveness, precise benefits and costs of the initiative will depend on the policy choices of individual MS and the interventions stemming from them. Improvements in physical activity levels that could be expected from an EU initiative are therefore likely to substantially differ across MS and regions.

### **5.1. Social impacts**

#### *The benefits of increased physical activity*

The social benefits would stem from increased HEPA among Europeans as a result of more effective HEPA policy in the EU MS and implementation of the EU PA GL, provided that MS are willing to develop and invest in such policies. Although the EU PA GL cover a wide range of policy areas, their overarching goal is that, through the development and implementation of national strategies, the MS achieve the WHO-recommended minimum of at least 150 minutes moderate-intensity physical activity weekly, or 75 minutes of vigorous-intensity physical activity, or an equivalent combination of moderate- and vigorous intensity activity.

The myriad benefits of meeting physical activity recommendations as well as the low rates of physical activity in the EU have been well documented and were described *inter alia* in the problem analysis section and in Annex II. Briefly, engaging in the

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<sup>90</sup> Given the wide range of actors involved in implementing the new initiative, and the fact that it will be implemented at MS rather than EU level, quantitative predictions concerning the precise benefits and costs are difficult and necessarily based on extrapolations from a limited supply of reliable data.

recommended amount of physical activity has above all beneficial health effects, addressing many chronic diseases and health problems, including but not limited to those linked to obesity. This includes significantly reduced risks of eight serious health conditions: heart disease, stroke, overweight and obesity, type 2 diabetes, colon cancer, breast cancer, falls in older people, and depression.<sup>91</sup>

The upshot of this is that people who do not undergo enough physical activity suffer from a **20-30% increased risk of all-cause mortality** compared with those engaging in at least the recommended 150 minutes weekly of moderate intensity physical activity.<sup>92</sup> Increased rates of physical activity among Europeans would result in a commensurate drop in the number of people suffering from this increased mortality risk.

Obviously, the detrimental effects of high levels of physical inactivity are borne first and foremost by those individuals who do not engage in sufficient HEPA. These negative impacts are more pronounced among specific countries and regions, and specific groups of people within them, in particular specific-at risk groups such as the elderly or socially disadvantaged people – as confirmed by many studies, also referred to in Annex II.<sup>93</sup> Thus, the initiative would be expected to make some inroads into reducing health disparities, improving social inclusion and protection. It would also contribute to ensuring a high level of human health protection (Article 35 of the EU Charter of Fundamental Rights) and to advancing equal opportunities of at-risk-groups, thereby promoting indirectly for instance the principle of non-discrimination (Article 21) and equality between women and men (Article 23). Furthermore, by providing initiatives at schools, for the elderly and "at-risk" or those from low socio-economic groups, the EU PA GL will undoubtedly have a direct or indirect positive effect on groups of society protected by the Charter: children (Article 24), the elderly (Article 25) and persons with disabilities (Article 26). When promoting or implementing such policies, the best interests of the child, the rights of the elderly to sustain an independent life and to participate in social life and the rights of persons with disabilities to benefit from measures to help them lead an integrated life in the community will come into play.

Given the manifold factors that play a role in life expectancy and similar statistics, it is not possible to attribute the differences in life expectancy directly between high- and low-physical activity countries to the level of physical activity.<sup>94</sup> Nonetheless, physical activity is certainly an important contributing factor for all of the reasons described above and in the problem definition section. Recent studies in the US associate leisure-time physical activity with longer life expectancy and confirm that even modest amounts of

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<sup>91</sup> Physical activity and health in Europe, WHO Europe, [http://www.euro.who.int/data/assets/pdf\\_file/0011/87545/E89490.pdf](http://www.euro.who.int/data/assets/pdf_file/0011/87545/E89490.pdf).

<sup>92</sup> Ibid.

<sup>93</sup> According to the 2010 Eurobarometer on sport, the countries with the highest inactivity rates are all in Southern and Eastern Europe. Moreover, lack of leisure-time physical activity tends to be more common in the lower socio-economic groups – these people tend to die at a younger age and to have, within their shorter lives, a higher prevalence of all kinds of health problems. [http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_334\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_334_en.pdf).

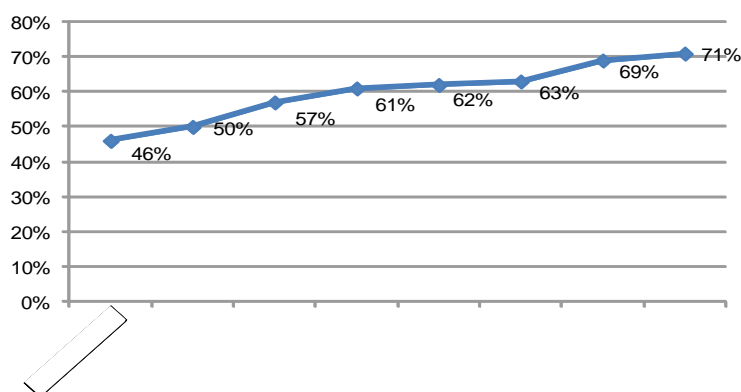
<sup>94</sup> There are large differences between MS, due to a number of factors that determine health, including variations in living and working conditions, as well as in lifestyles. See COM(2013) 83 final.

physical activity can add years to people's life (even if it does not result in weight loss)<sup>95</sup>. A simplified calculation shows that in the EU, **levels of physical activity are positively correlated with life expectancy**, meaning that those countries with higher levels of physical activity tend to have a higher life expectancy.<sup>96</sup>

*The extent to which effective policy can lead to increased physical activity levels*

Always bearing in mind that improvements are likely to substantially differ across the EU, in order to estimate how policies to promote physical activity can impact HEPA levels over the medium and long term, it is worth looking at an example. Finland identified low physical activity levels as an issue to be addressed earlier than most MS and has continued to both prioritise HEPA and monitor comparable yearly data on physical activity levels since the early 1980s. It is therefore an excellent example of a country where the medium- and long-term **results of effective HEPA policy can be measured**. Undoubtedly the evolution of HEPA rates over time in Finland has been affected by a range of factors other than policies specifically aimed at increasing HEPA (e.g. individual behaviour, socio-demographic factors, seasonality). Nonetheless it is instructive to consider the change in HEPA rates in Finland which, as shown in the chart below, amount to a sustained increase of about 1% increase per year over a period of 27 years.

*Figure 2: Evolution of the proportion of Finns engaging in twice per week leisure time physical activity*



Source: *Health behaviour among the adult population*, Finnish National Public Health Institute<sup>97</sup>

Canada, which is outside the EU but socioeconomically and culturally similar to many EU countries, is another of the few examples of countries that have prioritised physical activity promotion already for a number of decades. It has achieved similar increases, with a 21% gain in leisure time physical activity participation from 1981-2002.<sup>98</sup> Such change over time is also **considered feasible and desirable by the WHO**, which in November 2012 recommended that individual countries should set a target of a 10%

<sup>95</sup> S. C. Moore et al, Leisure time physical activity of moderate to vigorous intensity and mortality: a large pooled cohort analysis. *PLoS Medicine*, 2012; 9 (11).

<sup>96</sup> Calculated on the basis of Eurostat physical activity ([http://ec.europa.eu/sport/library/documents/d/ebs\\_334\\_en.pdf](http://ec.europa.eu/sport/library/documents/d/ebs_334_en.pdf)) and life expectancy data ([http://epp.eurostat.ec.europa.eu/statistics\\_explained/images/2/20/Mortality\\_and\\_life\\_expectancy\\_statistics\\_YB2013.xls](http://epp.eurostat.ec.europa.eu/statistics_explained/images/2/20/Mortality_and_life_expectancy_statistics_YB2013.xls)).

<sup>97</sup> <http://www.thl.fi/thl-client/pdfs/4582dc7b-0e9c-43db-b5eb-68589239b9a3>

<sup>98</sup> WHO discussion paper, 22 March 2012, [http://www.searo.who.int/LinkFiles/mhnd\\_GMF.pdf](http://www.searo.who.int/LinkFiles/mhnd_GMF.pdf).

reduction in the prevalence of insufficient physical activity by 2025 (see section 2.1.2), with the magnitude of change that can be expected by decisive action in the order of about a 1% change per year.<sup>99</sup>

There are good practice examples illustrating how targeted policy interventions focusing on specific-at risk groups, for instance women in disadvantaged communities or senior citizens, have led to increased physical activity levels. For instance, good practices have been or are currently being collected as part of transnational cooperation projects financed under the Preparatory Actions in the field of sport, e.g. in 2009 (call focusing on ‘gender’) or 2012 (call focusing on ‘physical activity contributing to active ageing’) or under the Health programme 2008-2013.

## 5.2. Economic impacts

### *Economic benefits*

Enhanced health and well-being can be expected to lead to significant further **benefits of an economic nature**, as health care costs go down and the amount of economic output forgone due to illness and morbidity, sick leave and pre-mature death decreases. Studies have attempted to monetise the costs of these factors due to lacking physical activity. One study carried out for the British government identified costs to England of just over €3bn per year, or €63 per inhabitant<sup>100</sup>. Through a simplified analysis that extrapolates across the EU the same cost per inhabitant, the lack of physical activity in the EU can be calculated as **costing over €31bn per year**.<sup>101</sup>

With regard to these costs of physical inactivity, improved HEPA promotion policies if developed and implemented in line with the planned initiative would be expected to increase the proportion of EU citizens meeting physical activity recommendations, gradually chipping away at the cost of physical inactivity over time. Under an optimistic assumption based on scenarios in line with the Finnish and Canadian examples, and considering that investments would be required at different levels in the MS, effective HEPA policy can be expected to increase the proportion of citizens meeting recommended physical activity thresholds by up to about 1% per year. Taking the latest Eurobarometer figures from 2010 as a starting point, **implementing effective HEPA policy could theoretically see about 65% of Europeans meeting physical activity recommendations in 25 years**, with the cost of inadequate amounts of physical activity gradually heading downwards.

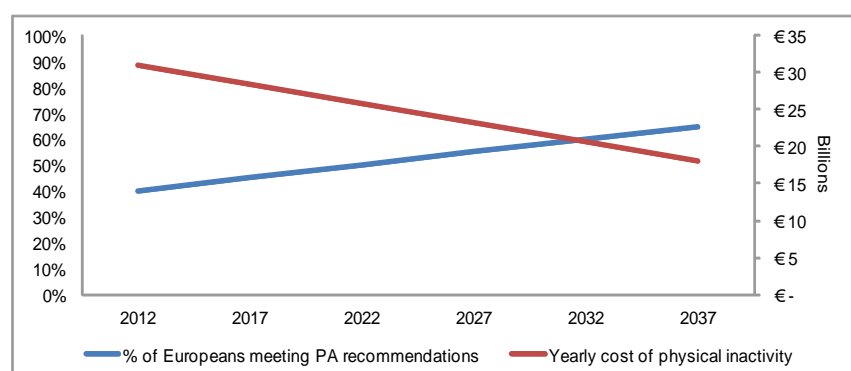
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<sup>99</sup> Formal meeting of Member States to conclude the work on the comprehensive global monitoring framework, including indicators, and a set of voluntary global targets for the prevention and control of NCDs, WHO, Geneva, 5–7 November 2012. On 27 May 2013, the World Health Assembly in Geneva has adopted an "[Omnibus Resolution](#)", endorsing the WHO Global Action Plan 2013-2020 for the prevention and control of non-communicable diseases NCD and adopting the respective global monitoring framework and the set of nine voluntary global targets, including one on physical inactivity.

<sup>100</sup> Game Plan: a strategy for delivering Government’s sport and physical activity objectives, [http://www.cabinetoffice.gov.uk/media/cabinetoffice/strategy/assets/game\\_plan\\_report.pdf](http://www.cabinetoffice.gov.uk/media/cabinetoffice/strategy/assets/game_plan_report.pdf). This figure can be seen as a realistic calculation since in other countries studies identified similar or higher costs (Annex II).

<sup>101</sup> The variables of the UK estimate, which are based on the costs to the NHS of lost day income and costs of premature death also based on lost income, are hence likely to differ across the EU. Nonetheless, this calculation serves as an approximation and uses the few data available.

Figure 3: Estimated economic savings through rising levels of physical activity



Source: TEP based on Eurostat data ([http://ec.europa.eu/sport/library/documents/d/ebs\\_334\\_en.pdf](http://ec.europa.eu/sport/library/documents/d/ebs_334_en.pdf)) and British government report 'Game Plan'

The scenario as depicted is simplified and depends on the capacity and willingness of the MS to prioritise and implement effective HEPA policy over the long term. Finland and Canada have achieved increases in HEPA levels of about 1% per year over reasonably long periods. 1% per year also seems realistic in the light of the abovementioned global target of a 10% relative reduction in prevalence of insufficient physical activity by 2025: EU MS, as members of the WHO, are part of the works concluded on the global monitoring framework (see fn 99) and the setting of these targets that apply to all countries, including low- and middle income countries.

Over time, maintaining a momentum of 1% p.a. would gradually become more difficult, eventually reaching a point of saturation where further improvements would be prohibitively expensive. Today the MS and the EU overall are far away from this point and the projected **economic benefits would be huge**, in terms of avoiding the costs of physical inactivity (health care savings and increased productivity), adding up to nearly €7bn after 5 years, €22bn over 10 years and €63bn over 20 years (taking, as an approximation, the costs calculated for England as a basis). This would in turn justify requisitely large expenditure on policies and initiatives to boost HEPA levels, as shown in the table hereafter.

Table 4: Economic value of increased HEPA levels<sup>102</sup>

Year	% of Europeans meeting PA recs*	Annual savings due to increased HEPA levels	Cumulative economic value of increased HEPA
2017	45%	€2.5bn	€6.7bn
2022	50%	€5.1bn	€11.5bn
2032	60%	€10.3bn	€31.3bn
2037	65%	€12.9bn	€63.4bn

\*figures based on the optimistic assumption of a 1% increase compared to 2010 levels of the Eurobarometer survey

<sup>102</sup> Figures are based on the methodology used for the British government report Game Plan and Eurostat population figures.

According to the table, under a best-case scenario, **EU-wide benefits of €6.7bn** would result from initiatives to increase HEPA rates by about 1% per year over the next 5 years. These are approximations; the exact results obviously have to be validated.

### *Economic costs*

#### - Impacts on Member States' budgets:

MS would have to bear costs relating to the implementation of HEPA policies following the new initiative and administrative costs stemming from the reporting requirements to the EU level. In addition, under options C and D, they would have to appoint a "national physical activity coordinator" (one per MS).

While the benefits of increased HEPA are manifold, implementing policies that encourage Europeans to take part in more HEPA entail a variety of **(substantial) implementation costs**. Depending on the specific policy in question, these range from the infrastructure costs of constructing, say, cycle lanes or leisure time infrastructure, to training teachers in physical activity promotion, to providing subsidies to employers that create a physical-activity friendly environment or encourage active commuting, to collecting data on HEPA-related topics so that policy can be continuously improved. The costs of HEPA promotion are not only spread around government ministries and authorities, but various NGOs and the private sector as well. Moreover, the different institutional and administrative structures, and diverse cultures of the EU MS ensure that **no two MS would take the same approach** to (effective) HEPA policy, meaning that costs would be highly variable. The benefits of increased physical activity largely depend on MS' willingness and ability to put money into HEPA promotion policies, with the consequence that MS would continue to evolve at different speeds. Moreover, a country such as Finland that already has monitoring in place would have to invest relatively less than a MS that has no strategic policy implementation in the field of HEPA.<sup>103</sup> The fact that limited information is currently made available in the MS on the budgets invested into HEPA promotion across policies makes it impossible to make an exact estimate on the investments to be made. The enhancement of monitoring provisions, as proposed by the planned initiative, should aim at addressing this shortcoming and help in adapting national policies on HEPA promotion, in particular in those MS that have been less successful in raising the physical activity levels of their citizens.

The envisaged policy coordination at EU level coupled with support for capacity building and monitoring (options C and D) would help the MS to target investments to the measures that are known to deliver the highest return, based on best practices. Thus the impacts on respective MS' budgets need to be quantified carefully as an early step in HEPA policy implementation.

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<sup>103</sup> At a recent meeting of the XG SHP FI confirmed that exact numbers on the effects of multisectoral co-operation on PA levels and the exact costs involved could not be provided at present. FI however also stated that "multisectoral co-operation has been experienced as being extremely valuable and crucial" and that "as a result of the governmentally directed nationwide cross-sectoral programmes to promote HEPA, after ten years of working, physical activity is stated as one of the main tools to improve health and wellbeing in the strategies of main cities".

Today, spending on HEPA is **not recorded comprehensively** across the EU. This is exacerbated by the fact that HEPA is by nature cross-sectoral, that many policies are tangentially related to HEPA and that policies which promote HEPA do not always (or often) include HEPA promotion as a primary objective. This makes calculating the budget currently allocated to HEPA fraught, especially for the purposes of making comparisons between countries. Even the HEPA PAT, which for seven countries contains the most in depth information available on physical activity promotion policies, **cannot provide any estimate of absolute expenditure on HEPA** in any individual EU country.<sup>104</sup>

It is also worth noting that MS will be responsible for the main budgetary considerations related to the initiative, in line with national circumstances and political priorities. Thus, while the effectiveness of the initiative will depend on substantial funds being allocated to HEPA promotion, the majority of the costs will be determined by MS themselves.<sup>105</sup>

The **administrative costs** of options B, C and D can be calculated, albeit only as a mere order of magnitude, by applying the **standard cost model**. This uses rough estimates for the time (in terms of FTEs) that would be required of MS administrations to estimate the administrative burden (based on average EU tariff per hour<sup>106</sup>). The calculation assumes a) that the first year would require more resources than subsequent years, as relevant staff familiarise themselves with the monitoring mechanism; and that b) relatively junior staff could be used to collect and manage the data. For option B, some limited reporting, however no monitoring based on indicators, would be foreseen and would require staff time.

Table 5: Administrative costs<sup>107</sup>

	Member State FTEs		Unit cost	Admin. burden per MS	
	Year 1	Year 2+		Year 1	Year 2+
<b>Option A</b>	-	-	-	-	-
<b>Option B</b>	0.06	0.04	€56,425.60 / year	€3,655	€2,244
<b>Option C</b>	0.2	0.1	€56,425.60 / year	€11,285	€5,643
<b>Option D</b>	0.4	0.2	€56,425.60 / year	€22,570	€11,285

- Impacts on the EU budget:

A smaller proportion of the costs emanating from the implementation of the new initiative would fall on the EU budget. Apart from costs relating to the organisation by

<sup>104</sup> This is why a new indicator on "Funding allocated specifically to HEPA promotion" is proposed to be included in the new monitoring framework accompanying the Commission's proposal.

<sup>105</sup> It should also be noted that a range of factors other than policies specifically aimed at increasing HEPA can lead to increases in physical activity levels, such as noted for FI.

<sup>106</sup> The hourly rate is the EU hourly wage average of ISCO 2 Professionals, taken from the Administrative Burden Calculator.

<sup>107</sup> The estimates are informed by the amount of time needed to collect and manage data for the NOPA database and HEPA PAT, and the fact that Option D would comprise significantly more indicators than Option C, requiring feedback from more stakeholders and more analysis.



the COM of Expert Group meetings at EU level (e.g. three meetings per year of the XG SHP) as provided for under all options, costs to the EU budget would mainly stem from the **costs of setting up and managing the monitoring mechanism and support to MS (capacity building)**. They would therefore vary depending on the option chosen, i.e. option C or D, which are the only options that propose establishing such a mechanism. Based on COM's experience of funding the NOPA database project and following expert judgement, the COM would bear some financial burden in identifying, coordinating and training national focal points, maintaining a centralised data base and producing periodic reports on progress. For option C, this could be expected to total approximately EUR 2,680,000 for the entire MFF period (2014-2020), with relatively higher costs for the first two years of the initiative and reduced costs in the following years, once the mechanism is fully operational. These costs would be higher for option D and would amount to an estimated EUR 3,369,000, given the more complex monitoring arrangements involving a higher number of indicators, setting benchmarks and targets and requiring additional evaluations. It is proposed that these costs would be covered by the Sport Chapter of the proposed Erasmus+ Programme.<sup>108</sup> Costs for meetings of the Expert Group would be covered by the general budget (Global envelope). The table hereafter provides a summary of the costs to the EU budget for 2014-2020. A further breakdown of these costs can be found in Annex V.<sup>109</sup>

**Table 6: Impact on EU budget**

Total costs to the EU budget for the period 2014-2020			
	3 meetings / year (19 in total as of mid-2014) at EU level (28 MS)	Support for PA monitoring framework and PA policy dev. + implementation	Total per option
<b>Option A</b>	EUR 532,000	-	EUR 510,000
<b>Option B</b>	EUR 532,000	-	EUR 510,000
<b>Option C</b>	EUR 532,000	EUR 2,680,000	EUR 3,212,000
<b>Option D</b>	EUR 532,000	EUR 3,369,000	EUR 3,910,000

### 5.3. Environmental impacts

Policies aimed at implementing the section of the EU PA GL that addresses transport, environment, urban planning and public safety (GL 25-32) could also result in **significant environmental benefits** and thereby contribute to a high level of environmental protection, enshrined in Article 37 of the EU Charter of Fundamental Rights. The extent of these benefits is dependent on several factors, namely whether MS, depending on their national priorities, prioritise this section of the Guidelines and whether it leads large numbers of people to switch from passive (i.e. motorised) to active forms of transport. While it is extremely difficult to make accurate predictions for either of these factors, recent scientific research can provide some insight into what can be considered the optimum scenario in terms of the environmental benefits of the initiative.

<sup>108</sup> Indicative annual allocation of the budget for HEPA estimated in the 2011 IA for the Sport Chapter: €3m.

<sup>109</sup> A precise breakdown of costs will be possible after the implementation of the 2013 Preparatory Action (direct agreement with WHO Europe to test the monitoring framework).

A recent study sought to predict the extent to which a reorientation of transport policy towards active transport in London would affect carbon emissions over 20 years in comparison with an evolution of the baseline.<sup>110</sup> Assuming a transition towards the cycling levels of Amsterdam, Copenhagen and other European cities, the study calculated that the **per person transport CO<sub>2</sub> emissions would be 62% lower** under the sustainable transport scenario, at 0.46 tonnes per year, than under the continuation of the baseline scenario, at 1.17 tonnes. While the specificities of London and the small scale of the study preclude EU-level extrapolations, the study is notable for demonstrating the **sheer scale of potential environmental benefits** of active transport policies. Increases in active transport of the magnitude described in the study would require significant political and financial investment over the long term and would doubtless require cooperation across the policy spectrum. It is not expected that, on its own, the subject of this IA would result in such change, but it could contribute to a wider policy shift.

#### 5.4. Analysis of effectiveness

The effectiveness of the four options relies on (voluntary) action by the MS. However, the options vary in the extent to which the EU calls for specific actions and / or policies and they are closely linked to the instrument chosen to implement the initiative.<sup>111</sup>

##### 5.4.1. Option A: baseline scenario

This option would be likely to see continued progress in those MS already pursuing relatively effective approaches to physical activity promotion. Likewise, these MS would continue to make some progress on implementing the EU PA GL. No additional action would be taken at EU level to encourage the uptake of the GL in other MS, but possibly some may seek 'inspiration' from the published text of the GL for policy formulation, as has been the case in recent years in Cyprus, Poland, Hungary, Slovakia and Spain.<sup>112</sup> Even in these countries, however, the small amount of available evidence indicates that HEPA rates are not evolving favourably, which suggests that stronger action is needed.<sup>113</sup> Under this option, despite existing actions, there would be **little movement towards the achievement of the first operational objective**, which relies on co-ordinated efforts between countries, and very limited or **no progress in improving HEPA data (second operational objective)**. Thus, overall, the **specific objective would only be achieved to a small extent**. For the EU as a whole physical activity rates would be likely to continue to stagnate or even fall, carrying with it the economic and social detriments highlighted in the problem analysis.

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<sup>110</sup> Woodcock, J. et al, Public health benefits of strategies to reduce greenhouse-gas emissions: urban land transport, *The Lancet*, Volume 374, Issue 9705, pages 1930-1943, 5 December 2009.

<sup>111</sup> In this section, the scale in the tables compares the option against the baseline scenario. Thus, each '0' indicates the same rating as the continuation of the status quo, 'pluses' indicate that options rate more favourable than the status quo (i.e. because they are more likely to be effective).

<sup>112</sup> As expressed by MS, e.g. at EU Sport Directors meetings or XG SHP meetings. (see Annex I)

<sup>113</sup> The IA for the Sport Chapter of the Erasmus+ programme also found that without further action progress to address the physical inactivity challenge would continue to be highly uneven.

Table 7: Effectiveness Option A

Option A	Effectiveness
<b>Specific objective:</b> effective HEPA policy based on EU PA GL	0
<b>Operational objective 1:</b> policy coordination	0
<b>Operational objective 2:</b> HEPA data	0

Details on operational objectives:

- 1) Enhance policy co-ordination between MS at EU level on HEPA

There are two main existing fora for policy co-ordination between the MS: the XG SHP, where members act in an official capacity, and which has secured the participation of nearly all MS, and the HLG, where all MS are represented. However, for various reasons, the continuation of these fora in their existing format is unlikely to result in substantially enhanced policy co-ordination on HEPA:

- The XG SHP, **without strong political support it is unlikely to have sufficient leverage** on its own to convince many MS to reconsider their national approaches to HEPA or to considerably step up efforts across sectors beyond sport – as confirmed by XG members meeting in 2012.
- The HLG, for reasons referred to in the problem section, has so far placed **stronger emphasis on nutrition and food reformulation** than promoting physical activity. A major shift towards a strong focus on physical activity in the continued activities of this group therefore seems unlikely.<sup>114</sup>

- 2) Facilitate the collection of data on HEPA and HEPA policies in the EU MS

As described in the section on the problem analysis, current provisions for monitoring and evaluation of HEPA and HEPA policies are insufficient in the majority of MS. This is strongly linked to another problem identified, i.e. the lack of cross-sectoral co-ordination that leads various actors to collect similar but incomparable data, and has resulted in the availability of non-comparable and fragmented data. Existing initiatives, such as the NOPA database project, offer insight into HEPA 'policies' and monitoring methods in use in different countries, but shed little light on the implementation or impacts of those policies. While work is on-going on the side of the WHO to improve the NOPA database, it will **not be able to address the fact that national physical activity data submitted within the current monitoring arrangements is of insufficient quality** or sometimes it is simply not provided.<sup>115</sup>

<sup>114</sup> The Evaluation of the Strategy on Nutrition, Obesity and Overweight-related Health issues found that the HLG made a significant contribution to progress on salt reduction, whereas discussions on other topics had few tangible results. The report also noted that "existing instruments have addressed nutrition to a considerably greater extent than physical activity. In order to alleviate this disparity, the Commission could focus on raising the profile of nascent initiatives which do focus on physical activity, such as the Expert Group on Sport, Health and Participation, (...)." (p. 162) – see fn 62.

<sup>115</sup> For this reason, the WHO represented in a recent HLG meeting in Brussels stated that in order to keep the database alive the cooperation of and input from the MS was required (see Annex I).

#### 5.4.2. Option B: Push for increased policy co-ordination

A new strategic focus at EU level on the importance of HEPA, including an outline of concrete actions aimed at the implementation of the EU PA GL, could, despite the lack of prescriptive content, result in some improvements to MS policies. Political attention for the EU PA GL has been rather low up to this point, partly due to their being published before the EU had an explicit competence for sport. This is likely to have acted as a brake on the extent to which the GL have been publicised, viewed as legitimate<sup>116</sup> and, ultimately, implemented across sectors. Therefore, an initiative that introduces a **new strategic and focused approach to HEPA with the EU PA GL building the cornerstone, would add political clout** to the GL, potentially leading to more thorough implementation. More political weight for the GL would provide the many actors interested in promoting HEPA policy<sup>117</sup>, incl. sport organisations, NGOs, etc., with a potentially powerful tool for **persuading funders and decision makers** to further prioritise HEPA and enact policies / programmes in line with the GL.

However, this option would also entail limitations to the achievement of the specific objective. Primarily, **a strategic focus alone would not provide a strong incentive to act** to those MS which currently lack the capacity and / or infrastructure to adopt effective HEPA policy. Judging from the abovementioned implementation report, eleven MS still have not reported any progress in implementing the GL. Of these, the vast majority are eastern and southern European countries that are particularly prone to low levels of physical activity and where current trends are most alarming.

Under this option, progress as compared to the baseline would therefore mostly stem from enhancing policy co-ordination and improving the implementation of the EU PA GL, albeit to a limited extent (first operational objective). However, this option would do little to address the collection of comprehensive data (second operational objective), since this would necessitate stronger political and co-ordination efforts. Thus, the overall effectiveness of this option, in terms of the policy objectives and benefits described above, would be **relatively low**.

Table 8: Effectiveness Option B

Option B	Effectiveness
<b>Specific objective:</b> effective HEPA policy based on EU PA GL	+
<b>Operational objective 1:</b> policy coordination	+
<b>Operational objective 2:</b> HEPA data	0

Details on operational objectives:

- 1): Enhance policy co-ordination between MS at EU level on HEPA

As pointed out in the section on the baseline scenario and as explained in Annex I, the formal structures for policy co-ordination, i.e. the XG and the HLG, have already gone some way to addressing this objective.

<sup>116</sup> See remark from Czech HLG member in his written submission (see Annex I).

<sup>117</sup> This has been confirmed by several MS in the consultation process (see Annex I).

However, the ability of the XG SHP and the HLG to coordinate policy successfully is inextricably linked to the importance bestowed on HEPA at political level. As noted under Option A above, without a strong political commitment the XG would be unable to realise its full potential, and it is currently not being realised through the HLG. With the weight of a new strategic focused approach of the EU on HEPA, based on the EU PA GL, setting out concrete actions for the MS and the COM and involving regular reporting to the EU level, members of the XG will be **better equipped to promote HEPA initiatives and to secure adequate resources within national administrations** for their implementation and evaluation. This is especially important given the cross-sectoral nature of HEPA – while physical activity promotion may already have traction within the lead Ministry responsible for HEPA promotion (often health or sport), the strategic orientation at EU level and a corresponding call for cross-sectoral actions would help the lead Ministry spur action more widely. With regard to the tool chosen under this option (Communication) provisions for progress reporting to the EU level would be proposed, but would remain largely voluntarily without any prescriptive effect. This could potentially weaken the effective enhancement of policy coordination.

– 2) Facilitate the collection of data on HEPA and HEPA policies in the EU MS

In comparison to the baseline scenario, MS would be invited to regularly report to the EU level on national progress in implementing the EU PA GL. This option does not propose to put into place any new structures for monitoring and evaluation based on jointly agreed indicators, leaving the onus for monitoring and evaluation of HEPA policies completely with the MS. However, the existing initiatives (e.g. NOPA database, the HEPA PAT) have, for various reasons (as pointed out in the baseline scenario and problem definition sections), not been able to provide adequate data. **Significant improvements on the availability of HEPA data are thus unlikely.**

#### 5.4.3. *Option C: Push for increased policy co-ordination and monitoring, based on key elements of the EU Physical Activity Guidelines*

A policy document with legal effect would be expected to add considerable weight to HEPA promotion in general and the EU PA GL in particular. A **Council Recommendation, committing the whole Council**, is more likely than e.g. a COM Communication (option B) or Council conclusions to improve the uptake and implementation of the GL across the relevant sectors (specific objective) and to provide for policy coordination engaging the MS and, ultimately, helping them to adopt effective HEPA policies. In addition, recommending rules for monitoring based on jointly agreed indicators would have a strong potential to drive MS policy, providing a framework for implementing the GL and recording progress.<sup>118</sup> The focus on high-level, quantitative and aggregate indicators would help concentrate minds on the **key aspects of HEPA promotion** while avoiding extensively costly data collection.<sup>119</sup> This option would **contribute significantly to both operational objectives** while allowing MS to prioritise effectively. The key difference with option B is the inclusion of a monitoring mechanism, which makes it very likely that the effectiveness of this option would be significantly greater, especially but not limited to progress towards the second operational objective.

