

*“Nothing is more
powerful than an idea
whose time has come”*

Victor Hugo



An idea whose time has come

New opportunities for **HEALTH IMPACT ASSESSMENT**
in New Zealand public policy and planning

The Public Health Advisory Committee (PHAC) is a sub-committee of the National Advisory Committee on Health and Disability (National Health Committee, NHC). It provides independent advice to the Minister of Health on public health issues, including the factors underlying the health of people and communities.

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Thanks to Alex Scott-Samuel for an idea for the title; to Martin Ward, Frances Graham, Margaret Earle, Gabrielle Baker, Jenny Skinner and Louise Signal for their helpful comments on the document; to Rob Quigley for many of the photos; and to Liz Price for editing.

This report is available on the Public Health Advisory Committee website: www.nhc.govt.nz/phac

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First published in February 2007

The Public Health Advisory Committee

Wellington, New Zealand

ISBN: 0-478-28518-3 (Book)

ISBN: 0-478-28519-1 (Internet)

HP: 4335

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Foreword by the Prime Minister

When people are asked what is important to their quality of life, good health and wellbeing is near the top of their list. As well, good health and wellbeing are essential ingredients of a productive and dynamic community.

The settings in which people live, work and play have a significant impact on their health and wellbeing but they are largely outside the influence of the health sector. Factors such as housing, income, access to education and employment, and the urban environment, all affect people's health and wellbeing. That means that improving the health and wellbeing of New Zealanders cannot be achieved by the health services acting alone.

Health Impact Assessment (HIA) can be used to harness and co-ordinate government policies in ways that enhance health outcomes. The Government is convinced of its benefits for public policy and has provided funding for three years to establish an HIA support team. The support team will provide technical advice and information to agencies undertaking HIA.

Our Government has signalled that government agencies will be expected to introduce some means of formal health assessment of new policies and legislation during their development. It is pleasing that some local authorities are already using health impact assessment processes to assist them in fulfilling their legislative requirement to improve the wellbeing of their communities.

This report from the Public Health Advisory Committee, and its companion volume, *A Guide to Health Impact Assessment*, will assist us to understand the benefits of HIA and to know where to go for more information.



Rt. Hon. Helen Clark
Prime Minister



Preface

The core premise of this report, its 2005 companion volume *A Guide to Health Impact Assessment* and the Public Health Advisory Committee's (PHAC's) other recently published report *Health is Everyone's Business* can be simply stated. Enhancing the processes of public policy to routinely take health impacts into account will significantly improve the health and wellbeing of all New Zealanders.

It has become commonplace to observe that health depends on much more than health services. Public policies relating to housing, transport, urban design, food standards, education and employment are just some of the policies that affect health and wellbeing. But policy makers have generally lacked the tools to identify the health effects of new policy settings and to take these effects into account in the policy-making process.

Health Impact Assessment (HIA) provides such tools. Once embedded in the process of policy development it makes visible the implications of particular policy settings for health. This allows the development of innovative solutions that enhance health while still accomplishing policy makers' other aims - and provides a platform for 'whole-of-government' approaches to policy making for health.

The National Health Committee (NHC) has a long and active commitment to HIA. In 1998 it recommended the development of formal mechanisms for assessing the effects of public policies on health in its advice to the Minister entitled *Social, Cultural and Economic Determinants of Health in New Zealand*. The first of 61 objectives in the subsequent *New Zealand Health Strategy 2000* was to 'assess public policies for their impact on health and health inequalities'.

The PHAC has been taking a lead on HIA in New Zealand since its establishment as a sub-committee of the NHC in 2001. As well as publishing this report and its 2005 companion document, it has been involved in training policy makers in HIA, supporting agencies in using HIA and in reviewing the HIAs undertaken at central and local government levels.

A handwritten signature in dark ink, appearing to read 'Geoff Fougere'.

Geoff Fougere

Chair of the Public Health Advisory Committee



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Executive Summary

The good health and wellbeing of the population is largely a product of the settings in which people live, work and play. This means that improving the health and wellbeing of the population requires more than the provision of health care services. It requires new ways of working together with new approaches and new tools (PHAC 2006).

Health Impact Assessment (HIA) is a formal process that aims to ensure public policies, programmes and plans enhance the potentially beneficial effects on health and wellbeing and reduce or mitigate the potential harm with innovative solutions. Although relatively new in New Zealand, it is a well-established approach internationally.

In September 2006, the Government announced funding to support HIA on new government policy and legislation. The funding will be used to establish an HIA support team to provide agencies with public health information and expertise.

Public policies aim to benefit the whole population but can result in unintended negative effects on health and wellbeing, including the widening of health disparities. HIA is used to assist in reducing health inequalities through planning and policy-making processes.

Use of HIA can also improve intersectoral collaboration and community participation, and is an effective way of promoting community wellbeing across sectors. It assists agencies to fulfil statutory obligations for community health and wellbeing, for example under the Local Government Act 2002, the Land Transport Management Act 2003 and the Building Act 2004. It also has strong links with sustainable development goals.

HIA is undertaken when there is a draft proposal(s) but no commitment has been made. There must be an opportunity to modify the policy proposal for improvement of health and wellbeing. The process is informed by both quantitative and qualitative evidence, and focuses on outcomes.

HIA experience is growing in New Zealand and internationally. Evaluations in New Zealand show positive responses to the process by agencies who have undertaken HIA. Completed HIAs have significantly influenced the policies and plans being assessed. In addition, HIAs have engaged Māori and other key stakeholders to be actively involved in the policy where there had previously been little involvement. They have also improved relationships across sectors, and resulted in the establishment of jointly-funded secondments and an improved understanding of what influences people's health and wellbeing.

