

March 2018

Revision of the drinking water directive

Impact Assessment (SWD(2017) 449, SWD(2017) 448 (summary) of a Commission proposal for a directive of the European Parliament and of the Council on the quality of water intended for human consumption (recast) (COM(2017) 753)

Background

This note seeks to provide an initial analysis of the strengths and weaknesses of the European Commission's [impact assessment](#) (IA) accompanying the above proposal, submitted on 1 February 2018 and referred to the European Parliament's Committee on Environment, Public Health and Food Safety (ENVI).

The EU has provided a legislative framework for the monitoring of its drinking-water quality since 1980 and, in the current [Drinking Water Directive 98/83/EC of 1998](#) (DWD), it sets minimum quality standards for 48 parameters to be monitored regularly (IA, p. 3). Control and enforcement of these standards are left to the Member States, as is appropriately informing consumers. In view of the revision of the current DWD, an [ex-post evaluation](#) was conducted in the framework of the Commission's Regulatory Fitness and Performance programme (REFIT) in 2015. It concluded that the current rules were generally effective and ensured a high level of compliance (99 % as of 2013) for most parameters in all Member States (IA, p. 4). However, it found the nearly 20-year-old list of monitoring parameters outdated and the preventive risk orientation of water control as well as consumer information on water quality insufficient.¹ It also criticised the inefficient and costly existence of divergent national approval systems for materials in contact with drinking water, which prevents the recognition of these materials across the internal market.

Another issue related to drinking water yet not covered by the current directive, was raised in December 2013 by the first successful European citizens' initiative, '[Right2Water](#)', which called on the Commission to ensure access to drinking water for all EU inhabitants (IA p. 5). The Commission decided to address this topic together with the above-mentioned weaknesses of the current DWD, given that people's access to good-quality drinking water can be a challenge if they have no connection to the public water-supply system. Moreover, the Commission seeks to support the EU Member States to ensure access to water for all in the framework of the UN's [Agenda 2030](#) for sustainable development². The revision of the DWD is part of the [EU Action plan for the circular economy](#) and was first included in the Commission's [2017 work programme](#) and then again in its [2018 work programme](#).

Problem definition

The IA's definition of the problems related to drinking-water quality in the context of the current DWD builds directly on the findings of the above-mentioned *ex-post* evaluation. It presents the problems, including their

¹ In 2015, Annexes II and III of the DWD were revised to allow Member States to carry out voluntary risk assessments; according to the IA, a more comprehensive risk-oriented approach is necessary (IA, p. 6).

² Goal 6 of the 17 sustainable development goals set out in UN Agenda 2030, adopted in 2015.

drivers and consequences, in a well-structured way. It also ranks them according to their priority (IA, pp. 4-11):

1. The parameters to monitor drinking-water quality are outdated and do not correspond to the latest scientific knowledge. The list has not been updated since 1998 and does not contain substances like *Legionella*, *Chlorite*, endocrine disrupting chemicals or other emerging substances.³
2. The method of monitoring, that is, at the consumer's tap (end-of-pipe), is not comprehensive enough and does not ensure preventive safety planning or systematic risk assessment of the water quality. It excludes microbiologically related water-polluting sources, such as *Legionella* and somatic *Coliphages*, in natural waters.
3. The information provided to consumers with regard to drinking-water quality and potential risks (for instance, leakages), is insufficient, leading to low consumer confidence in tap water.
4. Divergent national approval systems prevent the mutual recognition of products and materials, such as chemicals used in the production of drinking water or pipes that are in contact with drinking water. This creates obstacles to the internal market as well as administrative burdens, higher prices and legal uncertainty for producers and consumers.⁴
5. About 4.5 % of the EU population (23 million homeless people, nomadic communities and others) is not connected to public water systems, which may entail risks for water quality and health issues.⁵