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<sup>118</sup> MS noted inter alia that a renewed focus on the EU PA GL would "encourage engagement of national authorities". (Annex I).

<sup>119</sup> MS welcomed the "complexity and simple implementation" of this option. (Annex I)

However, this option would entail a **minor drawback**. While ensuring progress on all GL themes, the limited set of indicators represents a pragmatic choice that is unlikely to promote MS action on each of the GL at an individual level.

**Table 9: Effectiveness Option C**

Option C	Effectiveness
<b>Specific objective:</b> effective HEPA policy based on EU PA GL	++/+++
<b>Operational objective 1:</b> policy coordination	+++
<b>Operational objective 2:</b> HEPA data	++/+++

Details on operational objectives:

- 1): Enhance policy co-ordination between MS at EU level on HEPA

This option would build on the scenario described under option B, adding political momentum to the co-ordination already being carried out under the auspices of the XG and the HLG, but would allow for a greater level of effectiveness due to the inclusion of a monitoring mechanism and standardised set of indicators. These would be expected to **drive MS policy, provide an incentive for action and thereby increase the usefulness of existing co-ordination fora**. Apart from the sharing of information and good practice, through EU level coordination based on joint monitoring, MS would be able to discuss and compare policy approaches based on improved evidence. In combination with the targeted support for capacity building this should enable MS to develop and implement more effective policies.

This argument is strengthened by feedback from relevant stakeholders. A large number of MS expressed support for a monitoring mechanism, agreeing that it would help MS learn from the experiences of other countries. It was explained that, while an environment for peer learning is already in place (inter alia through the XG SHP), the lack of comparative evidence renders the taking of policy choices based on these meetings problematic.<sup>120</sup> MS and stakeholders have also emphasised that the **monitoring mechanism would ensure regular cooperation between MS**, enhancing their ability to prioritise HEPA promotion and develop more effective policies. The existence of a monitoring mechanism implemented through a Council Recommendation would provide the political influence needed to boost cooperation among the sectors concerned.<sup>121</sup> The choice of this instrument would give the leverage and political buying-in that is lacking today. Its implementation would ensure the involvement and political investment of the MS in the new initiative, laying the foundation for policies that would be developed and implemented mostly by individual Ministries.

- 2) Facilitate the collection of data on HEPA and HEPA policies in the EU MS

This option, in addition to the arguments outlined under operational objective 1, would make a significant contribution to this objective too, leading to systematic **and standardised collection of data** on HEPA rates and HEPA policies across the EU. A

<sup>120</sup> EU Sport Directors (6/2012) and HLG (6/2012). (Annex I).

<sup>121</sup> Statements in these fora can be found in Annex I.

centralised mechanism for storing and managing the data would ensure that it is **largely comparable both between countries and over time**, allowing the results to feed into decision making.<sup>122</sup>

However, given the voluntary nature of the initiative, its **effectiveness depends on MS' willingness to participate** in it. While, albeit limited, EU support is foreseen to build capacity for this process, the MS will be responsible for the data collection and for part of the reporting. This in turn hinges on ensuring that the costs of participating are considered feasible and reasonable by MS administrations. This option therefore calls for a limited set of (high-level and aggregate) indicators, developed by HEPA experts on the basis of feedback from MS representatives (i.e. by the XG SHP, Sport Directors and members of the HLG). This option would result in a significant improvement on the current provision of data; only in a few areas, notably relating to qualitative information and individual GL, potentially useful information is likely to be left out in the monitoring process.

#### 5.4.4. *Option D: Push for increased policy co-ordination and monitoring, based on implementing all 41 EU Physical Activity Guidelines*

Like for option C, an official endorsement by the Council would add political legitimacy and weight to the GL and thereby has the potential to **greatly improve the current situation** by leading to growing involvement of actors and an increasing number of actions in sectors covered by the EU PA GL (specific objective). Recommended rules for a comprehensive monitoring scheme based on the GL would have a strong potential to drive MS policy, providing a framework for implementing the GL and recording progress. This more complex monitoring framework than under option C could result in a more complete uptake of the GL and in more comprehensive data. This option as compared to the baseline would be expected to make progress towards both operational objectives, and thereby the specific objective. However, **retrieving the data** to comply with the more comprehensive set of qualitative and quantitative indicators will require **additional efforts**, including possible additional investment. In addition, benchmarks and targets would require **substantially more political will** from the MS. Some **MS may be reluctant** to agree on monitoring and reporting arrangements of that type because of a **perceived lack of authority**.<sup>123</sup> Moreover, given that the initiative would be voluntary, these difficulties could ultimately translate into a **lack of participation** (see chapter on feasibility and table 12 below).

**Table 10: Effectiveness Option D**

Option D	Effectiveness
<b>Specific objective:</b> effective HEPA policy based on EU PA GL	++/+++
<b>Operational objective 1:</b> policy coordination	++
<b>Operational objective 2:</b> HEPA data	++/+++

<sup>122</sup> MS noted that the monitoring framework would enable them to evaluate the impact of their national policies. (see Annex I).

<sup>123</sup> This was noted in a HLG meeting. (see Annex I)

### Details on operational objectives:

- 1) Enhance policy co-ordination between MS at EU level on HEPA

This option would provide a framework for **sustained political momentum, peer learning and sharing of experiences** through the existing XG SHP and HLG very similar to that described under option C. The reporting on specific targets would require an **additional level of political buy-in** and willingness to engage in benchmarking among MS. Provided that MS commit to this, policy coordination could be greatly enhanced, in particular in the longer run. However, if MS were to remain reluctant, benchmarks and **targets could potentially undermine the usefulness of the XG** as a forum for exchange and the open and free-flowing debate as expected under option C.

- 2) Facilitate the collection of data on HEPA and HEPA policies in the EU MS

It is in this area that this option could have the potential to contribute most effectively. Collecting data across a comprehensive set of quantitative and qualitative indicators, in addition to targets and benchmarks, would result in the **collection of holistic sets of data**, allowing for analysis on a wide variety of relevant topics over time and across countries. However, the important drawback here would be that many of the data are not yet recorded at national level, which would require **more time and investment to collect them**.<sup>124</sup>

### **5.5. Analysis of impacts per option**

Due to the varying effectiveness of the four options, the scale of the impacts of each option is expected to differ. The table on the next page provides a summary of the expected impacts of each of the options in comparison with the baseline scenario. The *outputs* and *outcomes* rows offer a preliminary description of the short- and medium-term results of the new initiative and are described in more depth in chapter 5.4 above. The *impacts* row refers to higher-level change in terms of the expected social, economic and environmental impacts. The estimates are necessarily based on assumptions about MS implementation of what is essentially a non-binding EU initiative, and thus any figures provided should be interpreted as an order of magnitude of the *potential* impacts and an indication of scale.

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<sup>124</sup> Several MS have indeed expressed concerns with regard to 'too extensive reporting requirements', the 'non-availability of data' and the 'need to plan the financial mechanism for data collection carefully'. (see Annex I)



	Option A (Baseline scenario)	Option B (Push for increased policy coordination)	Option C (Push for increased policy coordination and monitoring, based on a limited set of indicators)	Option D (Push for increased policy coordination and monitoring, based on a comprehensive set of indicators and evaluation against targets)
<b>Outputs</b>	<ul style="list-style-type: none"> <li>Continued policy co-ordination and promotion of EU PA GL under existing structures at EU level.</li> <li>Continued work on physical activity through EU-supported initiatives and projects.</li> <li>Continued provision of fragmented data</li> </ul>	<ul style="list-style-type: none"> <li>Minimally enhanced policy co-ordination and promotion of EU PA GL under existing structures at EU level.</li> <li>Continued work on physical activity through EU-supported initiatives and projects within a new strategic EU approach to HEPA.</li> <li>Continued provision of fragmented data</li> </ul>	<ul style="list-style-type: none"> <li>Significantly enhanced policy co-ordination and promotion of EU PA GL under existing structures at EU level.</li> <li>Provision of accurate and comparable monitoring data against limited set of physical activity and policy indicators.</li> </ul>	<ul style="list-style-type: none"> <li>Potential for strongly enhanced policy-coordination and promotion of EU PA GL under existing structures, but risk of lack of participation.</li> <li>Potential for provision of comprehensive monitoring data against a set of qualitative and quantitative indicators + reporting on benchmarks and targets.</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>Gradually improving physical activity policies and uptake of (principles of) EU PA GL in a limited number of MS, but un-changing policies in most others.</li> </ul>	<ul style="list-style-type: none"> <li>Gradually improving physical activity policies and uptake of (principles of) EU PA GL in a limited but larger number of MS than under option A, but un-changing policies in many others.</li> </ul>	<ul style="list-style-type: none"> <li>Significantly improved physical activity policies and uptake of main themes of EU AP GL in the majority of MS.</li> </ul>	<ul style="list-style-type: none"> <li>Significantly improved physical activity policies and uptake of EU PA GL in some MS (but risk of many MS not implementing the initiative).</li> </ul>
<b>Impacts</b>				
<b>Social</b>	<ul style="list-style-type: none"> <li>Stagnant or falling physical activity levels in most countries and persistence of social detriments of insufficient physical activity.</li> </ul>	<ul style="list-style-type: none"> <li>Small improvements in physical activity levels in some MS, but stagnant or falling levels in many others leading to only a slight reduction in social detriments of insufficient physical activity.</li> </ul>	<ul style="list-style-type: none"> <li>Physical activity levels increase at up to 1% / year leading to a significant reduction in social detriments of physical inactivity.</li> </ul>	<ul style="list-style-type: none"> <li>Physical activity levels increase at up to 1% / year (but risk of MS not implementing the initiative) potentially leading to significant reduction in social detriments of physical inactivity.</li> </ul>
<b>Economic</b> (Annex V provides a detailed assessment of costs to the EU and administrative costs in the MS)	<ul style="list-style-type: none"> <li>Persistence of costs of insufficient physical activity (estimated at €31bn / year)</li> </ul>	<ul style="list-style-type: none"> <li>Slight reduction in economic costs of physical inactivity and some economic benefits but significantly less than €6.7bn over five years that would be foreseen from effective policy.</li> <li>Some (difficult to quantify) costs to MS that dedicate resources to improving physical activity.</li> </ul>	<ul style="list-style-type: none"> <li>Significant reduction in economic costs of physical inactivity.</li> <li>Economic benefits of up to €6.7bn over five years.</li> <li>Some (difficult to quantify) costs to MS that dedicate increased resources to improving physical activity.</li> </ul>	<ul style="list-style-type: none"> <li>Significant reduction in economic costs of physical inactivity, but only in the MS implementing the initiative</li> <li>Significant (but difficult to quantify) economic benefits in the MS implementing the initiative.</li> <li>Some (difficult to quantify) costs to MS that dedicate increased resources to improving physical activity.</li> </ul>
<b>Environmental</b>	<ul style="list-style-type: none"> <li>Some benefits in MS that improve physical activity policy with regard to active transport.</li> </ul>	<ul style="list-style-type: none"> <li>Limited but notable benefits in MS that improve physical activity policy with regard to active transport.</li> </ul>	<ul style="list-style-type: none"> <li>Potentially significant benefits in MS that improve physical activity policy with regard to active transport.</li> </ul>	<ul style="list-style-type: none"> <li>Potentially significant benefits in MS that improve physical activity policy with regard to active transport.</li> </ul>

Table 11: Analysis of impacts per option

## 6. COMPARISON OF THE OPTIONS

This section compares the different options based on their likely effectiveness, efficiency, coherence with overarching EU policy objectives and feasibility of implementation and sustainability.

### 6.1. Effectiveness

The analysis of the effectiveness of the options was made when analysing the impacts of the initiative. While all of the options could be expected to achieve some progress towards the specific and the operational objectives set out in section 3, the degree of success each option could be expected to attain varies. If compared to options C and D, the less prescriptive provisions for progress reporting would weaken the coordination potential of option B. The analysis shows a similar level of effectiveness of options C and D, and comes to the result that the status quo and option B would be much less effective to reach the objectives identified.

### 6.2. Feasibility of implementation and sustainability

The options vary considerably in their feasibility of implementation (extent to which each option would attain buy-in from the MS, essential for a voluntary initiative) and sustainability (extent to which momentum attained in the short term would be maintained over a longer period of time):

- Option B: given that this option seeks to give strategic support to HEPA promotion based on the EU PA GL but does not make specific demands on MS to commit to data monitoring it is unlikely to face any serious implementation problems. However, since it relies on voluntary action by the MS, without a specific framework for prioritising this action and recording progress, this option is likely to suffer from a lack of sustainability, as political momentum fades over time.
- Option C: the pragmatic nature of this option, reflected by the support of MS (Sport Directors, HLG, Council Working Party on Sport), experts and stakeholders for a monitoring mechanism based on a limited set of high-level and aggregate indicators (as outlined in Annex III), is likely to result in few implementation problems due to its relatively low costs and ability to fit national circumstances. Moreover, the framework for collecting data and recording progress engendered by the monitoring mechanism and the reporting to the Council is likely to ensure the long-term sustainability of the initiative.
- Option D: this option faces serious problems of feasibility, since MS may not accept a comprehensive set of targets and benchmarks against the indicators<sup>125</sup> and may not be willing to invest high costs associated with

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<sup>125</sup> This has been confirmed in the discussion with MS representatives (XG SHP, Sport Directors, HLG). (see Annex I).

collecting both qualitative and quantitative data across a large set of physical activity-related indicators.<sup>126</sup> Moreover, given that not all 41 EU PA GL could be addressed universally by all 28 MS (see Annex III) there is little EU added value in promoting such a comprehensive monitoring. If such a comprehensive system was to be implemented and running, it might however provide a degree of sustainability also in the longer term.

### 6.3. Efficiency

This section analyses the extent to which each option would be expected to contribute to the objectives for a given level of resources (cost-effectiveness). The principal costs of all the options will consist of those associated with **developing and implementing policies to promote physical activity**.<sup>127</sup>

A number of recent studies examined the costs of various interventions to promote physical activity in terms of their effectiveness either in quality-adjusted life years (QALY) or savings on health care costs. While the studies found highly variable levels of cost effectiveness, **all of the interventions examined were proven cost effective** i.e. they justified their costs, especially in light of the vast costs for the economy of physical inactivity.

For example, a comparative meta-analysis carried out in 2010 by the Liverpool Public Health Observatory<sup>128</sup> provided evidence that HEPA promotion interventions are a cost-effective way of preventing health problems. The review included four types of interventions ('brief' interventions involving opportunistic advice or discussions, the environment, school and workplace interventions, and mass media campaigns), and found that in the vast majority of cases the benefits outweighed the costs (usually in terms of health-care cost savings), often by a very considerable margin (e.g. 11 to 1 in the case of cycling infrastructure, or 5.5 to 1 for a walking programme run by occupational health nurses). A similar study in the US looked at seven types of public intervention to promote HEPA, finding that each QALY cost from about USD 14-68 thousand, depending on the type of intervention.<sup>129</sup>

A further study looked solely at workplace interventions to promote physical activity, finding cost savings from decreased absenteeism from USD 2.5-4.9 for

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<sup>126</sup> This can be expected to be the case especially for those MS facing financial austerity measures and a lack of enthusiasm for the EU. SE for instance has argued against a Council Recommendation and EU monitoring, in the Council; and several MS have expressed concern with regard to funding/adequate budgets (see Annex I).

<sup>127</sup> As explained in chapter 5.2, these costs are very difficult to quantify for the MS due to the lack of information available on the funding of current HEPA interventions. It is therefore proposed to include in the new monitoring framework one indicator on funding allocated to HEPA promotion.

<sup>128</sup> [http://www.liv.ac.uk/PublicHealth/obs/publications/report/83\\_28th\\_Feb\\_Physical\\_activity\\_and\\_cost\\_FINAL.pdf](http://www.liv.ac.uk/PublicHealth/obs/publications/report/83_28th_Feb_Physical_activity_and_cost_FINAL.pdf)

<sup>129</sup> Cost effectiveness of community-based physical activity interventions, American Journal of Preventive Medicine, Volume 35, Number 6, 2008.

every dollar spent on the programme and reduced health care costs of USD 2.5-4.5 for each dollar spent.<sup>130</sup>

While the level of investment appropriate for each MS will vary depending on the scale of the problem in the country in question, activities already being undertaken and available capacity, the persistent lack of adequate physical activity in even those MS that have had some success in increasing HEPA indicates that a sufficient level of investment has not yet been attained. Moreover, since the initiative will be voluntary, each MS will set any additional expenditure at a level that fits national budgetary circumstances and political priorities.

In this regard, it is telling that evidence on both a micro and macro level demonstrates that the **benefits outweigh the costs** for a variety of types of government investment in physical activity promotion. In addition, the economic benefits of such policies, in terms of increased productivity and reduced health care costs are likely to be very large, thus justifying the even substantial costs.

In addition to implementation costs, the cost-effectiveness of each of the options relates to administrative costs for the MS and costs to the EU budget, as outlined in Annex V. The table hereafter analyses the cost-effectiveness for each option.

**Table 12: Cost-effectiveness**

Option	Cost / benefits	Value <sup>131</sup>
A	Although this option entails no additional costs for either MS or EU budgets, it cannot be described as a cost effective means since the gains it would be expected to achieve in terms of operational objectives 1 and 2 and the specific objective would be very minor or inexistent.	0
B	This option entails only limited costs for MS' and EU budgets and it can be described as a cost effective means of achieving the small gains that would be expected in terms of operational objectives 1 and 2 and the specific objective. However, only minor improvements to MS policy are foreseen, and thus the benefits from investment in HEPA promotion policies (described in section 5 above) are not likely to be large. Moreover, comprehensive data that would allow for comparison is not likely to be achieved under this option, despite the (limited) administrative costs for the MS.	+
C	This option would entail some costs for MS budgets, but the largest benefits, as the MS collect data to feed into the monitoring mechanism, allocate resources to new physical activity promotion policies and then benefit from increased HEPA rates. While the majority of the costs would stem from policy changes, some expenditure from the EU budget would be required in order to set up, administer and maintain the data from the monitoring mechanism; the EU would also be expected to play some role in helping the MS to collect relevant data.	++

<sup>130</sup> Proper, K., Effectiveness and economic impact of worksite interventions to promote physical activity and healthy diet, WHO, 2007.

<sup>131</sup> Legend for the values used: 0 not cost effective, + partly cost effective, ++ cost effective.

D	<p>Like for all options, the majority of the costs would stem from policy changes. Due to the more extensive monitoring mechanism, including more detailed and greater number of indicators against which data would need to be collected, this option would entail the largest administrative costs for the MS, in addition to higher costs to the EU budget than those for option C. However, these relatively high costs would not be offset by commensurate gains in effectiveness. Since the benchmarks and targets included in this option are not likely to be politically palatable for the MS, the gains due to improved policy are likely to be small, thus reducing the overall efficiency of the option.</p>	+/>++
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#### 6.4. Coherence

As outlined in sub-chapter 2.5.2, action to promote HEPA contributes to the Europe 2020 strategy. More specifically, options B, C and D are all coherent with EU policies in the field of health, transport, social inclusion and research. However, it is difficult to ascertain how the three options differ in their coherence to these policies. If only because option C is likely to be the most effective, it can be described as contributing more to EU policy goals than the other options. It is likely to result in the greatest economic benefits and productivity gains, in addition to the largest steps towards improving health, tackling health inequalities, encouraging active commuting and facilitating social inclusions. In addition, the coherence of options C and D strongly aligns with the policy tool proposed for their implementation. The choice of a Council Recommendation appears to be a coherent approach given that a) several "softer" EU policy documents expressing a commitment to HEPA already exist and that b) the need for action exists primarily at MS level.

## 7. SUMMARY: COMPARISON OF OPTIONS

Based on the differing effectiveness and efficiency of the policy options, the following table compares them against the baseline scenario (option A). Pluses indicate that options rate more favourably than the status quo (e.g. because they are more likely to be effective).

**Table 13: Comparison of options**

	Optio (baseline s	Option B (push for increase coordinatio	Option C (push for increase coordination monitoring, basec elements of EU PA GL	Option D (push for increase coordination monitoring, bas implementing all GL)
<b>Effectiveness</b>	<b>0</b>	+	++/+++	++/+++
- <b>Specific objective</b>	0	+	++/+++	++/+++
- <b>Operat. objective 1</b> (Pol. coordination)	0	+	+++	++
- <b>Operat. objective 2</b> (Monitoring / Data)	0	0	++/+++	++/+++
<b>Cost-effectiveness</b> (in relation to)	<b>0</b>	+	++	+ / ++
- <b>Costs to MS</b>	0	+	++	+ / ++
- <b>Cost to the EU</b>	0	+	++	+ / ++
- <b>Admin. Costs</b>	0	+	++	+ / ++
<b>Feasibility/sustainability</b>	<b>0</b>	+	++	+
<b>Coherence</b>	<b>0</b>	++	++ / +++	++

### 7.1. The preferred option

Based on the comparison of the three policy options against criteria for effectiveness, efficiency, feasibility / sustainability and coherence, option C poses the most appropriate and proportionate response to address the problems identified. It would be slightly more effective than option D in achieving operational objective 1, in addition to the specific objective. Moreover, concerning the monitoring framework, it presents a more cost-effective choice, as the mechanism it proposes entails smaller costs than the more extensive set of indicators, benchmarks and targets proposed under option D. This more flexible approach to the monitoring mechanism also increases the political feasibility / sustainability of option C, which has the strongest possibility of engaging the MS over the medium term, a key aspect of success for any voluntary initiative. While all three options are coherent with EU policy, option C, through its greater effectiveness and the proposed tool of a Council Recommendation, will lead to

larger steps towards the achievement of wider policy objectives. Overall, there is an advantage in implementing option C.

## **8. MONITORING AND EVALUATION**

The external study carried out in the context of this Impact Assessment (see Annex III) identified a set of 23 indicators against which the evolution of HEPA rates and HEPA policies and the implementation of the EU Physical Activity Guidelines can be measured.

Data on these indicators will be collected as part of the EU monitoring mechanism foreseen in the preferred option (option C) and will also provide the lion's share of information needed to monitor and evaluate the initiative as a whole: the general, specific and first operational objective will be directly informed by data collected against the indicators. Two other indicators are foreseen to monitor the implementation of operational objectives 1 and 2: the first indicator relates to enhanced policy coordination at EU level and should cover the extent to which MS participate in meetings and contribute in the reporting about the implementation of the Recommendation; the second indicator, which relates to the collection of comparable and comprehensive data on HEPA and HEPA policies, will measure the extent to which the data on the 23 indicators is collected and made available.

Progress in implementing the Council Recommendation will take the form of regular reports, every three years, from the COM to the Council. Such reports would include in particular an assessment/evaluation of the progress made based on the data collected via the monitoring mechanism (e.g. country snapshots) on the one hand, and, on the other, wider information regarding HEPA policy development and implementation of the EU PA GL in the MS (e.g. structural developments and processes to promote HEPA). The working structures for sport, in particular the XG SHP, and the physical activity focal points in the MS (to be established) would play a key role in providing input for this report. The draft report, as agreed by the XG SHP, would be transmitted to the Council Working Party on Sport. Other relevant fora, in particular the HLG, would be consulted and regularly informed at key stages of this reporting process. A full evaluation of the implementation of the Council Recommendation should be made after 6 years, involving an external contractor.

## 9. ANNEX I: CONSULTATION OUTCOMES

Over the past years, Member States (MS), the European Parliament, experts, sport stakeholders and the general public have been consulted at different levels about their views regarding the need of and scope for the promotion of physical activity (PA) in an EU context, either directly or indirectly related to the planned EU policy initiative on health-enhancing physical activity (HEPA), which is proposed to take the format of a Council Recommendation. After the adoption of the Communication on sport in January 2011<sup>132</sup>, which includes an action point to consider such a proposal, the Commission (COM) has regularly presented its plans and the work in progress for this initiative to the policy level and to stakeholders and sought feedback within different fora. This was notably done at all the events and meetings referred to hereunder as of early 2011, some of which were organised by or with support from the COM.

Section 9.1. below includes the discussions with the Member States in EU structures for sport and for health. The proposed initiative is mainly addressed to public authorities and therefore this section is considered particularly relevant. It reflects Member States' views on the idea of further promoting HEPA by means of a new EU policy initiative based on the EU Physical Activity Guidelines (EU PA GL), and the proposed monitoring framework.

Sections 9.2. – 9.4. summarise consultations with the European Parliament, HEPA experts, and sport stakeholders and the general public.

### 9.1. Member States (Council structures, informal level)

#### 9.1.1. *EU structures for sport*

The wish to address the promotion of sport and PA with a health-related purpose in the EU 'sport' context goes back to the informal cooperation preceding the inclusion of sport in the Lisbon Treaty, when MS gave the topic of 'sport and health' priority within their discussions under the EU rolling agenda for sport. Following a 2004 EU-funded study on young people's lifestyles and sedentariness that recommended the development at EU level of minimum standards for active living<sup>133</sup>, **a political process was launched with MS under the UK Presidency** and led to the set-up of an informal *EU Working Group 'Sport & Health'*, chaired by the COM and mandated to 'promote the role of sport in a healthy lifestyle for all age groups in Europe', which held its first meeting in 2005 (and continued meeting until mid-2011)<sup>134</sup>.

In the run up to the Treaty and in anticipation of the new EU competence for sport, the COM's 2007 White Paper on Sport<sup>135</sup> set a new strategic framework for

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<sup>132</sup> COM(2011) 12 final.

<sup>133</sup> [http://www.bso.or.at/fileadmin/Inhalte/Dokumente/Internationales/EU\\_Study\\_Young\\_Lifestyle.pdf](http://www.bso.or.at/fileadmin/Inhalte/Dokumente/Internationales/EU_Study_Young_Lifestyle.pdf).

<sup>134</sup> Reports from meetings: [http://ec.europa.eu/sport/library/consultation-and-cooperation\\_en.htm#health](http://ec.europa.eu/sport/library/consultation-and-cooperation_en.htm#health)

<sup>135</sup> COM(2007) 391 final.



the EU's dealing with sport, including PA, and, by foreseeing concrete actions regarding policy and funding, gave direction for the cooperation also in the field of HEPA with and between the MS at EU level. Most importantly, this led MS and the COM to work together jointly (WG Sport & Health), and with the support of a special group of HEPA experts appointed by MS, towards the **EU Physical Activity Guidelines (EU PA GL)**<sup>136</sup>. These GL emphasise the importance of a cross-sectoral approach and provide 41 concrete recommendations mainly addressed to policy makers in the MS. The drafting of these GL was closely coordinated with the COM's activities in the field of health led by DG SANCO, notably the Strategy for Europe on Nutrition, overweight and obesity-related health issues following the respective 2007 White Paper<sup>137</sup>. The GL were confirmed by EU Sport Ministers in 2008. The implementation of the GL was subsequently discussed in the WG on Sport and Health and progress in implementing the GL themes has inter alia been recorded in an "Implementation table"<sup>138</sup>. Work on collecting information for this table has been continued thereafter (last update in June 2012). These discussion and the information in the table show that **some MS have already used the GL as a source of inspiration, but the implementation has so far remained patchy** both with regard to the number of MS and with regard to the number of guidelines as well as guideline themes. In the latest update, 16 MS reported to have – at least partly – implemented the GL at national level (further details below). According to the 2010 progress report on the implementation of the Strategy for Europe on Nutrition, Overweight and Obesity-related Health issues, that is also measured against two indicators on PA, "nearly half of the MS have fully implemented their guidelines"<sup>139</sup>. The 2013 final evaluation notes the following: "However, as is the case for several of the indicators in the 2010 implementation report, it is difficult to assign concrete meaning to the findings. Both indicators are open to interpretation and could result in inconsistent reporting by NCPs [National Counter Parts] in different MS."<sup>140</sup>

<sup>136</sup> Full text of the EU PA GL: [http://ec.europa.eu/sport/library/documents/c1/eu-physical-activity-guidelines-2008\\_en.pdf](http://ec.europa.eu/sport/library/documents/c1/eu-physical-activity-guidelines-2008_en.pdf)

<sup>137</sup> COM(2007) 279 final.

<sup>138</sup> EU PA GL implementation table: <http://ec.europa.eu/sport/library/documents/c1/pag-implementation-table-revised-20120629.pdf>

<sup>139</sup> Regarding the reporting on PA, there are however no details provided in this report. Moreover, it is stated that the 'report benefitted from valuable contributions from the WHO Europe network of National Food Information Focal Points, from the Members of the HLG as well as from COM services, in particular DG RTD and AGRI'. In which way PA relevant actors or experts have been involved is not immediately visible. Strategy for Europe on nutrition, overweight and obesity-related health issues; Implementation progress report, December 2010.

<sup>140</sup> The evaluation report furthermore states (p. 45): "The second indicator in particular refers clearly to *two types of initiative*: physical activity guidelines, *and* education campaigns to raise awareness. One could imagine two NCPs reporting an identical situation in more than one way. Moreover, the two indicators are very narrow in scope. A true assessment of MS action on physical activity initiatives would need to consider myriad interventions aimed at many target groups and taking place in many settings. In addition, the EU Physical Activity Guidelines, published in November 2008, emphasise the need for a *cross-sectoral approach* to physical activity promotion, which the two indicators above do not capture. Leading from this, there are no comprehensive studies that examine progress against the two indicators subsequent to 2010. (...) While it is clear that many individual initiatives exist in the MS to promote physical activity, some of which are

After the inclusion of sport in the Lisbon Treaty, HEPA naturally also became a topic for MS' cooperation in the framework of the EYCS Council. The preparations of the first multi-annual cooperation plan for Sport under the Polish and in particular the Hungarian Presidency (2010-2011) **confirmed MS' wish to give due attention to the promotion of PA in their future cooperation at EU level.** The Council at its meeting on 11 May 2011 accordingly adopted a Resolution on the EU Work Plan for Sport<sup>141</sup> that identifies HEPA as a priority theme and called for the establishment of an *Expert Group on Sport, Health and Participation (XG SHP)* which should replace and build on the work in the former WG on Sport and Health. The XG SHP got the mandate to assist with the implementation of the Work Plan, namely to "**explore ways to promote health-enhancing physical activity and participation in grassroots sport**" and "to identify measures by mid-2013". To achieve this, the group composed of experts appointed by MS, agreed on a work schedule and defined five deliverables. The group's first deliverable, 'input for the planned EU initiative in the field of HEPA', is particularly **relevant for this IA exercise**, since it consisted of a) gathering further information about the implementation of the EU PA GL, or the principles underpinning them, in the EU MS and b) exploring ways to monitor the implementation of the GL with the help of a limited set of indicators. The group's first set of deliverables, including deliverable 1, was submitted to the Council Working Party on Sport and presented at the WPS meeting on 4 July.<sup>142</sup> With regard to the first aspect (a), the group provided input and/or updates to the existing implementation table and came to the conclusion that **16 MS were implementing (at least part of) the EU PA GL**, notably the following: AT, BE, CY, CZ, DE, ES, FI, FR, HU, IE, LT, LU, NL, PL, PT, UK (England and Scotland). Moreover, MS experts in the XG replied to a questionnaire aimed at gathering additional information about the implementation of the GL. According to the answers provided, the identified **barriers and challenges** for implementation in the MS were related to the **cross-sectoral cooperation**, the lack of a **leading entity**, the lack of a **monitoring mechanism** and the need to ensure **funding**. The **strengths** of the GL were identified to be the **availability and the sustainability of their content**; the **weaknesses** were the **broadness of their content and a perceived lack of information for the monitoring of their implementation**. Secondly, the XG discussed and provided oral and written input for the idea of a framework to monitor the implementation of the GL. Apart from its general support for a monitoring framework, the XG provided specific comments on the draft table of indicators, as prepared and presented by HEPA experts (forming part of the study consortium) and, at its meeting on 27 June 2012, endorsed the revised draft of that table (as included in annex III of this IA).<sup>143</sup> The XG SHP accordingly "agreed that deliverable 1 should consist of the group's advice to the Council to call for a new EU policy initiative to promote

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making positive impacts, it is also clear that in most countries a sufficiently holistic and comprehensive approach is not being followed." [http://ec.europa.eu/health/nutrition\\_physical\\_activity/docs/pheiac\\_nutrition\\_strategy\\_evaluation\\_en.pdf](http://ec.europa.eu/health/nutrition_physical_activity/docs/pheiac_nutrition_strategy_evaluation_en.pdf)

<sup>141</sup> Council Resolution on an EU Work Plan for Sport, 11 May 2011, OJ C162 of 1.6.2011.