International experience has shown that an explicit and systematic process, such as HIA, is needed to ensure the availability of sufficient technical information. It also ensures that health is broadly defined (to include wellbeing) and that equity issues are addressed. A systematic assessment process such as HIA needs to become part of agency ethos for it to become a routine part of decision-making. Agencies need access to quality public health information and support.

This report is a companion volume to the PHAC's 2005 publication *A Guide to HIA: a policy tool for New Zealand*.

**The good health and wellbeing
of the population is largely a
product of the settings in which
people live, work and play.**



Introduction

1 Chapter One

In September 2006, the Prime Minister announced a package of initiatives to address obesity in young New Zealanders ('Mission On'). One of these initiatives is the introduction of Health Impact Assessment (HIA) for new government policy and legislation through the establishment of an HIA Support Unit.

This report covers what health impacts are, the benefits of HIA, what the Public Health Advisory Committee (PHAC) has learned from its work on HIA, describes some HIA case studies, and considers what is needed to make HIA a routine part of policy making in New Zealand. It will be of particular relevance to policy makers in central and local government agencies and to public health practitioners who may be called on to support HIA.

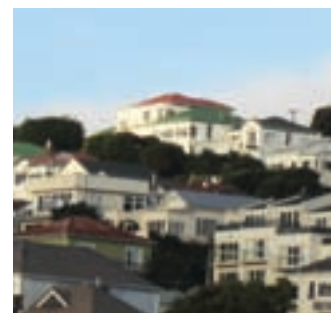
What are health impacts?

Health impacts are the health consequences of particular actions. They can be beneficial or harmful.

Historically, ill health has been, and always will be treated by health care services provided by the health sector. Although curative services have their limits, the health care sector has contributed to the overall health of the population by making sick people well. It has also had some success in improving the health of the population by reducing risk factors such as smoking, high blood pressure, and high cholesterol, therefore preventing disease.

However, health improvement depends on more than the health care sector can offer. Many risk factors of disease are influenced by factors outside the control of the health sector; factors such as the social and economic environments in which people make their lifestyle choices, and which in many circumstances actually remove choice. For example, the affordability of housing will determine the standard of housing chosen by a particular household; access to employment will affect people's ability to provide the essentials of life for their families/whānau; and the way people's neighbourhoods are designed will influence their exercise patterns, their air quality and their social networks. These influences are called the social determinants of health.

This section provides brief summaries of the potential influences that various settings may have on people's health and wellbeing.





Community wellbeing
is directly and
indirectly affected
by the social
environments in
which people live
their lives.



Overview of the health impacts of transport

Quick Facts

How transport affects health and wellbeing

- Transport provides **access** to education, employment, recreation, social networks, and public services including health services, all of which are important determinants of health and wellbeing.
- **Economic development** is aided by increased mobility of goods and services. Economic development leads to increased employment opportunities, employment being an important determinant of health.
- Opportunities for **exercise** may be improved or impeded through modes of transport - walking, cycling, and walking to and from public transport all benefit health.
- **Road traffic injuries** including deaths and injury for cyclists, pedestrians and passengers. Perceived danger from traffic restricts children's independent mobility and reduces their physical activity.
- **Ambient air quality** is affected by emissions from motor vehicles including oxides of nitrogen and sulphur, carbon monoxide, carbon dioxide and fine particulate emissions. Air pollution is associated with rises in deaths and hospital admissions particularly by

the aggravation of respiratory and cardiovascular conditions.

- **Climate change** is affected through greenhouse gas emissions from motor vehicles, such as carbon dioxide. Climate change will eventually compromise water quality and security, increase vector and waterborne diseases and increase algal blooms that are harmful to human health. These effects will be felt most by those with the fewest resources to respond.
- **Community connectedness** is affected by road patterns. Roads can link communities or if built through communities can cut residents off from safe access to social support, schools, public services, shops etc. Social support is beneficial to health and wellbeing but social contact tends to fall off as traffic increases.
- High and persistent **traffic noise** contributes to stress-related problems.
- **Inequalities** – the effects of transport policy do not fall evenly on all sectors of society. People with higher incomes can afford to live away from main roads and their harmful effects; older people, children, pedestrians, cyclists and people with disabilities will be the most disadvantaged by increased traffic.

For sources of evidence linking transport and health see Appendix One in this report.



Overview of health impacts of housing

There is a strong body of evidence linking housing conditions with health outcomes.

Quick Facts

How housing affects health and wellbeing

- **Dampness and cold.** Older housing tends to be damp and cold, conditions which create high risks for health. Much of New Zealand's older housing stock is not insulated and central heating systems are rare. Children and adults living in such conditions have a higher risk of developing respiratory conditions.
- **Housing improvements** such as better insulation and heating systems have been shown to reduce the incidence of respiratory conditions and consequent hospitalisations.
- **Safety devices** such as smoke alarms, hand rails, non-slip flooring and fenced balconies have been shown to reduce the risk of accidental injury.
- **Indoor air quality** can improve or aggravate respiratory conditions, allergic reactions and toxic reactions to contaminants. The groups most at risk from poor indoor air are those that spend a lot of time indoors such as children, older people, and people with existing health conditions. Known risk

factors for people with an existing health condition include second-hand tobacco smoke, nitrogen dioxide (from gas cookers and unflued heaters) toxic moulds, and dust mites.

- **Ambient air quality** is affected by emissions from domestic home heating. In some urban areas around New Zealand domestic home heating is the predominant source of air pollution which is associated with increases in deaths and hospital admissions.
- **Overcrowding** is associated with increased risk of infectious diseases, such as meningococcal disease, tuberculosis and rheumatic fever; as well as with stress.
- **High housing costs** can negatively affect health by reducing the amount households can spend on healthy food and heating.
- **Community safety** can be improved by the design of buildings and their surroundings. People's sense of their safety has a large impact on their mental health and wellbeing.
- **Levels of social support** are often related to the design of housing, especially multi-dwelling units. High levels of social support are necessary for community wellbeing.