The scope of the problems described is quite broad, although the IA considers health protection and improved water quality monitoring as the 'most urgent' ones (IA, pp. 10-11). The IA further explains that problem 5, which is not within the remit of the current DWD, was included in the IA, to address both the European citizens' initiative and the EU's commitment to the UN's Agenda 2030 (IA, pp. 5, 10). Given that ownership and provision of drinking water services are a national, not an EU competence, the IA underlines that the lack of access to water will be considered (only) as far as health problems are concerned (IA, p. 10). Moreover, it highlights that the idea of risk-based monitoring has been well received by Member States since its optional introduction in Annexes II and III to the DWD in 2015, and should be fully integrated into the main text of the directive (IA, p. 6). The IA considers the impact of the problems identified as far-reaching and potentially affecting all EU citizens and consumers, water suppliers and public authorities (IA, p. 40, Annex 3).

Objectives of the legislative proposal

The objectives of the Commission's proposal could have been presented in a more thorough and precise manner; as a result, the distinction drawn in the IA between the general and the specific objectives is not clear. The IA mentions the following *general* objectives: 1) contributing to effective and efficient health protection by ensuring continuous quality control of drinking water; 2) modernising and simplifying the current legislation; 3) changing the monitoring approach from the 'end of pipe' system to a more preventive one; 4) reducing the administrative burden through the use of new technologies; and, 5) increasing transparency for citizens as regards water quality. As *specific* objectives it lists the following:

1. The update of the list of parameters to monitor, in line with technical and scientific progress;
2. The simplification of monitoring and focus on contaminants with health risks;
3. Removal of obstacles to the internal market for materials and products in contact with drinking water;
4. Increasing transparency for citizens and consumers as regards water quality;
5. Improving/promoting access to drinking water.

³ In the meantime, the WHO has introduced significant updates to its [guidelines for drinking water quality](#), including the parameters and the monitoring approach, three times (see I. Kiendl Krišto, [Drinking Water Directive](#), EPRS 2017, p. 3).

⁴ This refers to Article 10 of the DWD, according to which Member States shall ensure that materials in contact with drinking water do not lower the protection of human health (IA, p. 7).

⁵ The IA notes that this estimation might be overestimated (pp. 21-22). No detailed data are available on these groups of people or the causes of non-connection.

According to the Commission's better regulation guidelines,⁶ general objectives should be based on the Treaty; but in this case, as they are quite specific, they make the specific ones look largely redundant (IA, p. 13). This non-distinction is problematic in view of developing clear policy options and their assessment, especially since the IA does not provide any *operational* objectives either, also contrary to the better regulation guidelines. Furthermore, the scale of some objectives remains vague. This is the case for specific objectives 3 and 5, while the meaning of specific objective 2 only becomes fully clear in the context of the policy options. Notwithstanding these weaknesses, the objectives are consistent with the problems identified and in line with, inter alia, the [Action plan for the circular economy](#), the [Water Framework Directive](#), the [Groundwater Directive](#) and the UN Agenda 2030. They seem, however, not to fulfil all of the SMART criteria of being specific, measurable, achievable, relevant and time-bound as required by the better regulation guidelines, to ensure a transparent assessment of the policy options and, later on, effective monitoring and evaluation of the adopted legislation.

Range of options considered

Before screening the policy options for achieving the objectives, the IA provides a thorough analysis of the baseline scenario for 2030 and 2050. Throughout the whole IA, the assumptions underlying the analysis are explained in detail, notably in the comprehensive Annex 4 (IA, pp. 14-17, Annex 4, pp. 81, 89-92, 97, 99-111). The IA points to the fact that since 2015, some Member States have started using a 'risk-based approach' in their management of drinking water, which is taken into account in the IA's projections for all policy options (IA, p. 15, Annex 4, pp. 98-111).⁷ In addition, to address the lack of data and the difficulty of establishing a direct causal relationship between drinking-water quality and health risks, the IA develops a new health indicator, the population potentially at health risk (PPHR) (IA, pp. 15-16, Annex 4, pp. 79-119). The quality of this indicator has been verified by the good correlation between the PPHR and data on diseases due to unsafe drinking water, provided by the European Centre for Disease Prevention and Control (ECDC). Besides the baseline scenario as a possible option (no policy change), the IA presents sets of options relating to each of the five specific objectives (IA, pp. 18-23). The IA's preferred options are shaded in grey.