<sup>142</sup> First set of deliverables submitted to the Council Working Party on Sport: [http://ec.europa.eu/sport/library/consultation-and-co-operation\\_en.htm#xgshp](http://ec.europa.eu/sport/library/consultation-and-co-operation_en.htm#xgshp)

<sup>143</sup> Full report from the XG SHP to the Council: [http://ec.europa.eu/sport/library/consultation-and-co-operation\\_en.htm#xgshp](http://ec.europa.eu/sport/library/consultation-and-co-operation_en.htm#xgshp)

HEPA, building on the EU PA GL. Such an initiative should usefully introduce a soft monitoring framework, including a set of indicators. The group also recommended that **the COM's proposal for such a monitoring framework should take inspiration from the draft table of indicators revised by the XG.**"

Also at the informal level, the COM regularly informed EU Sport Ministers and EU Sport Directors on its plans in the field of HEPA, including the planned proposal for a new EU policy initiative, as announced in the 2011 Communication on sport, and sought MS' views. In the run up to the first EU Work Plan for Sport, *EU Sport Ministers* at their meeting in Gödöllő, on 23 February 2011, discussed the planned EU incentive measures for sport and PA (2014-2020) noting the need to **concentrate on issues where EU action had an added value. HEPA was highlighted as one of the priority fields** in that regard.<sup>144</sup> In the context of the then expected COM proposal for a sport sub-programme (end of 2011) and corresponding negotiations in the Council, Sport Ministers at their meeting under the PL PRES (13-14 October 2011, Krakow) welcomed the idea of including HEPA as a priority, with FI and HU stressing that HEPA and the promotion of grassroots sport should be robustly presented in any proposal.<sup>145</sup> At their Informal Meeting under the Cyprus Presidency (Nicosia, 20-21 September 2012) Sport Ministers held a joint discussion with participants of the EU Sport Forum (see below) on the contribution of sport and PA to Europe's economy and a (closed door) exchange of views on **sport and health with a focus on active ageing**.<sup>146</sup> On the latter, Ministers highlighted the importance of promoting active ageing in the national policy context and listed the main initiatives taken (BE, DE, FI, FR, HU, IT, LT, NL, PL, PT, RO, SE, UK). Some MS (DE, NL, SE, UK) explicitly **supported the sharing of best practices** in that area at EU level. On the **EU's role in HEPA promotion**, HU wished to see the EU **supporting the development of national strategies**, including for PA at the work place. Several MS (FI, FR, UK) stressed the need for **more cross-sectoral cooperation between Ministries** and FR said it would specifically **welcome an EU impetus** to that effect. The idea of a **monitoring system was explicitly welcomed** by PT (system to evaluate progress), FR (common indicators, health benefits, wellbeing benefits, economic benefits), FI (need for better and comparable data) and NL (COM support through light monitoring). SE **questioned the need for a Council Recommendation** and remarked that Council conclusions providing for indicators based on which MS could evaluate progress could be more appropriate.

Also at the level of *EU Sport Directors*, HEPA has been a recurrent topic for the discussion. At their meeting in Gödöllő (27-28 June 2011), Sport Directors addressed the importance of cooperation with the sport movement when implementing the new EU Work Plan, including in the field of PA. Sport Directors under the PL PRES (15-16 December 2011, Gdansk) discussed the COM's proposal for the Sport Chapter under Erasmus for all; AT, DE, ES, FI, HU and PT expressed general support for the choice of topics (i.e. including HEPA), with FI and HU noting that HEPA should be a key priority. At their meeting under the DK Presidency (31/5-1/6/2012, Copenhagen), Sport Directors had a

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<sup>144</sup> Internal report: SI (2011) 45

<sup>145</sup> Internal report: SI (2011) 378

<sup>146</sup> Internal report: SI (2012) 416

focused exchange of views on the promotion of HEPA based on a PRES background paper outlining the EU policy context for HEPA and **asking for MS' feedback on the impact of the EU PA GL and on how to overcome barriers for their implementation**. In that context, MS discussed the idea of an EU policy initiative and more concretely the proposal for a monitoring framework including the indicators to further the implementation of the EU PA GL. At that meeting, the French chairman of the XG SHP informed about the group's conclusions according to which barriers for implementing the EU PA GL consisted mainly in a lack of cross-sectoral cooperation, a lack of a leading entity, a lack of a monitoring system and lack of available funding. In addition, an external expert illustrated how to foster policy development regarding HEPA promotion and the implementation of the EU PA GL. He noted the continuum between sport and PA and explained that the concept of HEPA was a wider one beyond leisure-time PA and including e.g. PA at work or physical transport. He stated "this has implications for policy development. For HEPA promotion, several factors come into consideration (personal, physiological, psychological and behaviour setting, political environment). HEPA promotion as a policy has to take into account that the problem will not disappear any time soon; it is complex and it is highly interdependent. **Adequate policy instruments therefore have to be sustainable and flexible, diverse and inter-sectoral**. The EU PA GL reflect these needs." A second external expert presented the on-going work at EU level to develop the framework to monitor the implementation of the EU PA GL. He inter alia stated: "**The evidence is there, but policy implementation faces so many barriers**; this has been the situation over many years. **HEPA should be a core interest of society in general and not just of one sector**. There is a need to regularly ask questions e.g. about the daily use of bikes, hours of PA in schools, national schemes to promote PA at the work place, community programmes for senior citizens, etc., in order to increase the chances of better PA promotion. The information was there, but needed to be updated and put together." In the subsequent discussion and in reply to the PRES background paper BG, CY, FI, FR, HU, IT, MT, NL, PL, PT, SE, UK confirmed the importance of HEPA promotion and almost all of them expressed **support for further EU action based on the EU PA GL, including a monitoring scheme**. NL noted that the GL were a useful instrument to check the state of play regarding the national policy; NL considered that **national policy was complying with the GL** without following each separate GL, noting that a lot of work was in progress and that sport and PA were leading topics in national discussions about lifestyle. The **challenges remained in cross-sectoral and multilevel cooperation**. The idea of **monitoring the implementation of the EU PA GL was useful**, including a limited set of indicators with data that should lead to policy action (**avoid a data cemetery**); **MS could learn from policy results in other countries**, but it should **remain a responsibility of the MS to carry out the monitoring**. Sport participation and PA should be part of the EU statistical programme and thus become part of 'EU Monitoring'. PL welcomed the EU PA GL as a comprehensive document that could be useful as a checklist for existing strategy papers; PL was using the GL at all levels and in different sectors; regarding monitoring, the work undertaken was appreciated and PL looked forward to further developments. FI stressed that the promotion of HEPA involved different stakeholders, **required continued cross-sectoral work and continued efforts**; FI had set up a cross-

sectoral HEPA steering group in 2011, which was developing new strategic guidelines and to address the challenge to involve other sectors than health and sport. Regarding monitoring, FI noted that the XG SHP was on the right track and **looked forward to the monitoring scheme**. CY expressed **full support for the proposed monitoring scheme**, based on reliable indicators, which could be a means to ensure regular cooperation between MS and to evaluate the implementation of the GL. The EU PA GL formed an important part of CY strategic plan 2020 “Right to PA: citizens in action” (published mid-2012). The main challenge was how to develop a new culture on PA (e.g. CY and DK were two different worlds and had different mentalities with regard to e.g. schools). UK had established a cross-sectoral committee on public health, covering levels of sport and PA. While a monitoring scheme was the way forward, UK experts in the XG SHP were of the view that **there should not be too many indicators**. In PT the **main challenge remained inter-sectoral cooperation**. Close monitoring of the GL was supported as a way to increase cross-sectoral cooperation and to mobilise civil society. The set of indicators was a neutral way of measuring the implementation of the EU PA GL and would allow for their close follow up. PT hoped that this mechanism would **provide more information to evaluate the impact of its national policies and measures**. HU confirmed that the biggest challenge at national level was the **lack of an inter-sectoral approach**, although sport was in the same Ministry as Public Health. Monitoring was considered a good idea for a country like HU, since **it could see how other countries were dealing with the problems and since it could encourage the engagement of national authorities**. HU looked forward to the indicators. It would be useful if the EU statistical programme could provide data for the monitoring exercise. FR recalled that the EU PA GL were adopted under its Presidency term, explained the specific HEPA promotion programmes in France and welcomed **further action to follow up on the EU PA GL by means of a monitoring scheme**. IT informed about the country's cross-sectoral approach to promote PA, greeted the activities by the XG SHP noting that they should get more support in the future, and welcomed the idea of monitoring the implementation of the GL; the **evaluation of outcomes would be useful**. MT presented the national action to promote PA, noting that best practice had illustrated the importance of a life cycle approach. Monitoring was in principle a good idea, but needed to be **sustained by adequate budgets and needed to account for national differences; benchmarks** could be identified. SE echoing NL, considered that it was **already complying with the GL**, cross-sectoral cooperation was indeed essential. In SE's view, indicators could be useful, while the **monitoring should remain the responsibility of the MS**. LU informed about its national action plan targeting the whole population “bouger plus, manger mieux” and noted the **crucial role of sport clubs** to promote PA. Monitoring could be supported in principle. BG referred to four national programmes aimed at promoting HEPA. PRES concluded that the discussion provided a lot of constructive input to the COM for the further work and that everybody agreed on the importance of monitoring and of having the right indicators.

The discussions at the policy level within the formal and informal EU structures for sport described above led the Cyprus Presidency to prepare Council conclusions on HEPA in the second half of 2012 that were adopted by the

Council on 27 November. These **Council conclusions on promoting HEPA** include the following key elements:

- (a) *support for the EU PA GL* as a basis to encourage cross-sectoral policies to promote PA by offering guidance to the MS in the development of their national strategies on HEPA,
- (b) *recognition of PA* being one of the most effective ways to prevent NCDs and on its positive effects on mental health and cognitive processes as well as for health systems and the economy at large,
- (c) *confirmation of the great disparities* between MS' approaches and the scope for further improving the implementation of HEPA policies following the GL;
- (d) *a call on MS* to continue progress in developing and implementing strategies and cross-sectoral policies to promote HEPA taking into account the EU PA GL; to support initiatives aimed at promoting PA within the sport sector,
- (e) *an invitation to the Presidency, MS and the COM* to intensify cooperation between policy areas that, in line with the EU PA GL, have responsibility for promoting PA; to improve the evidence base for policies designed to promote HEPA
- (f) *an invitation to the COM*, in light of the EU PA GL, to make a proposal for a Council Recommendation on HEPA, and to consider including a light monitoring framework to evaluate progress with the help of a limited set of indicators that build to the largest possible extent on available data sources; to consider establishing an annual European Week of Sport.

#### 9.1.2. *EU structures for health*

The promotion of HEPA has also been the subject of high-level discussions between MS in the health policy field. In the context of the Strategy for Europe on Nutrition, Overweight and Obesity-related Health issues ('EU strategy') the *High Level Group on Nutrition and Physical activity (HLG)*, set up in 2007, got the mandate **to discuss solutions to obesity-related health issues in the EU, including PA**. As an input to this work coordinated by DG SANCO, the COM (DG EAC) regularly presented its activities and plans in the field of sport and PA promotion. The concrete plans relating to the policy initiative were shared with the HLG at two meetings, on 3 February 2011 (11th meeting) and on 14 June 2012 (15th meeting).

The monitoring framework and set of indicators was discussed in June based on a background paper prepared by the COM services. At that meeting the HLG was invited to react, particularly on the proposed monitoring framework. The chairman noted that monitoring was an important aspect of the work of the HLG. Given that already existing databases in cooperation with the WHO would be used, HLG members were invited to welcome the initiative as it **reinforced**

**existing policy synergy without carrying an additional burden, given that it took account of existing monitoring tools.** In particular the following comments were made: SI informed that its Ministry of Health was very interested in the new development. The proposed **indicators were based on sound scientific evidence and responded to the needs of the MS.** SI noted that the national HEPA Strategy 2007–2013 had had **weak implementation, mainly due to insufficient cooperation among sectors.** SI proposed adding a few indicators on inter-sectoral cooperation. In conclusion, SI would support the policy initiative. FR pointed out that MS had **different administrative situations and therefore multi-sectoral realities.** This needed to be taken into account when identifying indicators and when comparing information on implementation. Currently, **different tools used to evaluate PA led to different results.** The chairman welcomed the HEPA policy initiative on behalf of the HLG. Particularly the **focus on monitoring was appreciated.** The WHO Europe representative informed that the running database (NOPA) was in the process of being updated. In order to keep it alive the cooperation of and input from the MS was required. Following the discussion at that meeting in June, the HLG provided **written comments** to the two questions in the background document, including the following:

Question 1: "What are the main challenges? What steps would need to be taken to ensure more sustainable promotion of HEPA across sectors?"

On that question HLG replies were as follows (slightly shortened):

DE: "One major challenge is the fact that **prevention is a multi-sectoral task** which also affects different areas and levels of policy. This is why **we need targeted co-ordination across the boundaries of various political sectors.** In DE, such a co-ordination effort has to be based on the federal structure, with the aim of observing regional peculiarities while at the same time achieving purposeful co-operation. It is also necessary for other important social actors in the area of prevention, such as the bodies responsible for providing social insurance benefits, the sports associations or employer and employee associations with their different responsibilities and interests to be included, as far as possible, in any co-ordinated action."

CH: "The main challenge is to **get all interested partners from all different fields on board,** to pursue the same goals and support the same strategies. The **EU PA GL provide concrete policy recommendations for each of the relevant sectors** of society, such as sport, health, education, transport, urban planning, working environment and services for senior citizens. CH implemented a lot of the recommendations from the GL. In CH the cross-sectoral implementation has made a lot of progress in recent years and one can see growing involvement and number of actions by other sectors."

FI: "**Traditions and cultures vary** in different countries. Cross-sectoral co-operation is difficult to start if there are a lot of barriers between different sectors."

EE: "One of the main challenges to promote HEPA is **the cross-sectoral issue** and the cooperation between different public and private sector organisation and the sport movement. Promoting HEPA is financed by different organisations in

different areas. There is surely the need to **ensure funding. EU should promote and support the sharing of best practices in the EU** regarding HEPA and participation in sport, inter alia through support for projects and public awareness campaigns."

SI: "SI agrees that the **influence of EU has a positive impact on countries' work** and the development of the national policy. We believe that **EU PA GL do offer guidance in the development of our policy for HEPA**, emphasising in particular the need for a more effective cross-sectoral approach. Regardless this positive influence on our country's work, we still confront with some challenges. The main challenge in SI is **cross-sectoral collaboration** (SI would require stronger and sustainable cross-sectoral collaboration, which would include open communication, better conditions and establishment of structural connection options, i.e. establishment of working group for this specific area of collaboration)."

NL (informal reaction): "The main challenges momentarily are to **organise long term concerted action, without a certain binding regulation and with strain on the budgets**, to establish a shift in structure and culture that mild and moderate exercise is normal and even strenuous exercise can be fun; the concerted action being a policy mix of 1) information/promotion, 2) effective HEPA methods & supply of sport/fitness and 3) measures on physical, social and financial environment; to persuade local governments to continue their support to sport and to extent their policy to HEPA. In NL the collaboration between sport sector and health sector is promising; the cooperation with the policy domains of infrastructure, traffic and finance is momentarily less strong. Important steps may be to **designate a national agency for HEPA promotion which has trans-sectoral power** and/or to make it compulsory to take into account the effect on the amount of light PA in HEPA for every new infrastructural plan and every relevant new policy or law/decreet, to commission a group of enthusiastic youngsters together with scientists to identify the real thresholds for PA and exercise in society, to find new ways of persuading people and to look for innovative measures in favour of frequent light PA and daily moderate exercise that will be accepted in (almost) all groups of society."

IT: "The EU PA GL are in line with the policies adopted at national level, based on an inter-sectoral approach, according to the principles of the "Health in all policies". PA promotion, in fact, is part of the National strategy "Gaining Health", a coordinated action plan for counteracting 4 leading risk factors for non-communicable diseases (physical inactivity, poor nutrition, alcohol abuse, tobacco consumption) led by the Ministry of Health and based on institutional alliance with Regions and Municipalities and partnership with different private sectors, civil society, consumer associations. The main challenges for promotion PA are to **ensure greater continuity of the actions identified as 'best practices' or 'evidence based' and promote a better integration between health policies and other sectors' policies** (transport, education, urban organisations) to ensure public policies aimed to increase opportunities for all citizens for an active lifestyle. The promotion of health through PA requires the adoption of policies that facilitate healthier choices, so that PA is the easiest choice. It is also needed to adapt the strategies to promote PA to the different 'local' contexts and



resources, involving broad sectors of society. Strategies to promote PA, therefore, require integrated interventions that should include facilities for leisure and sports, workplace and healthcare settings, as well as transport planning, traffic control, planning of buildings and urban environments and information activities in the territory. The inter-sectoral approach allows implementing interventions that modify unhealthy behaviours, promoting healthier individual choices by changing the environment. To increase PA and discourage sedentary behaviours it is crucial to **address the determinants of environmental, social and individual physical inactivity and implement sustainable actions through collaboration between multiple sectors at national, regional and local levels**. Urban planning, therefore, must be considered a fundamental instrument for the protection of individual and collective health. Currently, relations between the urban environment and health are becoming more evident. The school and the city are, or should become, learning spaces, experience and relationships to help young people. The public health sector should implement interventions designed to increase PA for specific target of population, such as elderly people or people with specific diseases (PA prescription), taking into account the environmental context of PA and the balance between benefits and possible increased risks of higher levels of PA. **Communication for health is also very important to raise awareness of the health benefits of PA**, so it is necessary develop information campaigns to promote PA but also to inform people about the opportunities existing at local level to practice PA (not only “sports” but also walking, bike-sharing in the cities, “walking bus to school” for children, etc.)."

Question 2: "What do you think of the idea of a monitoring mechanism to promote the implementation of the EU PA GL?"

On that question, HLG members provided the following comments (slightly shortened):

DE: "In principle, the Federal Ministry of Health **supports** such a monitoring mechanism. The indicators developed to monitor the implementation of the guidelines' principles will make it **possible to determine progress and diagnose fields of action** within the many areas in which efforts can be undertaken to promote PA. At the same time, comparative studies among countries can be conducted and priority areas in the individual countries examined in greater detail. DE nevertheless wishes to draw attention to the fact that **many of the indicators in question are not being recorded nationally at the present time** and that, even at EU level, not all of the necessary data are available. The decision to implement a monitoring process, using the corresponding indicators, **should not lead to a situation where new data would need to be collected at national level or extensive reporting be required**. To the contrary, as far as possible, already existing studies/data sources should be used exclusively."

CH: "Of course a monitoring mechanism to promote the implementation is **welcome**."

FI: "I **support warmly** the idea of a monitoring mechanism."

EE: "EE **fully supports** the idea of a monitoring mechanism to promote the implementation of the EU PA GL. The monitoring mechanism should be **simple**"

**and concentrate on the data, which already exists** or is collected by the MS. There should be **no costs for MS**. The monitoring mechanism **should be organised by the COM and provide added value for promotion HEPA** and exchanging the best practices between MS. Estonia has already adopted the national PA development plan for years 2011-2014. Development Plan main objective is, for the year 2014 a total of 45 per cent of the population should be involved in regular PA."

SI: "SI **supports** the idea of monitoring mechanism to promote the implementation of the EU PA GL. We consider all of the following approaches useful: a) indicators on direct effects, b) indicators on thematic groups and also c) detailed indicators. We believe that the indicators on direct effects are good approach because of the simple implementation and could be monitored each year. We also support more complex approach which could be implemented with detailed indicators on all 41 guidelines. In our opinion this could be monitored after a decade (10 years) and could than offer the possibility of changing the temporal niche. **Indicators on thematic groups with medium number of indicators are an excellent approach, because it includes both a complexity and a simple implementation.** In our view this kind of proposed approach could be monitored **in a period of 2 years**. Our suggestion would be to strongly integrate all these three approaches (a. indicators on direct effects, b. indicators on thematic groups and c. detailed indicators) into one structural approach e.g. into a pyramid approach, where they can mutually link and complement. In a decade we could therefore monitor all these three strongly integrated approaches within a proposed period of time (i.e. a. after each year, b. after 2 years and c. after a decade). In addition to this we would also like to **highlight the importance of financing mechanism**. We believe it is necessary to plan the financial mechanism carefully, in light of financial crisis and lack of resources."

NL (informal reaction): "This seems to be a **good idea** because the rule of thumb **'what is being measured will be done'**. On the other hand, national and local governments may be reluctant to agree with that because of **perceived loss of authority**, the possible administrative burden and future costs."

IT: "The **monitoring tools are essential** to define the priorities in public health. To know the problem and to guide the choices of decision makers and citizens through the promotion of PA, it is necessary to have a system of collection, analysis, interpretation and communication of data that is able to provide accurate information on PA practiced, on measures implemented and results achieved."

CZ: "We **fully support activities promoting PA** and fully appreciate that full advantage of work on NOPA is taken; However, mentioned EU PA GL were prepared by very close group of experts (sport experts mainly); these guidelines are more focused on sports (grassroots sports) than PA;<sup>147</sup> **these guidelines were endorsed only informally** by ministers for sport even though a lot of proposed activities (which are quite specific) is focused on health sector (health care, health insurance etc.). The focus of the EU guidelines and following activities on the health sector is quite strong. This could cause **some inconveniences as it is not easy for the EU to bring added value in areas the areas where it has no**

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<sup>147</sup> NB: The two latter statements are factually incorrect.

**competencies**, the division of competencies between the Union and MS as provided by the Treaty shall be taken in to account."

Beyond discussions in the framework of the 'EU Strategy', the *Council structures for health* have addressed the need to promote a healthy lifestyle, including PA. The Council conclusions of 1-2 December 2011 on "Closing health gaps within the EU through concerted action to promote healthy lifestyle behaviours"<sup>148</sup> recognise that "health gaps are understood as being population differences in premature mortality, morbidity and disability between and within MS" and that "these arise in part from the major unhealthy lifestyle behaviours, i.e. (...) lack of PA". The Council also recognises that "**Improved evaluation and assessment** can help determine whether strategies and policies are effective for addressing health inequities and the health needs of populations. It can thus support MS to develop and implement effective public health strategies and appropriate infrastructure". The Council commits in this text to "**accelerate progress on combating unhealthy lifestyle behaviours, such as (...) lack of PA** leading to increased incidence of NCDs (...), which are recognised to be important causes of premature mortality, morbidity and disability in the EU". It calls on MS to "**continue, intensify and/or develop policies and actions promoting healthy lifestyle behaviours**", "make optimal allocation of resources especially in relation to health promotion and prevention activities". It calls on MS and the COM to "**assess indicators to monitor progress** resulting from interventions focused on the aforementioned lifestyle behaviours" and to "reinforce and continue action to support healthy lifestyle behaviours including encouraging the development of urban and social environment policy conducive to PA for all". The Council calls on the COM to "**consider the need for (...) additional data and information on unhealthy lifestyle behaviours. (...) This should be obtained from sustainable health monitoring systems (...) which might be established at EU level.**" In addition, the Council conclusions on "Healthy ageing across the lifecycle"<sup>149</sup> adopted on 7/12/2012 recognise that "lifestyle behaviours are amongst the main determinants of health and addressing them through inter-sectoral action remains one of the challenges for achieving active and healthy ageing for all"; they invite the MS to "**adopt an approach that shifts the focus towards health promotion and disease prevention**", to "promote policies and actions that sustain the health of working age people leading to a healthy workforce, as a prerequisite for productivity and growth" and to "enhance and strengthen coordination (...) among MS promoting inter-sectoral action"; they invite the COM to "**support better use by the MS of the EU Physical Activity Guidelines**", and they invite the MS and the COM to "promote strategies for combating risk factors, such as (...) lack of PA".

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<sup>148</sup> Council of the European Union, Council conclusions on "Closing health gaps within the EU through concerted action to promote healthy lifestyle behaviours", doc. 16708/11, 17 November 2012; text adopted on 1-2 December 2011.

<sup>149</sup> Council of the European Union, Draft Council conclusions on "Healthy Ageing across the Lifecycle", doc. 15098/12, 19 October 2012.

## 9.2. The European Parliament

The promotion of PA and participation sport has also been a **recurrent topic for the work of the European Parliament (EP)**. For instance, when voting the budget for sport (i.e. Preparatory Actions 2009-2012), the Parliament has regularly given priority to the topic of HEPA. In its 2012 Resolution on the European dimension in sport<sup>150</sup>, the EP considers that "sport is a key factor for health in modern society", that "**promoting PA and sport makes for significant savings in terms of public expenditure on health**" and that "a key motivating factor behind citizen involvement in sport and PA is to improve personal health and well-being". It subsequently "urges the MS to establish clear guidelines to integrate sport and PA into all levels of education", "recommends that the COM encourages the practice of sport among senior citizens as it helps to promote social interaction and high rates of good health", "underlines that sports at all ages is an important area of great potential for increasing the overall health level of Europeans and therefore **calls on the EU and on MS to facilitate engagement in sport and to promote a healthy lifestyle fully exploiting the opportunities of sport, thereby reducing spending on healthcare**", "calls on the COM and MS to support more strongly the role of health professionals in the promotion of sports participation and to examine how health insurance providers could offer incentives as a way of encouraging people to take up sporting activities", "stresses the great socially-integrating power of sport in many areas, including (...) the promotion of good health", "encourages the COM and the MS to acknowledge the importance of sport as a means of promoting (...) public health", "notes that coaches can provide guidance for young people to develop a healthy lifestyle", "calls on the COM to organise a 'European Day of Sport' every year which promotes (...) the benefits of sport in terms of public health".

## 9.3. HEPA Experts

### Meetings of the HEPA Europe network<sup>151</sup>

HEPA Europe is a (pan-) European network launched in 2005 that aims at promoting HEPA and, together with other relevant institutions and organisations, at improving coordination in PA promotion across sectors and administrative structures. HEPA Europe closely collaborates with the WHO Regional Office for Europe (WHO Europe). Members are generally organisations or institutions, and to a lesser extent public authorities, active in the areas of research, promotion of PA and sport, education/training, and/or health promotion - all representative HEPA organisations from Europe today appear to be members of the network. The concept of HEPA as a bridge between PA/sport and health is gaining ground across Europe, with a constantly increasing membership (applications via WHO Europe) and an increasing number of activities (seminars, working groups, database, website, publications).

<sup>150</sup> 2011/2087(INI) of 2 February 2012.

<sup>151</sup> Information given and statements made in this section are further laid down in internal mission reports (COM participation in HEPA Europe Annual Meetings and Conferences 2008-2012).

HEPA Europe organises annual events (meetings and conferences) that bring together hundreds of participants active and/or interested in the field of HEPA (academia, research, civil society organisations, sport organisations, public authorities). Since 2008 the COM has regularly participated in these events and presented the emerging EU level activities in the field of HEPA (Public Health Programme, Platform on Diet, Physical Activity and Health, White Paper on Sport, White Paper on Obesity, EU PA GL, Communication on sport, planned EU policy initiative, etc.).<sup>152</sup> The meetings were a good opportunity to get feedback on the EU PA GL and to confirm that they were in line with the latest scientific and sociological evidence. The meetings repeatedly confirmed the huge need for more "PA advocacy" (i.e. efforts to explain the benefits of PA on public health, and in particular to explain the financial effects of physical (in)activity). It was inter alia noted at these Annual Conferences of HEPA Europe that

- "The cost of reaching a public health benefit through PA is generally far lower than reaching the same benefit through medical treatment, but politicians and policy-makers were generally not aware of this. In both Europe and the USA, public health institutions tend to have almost no members from the PA area."
- "Sport clubs generally perceive themselves as more health-promoting than they are in reality. However, **the effect of sport clubs on public health can be greatly increased** through public policies and programmes, as are in place e.g. in FI and NL. In the latter country, a system is being put in place to reward sport clubs for concluding cooperation agreements with schools from their area, apparently with good results."
- "HEPA as a cross-sectoral concept to enable people to move more as part of their daily routines is **a concept that is gaining ground in Europe.**"
- "The EU PA GL made an important contribution to the growing consensus about what HEPA is and why it should be supported by the public sector. At the same time, approaches and **practices in different MS remain divergent** in terms of quality, quantity, budget support etc., so that **exchange of good practices in this sector deserves support** and can make an important difference in terms of the EU population's lifestyles in the longer term."
- "Policy-makers can shape the urban environment and thus improve the conditions for HEPA (planning of streets, sidewalks, cycle paths, footpaths, lighting, safety, benches to sit on, parks, playgrounds, sport clubs, sport fields, location of supermarkets, etc.). While **excellent scientific tools exist** to help policy-makers make informed decisions,

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<sup>152</sup> COM presence at the following meetings: 1st Annual Conference of HEPA Europe and 4th Annual Meeting of HEPA Europe (8-10 Sept. 2008, Glasgow, UK); 5<sup>th</sup> Annual Meeting + Symposium (11-12 Nov. 2009, Bologna, IT); 6<sup>th</sup> Annual Meeting + Symposium (24-26 Nov. 2010, Olomouc, CZ); 7<sup>th</sup> Annual Meeting (11-13 Oct. 2011, Amsterdam, NL); 8<sup>th</sup> Annual Meeting (25-27 Sept. 2012, Cardiff, UK).

**most municipalities in the EU do not use such tools yet**, which leads to sub-optimal (or plainly wrong) decisions."

- "Cooperation among the relevant departments (health, education, youth, sport etc., at national, regional and local levels) is often a **serious problem**. Low awareness of the benefits of an active lifestyle is a problem among both policy-makers and citizens in most countries."
- "Partial PA programmes now seem to exist in most MS, but only as parts of either a health strategy or a transport strategy. **Few MS have comprehensive cross-sectoral HEPA strategies**. Yet such strategies bring the best results."
- "The importance of physical activity (PA) is **not only linked to tackling obesity** (only 10% of all benefits), though it must be considered the entering point for HEPA on the European agenda."
- "Today there is evidence that PA has a much broader impact on health, in particular **chronic stress** being the greatest disease these days."

Very importantly also for this Impact Assessment and the intended structures for the implementation of the Recommendation is the creation of the **HEPA Europe EU Contact Group**: The 4<sup>th</sup> Annual Meeting of HEPA Europe proved to be of considerable for the implementation of the 2<sup>nd</sup> action of the "Pierre de Coubertin" Action Plan ("The COM will support an EU Health-Enhancing Physical Activity (HEPA) network [...]") where COM together with HEPA Europe's Steering Committee could find common ground on modalities for cooperation and, in particular, the creation of an EU HEPA network based on the existing HEPA Europe network. It was considered that an EU (rather than European) HEPA Network could be **necessary to accompany the implementation of the EU PA GL and that there was a mutual interest and complementarity between the COM's activities and HEPA Europe**: the network would need the COM for strategic guidance and for targeted funding, while COM would need the network for expertise (e.g. several of the most active members of the Group of Experts which elaborated the draft EU PA GL in 2007-2008 were also members of the network), for "expert advocacy" of the HEPA concept vis-à-vis MS' authorities and for supporting COM in the implementation of the HEPA priorities and, in the future, the implementation of the EU PA GL. There was consensus that such a network should be a hub of ideas. At that meeting it was agreed that a future EU HEPA network could consist of the EU members of the existing network, and that it could hold meetings in conjunction with the annual meetings of the existing network. Agreement was reached, at the Annual Meeting in Bologna, in 2009, that the EU structure would be called "HEPA Europe EU Contact Group". The Contact Group officially constituted itself at the Annual meeting the year after in Olomouc, CZ. This first Contact Group meeting resulted in the adoption of draft terms of reference according to which the Group's role consists inter alia of:

- providing an interface between the HEPA Europe network and the COM;

- providing a common platform for the exchange of knowledge, information, practices and approaches in relation to the promotion of sport and health-enhancing physical activity (HEPA);
- supporting the dissemination of internationally agreed guidelines and strategies for PA policy promotion, such as the EU PA GL (2008), (...).