For sources of evidence linking housing and health, see Appendix One in this report.



Overview of the health impacts of social policies

Family/whānau and community wellbeing (te taha whānau) is directly and indirectly affected by the social environments in which people live their lives. Issues such as income, employment, job security, and social connectedness (or exclusion) all impact on health.

Quick Facts

How social policies affect health and wellbeing

- **Income** is a strong predictor of health and is represented by a gradient. As income increases, health status increases. New Zealand men on high incomes have half the risk of dying prematurely than is the case for men on low incomes. Income levels impact on other determinants of health such as quality of housing, nutrition and access to health services.
- **Employment** status is critical for determining income (see above) and is also associated with self-esteem, social inclusion, and social status, which independently affect health and wellbeing
- **Job insecurity** is associated with mild depression and those who are unemployed or facing a possible job loss have a lower self-reported health status. Less skilled, manual workers tend to be most exposed to low paid, temporary or insecure jobs, and in New Zealand, Māori and Pacific workers are significantly over represented in these occupational groups.



- **Occupational health and safety.**

Less skilled and manual occupations are most likely to be hazardous and unhealthy. Hazards include increased risk of accidental injury and death, and of ill-health due to exposure to toxic substances.

- **Social connectedness.** People with good social networks and support are likely to have a higher self-reported health status than those who are socially isolated.

- **Family and community safety.**

People who live in safe neighbourhoods and safe family environments have a higher self-reported health status than those who experience violence or perceive they are at risk of violence. A recent Australian report concludes that intimate partner violence is responsible for more ill-health and premature death in women under 45 than any other of the well-known risk factors including high blood pressure, smoking and obesity.

For sources of evidence linking social policies and health, see Appendix One in this report.

Overview of the health impacts of urban design

The relationship between the urban environment and the people who live in it is becoming increasingly complex as cities and towns grow. There is evidence that urban design, including built environments, land use, water quality and waste management, affects the health status of urban residents, physically, mentally, environmentally and socially.

Quick Facts

How urban design affects health and wellbeing

Good urban design supports health and wellbeing by:

- providing opportunities for physical activity through creating walkable streets and green spaces, access to leisure activities and integrated network of cycling paths



- improving social connection and participation through mixed use planning and integrated public transport
- improving personal safety through good street lighting and safely planted areas
- providing access to services, amenities and employment through well-connected street networks and integrated public transport
- including buildings that support human health and wellbeing by addressing such issues as indoor air quality, fungal growth, insulation and noise levels
- providing attractive civic spaces, such as town squares, and marketplaces, and green spaces such as parks and gardens
- providing transport infrastructure with accessible public transport interchanges.

Health damaging effects of poor urban design are linked to the increased use of motor vehicles, air pollution, urban sprawl, exposure to environmental hazards, physical inactivity and lack of an accessible, safe and well-maintained built environment and infrastructure. Poor urban design contributes to the incidence of obesity, respiratory conditions, cardiovascular diseases, traffic-related injury, stress and social isolation.

For sources of evidence linking urban design and health, see Appendix One in this report.

Why Health Impact Assessment (HIA)?

The good health and wellbeing of the population is largely a product of the settings in which people live, work and play. This means improving the health and wellbeing of the population requires more than the provision of health care services. It requires responsibility for health and wellbeing to be shared across public and private sectors, and across central and local government, working with communities to ensure that the settings in which people live, work and play support their health and wellbeing.



These new ways of working together require new approaches and new tools (PHAC 2006).

HIA is one approach where sectors work together to ensure that public policies, programmes and plans maximise the beneficial effects of proposals on health and wellbeing, and reduce potential harm.

What is HIA?

HIA identifies the potential impacts on the health of the population of any proposed policy, strategy, plan or project, prior to implementation. Once identified, a set of recommendations is prepared, to inform the proposal's decision-making process. These recommendations are evidence-based and outcomes focused. They propose practical ways to enhance the positive overall wellbeing/health effects of a proposal and to remove or minimise the negative health effects. They focus on potential overall health impacts and the distribution of those impacts across the population, to check no population groups will be disadvantaged by a proposal. HIA can therefore assist in achieving equity goals in addition to benefits for overall health improvement.

HIA identifies *direct* health impacts, for example, increased traffic causing increased traffic injuries. It also identifies *indirect* health impacts, such as the effect on health and wellbeing of high housing rental or of a road built through a community. HIA first identifies the potential impacts of a policy on these health influences (determinants of health).



Table 1 *Examples of the determinants of health*

<i>Categories of determinants of health</i>	<i>Examples of specific health determinants</i>	
<p>■ Social and cultural factors</p>	<p>Social networks, family connections, racism, cultural and spiritual participation, perception of safety</p>	
<p>■ Economic factors</p>	<p>Income level, affordability of housing, access to employment</p>	
<p>■ Environmental factors</p>	<p>Housing conditions and location, waste disposal, urban design, noise, transmission of infectious diseases eg. exposure to pathogens</p>	
<p>■ Population-based services</p>	<p>Access to quality education, housing, public transport, health care, disability support, childcare</p>	
<p>■ Individual/behavioural factors (these are affected by all of the above)</p>	<p>Personal behaviours (eg. smoking, physical activity, nutrition, alcohol and drug use), personal safety, employment status, educational attainment, stress levels</p>	
<p>■ Biological factors (unlikely to be affected by policy)</p>	<p>Biological age, genetics</p>	



Public policy is likely to directly affect the determinants in the first four rows of Table 1, personal behaviour choices will be influenced by these first four rows, and individual biological characteristics are least affected by public policy. For a more complete version of the table, see pg 36 of *A Guide to HIA* (PHAC 2005).