- **Objective 1: Updating the list of parameters** to monitor water quality

Option 1.1: Updating the existing parameters (on the basis of recent WHO standards)

Option 1.2: Extending the list of parameters through additional microbiological parameters, perfluorinated or endocrine-disrupting compounds (based on the precautionary principle, possibly stricter than WHO recommendations)

Option 1.3: Reducing the list of parameters

- **Objective 2: Simplifying the monitoring and risk-based approach**

Option 2.1: Applying a compulsory risk-based approach for larger water suppliers (core list of parameters to always be monitored; risk-based reduction of the level and frequency of required analyses and treatment)

Option 2.2: Applying a compulsory risk-based approach to larger and small water suppliers (transition period for the latter)

- **Objective 3: Removing obstacles to the internal market**

Option 3: Harmonising standards for products and materials in contact with water

- **Objective 4: Ensuring transparency and information to the consumer**

Option 4.1: Simplifying automatic electronic reporting and very substantially reducing the data to be reported, through the use of an online database

Option 4.2: Providing basic online information on water quality to consumers (depending on the size of the supplier)

Option 4.3: Providing advanced and smart online information (depending on the size of the supplier)

⁶ Better Regulation Guidelines, [SWD\(2017\) 350](#), European Commission, July 2017, and toolbox (tool 16).

⁷ The IA expects that by 2050, 74 % of the EU population will receive water from suppliers applying the risk-based approach (p. 15).

- **Objective 5: Improving access to drinking water, supporting measures of Member States)**

Option 5.1: Introducing a legal obligation for national governments to connect all EU citizens to the public water systems

Option 5.2: Introducing an enabling framework of measures: to promote access to water, including through self-supply systems (such as improved wells, local distribution systems or filtering devices for small communities); to encourage the use of tap water; to provide access to water for remote, vulnerable or marginalised groups; and to promote access to water, for instance, in public places.

While the featured options seem pertinent and evidence-based overall, their range is rather limited. There is only one option to achieve (specific) objective 3, and it remains as non-specific as the objective itself.⁸ In fact, it could have been explained more clearly that option 3 entails deleting the current Article 10 of the DWD, which created legal uncertainties, and including the idea of monitoring the materials that are in contact with water in the context of the proposed new obligatory risk assessment of the water distribution system. Harmonisation of standards is envisaged under internal market legislation, not the DWD (regulations on mutual recognition and construction products) (IA, pp. 7, 20, 102). Option 1.3 does not appear realistic and was discarded right away, as was option 5.1. (IA, pp. 24-25). As a result, there are mostly two options to choose from per objective – and only one for objectives 3 and 5. Also, the difference between options 4.1, 4.2 and 4.3. seems small and does not imply fundamentally different policy choices. The IA informs about further options that were discarded earlier in the process, namely the mutual recognition of product standards to remove obstacles to the internal market (deemed 'non-functioning' after 10 years of cooperation between four Member States to get there), and the introduction of product passports to guarantee that any product lawfully sold in one Member State can be sold in another, which was discarded due to the particular sensitivity of health issues (IA, pp. 19-20, 52). The extreme options of repealing and thus discontinuing the DWD, or of replacing it with a regulation, were discarded upfront, based on the findings of the ex-post evaluation (IA, p. 13).