The HEPA Europe-EU Contact Group meeting in the framework of the Annual Symposium 2012 focused more concretely on the planned EU policy initiative. Inter alia the following comments were made following the COM's intervention on its respective plans, including the monitoring framework:

- It was suggested to consider the possibility of **pilot testing in some MS** regarding the feasibility of the instrument (monitoring framework) - WHO Regional Office for Europe;
- Regarding the cost for implementation, it was proposed to develop on the 'cost of inaction' - British Heart Foundation;
- On the question how monitoring could work in practice, the **idea of focal points in the MS** (similar to those already existing for nutrition) was strongly supported by several participants;
- As to the possible role of HEPA Europe, the chairman of the network suggested that **capacity building and specific training** (e.g. summer schools) could be organised, for instance relating to specific themes of the EU PA GL; moreover the HEPA Europe conference could be an important platform for the dissemination of outcomes from the implementation of the present initiative;
- Regular **reporting on the implementation of the EU PA GL** (across sectors) was considered a crucial means to generate change;
- Concerning the indicators more particularly, the group had no questions but confirmed the importance of keeping the indicator on 'budgets'.

### Workshop on "EU Physical Activity Guidelines - indicators"

The workshop took place on 29 February 2012 and was organised by the COM in cooperation with the contractor that carried out the study commissioned by DG EAC to assist with the preparation of the planned initiative, in particular the development of a set of indicators to monitor progress. The workshop was led by the HEPA experts in the study team and was attended by academics and researchers with recorded experience in the field of HEPA, as well as WHO Europe and relevant COM services (EAC, SANCO, MOVE). After introductions by the COM (policy framework and state of play in preparing the initiative) and by the contractor (overview on work in progress regarding the study), the workshop focused on the proposed monitoring framework for the implementation of the EU PA GL. A representative of the study team presented the **scientific and methodological background**, i.e. outlining the difference between process,

output, outcome and impact indicators, reminding participants of key aspects of a 'good' indicator, and introducing existing efforts at national and international level to monitor HEPA policy. Several other presentations followed, including by a representative from WHO Europe who provided an overview of the joint COM-WHO monitoring project / **database on nutrition, obesity and physical activity (NOPA)** and shared experience from the NOPA project regarding the availability of relevant data, the process of compiling, validating and analysing data, and other challenges. Following the presentation, workshop participants highlighted the relevance of the NOPA database for the proposed initiative. Key conclusions were that in order for the planned initiative to be successful, the **indicators would have to be of interest to the MS, and it would have to be feasible for them to collect the required data**. Clarification was sought on issues such as the role of the national focal points, the process of data validation, and the difference between summary indicators (used in the NOPA project mainly for policy development) and detailed indicators (used mostly for policy implementation). Another presentation (KU Leuven) provided information on the 'study on harmonised collection of European data and statistics in the field of urban transport and mobility' carried out for the COM (DG MOVE). In exploring potential synergies between HEPA indicators and urban mobility indicators, the field of urban travel data and urban infrastructure data was highlighted. Workshop participants agreed that data on travel patterns and in particular on active travelling could be very relevant. However, it was noted that such data was usually collected at the city rather than at the national level, making it difficult to feed into a monitoring framework at MS level.

The second part of the workshop was dedicated to the discussion of an **initial list of proposed indicators to measure the implementation of the EU PA GL** in the MS. The discussion was based on the draft indicators table provided as part of the workshop background document. The first set of indicators discussed concerned the 'effects of the EU PA GL' (i.e. whether they are known by relevant stakeholders and whether MS have taken specific actions due to the EU PA GL). While many participants felt there would be value in measuring this, others had doubts as to whether this was feasible due to a number of conceptual, methodological and logistical concerns. Nonetheless, it was noted that even if direct attribution was not feasible, necessary and/or desirable, the **EU PA GL and the different intervention areas and sectors they cover provide an appropriate reference framework for monitoring MS policies**. In the area of 'International PA recommendations and guidelines' (guidelines 1-2), most participants agreed with the indicators proposed by the study team, although there was some discussion around whether or not to include a specific indicator on the PA levels of children. It was also noted that an indicator proposed under the topical area "health" on the existence of an appropriate system to monitor PA levels in each MS (usually as part of health monitoring) could be moved to this section. Under the heading 'Cross-sectoral approach' (guidelines 3-5), there was some constructive debate around the phrasing and level of detail of the proposed indicators. Generally, it was noted that ideally indicators should not be phrased as simple "Yes/No" questions, but rather seek additional information (e.g. concerning the mandate, capacity, resources etc. of national HEPA coordination mechanisms) that would allow for validating the claims of MS and actually tracking progress. The study team explained that this was the intention, and that



questionnaires for data collection would need to be drafted with this in mind. A **discussion ensued around the draft indicators for each of the different sectors at which the EU PA GL are aimed**, namely 'sport' (guidelines 6-13), 'health' (14-20), 'education' (21-24), 'environment, urban planning and public safety' (25-32), 'working environment' (33-34), and 'services for senior citizens' (35-37). Considering the potential validity, clarity, objectivity, sensitivity, action orientation and feasibility of each indicator in turn, the group suggested adding, amending or deleting certain indicators. These discussions were often informed by the relevant experiences of other projects, in particular the COM-WHO NOPA project, which provided a good indication of MS' ability to provide relevant data in different areas. Finally, participants discussed the proposed indicators in the areas of 'indicators, monitoring and evaluation' (guideline 38), 'public awareness and dissemination' (39), and 'EU HEPA Network' (40-41). Regarding the former two areas, there was widespread agreement on the proposed indicators, but the experts discussed critically whether specific indicators related to the EU HEPA Network would be appropriate.

Based on the feedback provided at that workshop the study team revisited the draft list of indicators. **Results were subsequently further shared and discussed in the following weeks and months** with relevant groups and/or fora, including the EU Expert Group on Sport, Health and Participation, the HEPA Europe Network, and a special workshop during the 2012 EU Sport Forum.

#### 9.4. Stakeholders and the general public

##### EU Sport Forum 2012

At the EU Sport Forum 2012 (Nicosia, 20-21 September) the Commission organised a high-level panel debate for Forum participants and EU Sport Ministers on "the contribution of sport and physical activity to Europe's economy".<sup>153</sup> Sport stakeholders inter alia called for a **'new transversal policy initiative to promote HEPA'** (President of the French Olympic Committee), noted that **'Physical activity was important to health and to Europe's economy and politicians had not yet managed to convince citizens'**, that 'the major weakness was the **lack of a cross-sectoral approach** in HEPA promotion policies and here useful documents existed at EU level, but their implementation remained patchy' and that therefore **'better use should be made of the EU Physical Activity Guidelines in national policies'** (chairman of the Cyprus Sport Organisation) and, commenting the results from a recent NIKE study, echoed the **'importance of integrating physical activity in citizens' daily lives** and to ensure an early positive experience for children in this regard' (President of the Federation of European Sporting Goods Industries).

##### Expert seminar on a possible EU initiative in the field of HEPA

In the context of the EU Sport Forum 2012 an Expert Seminar on a possible new EU policy initiative in the field of HEPA was organised on 19 September with the support from and co-chaired by the COM. The seminar served to introduce the

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<sup>153</sup> Internal report: SI (2012) 416

initiative and stimulate comment and discussion from participants, who consisted of about 40 experts representing a broad cross section of academe, sport stakeholders and MS officials. The seminar began with a welcome presentation and introduction to the initiative by the COM providing a summary of the evolution of EU sport policy and the underlying policy context. Representatives from the study team (study to support preparations of the COM proposal in the field of HEPA) made a basic introduction to the concept of Impact Assessment. In the discussion participants were favourable towards the new initiative and considered how would work in practice. A considerable number of participants stressed the **need for the monitoring mechanism to gather comparable and consistent data**. Several experts then added that this could be achieved in part by encouraging the MS to adopt either the International Physical Activity Questionnaire or the Global Physical Activity Questionnaire. Part of the discussion also centred on the nature of the problem – **whether Europeans choose to be physically inactive or whether the default options they face do not present adequate opportunities to engage in PA**, why some countries have had more success than others in implementing the GL and how improvements might be achieved in the future. The study team then presented the potential monitoring mechanism of the new initiative and the set of proposed indicators that would be used to gauge progress. In particular, it was explained that the monitoring mechanism should consist of a **medium number of (quantitative) indicators** (at that time: 26), based on a combination of different methods and focused on the thematic areas of the EU PA GL, rather than all 41 Guidelines. Such an approach would **strike a balance between exhaustiveness and flexibility and the need for the MS to play a large role in the data collection**. Participants expressed favourable views of the indicators, with questions focused on the nuance of specific indicators and the importance of using the limited set of indicators to capture as much relevant information as possible. The COM acknowledged that the proposed set of indicators was still in draft stage and would be finalised on the basis of participants' comments and further work in cooperation with experts in the study team.

### **EU Platform for Action on Diet, Nutrition and Physical Activity**

This EU Platform is a forum for European-level organisations, ranging from the food industry to health, consumer and sport NGOs, allowing its members to agree **commitments on tackling current trends in diet and physical activity**. The Platform meets 3-4 times per year. Since the inception in 2005, at least one of these annual meetings included physical activity promotion as its main topic. There have also been separate meetings on sport, and in September 2007, a separate Platform workshop was focusing on physical activity promotion. In addition, COM (EAC) presented its activities in the field of sport to the Platform in 2005, 2006, 2008 and 2011. The Platform charter<sup>154</sup> outlines the possible fields of action for Platform members, and promotion of physical activity is one of six such fields.

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<sup>154</sup> [http://ec.europa.eu/health/archive/ph\\_determinants/life\\_style/nutrition/platform/docs/platform\\_charter.pdf](http://ec.europa.eu/health/archive/ph_determinants/life_style/nutrition/platform/docs/platform_charter.pdf)

The Platform currently has 33 members, of which 5 have sport and HEPA as their main focus (European Confederation Sport and Health; European Cyclists' Federation; European Health and Fitness Association; European Non-Governmental Sports Organisation; the International Sport and Culture Association).<sup>155</sup>

There are **30 (out of a total of 255) commitments registered in the Platform database with physical activity promotion as their main type of activity**; of these 17 (out of a total of 122) are active now (13.9% of all active actions), and four of these are new commitments, running from 2012 and onwards.

Following the 5 year evaluation report of the Platform, where it was stated that: "the physical activity area being less represented and considered in the Platform...", **renewed objectives for the Platform were defined and adopted at the Platform plenary meeting in February 2011**. In the working document on renewed objectives<sup>156</sup> physical activity and sport were stated as one out of five priority areas and target groups for Platform commitments for 2011-2013. The Platform evaluation report also states the following regarding repartition per sector of Platform members in its conclusions: "That said, the education sector is not represented at all, in spite of the importance of the 'Lifestyles and education' area which accounted for more than half of the Platform's active commitments as at January 2010 (see EQ 2.2). **While the physical activity sector was perceived by a number of members as being under-represented, this sector is in fact represented by six Platform members (18% of the total), 336 sub-members (the third largest group) and 12 active commitments** (the fourth largest group). Therefore, the perceived lack of representation of this sector by members may be due more to its lack of visibility than an actual under-representation."

### Sportvision 2012 (DK Presidency)

The main stakeholder event organised by the International Sport and Culture Association (ISCA) on behalf of the DK Presidency in the field of sport was a Conference focusing on sport for all (Sportvision2012), which took place in Copenhagen on 19-20 March 2012. It inter alia focused on "sport and health" and was an opportunity to test the COM's ideas and seek feedback on the planned policy initiative in the field of HEPA. The event gathered around 400 participants from 35 countries; non-governmental sport stakeholders, academics, representatives from MS' sport departments. After high-level interventions, including from the Commissioner who highlighted the importance of sport for all in the EU level debate on sport and mentioned the COM's activities and plans in the field of HEPA, the following statements were made in the discussion: **"Promoting PA is the best buy in public health."**; "There is evidence that PA improves health, better health increases economic growth, physical inactivity is

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<sup>155</sup> Other organisations, such as the European Heart Network, European Region of the World Confederation for Physical Therapy, the European Association for the Study of Obesity, European Public Health Alliance, EuroHealthNet, European Network for prevention and Health Promotion in general practice/family medicine, The International Diabetes Federation – European Region, and the International Obesity Task Force also showed interest in physical activity promotion.

<sup>156</sup> [http://ec.europa.eu/health/nutrition\\_physical\\_activity/docs/evaluation\\_frep\\_en.pdf](http://ec.europa.eu/health/nutrition_physical_activity/docs/evaluation_frep_en.pdf)

costly (micro studies) and increasing PA increases economic growth (macro studies)."; **"There is a paradox of increased awareness about the positive effects of PA on the one hand and declining participation rates on the other."**; **"The sport sector should realise its potential** and take account of the need to meet new demands."; **"Further impetus from the EU level to promote participation and PA, including a possible policy initiative, would be welcomed."**

### Public (online) consultation

In preparation of its proposals to implement the new Treaty provisions for sport, the COM has carried out broad consultations with all concerned parties, the centrepiece of which was an online consultation in the first half of 2010 (2/4-2/6) which was a success as more than 1,300 valid submissions were received. Approximately 30% of respondents filled out the questionnaire on behalf of their organisations<sup>157</sup>. This ratio demonstrates that the online consultation **reached a considerable number of respondents outside organised sport.**

The objective of the public consultation was twofold. Firstly, it aimed at gathering stakeholders' views on the key challenges for sport in Europe. Secondly, it intended to help the COM identify priority areas for action at EU level. In parallel to the online consultation, the COM received written contributions in the form of 50 position papers from stakeholders. Both parts of the consultation contained **a number of questions on HEPA with direct relevance for the planned EU policy initiative.**

A Report was prepared that described the consultation process and analysed the contributions received.<sup>158</sup> It provided an overview of the wide range of suggestions and the diversity of opinions expressed in the course of that process. The quantified results of the online questionnaire relating to physical activity and the analysis referred to hereafter are reflected in the report from the consultation.

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<sup>157</sup> The term "organisation" has been used in a wide sense, including sport organisations (e.g. a sport federation), sport-related organisations (e.g. a sports betting provider), public authorities (e.g. a Ministry) or public bodies (e.g. a sport agency), as well as private companies, research centres or universities, consultancies, and some others.

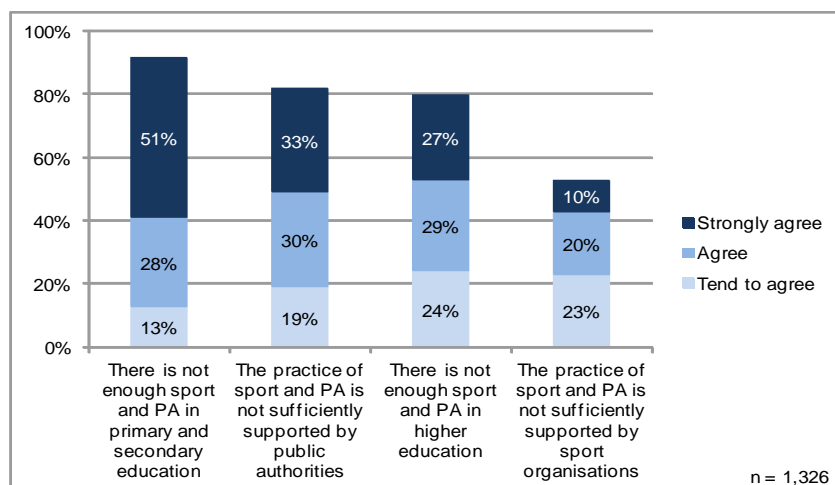
<sup>158</sup> Full report:  
[http://ec.europa.eu/sport/documents/library/100726\\_online\\_consultation\\_report.pdf](http://ec.europa.eu/sport/documents/library/100726_online_consultation_report.pdf)

Assessment points conversion table	
Field value	Corresponding relative value
Strongly agree	3
Agree	2
Tend to agree	1
Don't know	0
Tend to disagree	-1
Disagree	-2
Strongly disagree	-3

I) Part one of the questionnaire (*'Key challenges for sport in Europe'*) included **10 (out of 47) questions which can be directly related to physical activity / HEPA or which have relevance for the planned initiative (e.g. data collection):** Q1, 2, 3, 4, 5, 6, 7, 15, 28, 36.

- The practice of sport and physical activity is not sufficiently supported by public authorities (Q1);
- The practice of sport and physical activity is not sufficiently supported by sport organisations (Q2);
- Sport organisations concentrate too much on competitive sports at the expense of non-competitive activities and health-enhancing physical activity (Q3);
- There is not enough sport and physical activity in primary and secondary education (Q4);
- There is not enough sport and physical activity in higher education (Q5);
- Too many obstacles (e.g. physical obstacles, availability, expenses) exist to accessing sporting activities and facilities (Q6);
- There are unequal possibilities to access sporting activities and facilities between different socio-economic groups (Q7);
- There is not enough comparable data on the economic and social impact of sport in EU Member States (Q15);
- There is not enough communication among different EU Member States regarding different approaches they have in relation to sport and sport policy (Q28);
- Public funding for grassroots sport is not sufficiently stable (Q36).

Figure 1: Physical activity promotion in education, by public authorities and by sport organisation



On all these questions, respondents either 'strongly agreed', 'agreed' or 'tended to agree'. Concerning these key challenges for the EU in the field of sport, the report noted inter alia that "Replies to questions 4 and 24 represented the highest cumulative value, highlighting public concern about insufficient presence of sport and physical activity in education (all levels). This was confirmed by a number of position papers."

II) Regarding the second part of the questionnaire (*'Identifying policy priorities for EU action'*), respondents 'strongly agreed' or 'agreed' that the EU should:

- support the role of sport in enhancing public health through PA (Q. A1);
- promote sport and PA as a tool to achieve a more active lifestyle and to fight obesity (Q. A2);
- encourage EU MS and sport organisations to take action in order to increase participation levels in sport and PA (Q. A3);
- promote sport for all (Q. A9);
- promote knowledge-based decision making (Q. A13);
- collect and analyse comparable statistical data on the impact of sport in economic and social terms (Q. A14);
- foster coordination and cooperation among MS, sport organisations and other actors in the field of sport (Q. A21);
- pursue a better balance between the societal and commercial dimensions of sport (Q. A29).

The promotion of PA and the need for more evidence on sport and PA (i.e. weighted average relative values > 2), together with social inclusion, the fight against threats to sport and topics relating governance issues, clearly could be identified as those areas where **the public wishes the EU to play a role and to become active**. Accordingly, the report notes that "A considerable number of respondents referred to the fact that there were a number of tasks that the EU could do in relation to the social and educational functions of sport. **Support and promotion of sport as a health-enhancing activity ranked particularly high in the replies.**"

The **importance of EU action in the field of HEPA was furthermore underlined in the position papers** submitted on behalf of 'organisations' in the framework of the consultation process.

The report concludes that the public consultation based on the online questionnaire and the written contributions served as an important source of information to give indication regarding **priority areas for future EU action**. Among the four areas receiving the highest degree of attention from the general public and stakeholders the summary report mentions

- promotion of the social and educational functions of sport, including **health-enhancing PA**, ..., participation levels in sport, ..., sport for all.

Among the three horizontal priorities the report identified as a main area

- support for **knowledge-based decision-making** in the field of sport.

## 10. ANNEX II: ADDITIONAL EVIDENCE ON PHYSICAL ACTIVITY IN THE EU

### 10.1. The benefits of physical activity and detriments caused by physical inactivity

The WHO has recently identified insufficient physical activity as the fourth leading risk factor for **premature mortality and disease globally**<sup>159</sup>, being responsible for about 1 million deaths per year in the European Region alone. Overweight and obesity, among the most visible effects of insufficient physical activity, have tripled in many countries in the WHO European Region since the 1980s, and the numbers of those affected continue to rise at an alarming rate, particularly among children. Physical inactivity also plays a role in a **host of health problems** aside from obesity. According to the WHO, it is estimated to cause around 21-25% of breast and colon cancers, 27% of diabetes and about 30% of ischaemic heart disease.<sup>160</sup> Physical activity's role in development has also been demonstrated, as research has shown direct links between adolescent inactivity and overweight and obesity and related diseases, breast cancer and bone health in later life.<sup>161</sup> Overall, the WHO estimates that people who are insufficiently physically active have a 20-30% increased risk of all-cause mortality compared to those who engage in at least 30 minutes of moderate intensity physical activity on most days of the week.<sup>162</sup>

Also the **mental health effects** of physical activity, including sport and exercise, are well documented and recognised, including in a range of scientific publications.<sup>163</sup> Physical exercise improves mental health, helps prevent depression and helps to promote or maintain positive self-esteem.<sup>164</sup> People who regularly engage in physical activity show better health outcomes, including better general and health-related quality of life, better functional capacity and better mood states.<sup>165</sup> Some studies have found significant positive relationships between physical activity and cognitive outcomes.<sup>166</sup> Studies on the relationship of physical activity and stress underline that physical activity plays a key role in the control of the body's response to physical stress and prevents telomere shortening.<sup>167</sup> Results from an EU study on mental health and physical activity

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<sup>159</sup> [http://www.who.int/healthinfo/global\\_burden\\_disease/global\\_health\\_risks/en/index.html](http://www.who.int/healthinfo/global_burden_disease/global_health_risks/en/index.html)

<sup>160</sup> *ibid*

<sup>161</sup> OECD (2010), *Health at a Glance: Europe 2010*, OECD Publishing.

<sup>162</sup> [http://www.who.int/chp/ncd\\_global\\_status\\_report/en/index.html](http://www.who.int/chp/ncd_global_status_report/en/index.html)

<sup>163</sup> E.g. *Journal of Public Mental Health*, *Official journal of the association of medicine and psychiatry*, *International Journal of Mental Health Promotion*, *Journal of Physical Education & Sport Pedagogy*

<sup>164</sup> *Sports Medicine*, Volume 29, Number 3, 1 March 2000, pp. 167-180(14).

<sup>165</sup> *Current Opinion in Psychiatry*: March 2005 - Volume 18 - Issue 2 - p 189-193.

<sup>166</sup> E.g. A. Fedewaa, S. Ahn, *The Effects of Physical Activity and Physical Fitness on Children's Achievement and Cognitive Outcomes*, *Research Quarterly for Exercise and Sport*, Volume 82 – Issues 3, 2011.

<sup>167</sup> Rimmele et al, *Level of PA affects adrenal and Cardiovascular Reactivity to Psychosocial Stress: Psychoneuroendocrinology* (2009) 43 190-198; Puterman E, Lin J, Blackburn E, O'Donovan A, Adler N, et al. (2010), *The Power of Exercise: Buffering the Effect of Chronic Stress on Telomere Length*.



indicated a positive relationship between physical activity level and mental health for population subgroups.<sup>168</sup>

In light of all these benefits, physical activity has been identified as the ‘**miracle drug**’ that can benefit every part of the body and substantially extend lifespan’.<sup>169</sup>

Conversely, physical inactivity puts a burden on society through the hidden and growing **cost of medical care** and **loss of productivity**.<sup>170</sup>

Obesity has been estimated to account for 2-8% of public health costs in different parts of Europe.<sup>171</sup> Factoring in other diseases, the total cost of physical inactivity is certainly much higher, and likely to increase even further due to the ageing population. In addition, physical inactivity also brings with it significant indirect economic costs, including the value of economic output lost because of illness, disease-related work disabilities and premature death.<sup>172</sup>

For example, a study based on three Dutch databases<sup>173</sup> found that workers who engage in vigorous physical activity at least three times per week had significantly less sick leave (up to four days per year). Similarly, a recent Danish study<sup>174</sup> calculated that in Denmark, 3.1 million days of sick leave each year are attributable to physical inactivity, which is equivalent to approximately 1.1 days per worker. The cost of the production loss from sickness and early retirement due to physical inactivity to the Danish economy was estimated at between EUR 400 and 900 million per year, equivalent to between 0.2% and 0.4% of GDP.<sup>175</sup>

The costs due to physical inactivity (health care costs, economic output forgone due to illness and morbidity, sick leave and pre-mature death) in England that the Impact Assessment uses as a basis to **calculate economic benefits** amount to €61 per inhabitant (chapter 5.2). While figures are not directly comparable, this can be seen as a realistic basis for the calculation, as in other countries studies estimated a similar or higher amount. In Hungary<sup>176</sup> all physical inactivity-related diseases were assessed to cost €1.1bn in 2009 (283.5bn HUF, exchange rate 1EUR/265HUF), or €110 per inhabitant (population 10 million). A study on the

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<sup>168</sup> K. Abu-Omar, A. Rütten, V. Lehtinen, International Journal of Public Health, Volume 49, Issue 5, pp 301-309, August 2004.

<sup>169</sup> The Lancet, Volume 380, Issue 9838, pages 192-193, 21 July 2012.

<sup>170</sup> *ibid.*

<sup>171</sup> <http://www.euro.who.int/en/what-we-do/health-topics/diseases-and-conditions/obesity>

<sup>172</sup> WHO Europe (2007): A European framework to promote physical activity for health, p. 9. URL: [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0020/101684/E90191.pdf](http://www.euro.who.int/__data/assets/pdf_file/0020/101684/E90191.pdf)

<sup>173</sup> K I Proper, S G van den Heuvel, E M De Vroome, V H Hildebrandt and A J Van der Beek: Dose–response relation between physical activity and sick leave. *Br. J. Sports Med.* 2006;40:173-178

<sup>174</sup> *Risikofaktorer og folkesundhed i Danmark. [Risk factors and public health in Denmark]*. Copenhagen, Statens Institut for Folkesundhed, 2006. English summary available at: [http://www.si-folkesundhed.dk/upload/2745\\_-\\_risk\\_factors\\_and\\_public\\_health\\_in\\_denmark.pdf](http://www.si-folkesundhed.dk/upload/2745_-_risk_factors_and_public_health_in_denmark.pdf)

<sup>175</sup> The higher and lower estimates correspond to alternative approaches to estimating the production loss, namely the human capital method and the friction method. GDP data is based on Eurostat.

<sup>176</sup> [http://unipub.lib.uni-corvinus.hu/440/1/Kszemle\\_CIKK\\_1259.pdf](http://unipub.lib.uni-corvinus.hu/440/1/Kszemle_CIKK_1259.pdf)

cost of physical inactivity in Australia<sup>177</sup> estimated direct health expenditure of about €0.93bn (\$1.5bn, exchange rate \$1/0.62EUR) in 2006 attributable to physical inactivity, or €46 per inhabitant (population 20.4 million). In Switzerland<sup>178</sup> insufficient physical activity is responsible for direct and indirect costs of €1.63bn (2.4bn CHF, exchange rate 1CHF/0.68EUR in 2003), or €23 per inhabitant (population 7.3 million in 2001). According to a Norwegian study in 2002, the cost of inactivity including medical treatment costs and to a varying degree production losses and loss of welfare amounts to 980 Euro per person per year.”<sup>179</sup> In Austria<sup>180</sup> costs (including direct costs in healthcare, work absence, early retirement, pension payments) of €3.3bn were estimated for 2010 due to physical inactivity, or €93 per inhabitant (population 8.4 million).<sup>181</sup>

In light of the above, according to experts, the issue of physical inactivity is being described as “**pandemic, with far-reaching health, economic, environmental and social consequences**” (The Lancet series Volume 380, Issue 9389, of 21 July 2012).

## 10.2. The persistent lack of physical activity in the EU

The **rates of physical inactivity in the EU remain alarmingly high**. The available data shows that the vast majority of Europeans do not engage in sufficient HEPA, a trend that has not shown much improvement in general terms.

Already in 2003, an **EU-wide survey on physical activity** showed that 41% of EU-15 residents had not engaged in any *moderate* physical activity (which includes e.g. carrying light loads, cycling at a normal pace) in the last seven days, and 57% reporting they had not engaged in any *vigorous* physical activity (which includes e.g. lifting heavy things, digging, aerobics or fast cycling).<sup>182</sup> When the survey was repeated in 2006, the results were very similar; the proportion of those who had not undertaken any *moderate* physical activity remained unchanged at 41%, although there was a small improvement in *vigorous* activity (with the proportion of those who had not undertaken any vigorous activity going down to 54%).<sup>183</sup>

More recent **EU-wide data** focusing exclusively on physical activity does not exist, but similar surveys **on sport and physical activity** suggest that the overall trend remains unchanged. In an EU-wide survey taken in 2004, for example, 53% of respondents claimed to exercise or play sport *seldom* (i.e. less than once per

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<sup>177</sup> [http://www.medibank.com.au/Client/Documents/Pdfs/pyhsical\\_inactivity.pdf](http://www.medibank.com.au/Client/Documents/Pdfs/pyhsical_inactivity.pdf)

<sup>178</sup> [http://sgsm-ssms.ch/ssms\\_publication/file/79/7-2001-3.pdf](http://sgsm-ssms.ch/ssms_publication/file/79/7-2001-3.pdf)

<sup>179</sup> Study carried out by the Norwegian Institute of Transport Economics in 2002 (cost-benefit analysis taking into account the health consequences of cycling and walking), <http://www.cycle-helmets.com/denmark.pdf>.

<sup>180</sup> [http://www.bso.or.at/fileadmin/Inhalte/Dokumente/Turnstunde/Praesentation\\_Studie\\_Turnstunde.pdf](http://www.bso.or.at/fileadmin/Inhalte/Dokumente/Turnstunde/Praesentation_Studie_Turnstunde.pdf)

<sup>181</sup> For Ireland, the economic cost of physical inactivity have recently stated to be “over €300 million per annum”. IE Presidency Conference, 8/3/2013.

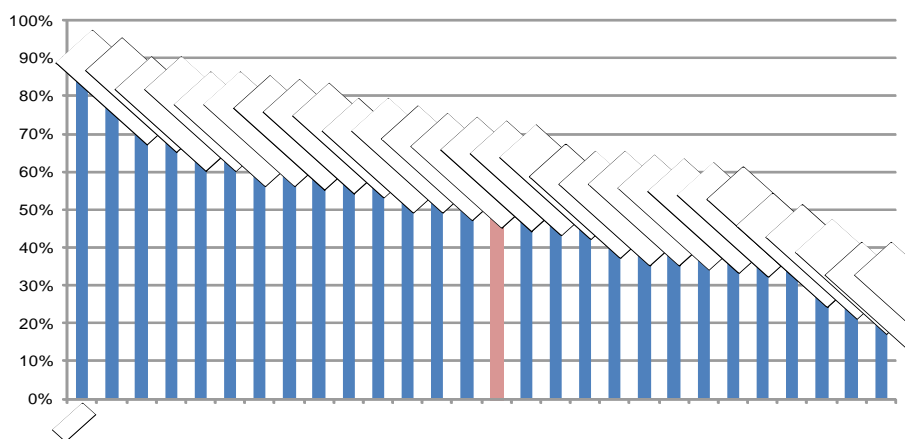
<sup>182</sup> European Commission: Special Eurobarometer 183-6 (December 2003). URL: [http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_183\\_6\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_183_6_en.pdf).

<sup>183</sup> European Commission: Special Eurobarometer 246 (November 2006). URL: [http://ec.europa.eu/health/ph\\_publication/eb\\_food\\_en.pdf](http://ec.europa.eu/health/ph_publication/eb_food_en.pdf).

week) or *never*, a figure that even grew to 60% of respondents by 2010.<sup>184</sup> The latest survey also demonstrates vast discrepancies between individual Member States. In Sweden and Finland, more than 70% of respondents ‘exercise or play sport’ *regularly* or *with some regularity* (i.e. at least once per week), while in Greece and Bulgaria the figure is below 20%.