HIA can take place at any level – local, regional or national. HIA could take place in any sector – public, private or voluntary – but in New Zealand and in other parts of the world it is currently being led by the public sector. The exception is Africa where HIA is being led by multi-national corporations. Considering the potential impact the private sector has on the health and wellbeing of the population, particularly the activities of large international companies, there is a strong case for HIA to be picked up by the business sector in New Zealand. HIA could also be used by communities for advocacy purposes.

This report will focus mainly on policy-level HIA. However, the New Zealand HIAs undertaken during the course of the PHAC

project have covered a range of policies, strategies, plans and projects, all of which are described here and their experience reviewed.

Policy-level impact assessment is not new. It has been used for economic, environmental and social reasons in recent decades. The practice of assessing policies for their impact on health and wellbeing and on health inequalities is new – an idea whose time has come.

How can HIA contribute to Māori health?

The disparities between Māori and non-Māori health outcomes have been well documented (Decades of Disparity 2003, 2004, 2006, Tatau Kahuhura: the Māori Health Chart Book). Health disparities between Māori and non-Māori reflect the unequal distribution of the economic, social, environmental and cultural influences on health. These influences are often the result of public policy being implemented that has not taken into account the impacts on Māori health, cultural values or identity (PHAC 2004). Māori are disproportionately represented in lower socio-economic groups (for example, lower income, no qualifications, no car access) with resulting disproportionately negative health outcomes.

However, socio-economic differences account for only about half of the ethnic disparities in mortality for working-age adults and one-third of the disparities in mortality for older adults.





Ethnicity is at least as important as socio-economic position for health outcomes (Ministry of Health & University of Otago 2006). This means an assessment of the effect of policies on socio-economic position alone will not provide an accurate picture of the possible impact of a policy.

HIA is not an instant fix but it is one way of ensuring that policies under development do not have the potential for increasing inequalities between Māori and non-Māori, or between any other groups in the population. HIA tools developed in New Zealand have been designed to specifically address the inequities that exist in New Zealand. *A Guide to HIA* uses a checklist that is based on partnership, protection and participation, and an appraisal tool that addresses disparities across the whole population. The Ministry of Health has developed a whānau ora HIA tool that assists in predicting the impact of government activities on whānau ora, the health of Māori families and communities and is specifically for use on policies that target Māori in particular (Ministry of Health, in publication, due for release 2007).