Scope of the impact assessment

In line with the ranking of the objectives, the IA assesses all options first for their acute and chronic health risks, then for their (macro-)economic, social and environmental impacts. It considers the short- and long-term effects and also highlights the potential for simplification and elimination of red tape (IA, pp. 36-37). Although the IA notes several times the important differences between Member States, for instance, as regards access and affordability of water and the PPHR indicator (IA, p. 10, Annex 4, pp. 88-89), and despite the cross-border location of relevant groundwater reservoirs and catchment areas, it has not assessed any territorial impacts. The IA justifies this – not entirely convincingly, though – with the subsidiarity principle, which applies to the access to water, and with the fact that territorial effects are expected to be marginal, since the evaluation had shown a generally good level of water quality in all Member States (IA, Annex 4, p. 115). The assessment is generally well-structured and logical, albeit rather concentrated in some parts, so that it seems advisable to read the comprehensive Annex 4 in parallel. The abundant calculations of direct and indirect costs, (societal, per household or per person), including the costs of bottled water consumption, on the one side, and the health benefits (total or per person) on the other, could have been presented in a more transparent way to facilitate comparison. Despite the generally solid evidence base, some aspects are not clearly substantiated, for example, why the investment to implement option 1.2 would be 33 times higher than that for option 1.1 (Annex 4, p. 96).

The IA explores the **health impacts** for all options, including the baseline. Based on the PPHR indicator, 20 million EU inhabitants would potentially be at short-term health risk by 2050 under the baseline (IA, p. 16). According to the IA, extending the list of parameters applied when monitoring water quality (option 1.2) would reduce this risk by 73.5 %, whereas option 1.1 (just update the current list) would reduce it by 39 % (IA, p. 26). In the long term, the number of people at risk is much higher under the baseline (131 million for 2050). In this

⁸ The IA does not explain or define the option under objective 3 in a satisfactory way, in spite of having commissioned an entire [study](#) on this aspect. It only refers to 'concrete provisions related to the wider domestic risk assessment' (IA, p. 19).

respect, option 1.2 would also bring the biggest annual *health benefits*, that is, savings on healthcare and in costs due to loss of production or productivity, estimated at €153 million per year (IA, p. 27, Annex 4, pp. 86-88, 115). Annex 4 provides, inter alia, information on the potential impacts and societal costs of the main substances known to create health risks in drinking water, such as *Cryptosporidium*, *Campylobacteriosis*, *E.coli* and *Legionella*. It also proposes an extended list of parameters that was developed in the framework of a cooperation project with the WHO, suggesting the removal of some and the addition of other substances (IA, Annex 4, Table 11, pp. 93-95).⁹

In terms of **economic impacts**, the IA provides estimates for the annual set-up costs and operating costs for suppliers to implement the different options in comparison to the baseline. It finds option 1.2 to lead to the largest increase in annual costs (€3.1 billion), while options 3, 2.1 and 2.2 would generate some savings (IA, Figure 8 on p. 28, and Annex 4, p. 117).¹⁰ For households, the expected increase in costs for water services would be €14.90 per year. According to the IA, the introduction of the risk-based approach (options 2.1 and 2.2) would create more savings (€93 million for small and large suppliers) than costs for its set-up (€25 million) (Annex 4, p. 72). In addition, the reduction of bottled water consumption, envisaged under options 4.2, 4.3 and 5.2, would bring estimated savings between €336 million and €610 million by 2050, which, in turn, could be a challenge for the bottled water industry (IA, pp. 30-33, Annex 4, pp. 118-119). In terms of the short-term societal cost for being sick due to contaminated tap water, the IA estimates it at roughly €298 per person as an EU average, with great variations between Member States (IA, Annex 4, pp. 86-88).¹¹ For some options, the IA acknowledges a lack of data and hence uncertainty of its quantifications, for example, as regards access to drinking water, obstacles in the internal market or the change of consumer behaviour (IA, p. 31, 52, 118). Nevertheless, it (briefly) mentions positive impacts on trade through the innovation-friendly options 2, 3, 4.2, 4.3 and 5.2 (IA, pp. 29-30). The biggest employment impact on water providers, namely a 6 % increase by 2050, is expected to derive from option 1.2 (only discarded option 5.1 showed a higher potential increase) (IA, pp. 30-31).