The graph below illustrates these disparities by highlighting the prevalence of lacking physical activity in all Member States. It demonstrates that the countries with the **highest inactivity rates are all in Southern and Eastern Europe**.<sup>185</sup>

*Figure 1: Europeans claiming to exercise ‘seldom or never’*



Source: Eurobarometer 334 Sport and Physical Activity (QF., page 10)

The differences between countries are also confirmed by a European survey carried out in 2010<sup>186</sup> addressing several aspects of the health of European Citizens. Physical activity patterns were looked at within the chapter "Healthy Life Style Awareness and Practice" that inter alia investigated particular occasions when people could get physical exercise. The level of activity varies with the occasion, and **strong contrasts occur between countries**. Activity is done by over 50% of Europeans: When on the go – going from one place to another; and When "in and around the home". But only a minority of Europeans claim to exercise as part of their recreational activities (about 40% having "some" or "a lot" / decreased since 2006), consciously dedicating some free time to exercising; and scores are even lower for activity at work. Results suggests that exercising for its own purpose – during recreational activities – is not improving, and remains a hobby for the wealthier social classes, as well as for young people.

<sup>184</sup> Special Eurobarometer 213 (November 2004) and 334 (March 2010). To be noted: While some of the increase between 2004 and 2010 can be attributed to the inclusion of Bulgaria and Romania to the latter survey, it is clear that sport / exercise rates fell overall.

<sup>185</sup> In response to these findings, the PT government has been looking for new policy strategies and programmes that could overcome these results and improve sport and physical activity participation, contributing to enhance health and well-being across generations (XG SHP meeting, July 2013).

<sup>186</sup> Special Eurobarometer 329 on health determinants: [http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_329\\_sum\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_329_sum_en.pdf).

The above Eurobarometer survey illustrates that lack of leisure-time physical activity tends to be more common in the lower socio-economic groups – these people tend to die at a younger age and to have, within their shorter lives, a higher prevalence of all kinds of health problems. The above survey indeed suggests that socioeconomically disadvantaged groups, such as early school leavers and people with financial problems, are far more likely to be physically inactive: 64% of people who had left the education system by the age of 15, and 56% of those who have trouble meeting financial obligations, never exercise or play sport (compared to 35% of Europeans who never have difficulty meeting financial obligations).

Regarding the elderly, a 2012 Special Eurobarometer on active ageing<sup>187</sup> highlights that although the majority of respondents believes their country and local area are “age-friendly”, most agree that it could be improved with regard to facilities for **older people** to stay fit and healthy (42%). In general, respondents from Southern countries and new Member States (e.g. CY 65%, EL 55%, SK 61%, SI 59%) stressed the lack of facilities as the main improvement most needed in their local area.

With regard to **children's** participation in daily physical activity, evidence suggests that many children do not meet the recommended guidelines of at least 60 minutes of moderate-to-vigorous physical activity daily<sup>188</sup>. Some of the factors influencing the levels of physical activity undertaken by adolescents include the availability of space and equipment, the child's present health conditions, their school curricula and other competing pastimes. Only one-in-five children in EU Member States report that they undertake moderate-to-vigorous exercise regularly<sup>189</sup>, according to results from the 2009-10 HBSC survey. It is of concern that physical activity tends to fall between ages 11 to 15 for most European countries. Daily moderate-to-vigorous physical activity for 2005-06 and 2009-10 averaged across 21 EU Member States has decreased for both boys and girls, and in all age groups, except boys aged 15 years.

**National data on HEPA rates** serves both to confirm such general trends, and also to highlight the significant differences between Member States. Because surveys are conducted using different methodologies, asking different questions under different timeframes, it is not possible to compare nationally generated physical activity data directly.<sup>190</sup> However, a look at data from individual countries reveals some interesting trends, in particular that some Member States have made considerable progress, while many others have made none or even regressed.

For example, a joint health monitor project in the **Baltic States and Finland** showed that, between 1998 and 2008, “Leisure-time physical activity and

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<sup>187</sup> [http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_378\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_378_en.pdf)

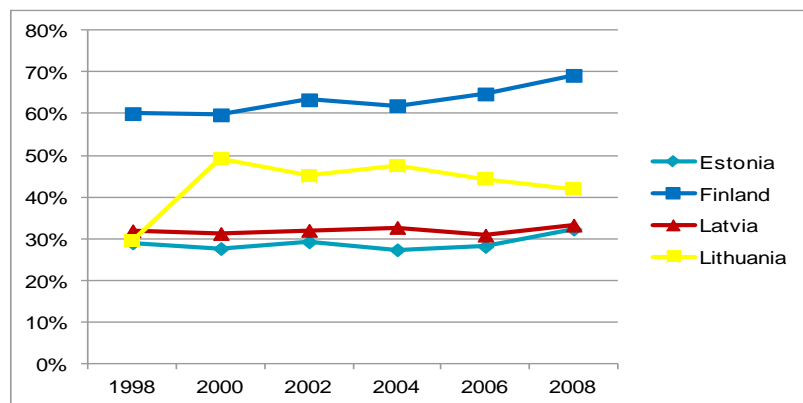
<sup>188</sup> Strong et al., 2005; Borraccino et al., 2009; Hallal et al., 2012.

<sup>189</sup> Health at the Glance 2012 (OECD): <http://www.oecd-ilibrary.org/sites/9789264183896-en/02/04/index.html;jsessionid=97t37ei8gnkj.x-oecd-live-02?contentType=&itemId=/content/chapter/9789264183896-23-en&containerItemId=/content/serial/23056088&accessItemIds=/content/book/9789264183896-en&mimeType=text/html>

<sup>190</sup> [http://www.euro.who.int/\\_data/assets/pdf\\_file/0005/148784/e95584.pdf](http://www.euro.who.int/_data/assets/pdf_file/0005/148784/e95584.pdf).

commuting physical activity have remained nearly at the same level for 10 years in all of the Baltic countries [Estonia, Latvia and Lithuania]. Finland was the only country where some increase in the level of leisure-time physical activity was found from 1998 to 2008.”<sup>191</sup> (See the table hereafter.)

*Figure 2: Evolution of leisure-time physical activity in Finland and the Baltic States*



*Trends of age-standardised prevalence of those who exercised twice a week or more in leisure time from 1998 to 2008; average of men and women (%). Source: FINBALT*

Regular surveys in **England** reveal a significant increase in the proportion of those who meet government recommendations for the minimum level of physical activity to achieve health benefits, from 27% in 1998 to 36% in 2008.<sup>192</sup> The number of those meeting government recommendations for HEPA in **Ireland** has also risen slightly, from 38% in 1998 to 41% in 2007.<sup>193</sup> In **France**, a study carried out in 2000 and in 2010 for people aged 15-75 identified a modest increase in the participation rates for almost all ‘families of activities and activities’ (including walking, swimming, gymnastics, cycling).<sup>194</sup> However, in **Italy** the proportion of the population that meets the minimum recommended physical activity levels stagnated between 2007 and 2009 (at 33%), and the percentage of those who are classified as “sedentary” (and undertake no physical activity at all) has even increased slightly, from 28% to 30% of the population.<sup>195</sup>

<sup>191</sup> THL — Report 25/2011: Social Determinants of Health Behaviours Finbalt Health Monitor 1998–2008, p 82. URL: <http://www.thl.fi/thl-client/pdfs/f316c417-cc1d-48e6-a2e2-7389fde28630>.

<sup>192</sup> Department of Health: Health Survey for England. URL: [www.dh.gov.uk/en/publicationsandstatistics/publishedsurvey/healthsurveyforengland/healthsurveyresults/index.htm](http://www.dh.gov.uk/en/publicationsandstatistics/publishedsurvey/healthsurveyforengland/healthsurveyresults/index.htm)

<sup>193</sup> Department of Health and Children: Survey of Lifestyle, Attitudes and Nutrition in Ireland, 2008. Regarding sport, the Chief Executive of the Irish Sports Council noted at the IE Presidency Conference on 7/3/2013 “the proportion that is ‘highly active’ adults increased from 26% to 30% between 2009 and 2011. (...) We acknowledge that there is a major challenge in keeping the rates at high level and that it is a sustained increase in engagement in sport and not a short term phenomena.”

<sup>194</sup> Les principales activités physiques et sportives pratiquées en France en 2010: [http://www.sports.gouv.fr/IMG/pdf/Stat\\_Info\\_no11-02\\_de\\_novembre\\_2011.pdf](http://www.sports.gouv.fr/IMG/pdf/Stat_Info_no11-02_de_novembre_2011.pdf)

<sup>195</sup> Ministry of Health: Behaviour Risk Factor surveillance system (PASSI). Annual reports 2007, 2008 and 2009. URL: <http://www.epicentro.iss.it/passi/sorvRisultatiNazionale.asp>

While this data is not directly comparable across countries<sup>196</sup>, it provides a clear indication that some Member States have had a degree of success in achieving increases in physical activity, while policy in many others has failed to produce the desired results.

Examples from different EU Member States show indeed that there are **successful interventions and practices to learn from**.<sup>197</sup> This is inter alia also reflected in the EU Physical Activity Guidelines that showcase best practice examples from the national level for each of the guidelines themes (i.e. sport, health, education, transport, environment, urban planning and public safety, working environment and services for senior citizens).<sup>198</sup> There are many other sources referring to efficient interventions in EU Member States focusing on specific target groups (e.g. youth<sup>199</sup>, elderly people<sup>200</sup>).

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<sup>196</sup> The English data refers to those who report 30 minutes or more of *moderate or vigorous* activity on at least five days per week. The IE data refers to the percentage reporting *moderate and/or strenuous* exercise three or more times per week for at least 20 minutes. The IT data includes those who either carry out "hard labour" (*lavoro pesante*) or meet government PA guidelines (30 minutes of *moderate* PA on five or more days per week, or more than 20 minutes of *vigorous* PA on at least three days per week).

<sup>197</sup> For instance a recent BBC report (14/12/2012) 'Why are Swedish women healthier than the British?' illustrated how successful SE has been in engaging females in sport and physical activity.

<sup>198</sup> [http://ec.europa.eu/sport/library/documents/c1/eu-physical-activity-guidelines-2008\\_en.pdf](http://ec.europa.eu/sport/library/documents/c1/eu-physical-activity-guidelines-2008_en.pdf)

<sup>199</sup> E.g. <http://www.euro.who.int/en/what-we-publish/abstracts/young-and-physically-active-a-blueprint-for-making-physical-activity-appealing-to-youth>

<sup>200</sup> E.g. [http://www.eunaapa.org/Products/Best\\_Practice\\_Reports/](http://www.eunaapa.org/Products/Best_Practice_Reports/)

## 11. ANNEX III: MONITORING FRAMEWORK AND PROPOSED TABLE OF INDICATORS

### 11.1. Introduction

This annex contains two elements:

- An overview of indicators proposed for the monitoring of the implementation of the EU Physical Activity Guidelines as an element for a future Commission initiative on HEPA;
- Additional information on the main existing information sources, databases and publications for a future monitoring framework.

This work was prepared by the study team, i.e. Economisti Associati srl (Lead Firm), The Evaluation Partnership (Partner), University of Zurich (sub-contractor), VU University Medical Center, Amsterdam (sub-contractor), and has been discussed at the EU expert and policy levels (see also Annex I "Consultations").

### 11.2. Identifying indicators to monitor the implementation of the EU PA GL (in line with the preferred policy option in the IA)

#### Definitions

Policy development and implementation comprises different elements which ideally should be captured by a comprehensive monitoring. In general, four different aspects of policy can be distinguished<sup>201</sup>:

- *Process* – comprising e.g. agenda-setting and formulation of a policy as well as administrative arrangements (coordination mechanisms to foster cross-sectoral cooperation, funding, responsibilities, budget etc.)
- *Outputs* – all physical, informal or service products of a policy, such as programs, community projects, information campaigns or courses carried out, coordination groups formed, etc., as well as the existence of a policy itself
- *Outcome* – directly policy-related changes in conditions, e.g. raised awareness, knowledge, political commitment or capacity to address the issue (e.g. in terms of new workforce trained) and change in behaviours
- *Impacts* – totality of - intentional or unintentional - effects, including also more distal changes, e.g. health effects.

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<sup>201</sup> Rossi P, Lipsey MW, Freeman H (2004): Evaluation: a systematic approach. 7th ed., Newbury Park, California: Sage Publications. Nutbeam D, Bauman A (2006): Evaluation in a Nutshell. Australia: Mc-Graw Hill.

The aspect of possible impacts of the EU PA GL are already addressed in the main part of the IA and will therefore be less of a focus here; however, some discussed indicators might relate to impacts as well, and there will be iterations and cross-fertilisation across the two tasks in this regard.

Indicators are a commonly used tool to assess the process and results of policies and programmes. It is therefore important to bear in mind the key principles for a “good” indicator, including<sup>202</sup>:

- Validity – it measures what it is supposed to measure, and at the desired level
- Clarity – it is unambiguous and clear what data is needed to measure it
- Objectivity – anyone reviewing the indicator should reach the same conclusion about progress
- Sensitivity – it is able to capture change at a realistic level, and for different sub-groups, if relevant
- Action orientation – it is addressing issues that are of relevance to the topic and amenable to change
- Feasibility – the necessary data is available and accurate or affordable to collect

### **Overview of work carried out**

The first step consisted of identifying successful national strategies, of collating relevant recent work through desk research as well as of familiarization interviews. This work addressed, amongst others, experiences regarding evaluation and monitoring of national policies relevant to the EU PA GL, problems that have prevented optimum implementation of the EU PA GL and expectations and concerns regarding the foreseen monitoring and evaluation of the EU PA GL.

In addition, available information sources and databases of relevance with regard to monitoring and evaluation of the EU PA GL were collated. The work revealed several relevant existing information sources and one key database, namely the WHO Regional Office for Europe’s Nutrition, Obesity and Physical Activity (NOPA) database.

The main aim of the second step was to define the scope, objectives and expected results of the evaluation of the implementation of the EU PA GL. As presented above, a monitoring scheme could have predominantly focused on process and output, or also try to address outcome and impacts. In addition, the level of detail

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<sup>202</sup> Based on: Government Assessment Portal: What makes a "good" governance indicator? (<http://www.gaportal.org/how-to/define-and-select-indicators/what-makes-good-governance-indicator>)



as well as direct attribution of Member States actions to the EU PA GL needed to be taken into account. Based on the work, three possible approaches to develop indicators for the monitoring of the EU Physical Activity Guidelines were identified:

(3) Indicators on direct effects of the EU PA GL

This would consist of a monitoring of action taken by Member States as a direct effect of the EU PA GL

(4) Indicators on thematic areas of the EU PA GL

This would include a limited number of indicators covering the thematic areas of the GL, but not covering every single guideline.

(5) Detailed indicators on all 41 guidelines

This would include a detailed monitoring of the implementation of all 41 guidelines of the EU PA GL.

Direct attribution of MS actions to the EU PA GL as foreseen in approach 1) would have faced a number of conceptual, methodological and logistical difficulties and in addition was not considered a priority of the Commission. With regard to approach 3), it was considered unlikely that all EU MS would implement all 41 sub-guidelines of the EU PA GL universally as their political priority setting, cultural approach to HEPA promotion and available resources would lead to a different priority setting. It was decided that indicators on the implementation of the EU PA GL for inclusion in a future Council Recommendation on HEPA should focus on a more aggregate level of information and more general aspects that can be expected to be more universally addressed by most or all EU Member States.

In addition, an initial analysis of the EU PA GL also revealed that many of the 41 Guidelines did not lend themselves easily to the development of specifically related indicators. Oftentimes, the guidelines contained several elements which would need to be addressed by different indicators. This was likely to lead to a very high total number of indicators. Moreover, not all guidelines had been formulated specifically and unambiguously enough to be directly measurable. Therefore, approach 3) was considered both impractical and methodologically problematic.

Therefore, **it was decided to develop indicators on thematic areas of the EU PA GL as proposed in approach 2)**, leading both to a manageable number of indicators and an acceptable level of detail with regard to monitoring the implementation of the EU PA GL. This approach was the basis for the preferred policy option (Option C) in the Impact assessment.

The third step of the work aimed at developing a finalised list of proposed indicators including a detailed description of the proposed methodology for their collection. The availability of information and data sources will be an important aspect to be considered, and new indicators will be defined where appropriate. The

proposed list of indicators was developed with the input of experts and consulted in expert fora, with the policy level and with stakeholders.

Amended versions of the list of proposed indicators were presented and discussed at the following meetings:

- 2<sup>nd</sup> and 3<sup>rd</sup> meeting of the Expert Group "Sport, Health and Participation" (XG SHP), 21 March and 27 June 2012
- Informal meeting of EU Sport Directors, 31 May – 1 June 2012
- Meeting of the High-level Group on Nutrition and Physical Activity, 14 June 2012<sup>203</sup>
- Expert seminar at EU Sport Forum 2012 in Cyprus, 19 September 2012

The comments received were taken into account in the further development of the proposed list of indicators.

#### **Indicator ideas which were not included into the proposed framework**

The reasons are laid down hereafter.

- *Indicators on the directly attributable effects of the EU PA GL* (e.g. knowledge on its existence, specific actions taken as a direct consequence etc.)

It was not deemed necessary to assess attribution, but it was decided that the framework should focus on assessing actions, which were in line with and inspired by the directions of the EU PA GL.

- "Sport for all" addressed in existing national HEPA policies

This indicator idea was not deemed feasible, as it would have required a content analysis of national HEPA policies. In addition, the other proposed indicators on this topic were deemed more useful and feasible.

- Programmes to increase traffic safety for pedestrians and cyclists

Even though the topic was deemed an important one, such an indicator was not regarded as being feasible to implement in the near future.

- Expansion of green spaces and play areas in urban areas

Assessment of data availability revealed limited feasibility at this time.

- Expansion of cycle and walking lanes

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<sup>203</sup> General approach to develop a monitoring framework presented but not the detailed list of indicators.

Assessment of data availability revealed limited feasibility at this time and consultation showed concerns regarding assessing infrastructure.

- *Promotion of better urban design to provide safe and attractive structures everyday physical activity, cycling and walking, e.g. through Healthy Urban Planning or indicator on Health Impact Assessments and whether they include active transport aspects*

Based on initial findings of a study on behalf of DG MOVE on “Harmonised collection of European data and statistics in the field of urban transport and mobility”, the necessary data on such indicators would not be available. Albeit considered important, they were therefore not included into the proposed list of indicators on grounds of limited feasibility.

- Awareness raising campaign as integrated part of an overarching national HEPA promotion strategy

The more generic indicator on the existence of an awareness raising campaign was deemed more useful and feasible.

- Inclusion of vocational training as a further category to indicator no. 14 (Physical education in primary and secondary schools)

Not included as other forms of tertiary level education are also not included and formal vocational training does not exist in many EU countries.

In addition, two proposed indicators on the guidelines no. 40 and no. 41 on an EU HEPA network (namely whether annual meetings take place and whether stable financial support was available for the HEPA Europe – EU Contact Group) were removed from the indicators table as it was felt they were not relevant for Member States and were more appropriately addressed by internal reporting; in this sense they would remain part of the monitoring framework but would not be listed in the indicators table.

In the final review of the proposed indicators table, three indicators ("Concerted action of national, regional and local level", "Funding allocated to HEPA-specific research", "National alliance for physical activity promotion amongst sedentary older people"), despite their value for evaluation of policies, were removed, because of the limited sources and in an effort to decrease administrative burden.

### **11.3. Overview of proposed indicators for the monitoring of the implementation of the EU PA GL**

The table below summarises the proposed list of indicators on the thematic areas of the EU PA GL. As the EU PA GL are mainly addressed to the national administration or other public authorities, indicators usually address this level and not actions or knowledge of all possible stakeholders or the general public. Exceptions were only made where thematic areas of the GLs specifically named responsible stakeholders outside the administration. In some cases, possible

integration of sub-national information is considered in view of the decentralized political and government structure of some Member States with regard to sport or health.

In the section following the table, the proposed methodology for each indicator is described. Key data sources are presented in more detail in chapter 3.

Table 1 – Proposed indicators to evaluate the implementation of the EU Physical Activity Guidelines

Thematic areas of the GL	Proposed indicators	Variables/units	Sources
“International PA recommendations and guidelines” (guidelines 1-2)	1. National recommendation on physical activity for health	Yes/no	NOPA
	2. Adults reaching the minimum WHO recommendation on physical activity for health	Percentage of adults reaching a minimum of 150 minutes of moderate-intensity physical activity per week, or 75 minutes of vigorous-intensity activity, or an equivalent combination	WHO global health data observatory or European Health Interview Survey (EHIS) Information on national surveys: NOPA
	3. Children and adolescents reaching the minimum WHO recommendation on physical activity for health	Percentage of children and adolescents reaching at least 60 minutes of mode-rate- to vigorous-intensity physical activity daily or on at least 5 days / week	Health behaviour in school-aged children survey (HBSC)
	4. National coordination mechanism on HEPA promotion	Yes/no; if yes: - Name? Since when in place? - Which sectors and stakeholders are participating (pre-defined list) - Which is the leading institution? - Has funding been allocated to this coordinating mechanism? If yes: o total funding; o per capita; o by gross domestic product at PPP per capita, in Euros	WHO/Commission Monitoring project (all items but information on funding can be included in the future)
“Cross-sectoral approach” (guidelines 3-5)	5. Funding allocated specifically to HEPA promotion	By sector (health, sport, transport etc.): - total funding; - per capita; - by gross domestic product at PPP per capita, in Euros	HEPA PAT for 5 EU countries Future monitoring by Expert Group ‘Sport, Health and Participation’
	6. National sport for all policy and/or action plan	Yes/no; if yes: name, status, issuing body, policy areas covered, web-link.	NOPA
	7. Sport Clubs for Health Programme	Implementation of the guidelines developed by HEPA Europe/TAFISA project: yes/no; if yes, description	Future monitoring by EU Expert Group ‘Sport, Health and Participation’*
	8. Framework to support opportunities to increase access to recreational or exercise facilities for low socio-economic groups	Existence of a framework: yes/ foreseen within the next 2 years/no; and if yes, description	WHO/Commission Monitoring project <sup>+</sup> (in the future also foreseen to ask on existences of a specific framework)
“Sport” (guidelines 6-13)			

Thematic areas of the GL	Proposed indicators	Variables/units	Sources
"Health" (guidelines 14-20)			Guidelines developed by IMPALA project <sup>§</sup>
	9. Target groups addressed by the national HEPA policy	By target group (groups in particular need of physical activity, e.g. low socio-economic groups, people with low levels of PA, elderly, ethnic minorities etc.)	NOPA (except for people with low levels of PA; this could be included in the future)
	10. Monitoring and surveillance of physical activity	Physical activity included in the national health monitoring system: yes/no If yes: name of the survey, year, measured items, age groups, socioeconomic, link to survey	WHO/Commission Monitoring project <sup>†</sup>
	11. Counselling on physical activity	Counselling on physical activity: yes / no If yes: reimbursed as part of primary health care services: yes/no	Partly in NOPA (information on existence of a scheme, but not yet on reimbursement, this could be included in the future)
	12. Training on physical activity in curriculum for health professionals	- number of hours for nurses, doctors <sup>**</sup> - mandatory or optional - clear assessment and accreditation structures to reflect the learning outcomes of the subject	Partly in WHO/Commission Monitoring project <sup>†</sup> (hours not collected but foreseen to be pilot-tested in next data collection)
	13. Physical education in primary and secondary schools	- number of hours per school level - mandatory or optional - national or sub-national regulation	Eurydice reporting WHO/Commission Monitoring project <sup>†</sup> (hours not yet collected but foreseen to be pilot-tested in next data collection)
"Education" (guidelines 21-24)	14. Schemes for school-related physical activity promotion	Existence of a national or sub-national (where relevant <sup>§§</sup> ) scheme Yes/no - active school breaks - active breaks during school lessons - after-school HEPA programmes (at schools, at sport clubs, in communities)	Not yet available, future monitoring by Expert Group 'Sport, Health and Participation' <sup>**</sup>
	15. HEPA in training of physical education teachers	HEPA being a module in training of PE teachers at bachelor's and/or master's degree level: yes/no; mandatory/optional	Partly in WHO/Commission Monitoring project <sup>†</sup> (relating to teacher training to promote PA in general, new information foreseen to be pilot-tested in next data collection)
	16. Schemes promoting active travel to school	National or sub-national (where relevant <sup>§§</sup> ) schemes to promote active travel to school	WHO/Commission Monitoring project <sup>†</sup> (information on existence of a scheme,

Thematic areas of the GL	Proposed indicators	Variables/units	Sources
“Environment, urban planning, public safety” (guidelines 25-32)	17. Level of cycling / walking	(e.g. walking buses, cycling): Yes/no, if yes: description Main mode of transport used for your daily activities (car, motorbike, public transport, walking, cycling, other)	but further information as provided by countries) Flash Eurobarometer or EHIS (wave 2)
	18. European Guidelines for improving Infrastructures for Leisure-Time Physical Activity	European Guidelines for improving Infrastructures for Leisure-Time Physical Activity (addressing sport infrastructure, leisure-time infrastructure and urban and green spaces) being applied systematically to plan, build and manage infrastructures: Yes / not yet but foreseen within the next 2 years / no	Guidelines developed by IMPALA project <sup>§</sup> Future monitoring by Expert Group ‘Sport, Health and Participation’*
“Working environment” (guidelines 33-34)	19. Schemes to promote active travel to work	Existence of a national or sub-national (where relevant <sup>¶</sup> ) incentive scheme for companies or employees to promote active travel to work (e.g. walking, cycling): yes/no, if yes: description	WHO/Commission Monitoring project <sup>†</sup> (information on existence of a scheme, but further information as provided by countries)
	20. Schemes to promote physical activity at the work place	Existence of a national or sub-national (where relevant <sup>¶</sup> ) incentive scheme for companies to promote physical activity at the work place (e.g. gyms, showers, walking stairs etc.): yes/no	Partly in WHO/Commission Monitoring project <sup>†</sup> Exchange to be sought with WHO Global Plan of Action on Workers’ health 2008-2014
“Senior citizens” (guidelines 35-37)	21. Schemes for community interventions to promote PA in elderly people	Existence of a scheme for community interventions to promote PA in elderly people Yes/no, if yes: description	Initial information collected through EUNAAPA project in 15 countries in 2007/2008 <sup>°</sup> Possible future information from 2012 EC-funded projects “European Partnerships on Sport” (active ageing) Future monitoring by Expert Group ‘Sport, Health and Participation’*
	22. National HEPA policies that include a plan for evaluation	x out of y national HEPA policies (sport, health, transport, environment, by sector) include a clear intention or plan and plan for evaluation	Based on national policies in NOPA database, complemented by sector-specific targeted information collections
“Public awareness” (guideline 39)	23. Existence of a national awareness raising campaign on physical activity	Yes/no, if yes: description	WHO/Commission Monitoring project <sup>†</sup>

- # Sub-national level only for countries with a decentralized or federal structure, otherwise only national level will be considered.
- \* Not yet included in monitoring by the EU Expert Group 'Sport, Health and Participation' but could possibly be included in the future with limited additional reporting burden to Member States.
- The Sport Clubs for Health Programme Guidelines were developed as a joint HEPA Europe/TAFISA project supported under the Preparatory action in the field of sport in 2010 (see also <http://www.kunto.fi/en/home/>).
- + Information collected in the country information templates for the WHO/Commission project on "Monitoring progress on improving nutrition and physical activity and preventing obesity in the EU", but the information is not yet directly available in the NOPA database (i.e. it is available offline in the templates as completed by the national focal points in 2008/9).
- For more information see <http://www.eunaapa.org>. Initial inventory of good practices and recommendations compiled as part of the EC-funded EUNAAPA project in 2007/2008 in 14 EU MS and Norway, available at [http://www.eunaapa.org/media/cross-national\\_report\\_expert\\_survey\\_on\\_pa\\_programmes\\_and\\_promotion\\_strategies\\_2008\\_.pdf](http://www.eunaapa.org/media/cross-national_report_expert_survey_on_pa_programmes_and_promotion_strategies_2008_.pdf).
- § For more information on the EC-funded project "Improving infrastructure for leisure time physical activity in the local arena" (IMPALA) see: [http://www.impala-eu.org/fileadmin/user\\_upload/IMPALA\\_guideline\\_draft.pdf](http://www.impala-eu.org/fileadmin/user_upload/IMPALA_guideline_draft.pdf)
- # For more information see project on "Building Policy Capacities for Health Promotion through Physical Activity among Sedentary Older People" (PASEO), funded by the Public Health programme in 2009-2010, <http://www.paseonet.org> and [http://ec.europa.eu/eahc/documents/news/PASEO\\_National\\_Alliances.pdf](http://ec.europa.eu/eahc/documents/news/PASEO_National_Alliances.pdf).



#### **11.4. Operationalization, methodology and data by proposed indicator**

In this section the proposed methodology for each of the 23 indicators is described in more detail. The key data sources are presented in chapter 11.5.

##### ***Indicator 1: National recommendation on physical activity for health***

###### ***What does this indicator tell us?***

National recommendations on how much physical activity the population should carry out to achieve health benefits serves as a benchmark for progress made to promote physical activity and is an important element of a national strategy to promote physical activity.

###### ***Definitions and operationalization***

A national recommendation on physical activity and health is an officially adopted national statement on the duration, intensity and frequency of physical activity behaviour that the population should reach. Recommendations issued by non-governmental bodies, which have not been officially endorsed by the national government, are not considered a national recommendation. Sub-national recommendations are only included for countries with a decentralized government structure, such as for federal states.

###### **Operationalization:**

Does a national recommendation on physical activity and health exist in your country, i.e. an officially adopted statement on the duration, intensity and frequency of physical activity behaviour that the population should reach?

Yes / no

If yes:

Currently being developed / not foreseen for development in the next 2 years

For adults / for young people / for elderly people

###### ***Data sources and methods used***

Information on this indicator has been collected through a joint WHO/Commission project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”. It is available in the European database on nutrition, obesity and physical activity (NOPA), an internet-based information and reporting system to describe and monitor progress diet, nutrition and physical activity in the fight against obesity (see also chapter 3).

## Geographic and temporal coverage

The project's "National Information Focal Persons" from 44 of the 53 WHO Member States responsible to collate all necessary information from the relevant ministries and institutions filled in reporting templates in 2009 and 2010. Information on national recommendations was updated in 2011 and is available for about 40 of 53 Member States.

## Frequency of update

An update of the information collection for NOPA is foreseen for 2012/2013; further updates depend on future funding.

## *References*

- Global recommendations on physical activity for health. Geneva, World Health Organization, 2010 (<http://www.who.int/dietphysicalactivity/global-PA-recs-2010.pdf>).
- WHO European database on nutrition, obesity and physical activity (NOPA). Copenhagen, WHO Regional Office for Europe, 2010 (<http://data.euro.who.int/nopa/default.aspx>, accessed 21 June 2012).

## ***Indicator 2: Adults reaching the minimum WHO recommendation on physical activity for health***

### ***What does this indicator tell us?***

Reaching the minimum recommendations is related to specific health benefits as identified by extensive scientific research. Thus, the proportion of adults reaching these recommendations illustrates the share of the adult population being sufficiently physically active not to risk negative health consequences related to insufficient physical activity.

### ***Definitions and operationalization***

The minimum WHO recommendation on physical activity for health for adults is as follows:

*Adults should do at least 150 minutes of moderate-intensity aerobic physical activity throughout the week, or do at least 75 minutes of vigorous-intensity aerobic physical activity throughout the week, or an equivalent combination of moderate- and vigorous-intensity activity.*

#### Operationalization:

Percentage of adults reaching at least 150 minutes of moderate-intensity aerobic physical activity throughout the week, or an equivalent of vigorous-intensity physical activity, or a combination of moderate- and vigorous-intensity activity.

Adults are often defined as 18–64 years olds but age ranges can differ and may in some countries also include the elderly. The minimum WHO recommendation for over 64-year olds is the same as for adults (but additional elements are recommended).

### ***Data sources and methods used***

#### *Internationally comparable data*

There are two potential data sources of international data for this indicator: 1) The Global Health Observatory of the WHO contains internationally comparable estimates on this indicator; and 2) the European Health Interview Survey (EHIS). For the second wave of EHIS (to be conducted in 2014) Commission Regulation 141/2013<sup>204</sup> was adopted and consequently these data will have to be used for the monitoring framework.