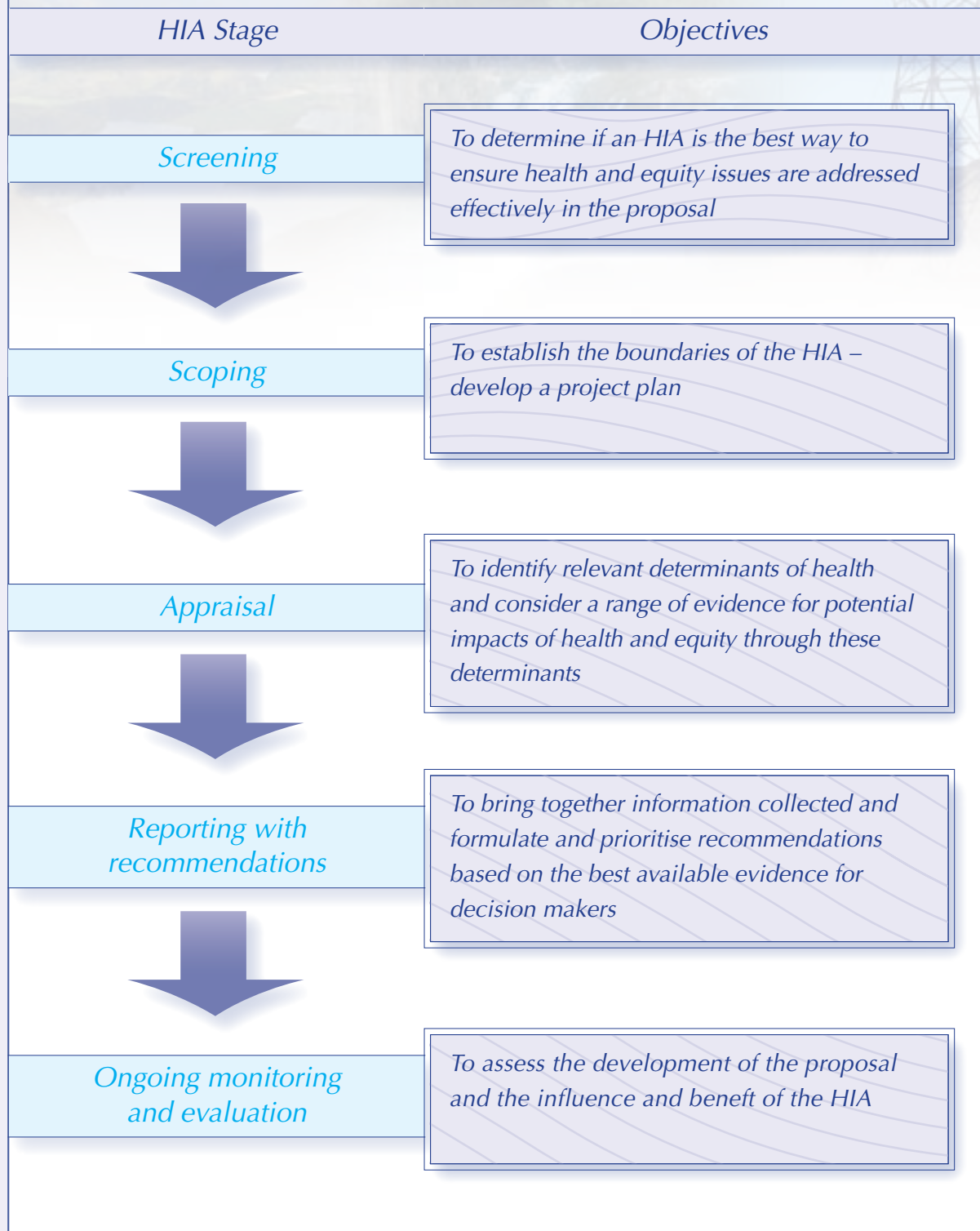


What is the HIA process?¹

HIA is a flexible but systematic approach that can be modified to fit the particular context and task. An HIA may be 'mini', 'rapid', 'intermediate' or 'comprehensive' depending on the constraints of resources and time. There are five main stages in an HIA (see Figure 1).

¹ See the PHAC publication *A Guide to Health Impact Assessment: a policy tool for New Zealand for a step by step guide to HIA*. Available at <http://www.nhc.govt.nz/phac/publications/guidetohia.pdf>

Figure 1 Stages in the HIA process



Source: Adapted from Health Development Agency, 2002. *Introducing HIA: Informing the decision-making process*.



HIA and New Zealand Public Policy

2 Chapter Two

The key benefits to policy agencies are that HIA:

- is an effective way of promoting community wellbeing, health and equity across sectors
- identifies the potential benefits and costs of any proposal to the wellbeing of the population, enabling the policy to be improved in ways likely to reduce controversy and increase the chances of funding a particular proposal
- can be the 'cement' to encourage agencies to work together towards common goals
- is inclusive and known to encourage participation of particular groups, such as Māori and other key stakeholders
- uses local and published evidence to inform decision-makers
- increases mutual understanding of agencies' roles.

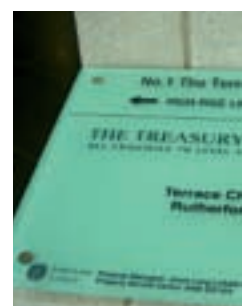
HIA is highly relevant to policy-makers across central and local government, and across the social, economic and environmental sectors. It provides evidence-based, outcomes-focused advice on ways to enhance the benefits of a policy to a population and to reduce the potential harm. It provides opportunities for stakeholder and public participation in policy development.

The HIA approach is anchored in the recognition that health is largely determined by the impacts activities outside the health sector have on the health of populations and on health inequalities. Understanding the potential impact of public policies on the health of the population should therefore be an integral part of the policy development process across central and local government.

This understanding is more than the use of a tool such as HIA. It involves developing an agency ethos that recognises the potential for policies to lead to health benefit or harm, and acting to enhance positive and mitigate negative impacts. HIA is just one way of achieving this.

How can HIA assist planning and policy development?

Public policies often aim to benefit the whole population but can produce unintended and unanticipated negative effects on population groups that widen health disparities. The HIA approach is a way of assisting decision-makers to identify potential impacts and put equity and health on their agenda in a more transparent and systematic way.





The HIA approach is anchored in the recognition that health is largely determined by the impacts activities outside the health sector have on the health of populations and on health inequalities.



Most policies will act indirectly on health through the wider determinants of health such as housing, income, transport, social development etc. Because a range of potential impacts need to be considered in the development of public policy, each with its own set of possibly conflicting directions, trade-offs will need to be made. It is not expected that HIA will drive the policy process but it will identify and develop important strands of evidence to be taken into account.

What proposals could benefit from an HIA?

The public sector at central and local government level produces a high volume of policies, programmes, strategies and plans. Clearly it would not be feasible to formally assess them all for their potential impact on health and wellbeing using the HIA tool. Priority should be given to policies with a potential for significant health impact, that will affect a large proportion of the population, and/or that will affect particular population groups.

So what makes a policy suitable for HIA? A series of screening questions can establish the need for an HIA (see pg 25 of the PHAC publication *A Guide to HIA*). Proposals that will

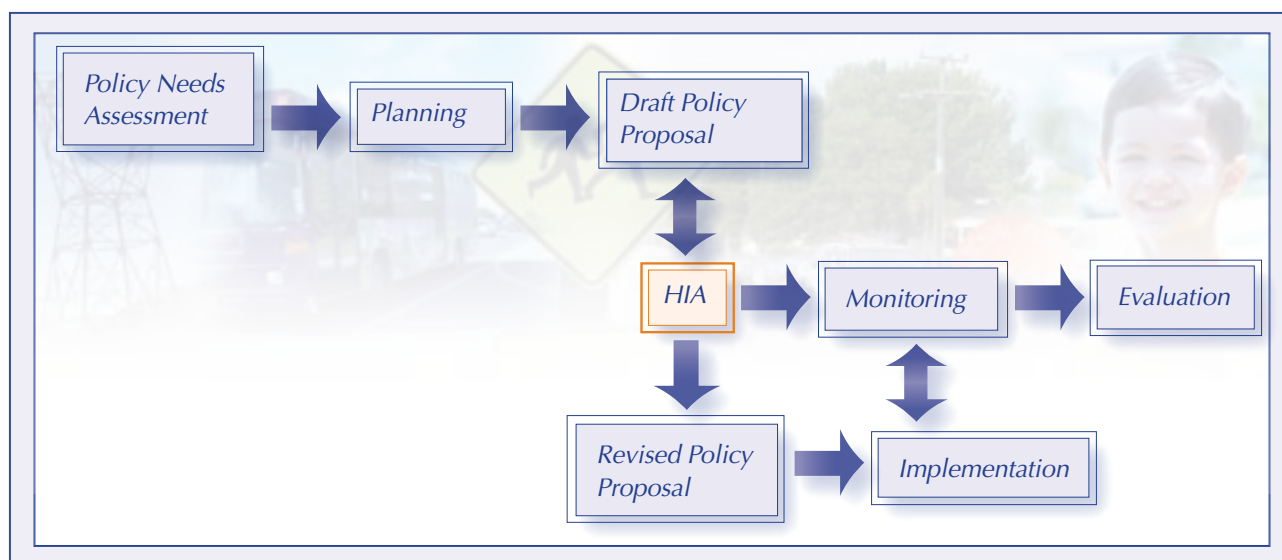
benefit from HIA are those that have potential for significant positive or negative health impacts across a population, and for groups within that population, particularly for communities with poorest health status (eg, Māori). Other issues to be taken into account include the level of public and political concern and the level of support for HIA from the policy agency.