The IA anticipates the proposed options to entail social **impacts** in the form of better information for consumers, increased trust in drinking-water quality and reduced bottled water consumption (IA, pp. 31-33). These impacts would lead to greater affordability of drinking water and to social inclusion through the promotion of greater accessibility of drinking water. The **environmental impacts** considered by the IA relate to water pollution, resource efficiency, including leakages that reach 23 % on average in the EU (up to 57 % in Bulgaria), and energy consumption (IA, pp. 9, 33-36, Annex 4, pp. 91-92). The IA expects that the reduction of pollutants in drinking water will not only benefit water quality for industrial, farming and other uses but will also have a positive effect on biodiversity (IA, p. 34). It estimates that lower consumption of bottled water (88 instead of 100 litres per person/year) could help reduce greenhouse gas emissions by 20 % of the total energy demand of the EU drinking-water supply by 2050 (IA, p. 36).

The assessment is balanced overall, even though the analysis of both the social impacts and the harmonisation of standards (option 3) could have been more complete. The IA compares the projected health protection benefits with the costs of the respective options, weighing the impact for health protection (measured in reduction of PPHR) twice compared to other impacts (IA, pp. 37-39). The combination (and ranking) of all options is quantified and illustrated in useful tables and figures (IA, pp. 41-46, Annex 4, pp. 112-127). It results in three 'feasible' combinations of options, also reflecting the synergies between the options to enhance the effectiveness and efficiency of the preferred package (IA, p. 40, Annex 4, pp. 119-125). However, the three packages seem quite similar, with the two more ambitious ones regarding health protection being identical, except that one contains option 5.2 on access to water and the other one does not. Both of the identical ones

⁹ The WHO also promotes risk-oriented water management, from the source to the consumer's tap (IA, p. 4).

¹⁰ The IA attributes 18 % (€8.3 billion) of the total annual cost (operating costs and annualised set-up costs) for the supply of drinking water in the EU (€46.3 billion in 2015) to the implementation of the DWD.

¹¹ The IA, Annex 4, p. 86, underlines the simplification in the assumptions made in the calculations, including different national health care systems as well as the variety of causes and illnesses treated. Based on estimated costs for a five-day stay at the hospital for an infectious disease and on the assumption that half of the cases need hospital treatment.

contain options 1.2, 2.2, 3, 4.1 and 4.3 (IA, p. 40).¹² In the end, the IA opts in favour of the largest package including option 5.2, even though it is more costly than the combination not addressing this problem. One explanation is that the IA considers the cost estimates for option 5.2 'probably overestimated', owing to a lack of reliable data and great variations between Member States (IA, pp. 22, 44 and 46).

Subsidiarity / proportionality

The IA checks the regulatory options to address the identified problems in the light of the principles of subsidiarity and proportionality. It stresses that the recast of the DWD corresponds to the shared competence between the EU and Member States in this area as stipulated by the Treaties, leaving it to the Member States to decide on the implementation of EU minimum standards at local, regional or national level (IA, pp. 11-12). Furthermore, according to the IA, the cross-border catchment areas and groundwater reservoirs in the EU require EU-level action to achieve harmonisation of water quality and health protection across the EU, as do efforts to contribute as a Union to the UN sustainable development goals. Respect for proportionality is reflected in the selection of the preferred options, as demonstrated by the choice of 'an enabling framework' in the place of legal requirements regarding access to water, and by the possibility for SMEs to transition progressively to the risk-based monitoring system.

At the time of writing, no reasoned opinions or contributions from national parliaments had been received. The subsidiarity deadline is 3 April 2018.

Budgetary or public finance implications

The IA provides no information on implications for the EU budget. According to the explanatory memorandum of the proposal (p. 13), there is no need for additional resources. The increase in costs for the implementation of the preferred options in the Member States is, according to the IA, 'outweighed by the health benefits' (IA, p. 46).

SME test / Competitiveness

The IA notes that most water suppliers are monopolists expected to pass costs on to consumers. Although it does acknowledge a lack of data on the share of SMEs in the Member States, it assumes that the impacts of the policy options would be similar for all sizes of enterprises (IA, p. 29). This aspect could have been explained in more detail. Expected positive effects of the preferred options on SMEs include a boost for innovation (options 1.2, 4.2, 4.3 and 5.2) and fewer barriers in the internal market (option 3). The latter is expected to support the competitiveness of SMEs, in particular in the food and tourism sectors and in the production of water installations (IA, pp. 28-30). The IA highlights that preferred option 2.2, providing for transition periods for SMEs towards a risk-based monitoring approach, will considerably reduce their burden in the long term (IA, p. 37).