#### *- Global Health Observatory*

Description of method used for comparable estimates (source see references):

*For comparable estimates of insufficient physical activity, surveys were included that presented sex- and age-specific prevalence with sample sizes (minimum: n=50), using the definition of not meeting any of the following criteria: at least 30 minutes of moderate-intensity activity per day on at least 5 days per week, or at least 20 minutes of vigorous-intensity activity per day on at least 3 days per week, or an equivalent combination. Only surveys were included that captured activity across all domains of life including work/household, transport and leisure time. Data had to come from a random sample of the general population, with clearly indicated survey methods.*

*In order to report comparable data for a standard year (2008) and standard age groups, adjustments were made for over-reporting of the International Physical Activity Questionnaire (IPAQ) (1-3) coverage (urban and rural), and age coverage of the survey. Using regression modelling techniques, crude adjusted prevalence values were produced for 5-year age groups, and then combined for ages 15+ years, using country population estimates. To further enable comparison among countries, age-standardized comparable estimates were produced. This was done by adjusting the crude estimates to an artificial population structure, the WHO Standard Population, that closely reflects the age and sex structure of most low and middle-income countries. This corrects for the differences in age and sex structure between countries. Uncertainty in estimates was analysed by taking into account sampling error and uncertainty due to statistical modelling.*

Data are presented as crude and age-standardized estimates, by sex and as total.

#### *- European Health Interview Survey (EHIS)*

The EHIS instrument used in the first wave (2007/2010) was a questionnaire which was based on the IPAQ (short version) to measure the proportion of populations performing moderate and vigorous physical activity (days and/or hours per week), derived from the

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<sup>204</sup> Commission Regulation 141/2013 of 19 February 2013 on EHIS: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2013:047:0020:0048:EN:PDF>. A derogation for the Netherlands was granted for the physical activity variables.

following questions (PE.1-6): During the past 7 days, a) days and time devoted to vigorous physical activities, b) days and time devoted to moderate physical activities, c) days and time spent walking. However, the EHIS wave 1 instrument used a different phrasing for the questions on time spent in vigorous or moderate activities than in the original IPAQ. Therefore, the exact measurement specifications for reliability, validity and specificity of the EHIS wave 1 questionnaire are unknown. In addition data on physical activity from the first wave of EHIS is only available for 12 countries. For EHIS wave 2 the variables and the questionnaire has been revised. The resulting outcome indicators of the EHIS wave 2 instrument cover three public-health-relevant domains of physical activity: (A) work-related physical activity, (B) transportation (commuting) activity, and (C) leisure-time physical activity. The new instrument is based on the framework of the Global Physical Activity Questionnaire (GPAQ) using a modified version of the current question from the Behaviour Risk Factor Surveillance System (BRFSS) to assess work-related physical activity, the current NHIS-PAQ question to assess muscle-strengthening physical activity and modified versions of the GPAQ questions to assess transportation physical activity, and leisure-time physical activity. In addition, it is designed to measure compliance with the new WHO physical activity recommendations for the adult population aged 18-64.

Data is foreseen to be available by country, calendar year, sex, age groups (15-64, 65+, or others) and socio-economic status (educational level, ISCED aggregated groups, etc.). Eurostat can also calculate age-standardized EHIS data.

#### Information on national surveys

Information on available national surveys in all EU countries on levels of physical activity in adults has been collected through a joint WHO/Commission project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”. The information is included in the European database on nutrition, obesity and physical activity (NOPA) and will become available for the public before the summer 2013. An initial analysis published in the summary has shown that data from national surveys are usually not easily comparable across countries as they use different questionnaires and methodologies.

#### Geographic and temporal coverage

In the Global Observatory, data for 2008 is presented for all EU countries as well as some neighbouring countries, including Croatia, Iceland, Norway, Poland, Serbia, Switzerland and others).

Data on physical activity from the first wave of EHIS is available for 12 countries. The second wave is foreseen for implementation in all EU countries following the 2013 Commission Regulation on EHIS.

The national data from the WHO/Commission project is available for all EU countries and is covering largely varying time frames, as available on national level.

#### Frequency of update

Updates of the global observatory are foreseen to take place about every 2 to 3 years.

The EHIS is foreseen to be carried out every 5 years. MS are requested to provide micro data for the reference year 2014 (or 2013 or 2015 for some countries) to be made available at the latest by 30/9/2015 or 9 months after the end of the national data collection period in cases where the survey is carried out beyond 12/2014.

An update of information on national surveys is foreseen for 2012/2013; further updates depend on future funding.

### *Comments*

With regard to the vigorous-intensity part of the recommendations it has to be noted that the global recommendations on physical activity for health recommend 75 minutes per week. The Global Health Observatory of the WHO used the definition of at least 20 minutes of vigorous-intensity activity per day on at least 3 days per week. Both definitions can be used by countries; the exact definition is to be reported along with the data

EHIS (wave 1) used the definition of percentage of the population practising at least 30 minutes of physical activity (moderate or intense) per day. The second wave of EHIS was adapted to include 8 basic variables on physical activity taking into account WHO recommendations of 2011.<sup>205</sup>

### *References*

- Global recommendations on physical activity for health. Geneva, World Health Organization, 2010 (<http://www.who.int/dietphysicalactivity/global-PA-recs-2010.pdf>, accessed 20 April 2012).
- International Physical Activity Questionnaire (IPAQ) [website]. The IPAQ group (<https://sites.google.com/site/theipaq/home>, accessed 20 April 2012).
- Global Health Observatory: Prevalence of insufficient physical activity [website]. Geneva, World Health Organization, 2012 ([http://www.who.int/gho/ncd/risk\\_factors/physical\\_activity\\_text/en/index.html](http://www.who.int/gho/ncd/risk_factors/physical_activity_text/en/index.html), accessed).
- Global Health Observatory Data Repository (see Noncommunicable diseases, risk factors, physical inactivity) [website]. Geneva, World Health Organization, 2012 (<http://apps.who.int/ghodata/>, accessed 20 April 2012).
- European Health Interview Survey (EHIS wave 1) Questionnaire – English version. Brussels, European Commission EUROSTAT and Partnership on Public Health Statistics Group HIS, 2006 ([http://ec.europa.eu/health/ph\\_information/implement/wp/systems/docs/ev\\_20070315\\_ehis\\_en.pdf](http://ec.europa.eu/health/ph_information/implement/wp/systems/docs/ev_20070315_ehis_en.pdf), accessed 1 November 2012).

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<sup>205</sup> [http://www.who.int/dietphysicalactivity/factsheet\\_adults/en/index.html](http://www.who.int/dietphysicalactivity/factsheet_adults/en/index.html)

- Commission Regulation (EU) No 141/2013 of 19 February 2013 implementing Regulation (EC) No 1338/2008 of the European Parliament and of the Council on Community statistics on public health and health and safety at work, as regards statistics based on the European Health Interview Survey (EHIS); <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2013:047:0020:0048:EN:PDF>
- WHO European database on nutrition, obesity and physical activity (NOPA). Copenhagen, WHO Regional Office for Europe, 2010 (<http://data.euro.who.int/nopa/default.aspx>, accessed 21 June 2012).
- Report of the workshop on integration of data on physical activity patterns. Zurich, Switzerland, 25–26 February 2009. WHO/Commission Project on monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union. Report no. 4. Copenhagen, WHO Regional Office for Europe, 2010 ([http://www.euro.who.int/\\_data/assets/pdf\\_file/0004/87430/E93705.pdf](http://www.euro.who.int/_data/assets/pdf_file/0004/87430/E93705.pdf)).

### ***Indicator 3: Children and adolescents reaching the minimum WHO recommendation on physical activity for health***

#### ***What does this indicator tell us?***

Reaching the minimum recommendations is related to specific health benefits as identified by extensive scientific research. Thus, the proportion of children and adolescents reaching these recommendations illustrates the share of the young population being sufficiently physically active not to risk negative health consequences related to insufficient physical activity.

#### ***Definitions and operationalization***

The minimum WHO recommendation on physical activity for health for children and adolescents is as follows:

*Children and youth should accumulate at least 60 minutes of moderate- to vigorous-intensity physical activity daily.*

#### **Operationalization:**

Percentage of children and adolescents reaching at least 60 minutes of moderate- to vigorous-intensity physical activity (MVPA) daily or on at least 5 days per week (the 2005/2006 HBSC analysis - see *Data sources* below - used daily activity as the cut-off point, the 2001/2002 used daily activity).

As part of the WHO's European Environment and Health Information System (ENHIS), a fact sheet on "Percentage of physical active children and adolescents" was produced for which a special analysis of the data from the 2001/2002 survey was conducted using 60 minutes of MVPA on at least five days a week as cut-off point to allow for comparison of the results with those obtained from the 2001/2002 survey.

Children and adolescents have been defined as aged 5 to 17 years in the WHO Global Recommendations on Physical Activity for Health but this can differ and the exact age range used by countries is to be reported along with the data.

### ***Data sources and methods used***

The Health Behaviour in School-Aged Children (HBSC) study collects data on this indicator in 11, 13 and 15 year olds. It uses an internationally standardised questionnaire that has been validated against objective measurements in a US sample. To date, no internationally comparable data on younger children is available, and due to different instruments used, national data are often not comparable.

### **Geographic and temporal coverage**

Twenty-five EU countries participate in the study, as listed on the HBSC website (see references below). Data on physical activity in youth was collected in 2001/2001, 2005/2006 and 2009/10.

### **Frequency of update**

HBSC surveys are carried out at four-year intervals.

### ***References***

- The Health Behaviour in School-Aged Children: WHO Collaborative Cross-National Study (HBSC) [website]. St Andrews, The University of St Andrews, 2002 (<http://www.hbsc.org>, accessed 23 April 2012).
- A fact sheet fact sheet on “Percentage of physically active children and adolescents”. WHO’s European Environment and Health Information System (ENHIS). Copenhagen, WHO Regional Office for Europe, 2009 ([http://www.euro.who.int/data/assets/pdf\\_file/0012/96987/2.4.-Percentage-of-physically-active-children-EDITED\\_layoutedV2.pdf](http://www.euro.who.int/data/assets/pdf_file/0012/96987/2.4.-Percentage-of-physically-active-children-EDITED_layoutedV2.pdf), accessed 23 April 2012).

## ***Indicator 4: National coordination mechanism on HEPA promotion***

### ***What does this indicator tell us?***

HEPA promotion needs to take an intersectoral approach to be successful. Coordinated and concerted action of all relevant sectors is crucial to avoid duplication or contradictory action. The existence of a national coordination mechanism shows that steps have been taken to promote concerted action across sectors.

### ***Definitions and operationalization***

In order to ensure coordinated action of all relevant government sectors and stakeholders, some countries have installed a national coordination mechanism. Such a mechanism can for example take the form of an informal working group, an advisory body or a formal intersectoral government body. In order to be applicable for this indicator, the body must have a clear mandate on the promotion of physical activity, and not focus mainly on NCDs, obesity or other areas.

Stakeholder: any person, group or organisation who holds an important or influential community position, and who might have an interest, investment or involvement in the issue being investigated. Stakeholders include people in government and other positions of power at a national, regional or city level; local policy makers and service providers, people in the community where projects may be introduced; and people who may benefit (or lose out in some way) from the intervention

#### **Operationalization:**

Has a specific coordinating mechanism (e.g. working group, advisory body, coordinating institution etc) been developed for HEPA promotion in your country?

Yes / no.

If yes:

What is the name of the body?

Since when is it in place?

Which stakeholders are participating (pre-defined list)

Which is the leading institution?

Has funding been allocated to this coordinating mechanism?

If yes, how much (in EUR)?

1) total funding;

2) funding per capita;

3) funding by gross domestic product at PPP per capita.

### ***Data sources and methods used***

Information on this indicator has been collected in 2009 and 2010 for all items but information on funding (which could be included in the future) through a joint WHO/Commission project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”. It is available publicly in the



European database on nutrition, obesity and physical activity (NOPA). A summary of the available information as at 2010 has been published.

#### Geographic and temporal coverage

The WHO/Commission project's "National Information Focal Persons" responsible to collate all necessary information from the relevant ministries and institutions filled in reporting templates in 2009 and 2010. Information is available from 44 of the 53 WHO Member States, including all EU countries.

#### Frequency of update

An update of the information collected for NOPA is foreseen for 2012/2013; further updates depend on the new structures to be set up as part of the proposed Recommendation on HEPA and the related funding.

#### ***References***

- WHO European database on nutrition, obesity and physical activity (NOPA). Copenhagen, WHO Regional Office for Europe, 2010 (<http://data.euro.who.int/nopa/default.aspx>, accessed 21 June 2012).
- Review of physical activity promotion policy development and legislation in European Union Member States. WHO/Commission Project on monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union. Report no. 10. Copenhagen WHO Regional Office for Europe, 2010 ([http://www.euro.who.int/\\_data/assets/pdf\\_file/0015/146220/e95150.pdf](http://www.euro.who.int/_data/assets/pdf_file/0015/146220/e95150.pdf), accessed 4 July 2012).

#### ***Indicator 5: Funding allocated specifically to HEPA promotion***

##### ***What does this indicator tell us?***

Financial resources allocated specifically to HEPA promotion is a strong indicator of the importance a country attaches to this topic within its policy agenda. Broken down into the sources from which the funding comes from also gives an indication on the 'intersectorality' of a country's approach.

##### ***Definitions and operationalization***

HEPA promotion includes all forms of physical activity that are beneficial for health without undue harm or risk, i.e. health, sport, transport, environment or leisure time approaches.

##### Operationalization:

Yearly funding (in Euros) allocated specifically to HEPA promotion.

Sources from all relevant sectors have to be included; it is preferable to report data by sector, including if possible information on the development of funding over the last 5 years if reported for the first time. In general, only national funding from government sources should be included; in countries with a decentralized and/or federal structure, sub-national funding can be included if relevant.

To correct for country size and economic development, information has to be reported as: 1) total funding; 2) funding per capita; 3) funding by gross domestic product at purchasing power parity per capita.

In cases where it is not possible at the current stage to report quantitative information, the state of funding can be described qualitatively, including if possible information on the development of funding over the last 5 years if reported for the first time.

### *Data sources*

Information on this indicator has been collected in 7 countries within the framework of a project of the HEPA Europe working group on “National approaches to physical activity” on the HEPA Policy Audit Tool (PAT) – see above and chapter 3. The PAT provides a protocol and method for a detailed compilation and communication of country level policy responses on physical inactivity.

In the future, the information would need to be collected by questionnaire through the Expert Group on “Sport, Health and Participation” (XG SHP).

### Geographic and temporal coverage

So far, information is available for 2010 for Finland, Italy, Norway, the Netherlands, Portugal, Slovenia, and Switzerland from the HEPA PAT project.

The XG SHP is supposed to cover all EU countries.

### Frequency of update

An update of NOPA is foreseen for 2012/2013; further updates depend on future funding. The Expert Group monitoring frequency of update can be further defined, based on need and feasibility.

### *References*

- Gross domestic product based on purchasing-power-parity (PPP) per capita GDP:  
World Economic Outlook Database. Washington, International Monetary Fund, 2012 (<http://www.imf.org/external/pubs/ft/weo/2012/01/weodata/index.aspx>, accessed 21 April 2012).  
World Development Indicators database, Washington, World Bank, 2012

(<http://databank.worldbank.org/ddp/home.do?Step=12&id=4&CNO=2>, accessed 21 April 2012).

- Bull FC, Milton K, Kahlmeier S. Health-enhancing physical activity (HEPA) policy audit tool. Copenhagen, WHO Regional Office for Europe, 2011 ([www.euro.who.int/hepat](http://www.euro.who.int/hepat), accessed 21 April 2012).

### ***Indicator 6: National Sport for All policy or action plan***

#### ***What does this indicator tell us?***

Sport promotion is a crucial part of a comprehensive HEPA promotion strategy, provided that it includes a strong focus on Sport for All approaches and does not mainly favour elite sports. The development of a national Sport for All policy or action plan illustrates such a focus.

#### ***Definitions and operationalization***

Sport for All: refers to the systematic provision of opportunities for physical activity that are accessible for everybody.

Policy: written document that contains strategies and priorities, define goals and objectives, and is issued by a part of the administration. It may also include an action plan on implementation.

Action plan: usually prepared according to a policy and strategic directions and should ideally define who does what, when, how, for how much, and have a mechanism for monitoring and evaluation.

#### **Operationalization:**

Does your country have a national policy and/or a national action plan on Sport for All promotion? Alternatively, is Sport for All addressed specifically in other policy documents?

Yes / no.

If yes, please provide: name, year of publication, status (adopted, final version, draft version), issuing body, policy areas covered, web link to the document.

#### ***Data sources***

Information on this indicator has been collected in 2009 and 2010 through a joint WHO/Commission project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”. Information on sport policies has been complemented through the joint WHO/DG EAC project NET-SPORT-HEALTH which analysed sport policies in the European region, with a focus on synergies between sport and health policies. The data is available in the European database on nutrition, obesity and

physical activity (NOPA), an internet-based information and reporting system to describe and monitor progress diet, nutrition and physical activity in the fight against obesity (see also chapter 3).

#### Geographic and temporal coverage

The WHO/DG SANCO project's "National Information Focal Persons" responsible to collate all necessary information from the relevant ministries and institutions filled in reporting templates in 2009 and 2010. Information is available from 44 of the 53 WHO Member States, including all EU countries.

The NET-SPORT-HEALTH project collected information in 2010, receiving replies from 20 of the 27 EU countries.

#### Frequency of update

An update of the information collected for NOPA is foreseen for 2012/2013; further updates depend on future funding.

#### **References**

- WHO European database on nutrition, obesity and physical activity (NOPA). Copenhagen, WHO Regional Office for Europe, 2010 (<http://data.euro.who.int/nopa/default.aspx>, accessed 21 June 2012).
- Promoting sport and enhancing health in European Union countries: a policy content analysis to support action. Copenhagen, WHO Regional Office for Europe, 2011 (<http://www.euro.who.int/en/what-we-do/health-topics/disease-prevention/physical-activity/publications/2011/promoting-sport-and-enhancing-health-in-european-union-countries-a-policy-content-analysis-to-support-action>, accessed 7 July 2012).
- Christiansen N, Kahlmeier S, Racioppi F: Sport promotion policies in the European Union: results of a contents analysis. *Scandinavian Journal of Medicine and Science in Sports*, in press.
- Review of physical activity promotion policy development and legislation in European Union Member States. WHO/Commission Project on monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union. Report no. 10. Copenhagen WHO Regional Office for Europe, 2010 ([http://www.euro.who.int/\\_data/assets/pdf\\_file/0015/146220/e95150.pdf](http://www.euro.who.int/_data/assets/pdf_file/0015/146220/e95150.pdf), accessed 4 July 2012).

#### **Indicator 7: Sport Clubs for Health Programme**

*What does this indicator tell us?*

Sport promotion is an important part of a comprehensive HEPA promotion strategy and sport clubs, the backbone of the sport movement, can make an important contribution to address low levels of physical activity in Europe. However, an analysis of current approaches has shown that the link between sport and health promotion can be further strengthened. The Sport Clubs for Health Programme has been specifically designed to support Sport Clubs in providing programmes with a stronger health promotion approach.

### ***Definitions and operationalization***

**Sport Club:** the basic local functional unit of many sport systems, usually voluntary civic-organisations in which people engage in sport.

**Sport Club for Health (SCforH):** an approach in which sport clubs are encouraged to invest into health-related sport activities and /or health promotion within sport activities. Health-oriented sport clubs recognises health in their activities. Health promotion is not the main orientation, but has been recognised as one of the main operating principles.

**Guidelines for SCforH:** a manual has been developed as part of a HEPA Europe/TAFISA working group, supported by a grant of DG EAC as part of the "2009 Preparatory action in the field of sport".

#### **Operationalization:**

Are the Sport Clubs for Health Guidelines implemented in sport clubs in your country?

Yes / no

If yes: description of implementation activities (outline of number of sport clubs that implement the programme, support provided from the national or sub-national level for the implementation of the programme, existence of a coordinator and if yes, contact information for further information).

### ***Data sources***

Data on this indicator is not yet being collected. The information could be collected by questionnaire through the Expert Group on "Sport, Health and Participation" (XG SHP).

#### **Geographic and temporal coverage**

Data should be collected from all EU countries by year. The XG SHP is supposed to cover all EU countries.

Data should be updated yearly.

### ***References***

- Sport Clubs for Health project. Helsinki, Finnish Sport for All Association, 2011 (<http://www.kunto.fi/en/sports-club-for-health/>, accessed 7 July 2012).
- Kokko S, Oja P, Foster C, Koski P, Laalo-Haikio E, Savola J (Eds.): Sports Club for Health – Guidelines for health-oriented sports activities in a club setting. Nurmijarvi, Finnish Sport for All Association, 2011 ([http://www.kunto.fi/@Bin/463608/SCforH\\_Guidelines.pdf](http://www.kunto.fi/@Bin/463608/SCforH_Guidelines.pdf), accessed 7 July 2012).
- Sport clubs for health (<http://www.euro.who.int/en/what-we-do/health-topics/disease-prevention/physical-activity/activities/sport-clubs-for-health>, accessed 7 July 2012). Copenhagen, WHO Regional Office for Europe.

***Indicator 8: Framework to support offers to increase access to exercise facilities for socially disadvantaged groups***

***What does this indicator tell us?***

While low levels of physical activity are widespread across Europe, they are particularly prevalent in low socio-economic groups. This is of particular concern as often, detrimental health behaviours are clustered within these groups, such as unhealthy nutrition, inactivity and smoking. Thus, addressing such groups by targeted approaches is crucial from a health, social and economic point of view. Classic sport or health promotion approaches are often not sufficient to reach such groups. Providing specific frameworks addressing low socio-economic groups is therefore indicative of the recognition of this problem and the willingness to invest into particular activities directed at such groups.

***Definitions and operationalization***

Socially disadvantaged groups: groups of the society which are disadvantaged with regard to socio-economic aspects (income, socio-economic status, education or employment), age and social determinants such as gender, ethnicity, culture or religion.

Framework to support offers to increase access to recreational or exercise facilities: such frameworks can take different forms, such as a specific national or sub-national programme on this topic, incentive schemes to address such aspects within existing facilities or the development of specifically designed offers.

Recreational facilities: include buildings or places that provide services aimed specifically at spending leisure time outside of work or school or home duties. This can include sport/exercise facilities, leisure time infrastructure and urban and green spaces (e.g. gyms, public pools, parks, cycling paths, water fronts, woods, play grounds, etc.).

Exercise facilities: include buildings or places that provide services aimed specifically at being physically active to improve health or wellbeing.

**Operationalization:**

Does a specific framework exist to support offers to increase access to recreational or exercise facilities for socially disadvantaged groups in your country?

Yes / foreseen within the next 2 years / no

If yes: please describe the nature of the framework (name, year(s) of implementation, expansion across the country, leading institution, funding).

### *Data sources*

As part of the joint WHO/Commission project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”, information was collected on whether there was a specific focus on disadvantaged social or socioeconomic groups in a list of 42 activities, programmes and strategies of national governments addressing, amongst others, active transport, physical activity and sport promotion and education in physical activity. Information on the existence of a specific national or sub-national framework was not specifically collected but is foreseen for the next data collection. The information is not yet available in the European database on nutrition, obesity and physical activity (NOPA), an internet-based information and reporting system to describe and monitor progress diet, nutrition and physical activity in the fight against obesity.

### Geographic and temporal coverage

The project’s “National Information Focal Persons” responsible to collate all necessary information from the relevant ministries and institutions filled in reporting templates in 2009 and 2010. Information is available from 44 of the 53 WHO Member States, including all EU countries.

### Frequency of update

An update of the information collection for NOPA is foreseen for 2012/2013; further updates depend on future funding.

### *References*

- Reporting template 1 (2009). WHO/Commission Project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”. Copenhagen, WHO Regional Office for Europe, 2009.

### ***Indicator 9: Target groups addressed by the national HEPA policy***

#### *What does this indicator tell us?*

There are notable differences in levels of physical activity and sport participation between different socioeconomic and cultural subgroups of populations in European countries. It is

thus important to develop target-group specific activities as part of an overall national HEPA promotion policy. Evidence of a specific focus on different target groups is thus illustrative of the recognition of the need to devise target-group specific action in order to achieve an overall increase in physical activity levels.

### ***Definitions and operationalization***

Policy: written document that contains strategies and priorities, define goals and objectives, and is issued by a part of the administration. It may also include an action plan on implementation.

HEPA promotion policy: a policy aimed at increasing health-enhancing physical activity, i.e. any type of a physical activity that is beneficial to one's health bearing minimum risks. It can include health, sport, transport or environmental approaches.

#### Operationalization:

Which target groups does / do the national or sub-national (where relevant, i.e. in countries with a decentralized or federal structure) HEPA promotion policy/policies address, especially regarding groups in particular need of physical activity (e.g. low socio-economic groups, people with low levels of physical activity, elderly people, ethnic minorities etc.)?

### ***Data sources***

As part of the joint WHO/Commission project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”, information was collected on all items of this indicator except for groups with low levels of physical activity (which could be included in the future). The information is available publicly in the European database on nutrition, obesity and physical activity (NOPA) for each policy document except for groups with low levels of physical activity.

The project on “Improving Infrastructures for leisure-time physical activity in the local arena” (IMPALA), which received support by the Commission, developed guidelines on planning, building, financing, and managing infrastructures for leisure-time physical activity with a special focus on social equity. Aspects highlighted include an assessment of whether existing infrastructure policies support social equity, the use of participatory approaches in infrastructure planning, the consideration of social equity issues in the design of new infrastructures, the use of financing mechanisms that reduce entry barriers, and the use of facility management models that improve access for socially disadvantaged groups.

#### Geographic and temporal coverage

The WHO/Commission project's “National Information Focal Persons” responsible to collate all necessary information from the relevant ministries and institutions filled in reporting templates in 2009 and 2010. Information is available from 44 of the 53 WHO Member States, including all EU countries.



IMPALA Project: The guidelines were developed based on information collected in 11 EU countries and Norway in 2009 and 2010.

### Frequency of update

An update of the information collected for NOPA is foreseen for 2012/2013; further updates depend on future funding.

### *References*

- WHO European database on nutrition, obesity and physical activity (NOPA). Copenhagen, WHO Regional Office for Europe, 2010 (<http://data.euro.who.int/nopa/default.aspx>, accessed 21 June 2012).
- Proposed European guidelines: Improving infrastructures for leisure-time physical activity in the local arena. Towards social equity, intersectoral collaboration and participation. Erlangen Nürnberg, Friedrich-Alexander-University of Erlangen-Nuremberg and Institute of Sport Science and Sport, 2010 ([www.impala-eu.org/fileadmin/user\\_upload/IMPALA\\_guideline\\_draft.pdf](http://www.impala-eu.org/fileadmin/user_upload/IMPALA_guideline_draft.pdf), accessed 9 July 2012).

## ***Indicator 10: Monitoring and surveillance of physical activity***

### ***What does this indicator tell us?***

Knowledge on the levels and trends of physical activity over time are a crucial pre-requisite to develop a comprehensive, targeted national strategy to increase physical activity. Inclusion of physical activity into the national health monitoring and surveillance system is an important indication of the recognition of its importance as a health determinant and policy area.

### ***Definitions and operationalization***

National health monitoring and surveillance system: systematic collection, consolidation, analysis and dissemination of data on the health status of the population for use in public health action to reduce morbidity, mortality and to improve health.

#### Operationalization:

Does your country have an established surveillance or health monitoring system that includes population-based measures of physical activity?

Yes / no.

If yes, please provide survey name and year(s), measured items (frequency, duration, intensity, cycling/walking, sedentary behaviour), age groups and socio-economic items

covered, link to survey.

### ***Data sources***

Information on this indicator was collected as part of the joint WHO/Commission project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”. The information is not yet available publicly through the European database on nutrition, obesity and physical activity (NOPA) but is foreseen for inclusion.

### **Geographic and temporal coverage**

The WHO/Commission project’s “National Information Focal Persons” responsible to collate all necessary information from the relevant ministries and institutions filled in reporting templates in 2009 and 2010. Information is available from 44 of the 53 WHO Member States, including all EU countries.

### **Frequency of update**

An update of the information collected for NOPA is foreseen for 2012/2013; further updates depend on future funding.

### ***References***

- Reporting template 1 (2009). WHO/Commission Project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”. Copenhagen, WHO Regional Office for Europe, 2009.

## ***Indicator 11: Counselling on physical activity***

### ***What does this indicator tell us?***

Individualized counselling on and prescription of physical activity can increase physical activity levels. Thus, it can be suitable in an ordinary primary health care setting to promote a more physically active lifestyle, in particular in target groups that are otherwise difficult to reach. As it has been shown that it can be difficult to encourage health care providers to include yet another topic into their general counselling activities, financial incentives can be provided. For example, physicians in primary health care can be financially rewarded for encouraging patients to move more. Including counselling on physical activity into, for example, schemes of insurance providers allows defining and monitoring quality criteria related to the processes and outcomes of counselling programmes.

### ***Definitions and operationalization***

#### **Operationalization:**

Does a programme or scheme to promote counselling on physical activity exist in your country?

Yes / no.

If yes, is it reimbursed as part of primary health care services, e.g. by insurance companies? Please provide information on the programme or scheme to promote counselling.

### *Data sources*

As part of the joint WHO/Commission project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union” information was collected on this indicator, in particular whether such a scheme was a) not existing, or not clearly stated in any policy document, and not planned within 2 years; b) clearly stated, partly implemented or enforced; or c) clearly stated and entirely implemented and enforced. No information on reimbursement schemes was collected but this could be included in the future. The information is not yet available publicly in the European database on nutrition, obesity and physical activity (NOPA) but foreseen for inclusion.

### Geographic and temporal coverage

The WHO/EC's project's “National Information Focal Persons” responsible to collate all necessary information from the relevant ministries and institutions filled in reporting templates in 2009 and 2010. Information is available from 44 of the 53 WHO Member States, including all EU countries.

### Frequency of update

An update of the information collected for NOPA is foreseen for 2012/2013; further updates depend on future funding.

### *References*

- Reporting template 1 (2009). WHO/Commission Project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”. Copenhagen, WHO Regional Office for Europe, 2009.

## ***Indicator 12: Training on physical activity in curriculum for health professionals***

### *What does this indicator tell us?*

Health professionals can play an important role in advocating for physical activity and as facilitators between health insurance providers, their members or clients, and providers of physical activity programmes. To fulfil this role, they need to be appropriately trained on

physical activity and health matters. This indicator illustrates the degree to which this topic is addressed in their curricula.

### ***Definitions and operationalization***

Number of hours of training in curriculum for health professionals (nurses, doctors) addressing physical activity, and whether mandatory or optional

#### Operationalization:

- (a) Is physical activity and health (health effects, determinants, effective interventions etc.) taught in a module of the curriculum of medical doctors?

Yes / no

If yes: provide more information:

- on the number of hours of the respective module (or give a range of hours in case of different sub-national programmes, or give a qualitative description)
- if the respective course is mandatory or optional
- if there are clear assessment and accreditation structures to reflect the learning outcomes on the subject.

- (b) Is physical activity and health (health effects, determinants, effective interventions etc.) taught in a module of the curriculum of nurses?

Yes / no

If yes: provide more information:

- on the number of hours of the respective module (or give a range of hours in case of different sub-national programmes, or give a qualitative description)
- if the respective course is mandatory or optional
- if there are clear assessment and accreditation structures to reflect the learning outcomes on the subject.

### ***Data sources***

Within the framework of a joint WHO/Commission project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”, some information on this indicator has been collected in 2009 and 2010. The reporting template asked if “physical activity was included in the curriculum of health professionals training” (programme not existing, or not clearly stated in any policy document, and not planned within 2 years / clearly stated, partly implemented or enforced / clearly stated and

entirely implemented and enforced). Further information as suggested above was not collected but is foreseen to be included as a pilot-test into the next round of data collection. The information is not yet available in the European database on nutrition, obesity and physical activity (NOPA), an internet-based information and reporting system to describe and monitor progress diet, nutrition and physical activity in the fight against obesity but foreseen for publication.

#### Geographic and temporal coverage

The WHO/Commission project's "National Information Focal Persons" responsible to collate all necessary information from the relevant ministries and institutions filled in reporting templates in 2009 and 2010. Information is available from 44 of the 53 WHO Member States, including all EU countries.