Policies that would benefit from an HIA include those in areas such as employment, town planning and other local government policy, transport, housing, social development and economic policy, as it is these policies that have strong influences on health and wellbeing. There is currently an interest in the effect of policies such as transport, urban design and development, and food marketing and labelling, on obesity across the population. HIA is a process that will effectively predict these impacts.

Where does HIA fit in the policy process?

HIA should be undertaken where policy alternatives are being considered but before a commitment is made. There must be opportunity to modify any policy proposal so the HIA is undertaken when there is a draft proposal and/or policy options to consider.

Figure 2 *Where does HIA fit in the policy process?*



HIA is not a process that necessarily produces definitive policy solutions because it takes place in a complex political and administrative environment with many influences on the policy process. HIA is a contribution to decision-making and informs the policy process by predicting the probable impacts of the policy on the population. Recommendations from the HIA get fed back into the process to enable policy revision for health and wellbeing benefit.

■ HIA and decision-making

Decision-makers will have a range of evidence and information to take into account when developing policy. An HIA will provide an evidence-based and practical set of recommendations to feed into the process, but the HIA will only be as good as the evidence used and will not guarantee policy change. In addition, the quality of the evidence will affect the specificity of the recommendations. A recommendation that is very general will not convince decision-makers. The evidence needs to be broad ranging from a variety of sources, and needs to include evidence to support the reversibility of adverse factors damaging to health.

The potential impacts on the wider determinants of wellbeing and health, however, are politically compelling when developing policy that affects a community. In addition, any HIA undertaken will have had influence even if it does not bring about changes in the policy (Davenport et al 2006). It will have increased understanding of the determinants of health in individuals and agencies, improved cross-agency relationships, and may have increased participation from previously uninvolved groups.

Evidence base for HIA

Davies and Nutley (2001) said that policy can only ever be evidence-informed. It will seldom be totally evidence-based because of other influential factors such as political views and public perceptions. They believe that there

are four requirements for evidence to have an impact on policy-making:

- agreement as to the nature of evidence; information will be more balanced if both quantitative and qualitative evidence is used
- a strategic approach to the creation of evidence, together with the development of a cumulative knowledge base
- effective dissemination of knowledge; together with development of effective ways to access information
- initiatives to increase the uptake of evidence in both policy and practice.

HIA provides a context in which there can be honest discussions about what constitutes useful evidence; it assists in the development of a cumulative knowledge base; it provides greater access to evidence; and because of its commitment to the use of evidence, it increases the use of evidence in policy-making.

There are three sources of evidence used in HIA – that from stakeholders, local data including demographic and health-related data, and evidence from past studies (Mindell et al 2004). The quality of these sources of evidence will vary and often judgements will need to be made on the basis of the best evidence available, which may not be ‘gold standard’.

A Guide to HIA lists evidence as qualitative, estimable or measurable. This three-way classification does not judge, but gives transparency to the source of evidence. Qualitative evidence will be gathered from community surveys, focus groups and key informants. Estimable evidence will be a ‘best guess’ based on available data. Measurable evidence will be hard data gathered by quantitative methods. Quantitative data will include demographic information, other statistical information – for example data on traffic accidents and environmental health data, and modelling techniques that simulate reality. All three forms of evidence are important in the HIA process.



Related types of impact assessment

It is important to view HIA in the context of other types of impact assessment, some of which may be carried out on the same policy as the HIA. Morgan (2005) has pointed out the importance of all impact assessors of the same policy communicating effectively. A number of related forms of impact assessment exist.



- Strategic Environmental Assessment (SEA) is the environmental equivalent of policy-level HIA, assessing policies, programmes or plans for their potential impacts on the environment.



- Environmental Impact Assessment (EIA) is carried out project by project. In the context of the Resource Management Act 1991 (RMA), the EIA process (now referred to as an Assessment of Environmental Effects (AEEs) should identify risks to people, communities, ecosystems, natural and physical resources, amenity values, and social, economic, aesthetic and cultural conditions. There is no specific requirement in the RMA for HIA, and AEEs may not adequately address all health impacts. To emphasise health in the environmental impact process, some literature refers to the term Environmental Health Impact Assessment.



- Social Impact Assessment (SIA) predicts the potential social consequences of a policy. It has a lot in common with the social determinants of health on which policy-level HIA is based.



- Integrated Impact Assessment or Human Impact Assessment recognises the need for policy-makers to assess a variety of potential impacts, for example, social, environmental, economic, and health impacts of a proposal. It brings all together but should involve a formal process, such as SEA and/or SIA.



- Whānau Ora Impact Assessment has been developed by the Ministry of Health for use in New Zealand. This tool is based on the PHAC tools for HIA and is designed to put the focus on the impacts of policies on the health/wellbeing of Māori families.



- Health Equity Assessment Tool (HEAT) was developed by the Wellington School of Medicine for the Ministry of Health. It focuses on how particular inequalities in health have come about, and where the effective intervention points are to tackle them. It is used in conjunction with the *Health Inequalities Intervention Framework* (Ministry of Health 2002).