Simplification and other regulatory implications

The IA discusses the simplification of the current legislation with a view to reducing the administrative burden in a consistent way. Specific objective 2, and also objectives 3 and 4, are linked to this goal (IA, p. 38). For example, the IA quantifies the potential for an annual reduction of the burden for manufacturers of materials in contact with drinking water – assuming these were fully recognised in the internal market – at €669 million (IA, p. 37). Moreover, more limited reporting requirements for Member States would bring cost savings from compliance worth €96 million per year (IA, Annex 4, p. 76). Some details about the implementation of simplified procedures, such as the interconnection among newly developed software systems, remain to be seen (IA, p. 36).¹³

¹² Annex 3 of the IA contains a comprehensive table summarizing all costs and benefits of the preferred options (pp. 71-78).

¹³ 'Whether the simplified reporting can be ... interlinked with the ... Water Information System for Europe (WISE), or a new reporting tool ... remains to be seen.' (IA, p. 36).

Quality of data, research and analysis

The IA analysis and assessments are reasonable and are underpinned by solid evidence and internal and external expertise. Besides the [study](#) that served as the basis for preparing the Commission's evaluation report, a separate [support study](#) was carried out for the IA process. The IA can be considered an example of a 'good practice' as regards the 'evaluation first' principle, as it frequently refers to the findings of the ex-post evaluation (or the study it is based on). Importantly, although the IA mentions some time overlap between the ex-post evaluation and the ex-ante IA, it applies these methodologies without mixing them. Further input came from a cooperation project with the WHO Regional Office for Europe, launched in December 2015, to get the most recent scientific knowledge for the revision of the parameters, from the European Centre for Disease Prevention and Control (ECDC) and from the European Environment Agency (EEA) (IA, p. 18).

The IA informs in a transparent way both about the main assumptions underlying the analysis, and their limitations and uncertainties. This is particularly relevant regarding the quantification of impacts and the development of the new indicator, PPHR (IA, p. 15 footnote 48, p. 21, Annex 4). Well-illustrated and helpful, the figures and tables are complemented by a wealth of information in the annexes. At times, the use of alternating categories of costs and benefits leads to a rather complex set of calculations that the reader might not always be able to relate to or make comparisons.

Stakeholder consultation

Several broad stakeholder consultations were carried out to prepare this IA. Following the European citizens' initiative, 'Right2Water', the Commission ran an open public consultation, in all languages, on drinking water quality (from 23 June to 23 September 2014) (IA, p. 8, Annex 2). It received 5 908 replies and 138 opinions from a wide spectrum of stakeholders from all EU countries,¹⁴ including water and industrial associations, non-government organisations, interest groups, academics and – most of all (about 88%) – from citizens (IA, Annex 2, p. 55). In 2014 and 2015, two stakeholder dialogues – on transparency and benchmarking – were organised, and a targeted stakeholder consultation in May 2015 included regional and national authorities. Another stakeholder conference in December 2015 looked more precisely into possible policy options to address the existing problems. Furthermore, in 2016 the Commission sent questionnaires to the Member States and received 15 responses and 16 position papers (IA, Annex 2, p. 56). In September 2016, another large stakeholder conference was co-organised with the WHO on drinking water parameters. Finally, after the publication of the Inception IA, another 32 replies from stakeholders were registered on the Commission's better regulation portal. The stakeholders' feedback has regularly been discussed in the EU's Drinking Water Expert Group (IA, p. 48, 55).