#### Frequency of update

An update of the information collection for NOPA is foreseen for 2012/2013; further updates depend on future funding.

#### *References*

- Reporting template 1 (2009). WHO/Commission Project on "Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union". Copenhagen, WHO Regional Office for Europe, 2009.

### ***Indicator 13: Physical education in primary and secondary schools***

#### *What does this indicator tell us?*

Schools are an important setting to enhance physical activity of young people. School-based physical education contributes to levels of physical activity and to improve motor skills. In the last years, physical education lessons were reduced in some countries due to economic or academic pressures. This indicator provides an overview of amount of physical education provided at different age ranges.

#### *Definitions and operationalization*

##### Operationalization:

- (c) What is the number of hours of physical education provided in primary schools?
- Are all of them or part of them mandatory or optional?
  - Has this number of hours changed over the last 3 years?

- Please provide a qualitative overview in case of sub-national regulations of physical education at schools.
- (d) What is the number of hours of physical education provided in secondary schools?
- Are all of them or part of them mandatory or optional?
  - Has this number of hours changed over the last 3 years?
  - Please provide a qualitative overview in case of sub-national regulations of physical education at schools.

### *Data sources*

The Eurydice Network provides information on and analyses of European education systems and policies. Information on physical education as a percentage of taught time has been included in key data on education, which was published last in 2012. Absolute numbers of hours of physical education taught in compulsory education are included in the annual reports on taught time, last in 2011/2012. The absolute has also been covered in the framework of a joint WHO/Commission project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”, some information on this indicator has been collected in 2009 and 2010. The reporting template asked on “mandatory inclusion of physical education in the curriculum of primary and secondary school pupils” (not existing, or not clearly stated in any policy document, and not planned within 2 years / clearly stated, partly implemented or enforced / clearly stated and entirely implemented and enforced). Further information as suggested above was not collected but is foreseen to be pilot-tested in the next round of data collection. The information is not yet available in the European database on nutrition, obesity and physical activity (NOPA), an internet-based information and reporting system to describe and monitor progress diet, nutrition and physical activity in the fight against obesity but foreseen for publication.

### Geographic and temporal coverage

As from 2013 the Eurydice network consists of 40 national units based in all 36 countries participating in the EU's Lifelong Learning programme (EU Member States, EFTA countries, Croatia, the former Yugoslav Republic of Macedonia, Montenegro, Serbia, and Turkey). It is co-ordinated and managed by the EU Education, Audiovisual and Culture Executive Agency in Brussels, which drafts its studies and provides a range of online resources.

The WHO/Commission project's “National Information Focal Persons” responsible to collate all necessary information from the relevant ministries and institutions filled in reporting templates in 2009 and 2010. Information is available from 44 of the 53 WHO Member States, including all EU countries.

### Frequency of update

Key data on Education (including information on physical education) is published every three years. Taught time diagrams are published annually. The next edition will be published for the academic year 2012/2013.

An update of the information collection for NOPA is foreseen for 2012/2013; further updates depend on future funding.

### **References**

- Reporting template 1 (2009). WHO/C Project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”. Copenhagen, WHO Regional Office for Europe, 2009.

### **Indicator 14: Schemes for school-related physical activity promotion**

#### ***What does this indicator tell us?***

Schools are an important setting to enhance physical activity of young people. While school-based physical education is an important contribution, it is only provided a few times per week and thus, additional school-related physical activity offers are crucial to contribute to the recommended at least one hour of daily physical activity for young people. This indicator gives an overview of the provision of selected offers of school-related physical activity promotion.

#### ***Definitions and operationalization***

Active school breaks: provision of offers and appropriate infrastructure to support young people to include physical activity into their school breaks, including e.g. walking paths around school ovals, adequate playground facilities or access to equipment.

Active breaks during school lessons: structured brief activity sessions during school lessons to break up longer sitting periods.

After-school HEPA promotion programmes (at schools, at sport clubs or in communities): provision of offers and appropriate infrastructure as well as access to community infrastructure (e.g. bowling club, aquatic centre, cycling arena etc.) to support young people to include physical activity into their after-school programme. This can also include sports homework.

#### **Operationalization:**

Existence of a national or sub-national (where relevant, i.e. in countries with a decentralized or federal structure) scheme for:

- (e) active school breaks
- (f) active breaks during school lessons
- (g) after-school HEPA promotion programmes (at schools, at sport clubs or in communities)

Yes / no

If yes, please provide a brief description of the scheme(s) (lead institution, main contents, funders, spread).

### ***Data sources***

Data on this indicator is not yet being collected. The information could be collected by questionnaire through the Expert Group on “Sport, Health and Participation” (XG SHP).

### Geographic and temporal coverage

Data should be collected from all EU countries by year. The XG SHP is supposed to cover all EU countries.

### Frequency of update

Information on this indicator should be updated every 2 to 3 years.

## ***Indicator 15: HEPA in training of physical education teachers***

### ***What does this indicator tell us?***

Through the provision of regular physical education (PE) classes, PE teachers play an important role with regard to the promotion of physical activity and sport in young people and as role models. It is thus important that they are fully trained on the broader concept of HEPA, including all forms inside and outside the sport arena and not only on classic sport approaches which are often not adequate to reach those young people most in need of more activity. This indicator illustrates to which degree the broader HEPA topic is addressed in the training of PE teachers.

### ***Definitions and operationalization***

HEPA promotion: includes all forms of physical activity that are beneficial for health without undue harm or risk, including sport, health, transport, environment or leisure time approaches.

### Operationalization:

Is HEPA a module in the training curriculum of PE teachers at bachelor's and/or master's degree level?

Yes / no

If yes: is this module mandatory or optional?



Please provide a qualitative overview in case of sub-national regulations on teacher training.

### *Data sources*

Within the framework of a joint WHO/Commission project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”, information on general teacher training to promote physical activity has been collected in 2009 and 2010. Specific information on PE teacher training has not been collected but is foreseen to be pilot-tested in the next round of data collection.

### Geographic and temporal coverage

The WHO/Commission project’s “National Information Focal Persons” responsible to collate all necessary information from the relevant ministries and institutions filled in reporting templates in 2009 and 2010. Information is available from 44 of the 53 WHO Member States, including all EU countries.

### Frequency of update

An update of the information collection for NOPA is foreseen for 2012/2013; further updates depend on future funding.

### *References*

- Reporting template 1 (2009). WHO/Commission Project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”. Copenhagen, WHO Regional Office for Europe, 2009.

## ***Indicator 16: Schemes promoting active travel to school***

### *What does this indicator tell us?*

Active transport, i.e. walking, cycling, rollerblading, kick-boarding etc., is increasingly recognised as an important possibility to increase overall physical activity. It could be illustrated in different countries that young people who travel to school in a physically active way are also overall more physically active. This indicator informs on the existence of schemes to promote active school travel.

### *Definitions and operationalization*

Active travel: all non-motorised forms of travel to school, walking, cycling, rollerblading, kick-boarding etc. In most countries, the most prevalent forms will be walking or cycling.

Scheme to promote active travel to school: such schemes can either consist of structured offers such as “Safe Routes to School” or “Walking Bus” projects or can take the form of a specific focus being put on the topic of active school travel in a national transport or school policy.

#### Operationalization:

Does a national or sub-national (where relevant, i.e. in countries with a decentralized and/or federal structure) scheme exist to promote active travel to school (e.g. walking buses, cycling)?

Yes / no

If yes, please provide a brief description (national / sub-national, lead institution government, schools, NGO etc., funding, spread)

#### *Data sources*

Within the framework of a joint WHO/Commission project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”, some information on this indicator has been collected in 2009 and 2010. The reporting template asked if there was a programme existing or planned “promoting active travel (e.g. walking buses, cycling) for school children”. Further information as suggested above would need to be retrieved from the additional information, if provided, in the country information templates. The data is not yet available in the European database on nutrition, obesity and physical activity (NOPA), an internet-based information and reporting system to describe and monitor progress diet, nutrition and physical activity in the fight against obesity but foreseen for publication.

#### Geographic and temporal coverage

The WHO/Commission project’s “National Information Focal Persons” responsible to collate all necessary information from the relevant ministries and institutions filled in reporting templates in 2009 and 2010. Information is available from 44 of the 53 WHO Member States, including all EU countries.

#### Frequency of update

An update of the information collection for NOPA is foreseen for 2012/2013; further updates depend on future funding.

#### *References*

- Reporting template 1 (2009). WHO/Commission Project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”. Copenhagen, WHO Regional Office for Europe, 2009.

## **Indicator 17: Level of cycling and walking**

### ***What does this indicator tell us?***

Cycling and walking are increasingly recognized as an important contribution to overall physical activity, especially since these are forms of activity which are accessible to almost everybody and which can be easily integrated into an already busy day, e.g. during commuting, shopping or social activities, and require minimal personal financial investments. The level of cycling and walking thus illustrates the level of development of a country in this field and can highlight potentials to increase investments into this area of physical activity promotion.

### ***Definitions and operationalization***

Data on the level of cycling and walking: such data can be collected in different ways, including through objective measurements (e.g. GPS-tracking), national travel surveys using detailed individual travel diaries or as part of other national surveys. From national travel surveys, data are usually collected as “kilometres travelled (or time spent) cycling / walking per day for all travel purposes (commuting, shopping, leisure, work)”. Alternatively, the level of cycling / walking can also be defined as “main mode of transport used to get around on a daily basis”.

#### Operationalization:

As a recent EU-funded study showed that currently, the availability of comparable data on “kilometres travelled (or time spent) cycling / walking per day” is insufficient (see Data sources below), it is suggested to operationalize this indicator as follows:

What is the main mode of transport that you use for your daily activities?

Car, motorbike, public transport, walking, cycling, other, no daily / regular mobility.

As an alternative EHIS wave 2 can offer data on walking and bicycling as its module on physical activity foresees to measure time per day and number of days per week on walking and bicycling. (see indicator 2 for references)

### ***Data sources***

A recent Commission study (led by DG MOVE) on “Harmonised collection of European data and statistics in the field of urban transport and mobility” described existing projects which have collected and harmonized data on urban mobility at European and/or international scale and to collect information on the availability of, and satisfaction with existing data and statistics at local level. For this purpose, data from 64 cities in all 27 EU countries has been collected by online survey and interview. Results show that many countries have carry out a national travel survey. However, currently there are no standardized data on the level of walking and cycling across the 27 EU countries available from these surveys. In a number of countries, walking and cycling are included in the national travel surveys, while others still

focus on motorized transport only. Sampling frameworks and data collection methods are also not standardized. The study underlines the need for European survey standards to accurately assess walking as well as cycling. First attempts are underway, in particular through the project “Measuring walking”, a joint project of the European COST Action 358 “Pedestrian Quality Needs” and the WALK21 international conference series.

Information on this indicator has also been collected for the first time in a Flash Eurobarometer in 2011.

#### Geographic and temporal coverage

The Flash Eurobarometer on “Future of transport” was carried out in 2011. Eurobarometer surveys cover all 27 EU countries with a representative sample of about 1000 respondents aged 15 and older per country. Statistical results were weighted to correct for known demographic discrepancies.

The above study covers selected cities in all EU countries.

#### Frequency of update

Flash Eurobarometers are usually not carried out on a regular basis. No information exists as to when to repeat this survey in the future.

#### *Comments*

It should be borne in mind that data from general surveys such as a Eurobarometer has some weaknesses in comparison to data from national travel surveys. Travel surveys are based on very detailed travel diaries where every bout of movement of a certain length has to be recorded, in some cases starting as of 50 metres or 100 metres of length, depending on the methodology used. Respondents are well instructed and accompanied during the survey, which is carried out over the whole year to avoid a bias due to seasonality. Usually, the sample sizes of such surveys are much larger than for normal phone surveys. This methodological approach leads to more precise and reliable data. Also, the use of different modes of transport throughout the survey day(s) is recorded, while in the Eurobarometer survey, respondents had to decide on one mode of transport only. Fieldwork was carried out during one month only (October 2011). In addition, the Eurobarometer surveys might be more prone to underreporting non-motorized modes of transport if they are not yet fully recognized as a standard means of transport, which is still often the case for walking, and to some degree, cycling, in some countries.

For the future, further standardized collection of travel survey data on countries' transport systems, including collection of separate data on the amount of walking and of cycling, should be encouraged.

#### *References*

- Flash Eurobarometer Series no. 312: Future of transport. Analytical report. Survey requested by the Directorate General Mobility and Transport. Brussels, European

Commission, 2011 ([http://ec.europa.eu/public\\_opinion/flash/fl\\_312\\_en.pdf](http://ec.europa.eu/public_opinion/flash/fl_312_en.pdf), accessed 4 July 2012).

- Study on “Harmonised collection of European data and statistics in the field of urban transport and mobility” (MOVE/B4/196-2/2010). University of Leuven, the Netherlands, on behalf of DG for Mobility and Transport (MOVE). Final draft report\_revision July 2012.
- Measuring Walking: Towards internationally standardised monitoring methods of walking and public space (website). (<http://www.measuring-walking.org/project/index.html>, accessed 21 August 2012).

### ***Indicator 18: European Guidelines for improving Infrastructures for Leisure-Time Physical Activity***

#### ***What does this indicator tell us?***

Leisure-time is an important setting for physical activity, including but also extending beyond classic sport activities. Availability and access for all population groups to infrastructure for active leisure-time pursuits is a prerequisite for active leisure time choices. European Guidelines have been developed to promote comprehensive concepts to improve such infrastructure and this indicator will inform on their diffusion and implementation.

#### ***Definitions and operationalization***

Infrastructures for leisure-time physical activity: includes sport infrastructure, leisure-time infrastructure and urban and green spaces;

Improvement of infrastructures: includes development of appropriate policies as well as aspects pertaining to planning, building, financing and management of infrastructures;

European Guidelines for improving Infrastructures for Leisure-Time Physical Activity: these guidelines were developed with eleven EU Member States and Norway as part of the EC-funded IMPALA project. They were presented in 2010 and include good practice criteria and examples.

#### **Operationalization:**

Are the “European Guidelines for Improving Infrastructures for Leisure-Time Physical Activity” applied systematically to develop leisure-time infrastructure?

Yes / not yet but foreseen within the next 2 years / no.

### *Data sources*

Information on existing national mechanisms, policies and processes to plan infrastructure was collected as part of the IMPALA project. Based on its project results, IMPALA proposed “European Guidelines for Improving Infrastructures for Leisure-Time Physical Activity in the Local Arena”. Aspects highlighted include the involvement of relevant decision-making levels and policy sectors; the application of appropriate and participatory planning procedures; the use of a systematic assessment of existing infrastructures, physical activity behaviour, and public needs; the development of accessible, ecological, safe, multi-use infrastructures; the selection of appropriate and socially acceptable funding mechanisms; and the choice of appropriate and flexible owner and operation models.

Information on the future application of the guidelines in the 28 EU countries could be collected by questionnaire through the Expert Group on “Sport, Health and Participation”.

### Geographic and temporal coverage

IMPALA: The guidelines were developed based on information collected in 11 EU countries and Norway in 2009 and 2010.

Future data should be collected from all EU countries by year. The Expert Group covers all EU countries.

### Frequency of update

Information on this indicator should be updated every 2 to 3 years.

### *References*

- Proposed European guidelines: Improving infrastructures for leisure-time physical activity in the local arena. Towards social equity, intersectoral collaboration and participation. Erlangen Nürnberg, Friedrich-Alexander-University of Erlangen-Nuremberg and Institute of Sport Science and Sport, 2010 ([www.impala-eu.org/fileadmin/user\\_upload/IMPALA\\_guideline\\_draft.pdf](http://www.impala-eu.org/fileadmin/user_upload/IMPALA_guideline_draft.pdf), accessed 9 July 2012).
- Engbers LH et al.: Improving Leisure-time Physical Activity in the Local Arena (IMPALA): Report on work package 1 (European comparison of national policies). Leiden, TNO Quality of Life, 2010 ([http://www.impala-eu.org/fileadmin/user\\_upload/impala\\_report\\_wp1\\_policies.pdf](http://www.impala-eu.org/fileadmin/user_upload/impala_report_wp1_policies.pdf), accessed 9 July 2012).

## **Indicator 19: Schemes to promote active travel to work**

### ***What does this indicator tell us?***

Active transport, i.e. walking, cycling, rollerblading, kick-boarding etc., is increasingly recognised as an important possibility to increase overall physical activity. It has been shown in different countries that adults who commute to work in a physically active way are also overall more physically active and, for example, less overweight. This indicator informs on the existence of schemes to promote active travel to work.

### ***Definitions and operationalization***

Active travel: all non-motorised forms of travel to school, walking, cycling, rollerblading, kick-boarding etc. In most countries, the most prevalent forms will be walking or cycling.

Schemes to promote active travel to work: such schemes can either be directed at employers, e.g. in the form of a requirement to develop mobility plans above a certain number of employees, a financial incentive schemes or of an NGO-lead programme, or can provide incentives or subsidies to employees who use active forms of commuting.

#### Operationalization:

Does a national or sub-national (where relevant, i.e. in countries with a decentralized and/or federal structure) scheme exist to promote active travel to work (e.g. walking, cycling)?

Yes / no

If yes, please provide a brief description (national / sub-national, lead institution - government, NGO etc. -, contents, funding, spread)

### ***Data sources***

Within the framework of a joint WHO/Commission project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”, some information on this indicator has been collected in 2009 and 2010. The reporting template asked if there was a programme existing or planned “promoting active travel (walking or cycling) to work”. Further information as suggested above would need to be retrieved from the additional information, if provided, in the country information templates. The data is not yet available in the European database on nutrition, obesity and physical activity (NOPA), an internet-based information and reporting system to describe and monitor progress diet, nutrition and physical activity in the fight against obesity but foreseen for publication.

#### Geographic and temporal coverage

The project’s “National Information Focal Persons” responsible to collate all necessary information from the relevant ministries and institutions filled in reporting templates in 2009

and 2010. Information is available from 44 of the 53 WHO Member States, including all EU countries.

#### Frequency of update

An update of the information collection for NOPA is foreseen for 2012/2013; further updates depend on future funding.

#### ***References***

- Reporting template 1 (2009). WHO/Commission Project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”. Copenhagen, WHO Regional Office for Europe, 2009.

### ***Indicator 20: Schemes to promote physical activity at the work place***

#### ***What does this indicator tell us?***

The work place is increasingly recognised as a setting where physical activity can be promoted. Provided that provisions are taken to reach all groups of employees, work place-related physical activity promotion can contribute to increasing levels of physical activity. This indicator informs on the existence of schemes to promote physical activity at the work place.

#### ***Definitions and operationalization***

Schemes to promote physical activity at work: such schemes can include structured offers, e.g. sport programmes or walking classes during lunch time, provision of infrastructure (gym, showers, walking tracks etc.), systematic consideration of the topic in all work processes (stand-up desks, walking meetings etc.), or incentives or subsidies for employees who use specific offers. In this setting it has shown to be important to take provisions to reach all groups of employees and not, for example, mostly those who are already physically active.

#### Operationalization:

Does a national or sub-national (where relevant, i.e. in countries with a decentralised and/or federal structure) scheme exist to promote physical activity at work places?

Yes / no

If yes, please provide a brief description (national / sub-national scheme, lead institution - government, NGO etc. - , contents, funding, spread)

#### ***Data sources***



Within the framework of a joint WHO/Commission project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”, some information on this indicator has been collected in 2009 and 2010. The reporting template asked if there was a programme existing or planned “providing facilities for physical activity at the work place (e.g. gym, basketball court, field etc.)”. Further information as suggested above is not being collected and feasibility would need to be assessed in the next round of data collection. The data is not yet available in the European database on nutrition, obesity and physical activity (NOPA), an internet-based information and reporting system to describe and monitor progress diet, nutrition and physical activity in the fight against obesity (see also Annex) but foreseen for publication.

Exchange should also be sought with the WHO’s Global Plan of Action on Workers’ health 2008-2014 which includes the promotion of physical activity at the workplace and is foreseeing a monitoring framework on its implementation.

#### Geographic and temporal coverage

The WHO/Commission project’s “National Information Focal Persons” responsible to collate all necessary information from the relevant ministries and institutions filled in reporting templates in 2009 and 2010. Information is available from 44 of the 53 WHO Member States, including all EU countries.

#### Frequency of update

An update of the information collection for NOPA is foreseen for 2012/2013; further updates depend on future funding.

#### *References*

- Reporting template 1 (2009). WHO/Commission Project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”. Copenhagen, WHO Regional Office for Europe, 2009.
- Occupational health [website] (including link to Global Plan of Action on Workers’ health 2008-2014). Geneva, World Health Organization, 2012.

### ***Indicator 21: Schemes for community interventions to promote PA in elderly people***

#### ***What does this indicator tell us?***

Remaining physically active is of particular importance for older adults to maintain mental and functional capacity and independence and to prevent falls. In view of the ageing of most European societies, this topic will be of increasing importance. This indicator will highlight the existence of specific schemes for community interventions to promote physical activity in this age group.

### *Definitions and operationalization*

Scheme for community interventions to promote PA in elderly people: such schemes can take different forms, such as government-run programmes with specific offers for elderly, investment in suitable leisure-time infrastructure or to increase access to existing infrastructures (including transport infrastructures), NGO-run projects and programmes in the general community or directed at specific settings, such as nursing homes.

#### Operationalization:

Existence of a specific scheme or programme for community interventions to promote PA in elderly people

### *Data sources*

An initial collection of good practices of physical activity programmes and physical activity promotion strategies for older people was compiled as part of the EC-supported project "European Network for Action on Ageing and Physical Activity" (EUNAAPA) in 2007/2008 in 14 EU Member States and Norway. The information collected included an overview of programmes and strategies deemed "successful" by national-level experts and policy-makers, and an overview of existing recommendations for the design of such programmes and strategies.

Future information could possibly come from one of the EC-funded projects on "European Partnerships on Sport" (promoting physical activity supporting active ageing) that started in 2013. Otherwise, information could be collected by questionnaire through the Expert Group on "Sport, Health and Participation".

#### Geographic and temporal coverage

EUNAAPA: Data were collected in 14 EU Member States and Norway in 2007 and 2008.

Future data should be collected from all EU countries. The Expert Group is supposed to cover all EU countries.

#### Frequency of update

Information on this indicator should be updated every 2 to 3 years.

### *References*

- Scott F et al. Expert survey on physical activity programmes and physical activity promotion strategies for older people. Cross-national report. EUNAAPA – Work Package 5, 2008

([http://www.eunaapa.org/media/cross-national\\_report\\_expert\\_survey\\_on\\_pa\\_programmes\\_and\\_promotion\\_strategies\\_2008\\_.pdf](http://www.eunaapa.org/media/cross-national_report_expert_survey_on_pa_programmes_and_promotion_strategies_2008_.pdf), accessed 9 July 2012)

## **Indicator 22: National HEPA policies that include a plan for evaluation**

### ***What does this indicator tell us?***

National policies are a centre-piece of a national strategy to promote physical activity. They will give support, coherence and visibility at the political level, and at the same time make it possible for the institutions involved, such as national government sectors, regions or local authorities, stakeholders and the private sector, to be coherent and consistent by following common objectives and strategies as well as to assign roles and responsibilities. Recent analyses have shown that evaluation is not yet a sufficiently strong element in many national policies. Evaluation is crucial for accountability and to support adaptation of implementation to address weaknesses and improve effectiveness. This indicator will provide an overview of the existence of national policies and which of those have a clear commitment and plan for evaluation included.

### ***Definitions and operationalization***

**Policy:** written document that contains strategies and priorities, define goals and objectives, and is issued by a part of the administration. It may also include an action plan on implementation.

**Action Plan:** usually prepared according to a policy and strategic directions and should ideally define who does what, when, how, for how much, and have a mechanism for monitoring and evaluation.

**HEPA promotion:** includes all forms of physical activity that are beneficial for health without undue harm or risk, including sport, health, transport, environment or leisure time approaches.

#### Operationalization:

Share of national or sub-national (where relevant, i.e. in countries with a decentralized or federal structure) HEPA policies (sport, health, transport, environment) that include a clear intention or plan for evaluation

X out of y policies (by sector) include a clear intention or plan for evaluation (alternatively: all / many / some / few / none<sup>206</sup>)

### ***Data sources***

Information on this indicator has been collected in 2009 and 2010 through a joint WHO/Commission project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”. The policy documents are available

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<sup>206</sup> A percentage would be prone to misinterpretation here: For example, if a country just has one policy that includes evaluation they would get 100% but a country with a comprehensive range of policies but only 8 out of 10 policies have evaluation built-in would only get 80%.

in the European database on nutrition, obesity and physical activity (NOPA), an internet-based information and reporting system to describe and monitor progress diet, nutrition and physical activity in the fight against obesity. The information provided also includes whether a monitoring and evaluation plan for the policy document exists.

#### Geographic, topical and temporal coverage

The WHO/DG SANCO project's "National Information Focal Persons" responsible to collate all necessary information from the relevant ministries and institutions filled in reporting templates in 2009 and 2010. Information is available from 44 of the 53 WHO Member States, including all EU countries.

An earlier complementary collection of sport-related policies (see also indicator 8: National sport for all policy or action plan) identified more than 100 additional policy documents, showing that it is likely that the currently available information in NOPA is more complete for directly health-related information than for other sectors. For a more complete coverage in particular of transport and environment policies relating to physical activity, targeted information collection projects would be advisable, based for example on the approach taken in the NET-SPORT-HEALTH project.

#### Frequency of update

An update of the information collected for NOPA is foreseen for 2012/2013; further updates depend on future funding.

#### ***References***

- WHO European database on nutrition, obesity and physical activity (NOPA). Copenhagen, WHO Regional Office for Europe, 2010 (<http://data.euro.who.int/nopa/default.aspx>, accessed 21 June 2012).

### ***Indicator 23: National awareness raising campaign on physical activity***

#### ***What does this indicator tell us?***

A national awareness raising campaign is a frequent element of national strategies to promote physical activity. It can contribute to the dissemination of knowledge and change of attitudes and, if complemented by specific offers, support a behaviour change. This indicator will inform on the existence of such campaigns.

#### ***Definitions and operationalization***

Awareness-raising campaign: a mass media based approach to inform a community's attitudes, behaviours and beliefs

### Operationalization:

Does a clearly formulated, national campaign for physical activity education and public awareness raising exist?

Yes / no

If yes, please specify: name and link to web site, topics covered, responsible body, yearly budget in Euros.

To correct for country size and economic development, information has to be reported as: 1) total funding; 2) funding per capita; 3) funding by gross domestic product at purchasing power parity per capita.

### *Data sources*

Information on this indicator has been collected in 2009 and 2010 through a joint WHO/Commission project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”, except for correcting the funding information for country size and economic development. The information is not yet available in the European database on nutrition, obesity and physical activity (NOPA), an internet-based information and reporting system to describe and monitor progress diet, nutrition and physical activity in the fight against obesity but foreseen for publication.

### Geographic and temporal coverage

The WHO/Commission project’s “National Information Focal Persons” responsible to collate all necessary information from the relevant ministries and institutions filled in reporting templates in 2009 and 2010. Information is available from 44 of the 53 WHO Member States, including all EU countries.

### Frequency of update

An update of the information collected for NOPA is foreseen for 2012/2013; further updates depend on future funding.

### *References*

- Reporting template 1 (2009). WHO/Commission Project on “Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union”. Copenhagen, WHO Regional Office for Europe, 2009.

### **11.5. Key information sources**

- *European database on nutrition, obesity and physical activity (NOPA)*

The most comprehensive overview on HEPA policy-relates aspects is now available from the joint WHO/Commission project on “Monitoring progress on improving nutrition and physical

activity and preventing obesity in the European Union”, which was carried out from 2008 to 2010. Its main goal was to develop a European database on nutrition, obesity and physical activity (NOPA), an internet-based information and reporting system to describe and monitor progress diet, nutrition and physical activity in the fight against obesity. The system aims at assisting the EU and Member States in monitoring action to implement policies with regard to key commitments contained in the three main policy documents: the European Charter on Counteracting Obesity, the Commission White Paper “A strategy for Europe on nutrition, overweight and obesity related health issues” and the WHO European Action Plan for Food and Nutrition Policy.

It compiles information for most of the 53 WHO European Member States from different available sources as well as reporting templates filled in by the project’s “National Information Focal Persons” responsible to collate all necessary information from the relevant ministries and institutions; 44 of 53 Member States provided information which was (and on some items currently still is being) verified before inclusion into the database. The database contains information on all EU Member States.

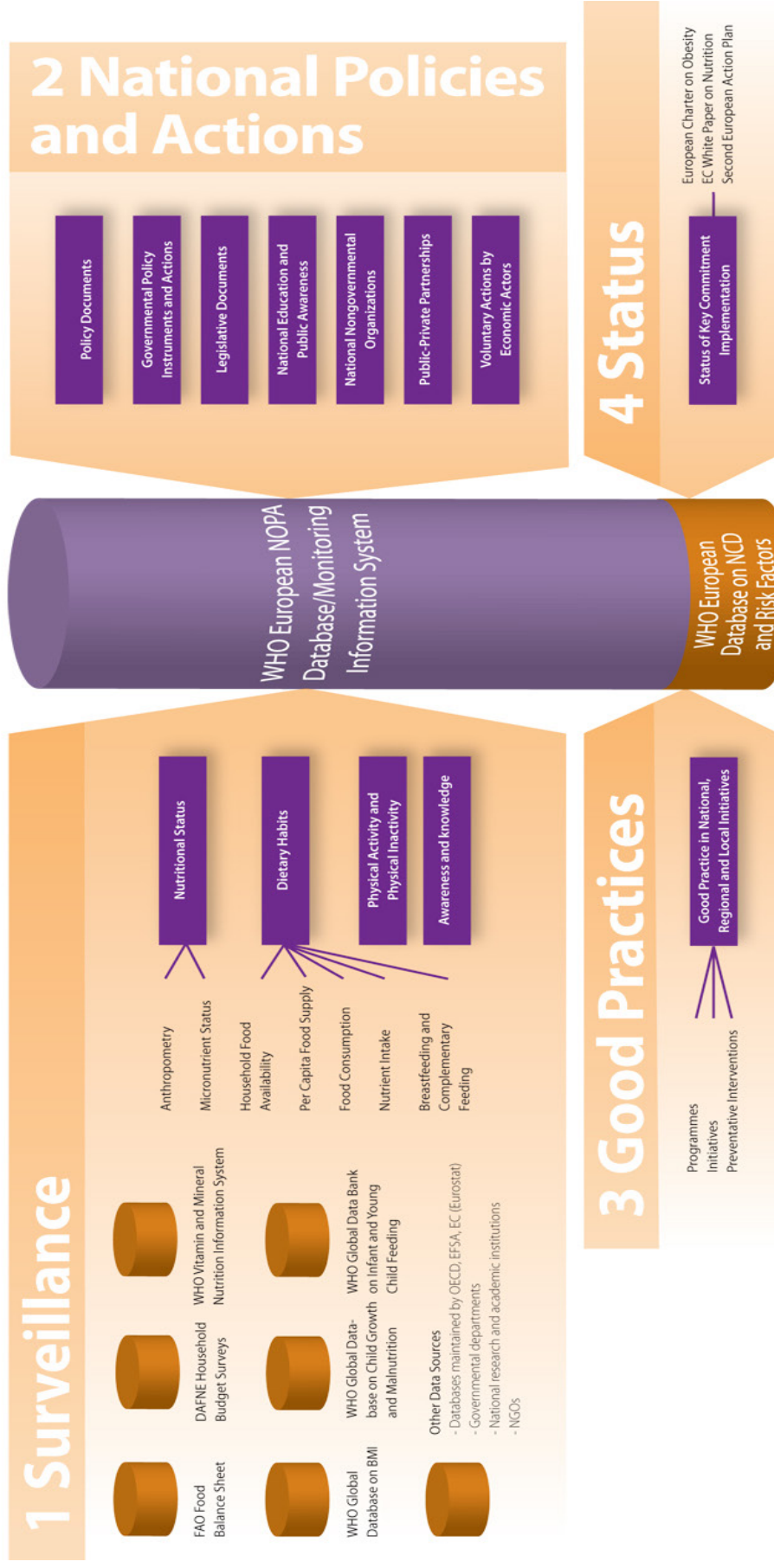
The chart hereafter gives an overview of NOPA. It illustrates that NOPA contains a range of process and outcome related information (e.g. national coordination, national policy documents national physical activity recommendations). In addition, action on different community interventions is included<sup>207</sup> (not existing and not planned within 2 years, clearly stated, partly implemented or enforced, clearly stated and entirely implemented and enforced, or not yet existing, but planned within the next 2 years).