Health Needs Assessment and HIA

HIA is frequently confused with Health Needs Assessment (HNA), as set out in the New Zealand Health and Disability Act 2000, which systematically reviews the health needs of the population. Figure 3 shows the different starting points of the two approaches. HIA starts with a proposal and predicts the impact on the health of the population. HNA starts with the health of the population and predicts its needs.

Figure 2 Starting Points of HIA and HNA process



Source: Based on Quigley et al 2004

HIA and statutory public health responsibilities

HIA can assist agencies to meet their statutory responsibilities for promoting public health and wellbeing. In New Zealand, four recently-introduced pieces of legislation have increased sector responsibility for protecting the health and wellbeing of the population – the Local Government Act 2002, the Land Transport Management Act 2003, the Building Act 2004 and the Gambling Act 2003. In addition, the proposed Public Health Bill is likely to include a statutory acknowledgement of the importance of HIA.

Local government

Local government is required under the Local Government Act 2002, to 'promote the social, economic, environmental and cultural wellbeing of communities'. The Act also requires each council to prepare a Long Term Council Community Plan (LTCCP) which sets out a community's judgement about what it wants for its wellbeing (community outcomes) and how the Council will contribute to those outcomes. In addition, the Health Act 1956 states that every territorial authority has a duty

to 'improve, promote and protect public health within its district'. HIA provides a systematic and evidence-based process that would assist in meeting these obligations.

Social, economic, environmental and cultural factors (the 'four wellbeing's') are the four cornerstones of the sustainability framework, which looks at social, cultural, economic and environmental dimensions of proposals and decisions. They also represent the four major factors that influence health (the wider determinants of health). There is therefore a strong linkage between sustainability and health outcomes. This is an important linkage for all policy makers and for local government in particular.





Transport sector

The Land Transport Management Act 2003 requires that transport agencies must ensure their work 'protects and promotes public health'. HIA is a tool that can assist agencies to fulfil this statutory obligation. It can be used to broaden the scope of transport planning beyond the traditional public health considerations of vehicle emissions, noise and vibration. A focus on the wider determinants of health, such as social support, and access to services and cultural resources, will significantly increase the quality of information available to decision-makers on the public health impacts of transport decisions.

The requirement for local authorities to develop and regularly review Regional Land Transport Strategies would be greatly assisted in meeting the public health obligation by an HIA process.

Building and housing sector

The Building Act 2004 administered by the Department of Building and Housing, requires that people who use buildings can do so without endangering their health, and that 'buildings have attributes that

contribute appropriately to the health, physical independence, and wellbeing of the people who use them'. It also requires a review of the Building Code to ensure the new requirements of the Act are met. This review is due to be finalised in November 2007 and will take into account the Act's requirements for sustainability and for buildings to help people to stay healthy and comfortable.

The body of New Zealand evidence for the association between housing and health has grown to be extremely persuasive in the past decade, particularly during the research by the Wellington School of Medicine and Health





Sciences and others in their *He Kainga Oranga/Housing and Health Research Programme*. We now know that by insulating houses where there are residents with existing respiratory conditions, houses are warmer and drier, and hospitalisations and days off work/school are reduced. The Counties Manukau Healthy Housing programme resulted in a 37 percent fall in acute housing-related hospitalisations in the first year following intervention (Counties Manukau DHB 2006).

HIA will assist in accessing this type of information on which to base building policy to ensure the standards meet legislative requirements.



Gambling sector

The Gambling Act 2003 introduced a problem gambling levy in order to fund the development, management and implementation of an integrated problem gambling strategy that is focused on public health. The Act states that this strategy is to include 'measures to promote public health by preventing and minimising the harm from gambling'. The Gambling Act also requires local government to develop a policy on non-casino gaming machine venues, and as part of this process, must have regard to the social impact of gambling within the local area.

HIA can be used to identify policy areas that could potentially reduce the harm from gambling.



Public health sector

As this report goes to print, the New Zealand Health Act 1956 is being reviewed. The Public Health Bill is likely to include a statutory acknowledgement of HIA that will encourage but not require HIA to be carried out on significant pieces of new policy and legislation at both central and local government levels.



New Zealand experience of HIA

3 Chapter Three

Agency experience of using HIA in New Zealand²

Individuals in policy agencies surveyed after HIA were strongly positive about their experience. They found that HIA introduced new information to the policy and improved the understanding and use of information already gathered. It was a more effective means of engaging stakeholders than had been used in the policy process previously and as such, improved understanding of participating organisational roles and responsibilities.

One of the key outcomes for local government has been the participation of stakeholders who had not previously been engaged. For example, the participation of Ngai Tahu in the Greater Christchurch HIA has led to their meaningful participation in the Urban Development Strategy. The Auckland City Council developed relationships with locally-based central government agencies through the HIA and strengthened its relationship with the Auckland Regional Public Health Service. The Office of the Parliamentary Commissioner for the Environment (PCE) involved a new group of stakeholders, not previously involved in PCE consultations, which enriched discussions.

Since the HIAs, the policy agencies have been proactively incorporating an improved understanding of the health implications of their activities. The Auckland City Council sees the value in developing a wellbeing impact assessment process that will be designed specifically for local government use. The PCE has recognised health implications as an additional lever to promote change, and is incorporating some of the key elements of HIA in its processes. Greater Christchurch has incorporated population health outcomes as a key focus of the Urban Development Strategy.

The most frequently cited barrier to agencies undertaking HIA is the lack of capacity and resources. This is especially true for local governments in the regions, both for the local authority itself and for the public health unit to which it looks for support. This is an internationally recognised problem. However, HIA is a very flexible process and can be tailored according to the constraints of capacity, time and resources. HIAs range from simple desk-top approaches, usually involving a checklist, through rapid appraisals with a small group of people, to large-scale and very comprehensive assessments involving in-depth research and intersectoral participation.