According to the IA, stakeholders generally supported the need for revising the monitoring parameters and harmonising the standards for materials in contact with drinking water, with split opinions among Member States as regards the extension, or not, of the list of parameters (IA, Annex 2, p. 57). Some Member States asked for careful consideration of the costs that new provisions would entail. As regards the risk-based-approach, many Member States asked for guidelines on its implementation, while many citizens required more up-to-date information on water quality (IA, Annex 2, p. 58). The exact standpoints on the different issues at stake would need to be checked on a case by case basis, but overall, the effort made to consult as many stakeholders as possible, at different stages of the IA and evaluation process, seems convincing enough for a reliable insight into their positions as a useful component of the IA.¹⁵

Monitoring and evaluation

The IA concludes that the current monitoring system, used for checking compliance with the water quality parameters, is outdated and needs to be replaced (IA, p. 47). It stresses the importance of a regular review of these parameters based on scientific and technical progress. As regards a comprehensive ex-post evaluation of

¹⁴ According to the IA, Annex 2, p. 55, Poland, Denmark, the United Kingdom, Sweden and Estonia were under-represented.

¹⁵ Even if many respondents to the public consultation did not specify their institution or sector (IA, Annex 2, p. 57).

the entire legislation, it suggests to conduct it no later than 12 years after transposition, to enable the inclusion of data from two cycles of supply risk assessment. Despite the missing operational objectives, the IA proposes a list of success indicators that refer to each specific objective and were developed in cooperation with the EEA (IA, p. 48, Annex 5, pp. 128-131). However, while the presented indicators seem to be pertinent, for example, regarding Member States' reporting on incidents, the accessibility of public drinking-water supplies or the level of leakages in the networks, some elements could have been elaborated further. The IA also indicates a need for further (epidemiological) research to specify effective targets or measurements (IA, p. 48).

Commission Regulatory Scrutiny Board

The Commission's Regulatory Scrutiny Board gave the draft IA a positive [opinion](#) with reservations. It criticised the unclear scope of the assessment and the lack of clear explanations regarding the planned update of the list of parameters. Both aspects were addressed in the final IA, which clarifies the priority of the health protection objectives and the development of the updated parameter list, after taking into account the recommendations of the WHO cooperation project, on the one hand, and the application of the precautionary principle, on the other. Still, as indicated above, the partly unspecified scope of the objectives remains a weakness of the IA.

Coherence between the Commission's legislative proposal and the IA

The Commission's legislative proposal follows the IA's recommendations and preferred options. It transfers the obligation of the water supplier to carry out a risk assessment from Annex II to Article 9 and includes the risk assessment of the water distribution system (new Article 10).¹⁶ The current Article 10, asking Member States to ensure that materials in contact with water do not create health issues, is deleted, while the harmonisation of standards for these materials is envisaged to take place outside the scope of the DWD (IA, pp. 7, 19).

Conclusions

The IA builds on solid internal and external expertise, a reliable evidence base and extensive stakeholder consultations. While it seeks primarily to address the health risks related to drinking water, a number of other identified problems, such as harmonisation of standards for products in contact with drinking water and access to water (options 3, 5.1 and 5.2), have only partly been analysed. A more precise definition of the objectives would have contributed to greater clarity in this regard, also because the IA does not provide operational objectives. The overall thorough, albeit concise analysis provides a wealth of cost and benefit quantifications relating to all policy options and resting on complex sets of assumptions presented in a transparent way. The range of options is, however, limited – one or two per objective – and leads to a rather predictable selection of preferred options. Finally, monitoring, which is an important aspect of the proposal, could have been explored more thoroughly to ensure effective evaluation of the legislation.

This note, prepared by the Ex-Ante Impact Assessment Unit for the European Parliament's Committee on Environment, Public Health and Food Safety (ENVI), analyses whether the principal criteria laid down in the Commission's own Better Regulation Guidelines, as well as additional factors identified by the Parliament in its Impact Assessment Handbook, appear to be met by the IA. It does not attempt to deal with the substance of the proposal. It is drafted for informational and background purposes to assist the relevant parliamentary committee(s) and Members more widely in their work.

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¹⁶ Large water suppliers will be expected to implement the risk-based approach within three years, small ones within six years.