While NOPA contains a unique range of documents and information on physical activity, a project to analyse the state of affairs regarding physical activity recommendations showed that the database needs continuous updating to preserve its high value as information repository, as most of the information was collected in 2009 and 2010. The specific scope and frequency of updating NOPA has until now been negotiated between the WHO and the European Commission (DG SANCO). In some cases, the National Information Focal Persons have had better access to nutrition-related information than to data and documents on physical activity, especially on aspects outside the health sector. This fact will be addressed by the proposed Council Recommendation that foresees the establishment of national HEPA co-ordinators.

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<sup>207</sup> With regard to PA, these include: promotion of physical activity in schools, physical education in primary and secondary schools, promoting active travel (e.g. walking buses, cycling) to school or work, teacher training to promote physical activity, provision of facilities for physical activity at work places, government subsidy scheme for companies to support active travel, programmes to increase traffic safety for pedestrians and cyclists, expansion of pedestrian zones (car-free zones) in cities, expansion of green spaces and play areas in urban areas and of cycle and walking lanes, provision of sport facilities and equipment to schools stated in national school policies, offers to increase access to recreational or exercise facilities (e.g. subsidy schemes), promotion of better urban design to provide safe and attractive structures everyday physical activity, cycling and walking, e.g. through Healthy Urban Planning, promoting stair use at workplace, physical activity counselling in primary health care, physical activity included in the curriculum of health professionals training.

## European database on nutrition, obesity and physical activity (NOPA)



From: Wijnhoven T, Bollars C, Racioppi R: WHO European Database on Nutrition, Obesity and Physical Activity (NOPA). Presentation at the 2<sup>nd</sup> Meeting of the HEPA Europe-EU Contact Group, Amsterdam, 12 October 2011.



- ***Overviews and content analyses of national policies***

Internationally, one of the first analyses of selected national policies was published in 2004<sup>208</sup>.

For Europe, Daugbjerg et al.<sup>209</sup> published the state of affairs as of April 2007, based on the International Inventory of Physical Activity Promotion. 54 national HEPA policy documents from 24 countries had been identified, of which 27 documents published in English were included in a systematic content analysis. Studied elements were publication date, legal status, target groups, implementation mechanisms, budget and evaluation and surveillance. Analysis showed that many general recommendations for policy developments were being followed. However, limited evidence for cross-sectoral collaboration was found and quantified goals for physical activity were the exception. Population groups most in need were rarely specifically targeted. Only about half of the policies indicated an intention or requirement for evaluation. While this study provided for the first time an overview on the state of affairs regarding HEPA promotion in Europe and provided important findings, the content analysis only analysed information as provided in the written policy documents.

The overview of HEPA policy documents has been updated for the EU Member States recently<sup>210</sup>.

- ***WHO Global InfoBase and Global Health Data Observatory***

Since the adoption of the Global Strategy on Diet, Physical Activity and Health in 2004, the WHO has undertaken activities to collect information on the prevalence of NCDs as well as important risk factors, including insufficient physical activity. Global surveillance data is available in the WHO Global InfoBase. However, inter-country comparisons of national data on physical activity from most European countries is difficult since most of them use nationally-developed questionnaires that are not comparable; in addition methodological challenges around the Eurobarometer surveys have been mentioned elsewhere<sup>211</sup>.

- ***HEPA Policy Audit Tool***

Based on previous analyses and international guidance on the development of national approaches, work by the HEPA Europe working group on “National approaches to physical

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<sup>208</sup> Bull FC, Bellew B, Schoppe S, Bauman AE. (2004) Developments in national physical activity policy: an international review and recommendations towards better practice. *Journal of Science and Medicine in Sport, Physical Activity Suppl*, 7(1), 93-104.

<sup>209</sup> Daugbjerg SB, Kahlmeier S, Racioppi F et al. (2009): Promotion of physical activity in the European region: content analysis of 27 national policy documents. *Journal of Physical Activity and Health*, 6, 805-817.

<sup>210</sup> As of 2009, almost 140 national policies or legislative documents were identified from 26 Member States. Seventy-three documents from 24 countries took a public health approach to HEPA promotion, 34 from 16 countries had a sport focus and 22 from ten countries were on transport approaches, while environmental approaches were even more rarely identified. To a certain extent, this might be a problem of underreporting non-health related documents.  
([http://www.euro.who.int/\\_data/assets/pdf\\_file/0015/146220/e95150.pdf](http://www.euro.who.int/_data/assets/pdf_file/0015/146220/e95150.pdf)).

<sup>211</sup> WHO Regional Office for Europe (2010): Review of physical activity surveillance data sources in European Union Member States. WHO/Commission Project on monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union. Report no. 6. Copenhagen, WHO Regional Office for Europe  
([http://www.euro.who.int/\\_data/assets/pdf\\_file/0005/148784/e95584.pdf](http://www.euro.who.int/_data/assets/pdf_file/0005/148784/e95584.pdf)).

activity” led to the HEPA Policy Audit Tool (PAT)<sup>212</sup>. It provides a protocol and method for a detailed compilation and communication of country level policy responses on physical inactivity. It is structured around a set of 17 key attributes identified as essential for successful implementation of a population-wide approach to the promotion of physical activity across the life course, using the experience of several previous international comparative studies of physical activity policy:

- (1) Consultative approach in development
- (2) Evidence based
- (3) Integration across other sectors and policies
- (4) National recommendations on physical activity levels
- (5) National goals and targets
- (6) Implementation plan with a specified timeframe for implementation
- (7) Multiple strategies
- (8) Evaluation
- (9) Surveillance or health monitoring systems
- (10) Political commitment
- (11) On-going funding
- (12) Leadership and coordination
- (13) Working in partnership
- (14) Links between policy and practice
- (15) Communication strategy
- (16) Identity (branding/logo/slogan)
- (17) Network supporting professionals

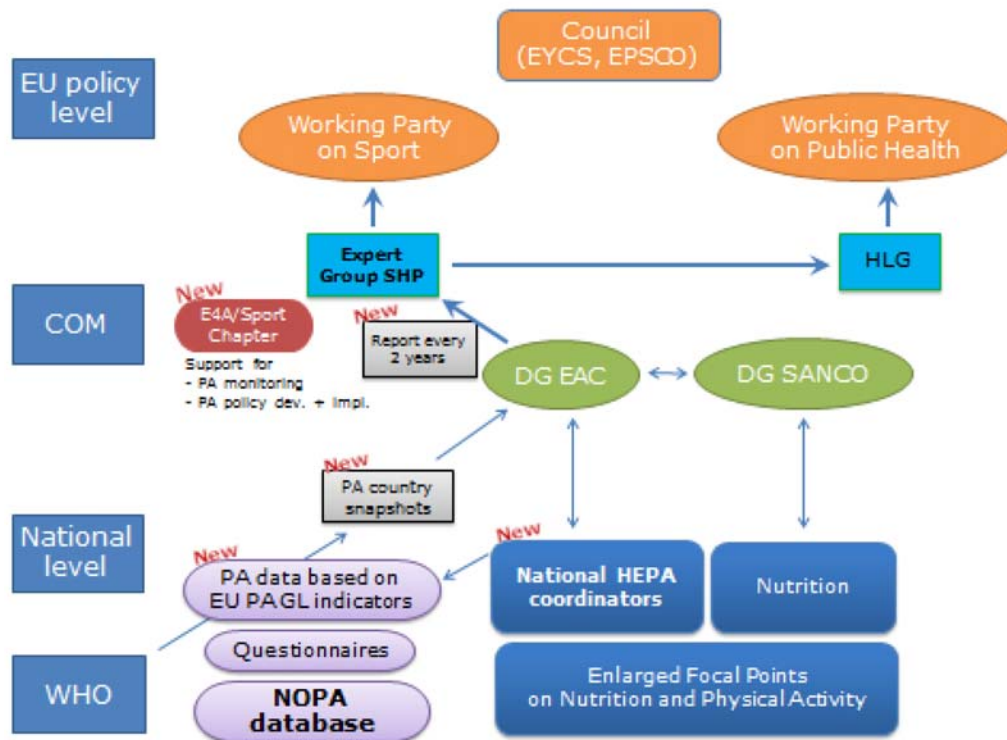
Completion of the HEPA PAT provides a comprehensive overview of the breadth of current policies related to HEPA and can identify synergies and discrepancies between policy documents as well as possible gaps. It does not, however, provide a quantified assessment or scoring of a national HEPA policy approach.

The HEPA PAT has been applied in 7 pilot countries (Finland, Italy, the Netherlands, Norway, Portugal, Slovenia, and Switzerland); a cross-country analysis is currently underway. Further updates are foreseen.

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<sup>212</sup> <http://www.euro.who.int/hepatpat>

12. ANNEX IV: DIAGRAM (PHYSICAL ACTIVITY MONITORING UNDER A RECOMMENDATION ON HEPA, AS OF MID-2014)



### **13. ANNEX V: COSTS TO THE EU BUDGET AND ADMINISTRATIVE COSTS IN THE MEMBER STATES**

#### **13.1. Costs to the EU budget**

##### **Option A:**

Under the baseline scenario, meetings with Member State representatives will continue to be organised at EU level with financial support from the COM. Currently, on average, the Expert Group on Sport, Health and Participation (XG SHP), meets 3 times per year (corresponding to approximately EUR 84,000 per year). This adds up to EUR 532,000 / 28 MS for six years assuming that meetings will start in the second half of 2014.

##### **Option B:**

No additional costs for the EU budget would be incurred as compared to the baseline scenario.

##### **Options C and D:**

Regarding options C and D, the additional costs for the EU budget, as compared to the baseline scenario, have been calculated taking account of

- the on-going project entitled "Monitoring the implementation of the European Strategy for Nutrition and Physical Activity jointly with WHO (NOPA II)", introduced through the EU contribution agreement with the WHO<sup>213</sup>, which has a duration of two years (until mid-2014);
- consultations with HEPA Europe experts who provided advice with regard to costs to be expected for support for action in the Member States (e.g. support for countries to identify priority action areas, country assessments, training of HEPA focal points).

An estimated break down of the expected costs for the EU for the implementation of the planned initiative, notably the support mechanism for the Council Recommendation on HEPA, would be related to two areas:

- (h) monitoring of the implementation of the EU PA GL and
- (i) support for action / implementation at national level through a country-specific situation analysis to identify priority areas for action and related capacity building.

In area a), regular surveys will be carried out using standardized questionnaires and reporting tools, based on the EU PA GL monitoring framework (set of indicators) and the planned national HEPA focal points. The information will be verified and included into the WHO NOPA Database (<http://data.euro.who.int/nopa/>). The database will be adapted so as to facilitate the production of ad-hoc snapshots of implementation levels in individual Member States, using the EU PA GL monitoring framework. Such reports would be delivered to the Commission at regular intervals to form part of the reporting activities on the Council Recommendation.

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<sup>213</sup> Identification number of the contribution agreement: 2011 52 02. Contracting authority: EAHC.

The main outcomes would be as follows:

- National HEPA focal points trained in applying the Monitoring Framework;
- Up-to-date information system on the level of implementation of the EU PA GL including good practices;
- Regular reports (country snapshots) to the Commission on the national implementation level of the EU PA GL according to the Monitoring Framework.

For **option C**, this would lead to the following activities and costs for the entire MFF period:

Option C: Activity	Costs	Timeline (year)
1. Coordination, data collection, validation and updating of the NOPA database with data from the monitoring of the EU PA GL	EUR 532,000	1-7
2. Technical maintenance and programming of NOPA database	EUR 175,000	1-7
3. Development of capacity building material on Monitoring Framework for meeting under activity 4 below	EUR 20,000	1
4. Two meetings of national HEPA focal points from 28 Member States on capacity building for the national application of the monitoring framework	EUR 60,000	1-7
5. Collection of good practices of country level implementation of the EU PA GL (to be included in the NOPA database in addition to the monitoring framework data)	EUR 50,000	1-7
<b>Total 2014-2020</b>	<b>EUR 837,000</b>	

Under **option D** the complex mechanism to monitor the implementation of the EU PA GL by using a more comprehensive set of indicators will result in additional costs regarding activities 1, 2 and 3. This is, to a large extent, explained by the bigger volume of the data.

Option D: Activity	Costs	Timeline (year)
1. Coordination, data collection, validation and updating of the NOPA database with data from the monitoring of the EU PA GL	EUR 784,000	1-7
2. Technical maintenance and programming of NOPA database	EUR 210,000	1-7
3. Development of capacity building material on Monitoring Framework for meeting under activity 4 below	EUR 30,000	1
4. Two meetings of national HEPA focal points from 28 Member States on capacity building for the national application of the monitoring framework	EUR 60,000	1-7
5. Collection of good practices of country level implementation of the EU PA GL (to be included in the NOPA database in addition to the monitoring framework data)	EUR 50,000	1-7
<b>Total 2014-2020</b>	<b>EUR 1,134,000</b>	

Area b) will take account of the fact that the implementation of the EU PA GL varies significantly across the EU. As such, support to national action on PA needs to take into account the context of each MS and should be provided on a voluntary basis upon request.

Support for the MS is proposed to take place in 2 phases: (I) situation analysis and identification of priority action areas (i.e. analysis of current policy development and implementation levels on PA and derivation of areas that require action) and (II) capacity building of national focal points on HEPA policy development and implementation at national level, addressing the priority action areas identified in phase I. Both phases would be supported through the expertise available in the HEPA Europe network, build on existing tools (e.g. WHO's HEPA Policy Audit Tool), and would be fully aligned with the proposed new monitoring framework (as explained in Annex III for the preferred option C). The existing annual meetings of HEPA Europe could stimulate relevant exchange between the scientific and policy-making levels by bringing together the HEPA Europe network and the national HEPA focal points.

The main outcomes are expected be as follows:

- Situation analysis tool for countries to identify priority action areas;
- Country assessments of the level of implementation of the EU PA GL (10 countries);
- Training package for capacity building on implementing EU PA GL at national level;
- Trained national PA focal points on implementing EU PA GL.

This would lead to the following activities and costs for the entire MFF period:

Option C: Activity	Costs	Timeline (year)
1. Support to HEPA Europe: meetings of the Steering Committee (SC) and annual meetings to bring together science and policy levels and present the tools and activities of phases I and II to Member States, i.e. support participation of 28 MS (incl. EU Contact Group)	EUR 372,000	2-7
2. Development of tool for situation analysis and identification of priority action areas (see activity 3 below), based on existing tools, such as the HEPA PAT, and adapted to the Monitoring Framework and aligned with the capacity building modules (see activities 4 and 5 below)	EUR 55,000	1
3. Situation analysis and identification of priority action: initial assessment of policy situation in MS to identify priority action areas (max. 12 countries)	EUR 300,000 (EUR 25,000 per country)	1-7
4. Development of capacity building course material (concept, training modules and teaching plan) on national PA policy development and implementation	EUR 180,000	1
5. Organisation of annual capacity building workshop (5 days) for national HEPA focal points (to address the priority action areas identified in activity 3 above)	EUR 654,000	2-7
6. Steering committee (10 persons) on support for action in Member States: 3 meetings to address structure of training material, scope of modules, identification for evidence for action	EUR 30,000	1-7
7. Staff time for coordination of activities 1 - 6 above	EUR 252,000	1-7
<b>TOTAL 2014-2020</b>	<b>EUR 1,843,000</b>	

Under **option D**, tasks for the Member States to comply with the Recommendation will be more demanding, not least because of the requirement to report on progress to the EU level in promoting HEPA and to reach the benchmarks and targets agreed and set by the Council. Accordingly, the support which is proposed to be provided to national action on PA needs, in particular the training of national HEPA focal points will have to be more substantial. Additional costs would occur under this option, as follows:

Option D: Activity	Costs	Timeline (year)
1. Support to HEPA Europe: meetings of the Steering Committee (SC) and annual meetings to bring together science and policy levels and present the tools and activities of phase I and II to Member States, i.e. support participation of 28 MS (incl. EU Contact Group)	EUR 372,000	2-7
2. Develop tool for situation analysis and identification of priority action areas (see activity 3 below), based on existing tools, such as the HEPA PAT, and adapted to the Monitoring Framework and aligned with the capacity building modules (see activities 4 and 5 below)	EUR 65,000	1
3. Situation analysis and identification of priority action: initial assessment of policy situation in MS to identify priority action areas (max. 16 countries)	EUR 400,000 (EUR 25,000 per country)	1-7
4. Development of capacity building course material (concept, training modules and teaching plan) on national PA policy development and implementation	EUR 200,000	1
5. Organisation of annual capacity building workshop (5 days) for national HEPA focal points (to address the priority action areas identified in activity 3 above)	EUR 654,000	2-7
6. Steering committee (10 persons) on support for action in Member States: 4 meetings to address structure of training material, scope of modules, identification for evidence for action	EUR 40,000	1-7
7. Staff time for coordination of activities 1 - 6 above	EUR 504,000	1-7
<b>TOTAL 2014-2020</b>	<b>EUR 2,235,000</b>	

The following **total costs** would occur for the EU budget for the MFF period:

- **General budget:** for all options an estimated EUR 532,000 for the organisation of meetings (e.g. Expert Group meetings), including reimbursement of travel costs;
- **Sport Chapter in Erasmus+ 2014-2020:**
  - Option C: EUR 2,680,000 EUR
  - Option D: EUR 3,369,000 EUR

### 13.2. Administrative costs in the Member States

On the following pages, the calculation has been made (using the EU Standard Cost model) to assess the administrative costs (burden) in the Member States for the first year and for second (+ subsequent) years of the implementation of the planned initiative. These costs relate above all to the reporting requirements to the EU level and thus apply in particular to options C and D (new monitoring framework including set of indicators) and, to a lesser extent, also to option B (provision of regular updates on the implementation of the EU PA GL to the EU

level). No costs would be incurred for option A. For the preferred option C, the total administrative cost per MS for the period 2014-2020 is expected to amount to roughly 47,300 EUR. This is based on the calculation that the average cost per MS would amount to roughly EUR 11,300 for the first year and EUR 6,000 for subsequent years. This is inter alia based on the assumption that already existing tasks in different governmental departments relating to data collection activities on HEPA promotion will be prioritised in order to comply with the new monitoring framework.



<b>Proposal for an EU initiative on HEPA - Option B - year 1</b>												Regulatory origin (%)																																	
If the act assessed is the transposition of one or several acts adopted at another level, insert here the name and reference of that or these 'original' acts												Total Administrative Burdens (AC- BAU)	Business As Usual Costs (% of AC)	Total Administrative Costs	Outsourcing costs (per entity & per year)	Equipment costs (per entity & per year)	Total number of actions	Nbr of entities	Freq (per year)	Price (per action)	Time (hours)	Tariff (€ per hour)	Int	EU	Nat	Reg																			
No.	Art.	Orig. Art.	Type of obligation	Description of required action(s)	Target group																																								
1			Submission of (recurring) reports	Familiarising with the information obligation	Member State administrations		32,06	22	705	1	27	27	0	19 043	0%	19 043	0	0	0	0				100%																					
2			Submission of (recurring) reports	Training members and employees about the information obligations	Member State administrations		32,06	22	705	1	27	27	0	19 043	0%	19 043	0	0	0	0				100%																					
3			Submission of (recurring) reports	Retrieving relevant information from existing data	Member State administrations		32,06	50	1 603	1	27	27	0	43 281	0%	43 281	0	0	0	0				100%																					
4			Submission of (recurring) reports	Filing forms and tables	Member State administrations		32,06	20	641	1	27	27	0	17 312	0%	17 312	0	0	0	0				100%																					
												<b>98 680</b>																																	
												Total administrative costs (€)																																	
												Total administrative burden (€)																																	
												Administrative costs by origin (€)																																	

Regulatory act refers to legislative and statutory acts

For the reference of the proposal / act, use EU-Lex format ('cut and paste' of the reference given by [http://europa.eu.int/eur-lex/lex/RECH\\_menu.do?hmmang=en](http://europa.eu.int/eur-lex/lex/RECH_menu.do?hmmang=en)).

No. = gives a number for each action.

Art. = article and § detailing the obligation assessed on that line.

Orig. Art. = if the act assessed is the transposition of an act adopted at another level, insert here the article and § of the 'original' act corresponding to the obligation assessed on that line

(for ex., article of the EC directive at the origin of one specific obligation imposed by national law)

Price per action (P) = Tariff \* Time. Total Nbr of actions (Q) = Frequency \* Number of entities. Total cost per action = P\*Q + Equipment + Outsourcing.

For equipment, yearly cost is calculated on the basis of the depreciation period.

When the act amends existing provisions and reduce the value of a parameter (lower frequency, lower number of entities concerned, etc), negative figures corresponding to that reduction should be typed in the relevant columns

Proposal for an EU initiative on HEPA - Option B- subsequent years										Regulatory origin (%)							
If the act assessed is the transposition of one or several acts adopted at another level, insert here the name and reference of that or these 'original' acts										Int	EU	Nat	Reg				
No. Art.	Orig. Art.	Type of obligation	Description of required action(s)	Target group	Tariff (€ per hour)	Time (hours)	Price (per action)	Freq (per year)	Nbr of entities					Total number of actions	Equipment costs (per entity & per year)	Outsourcing costs (per entity & per year)	Total Administrative Costs
1		Submission of (recurring) reports	Retrieving relevant information from existing data	Member State administrations	32,06	50	1 603	1	27	27	0	0	43 281	0%	43 281		
2		Submission of (recurring) reports	Filing forms and tables	Member State administrations	32,06	20	641	1	27	27	0	0	17 312	0%	17 312		
											<b>60 593</b>						
											Total administrative costs (€)	60 593					
											Total administrative burden (€)	60 593					
											Administrative costs by origin (€)	60 593					
Regulatory act refers to legislative and statutory acts																	
For the reference of the proposal / act, use EU-Lex format ('cut and paste' of the reference given by <a href="http://europa.eu.int/eur-lex/lex/RECH_menu.do?hl=lang=en">http://europa.eu.int/eur-lex/lex/RECH_menu.do?hl=lang=en</a> ).																	
No. = gives a number for each action.																	
Art.= article and § detailing the obligation assessed on that line.																	
Orig. Art. = if the act assessed is the transposition of an act adopted at another level, insert here the article and § of the 'original' act corresponding to the obligation assessed on that line (for ex., article of the EC directive at the origin of one specific obligation imposed by national law )																	
Price per action (P) = Tariff * Time. Total Nbr of actions (Q) = Frequency * Number of entities. Total cost per action = P*Q + Equipment + Outsourcing.																	
For equipment, yearly cost is calculated on the basis of the depreciation period.																	
When the act amends existing provisions and reduce the value of a parameter (lower frequency, lower number of entities concerned, etc), negative figures corresponding to that reduction should be typed in the relevant columns																	

Proposal for an EU initiative on HEPA - Option C - year 1								Regulatory origin (%)																								
If the act assessed is the transposition of one or several acts adopted at another level, insert here the name and reference of that or these 'original' acts								Int	EU	Nat	Reg																					
No.	Art.	Orig. Art.	Type of obligation	Description of required action(s)	Target group	Tariff (€/per hour)	Time (hours)					Price (per action)	Freq (per year)	Nbr of entities	Total number of actions	Equipment costs (per entity & per year)	Outsourcing costs (per entity & per year)	Total Administrative Costs (€)	Business As Usual Costs (% of AC)	Total Administrative Burdens (AC - BAU)												
1			Submission of (recurring) reports	Familiarising with the information obligation	Member State administrations	32,06	88	2 821	1	27	27	0	0	76 174	0%	76 174		100%														
2			Submission of (recurring) reports	Training members and employees about the information obligations	Member State administrations	32,06	88	2 821	1	27	27	0	0	76 174	0%	76 174		100%														
3			Submission of (recurring) reports	Retrieving relevant information from existing data	Member State administrations	32,06	111	3 762	1	27	27	0	0	101 565	0%	101 565		100%														
4			Submission of (recurring) reports	Filing forms and tables	Member State administrations	32,06	59	1 881	1	27	27	0	0	50 783	0%	50 783		100%														
Total administrative costs (€)														304 695																		
Total administrative burden (€)														304 695																		
Administrative costs by origin (€)														304 695																		
<p>Regulatory act refers to legislative and statutory acts</p> <p>For the reference of the proposal / act, use EU-Lex format ('cut and paste' of the reference given by <a href="http://europa.eu.int/eur-lex/lex/RECH_menu.do?hlmlang=en">http://europa.eu.int/eur-lex/lex/RECH_menu.do?hlmlang=en</a>).</p> <p>No. = gives a number for each action.</p> <p>Art. = article and § detailing the obligation assessed on that line.</p> <p>Orig. Art. = if the act assessed is the transposition of an act adopted at another level, insert here the article and § of the 'original' act corresponding to the obligation assessed on that line (for ex., article of the EC directive at the origin of one specific obligation imposed by national law)</p> <p>Price per action (P) = Tariff * Time. Total Nbr of actions (Q) = Frequency * Number of entities. Total cost per action = P*Q + Equipment + Outsourcing.</p> <p>For equipment, yearly cost is calculated on the basis of the depreciation period.</p> <p>When the act amends existing provisions and reduce the value of a parameter (lower frequency, lower number of entities concerned, etc), negative figures corresponding to that reduction should be typed in the relevant columns</p>																																

Proposal for an EU initiative on HEPA - Option C - subsequent years										Regulatory origin (%)						
If the act assessed is the transposition of one or several acts adopted at another level, insert here the name and reference of that or these 'original' acts										Int	EU	Nat	Reg			
No.	Art.	Orig. Art.	Type of obligation	Description of required action(s)	Target group	Tariff (€/per hour)	Time (hours)	Price (per action)	Freq (per year)					Nbr of entities	Total number of actions	Equipment costs (per entity & per year)
1			Submission of (recurring) reports	Retrieving relevant information from existing data	Member State administrations	32,06	117	3 762	1	27	27	0	0	101 565	0%	101 565
2			Submission of (recurring) reports	Filing forms and tables	Member State administrations	32,06	59	1 881	1	27	27	0	0	50 783	0%	50 783
												<b>Total administrative costs (€)</b>		<b>152 348</b>		
												<i>Total administrative burden (€)</i>		152 348		
												<i>Administrative costs by origin (€)</i>		152 348		
Regulatory act refers to legislative and statutory acts																
For the reference of the proposal / act, use EU-Lex format ('cut and paste' of the reference given by <a href="http://europa.eu.int/eur-lex/lex/RECH_menu.do?hmlang=en">http://europa.eu.int/eur-lex/lex/RECH_menu.do?hmlang=en</a> ).																
No. = gives a number for each action.																
Art.= article and § detailing the obligation assessed on that line.																
Orig. Art. = if the act assessed is the transposition of an act adopted at another level, insert here the article and § of the 'original' act corresponding to the obligation assessed on that line (for ex., article of the EC directive at the origin of one specific obligation imposed by national law)																
Price per action (P) = Tariff * Time. Total Nbr of actions (Q) = Frequency * Number of entities. Total cost per action = P*Q + Equipment + Outsourcing.																
For equipment, yearly cost is calculated on the basis of the depreciation period.																
When the act amends existing provisions and reduce the value of a parameter (lower frequency, lower number of entities concerned, etc), negative figures corresponding to that reduction should be typed in the relevant columns																

Proposal for an EU initiative on HEPA - Option D - year 1										Regulatory origin (%)								
If the act assessed is the transposition of one or several acts adopted at another level, insert here the name and reference of that or these 'original' acts										Total Administrative Burdens (AC- BAU)	Business As Usual Costs (% of AC)	Total Administrative Costs	Int	EU	Nat	Reg		
No.	Art.	Orig. Art.	Type of obligation	Description of required action(s)	Target group	Tariff (€/per hour)	Time (hours)	Price (per action)	Freq (per year)								Nbr of entities	Total number of actions
1			Submission of (recurring) reports	Familiarising with the information obligation	Member State administrations	32,06	176	5,643	1	27	27	0	0	152,348	0%	152,348	100%	
2			Submission of (recurring) reports	Training members and employees about the information obligations	Member State administrations	32,06	176	5,643	1	27	27	0	0	152,348	0%	152,348	100%	
3			Submission of (recurring) reports	Retrieving relevant information from existing data	Member State administrations	32,06	235	7,523	1	27	27	0	0	203,130	0%	203,130	100%	
4			Submission of (recurring) reports	Filing forms and tables	Member State administrations	32,06	117	3,762	1	27	27	0	0	101,565	0%	101,565	100%	
											<b>Total administrative costs (€)</b>	<b>609 390</b>						
											Total administrative burden (€)	609 390						
											Administrative costs by origin (€)		609 390					
Regulatory act refers to legislative and statutory acts																		
For the reference of the proposal / act, use EU-Lex format ('cut and paste' of the reference given by <a href="http://europa.eu.int/eur-lex/lex/RECH_menu.do?hlmlang=en">http://europa.eu.int/eur-lex/lex/RECH_menu.do?hlmlang=en</a> ).																		
Nb. = gives a number for each action.																		
Art. = article and § detailing the obligation assessed on that line.																		
Orig. Art. = if the act assessed is the transposition of an act adopted at another level, insert here the article and § of the 'original' act corresponding to the obligation assessed on that line (for ex., article of the EC directive at the origin of one specific obligation imposed by national law)																		
Price per action (P) = Tariff * Time. Total Nbr of actions (Q) = Frequency * Number of entities. Total cost per action = P*Q + Equipment + Outsourcing.																		
For equipment, yearly cost is calculated on the basis of the depreciation period.																		
When the act amends existing provisions and reduce the value of a parameter (lower frequency, lower number of entities concerned, etc), negative figures corresponding to that reduction should be typed in the relevant columns																		

Proposal for an EU initiative on HEPA - Option D - subsequent years										Regulatory origin (%)								
If the act assessed is the transposition of one or several acts adopted at another level, insert here the name and reference of that or these 'original' acts										Int	EU	Nat	Reg					
No. / Art.	Orig. Art.	Type of obligation	Description of required action(s)	Target group	Tariff (€/per hour)	Time (hours)	Price (per action)	Freq (per year)	Nbr of entities					Total number of actions	Equipment costs (per entity & per year)	Outsourcing costs (per entity & per year)	Total Administrative Costs	Business As Usual Costs (% of AC)
1		Submission of (recurring) reports	Retrieving relevant information from existing data	Member State administrations	32,06	235	7 523	1	27	27	0	0	203 130	0%	203 130			
2		Submission of (recurring) reports	Filing forms and tables	Member State administrations	32,06	117	3 762	1	27	27	0	0	101 565	0%	101 565			
												<b>304 695</b>						
												Total administrative costs (€)						
												Total administrative burden (€)						304 695
												Administrative costs by origin (€)						304 695
Regulatory act refers to legislative and statutory acts																		
For the reference of the proposal / act, use EU-Lex format ('cut and paste' of the reference given by <a href="http://europa.eu.int/eur-lex/lex/RECH_menu.do?hmlang=en">http://europa.eu.int/eur-lex/lex/RECH_menu.do?hmlang=en</a> ).																		
No. = gives a number for each action.																		
Art.= article and § detailing the obligation assessed on that line.																		
Orig. Art. = if the act assessed is the transposition of an act adopted at another level, insert here the article and § of the 'original' act corresponding to the obligation assessed on that line (for ex., article of the EC directive at the origin of one specific obligation imposed by national law )																		
Price per action (P) = Tariff * Time. Total Nbr of actions (Q) = Frequency * Number of entities. Total cost per action = P*Q + Equipment + Outsourcing.																		
For equipment, yearly cost is calculated on the basis of the depreciation period.																		
When the act amends existing provisions and reduce the value of a parameter (lower frequency, lower number of entities concerned, etc), negative figures corresponding to that reduction should be typed in the relevant columns																		