² This section is based on the findings from a review of New Zealand agencies involved in three different HIAs – Avondale Liveable Communities, Future Currents and the Greater Christchurch Urban Development Strategy (Ward 2006).

The Auckland City Council
sees the value in developing a
wellbeing impact assessment
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specifically for local
government use.





Who's doing HIA and on what?

Within its short history HIA has been shown to be an effective assessment approach both in New Zealand and overseas. This chapter summarises some examples of New Zealand and international HIAs.

New Zealand case studies

1. The Avondale Liveable Communities Plan

Auckland City had a draft plan that set out the proposed strategies to manage residential growth in Avondale over the next fifteen years, while strengthening the community, the economy and protecting the environment. Populations affected included the 14,000 people currently living within the Avondale area and the additional 5000 expected. The growth would be equivalent to about 40-50 new households on each street in the zone of change. The draft strategy was subject to a consultant-led HIA in 2005, undertaken at short notice and in a compressed timeframe.

The HIA included screening, scoping, assessment and reporting phases, as outlined in *A Guide to HIA*. A rapid literature review of the evidence base and assessment of the population affected informed a participatory half-day workshop attended by a range of stakeholders.

The results of this workshop, plus desk-based assessment work and information previously gathered in community consultations, provided the basis for the assessment and recommendations made.

Thirty-three of 35 HIA recommendations to modify the plan for health gain were accepted by the Auckland City Council. Workstreams are being set up to implement them.

Examples of the key recommendations from the HIA were:

- encourage greater access to community facilities
- consider design impacts on health and wellbeing when assessing developments
- consider a hierarchical approach to transport within the Avondale area, placing greater emphasis on facilitating walking and cycling as modes of transport over private motor vehicles
- encourage the development of travel plans for schools and businesses
- incorporate crime prevention features in design ie. improving lighting and surveillance
- encourage the location of affordable child care facilities close to places of employment
- review provision of public open spaces for recreation and the need to locate them in close proximity to residential areas
- improve the quality of parks and facilities to encourage greater use
- work with local businesses to encourage the hiring of local people for local jobs.

The HIA was funded by the Auckland Regional Public Health Service (ARPHS). Stakeholder involvement was principally community-level agencies, local staff from central government departments and the Community Board. Results of previous community consultations on the plan were fed into the HIA.

For the full report of this HIA see <http://www.quigleyandwatts.co.nz/>



2. The Greater Christchurch Urban Development Strategy (UDS)

The Greater Christchurch UDS is a community-based collaborative project to manage the impact of urban development and population growth within the Greater Christchurch area. It involves four local authorities, central government and local business and community leaders who meet regularly as the UDS Forum.

The UDS was subject to an HIA led by the DHB's Community and Public Health staff. Christchurch City Council also played a key role.

The HIA focused on five determinants of health agreed by participants – air and water quality, social connectedness, housing and transport. A separate workstream focused on developing an engagement process with local Māori around the UDS. The HIA facilitated meaningful participation by Māori in the UDS, an outcome that had previously been unsuccessful.

The HIA report has been accepted by the UDS Forum and has been incorporated as a working document into the strategy planning process. As a result, population health outcomes have become a key focus of the UDS (Stevenson 2006). In addition, the Christchurch City Council has seconded a public health registrar to continue public health oversight of council proposals.

For the full report of this HIA, see <http://www.greaterchristchurch.org.nz/RelatedInfo/HIAREpot.pdf>



3. The Future Currents: Electricity Scenarios for New Zealand 2005 - 2050

This is a report by the Parliamentary Commissioner for the Environment (PCE) that explores two different futures for electricity supply and demand in New Zealand. The two scenarios are:

- *Fuelling the Future* – assumes a small investment in energy efficiency with energy services provided by increased, largely bulk-generation capacity, ie, a 'business as usual' scenario
- *Sparkling New Designs* – smart design is used to increase energy efficiency with a focus on energy services being provided on a small scale with emphasis on energy efficiency.

The HIA was commissioned to identify the health and wellbeing issues associated with the two scenarios. Stakeholder involvement comprised representatives of the energy sector and related organisations. The determinants of health chosen for the HIA were:

- housing and building (new developments, rules in district plans, building codes, energy use, and indoor air pollution)
- economics (individual costs for energy, what the money is spent on, and local and regional business development)
- social connectedness (democracy, sense of control, and pride in community).



The HIA demonstrated the greater health benefits under the smart design scenario with its stronger focus on energy efficiency and small-scale generation. These benefits are additional to improved energy security and reduction in greenhouse gases. Three of the eight recommendations from the HIA were:

- the proposed energy strategy should include public health objectives
- the Building Code should be strengthened for energy efficiency
- the National Energy Strategy should support small scale generation and energy efficiency initiatives. (Office of the Parliamentary Commissioner for the Environment, 2006).

For the full HIA report, *Healthy, wealthy, and wise. A health impact assessment of Future Currents: Electricity scenarios for New Zealand 2005-2050* see http://www.pce.govt.nz/reports/allreports/1_877274_28_3.shtml

4. Greater Wellington Regional Land Transport Strategy

The Greater Wellington Regional Council (GWRC) produced a draft 10-year Regional Land Transport Strategy (RLTS) for the region with a public consultation planned for November 2006. The GWRC strategy 'seeks a resilient and sustainable transport network where getting around is easy, safe and affordable'.

The Land Transport Management Act stipulates that the RLTS must, among other things, 'promote and protect public health'. To ensure it does, the GWRC commissioned an HIA that assessed the potential impacts of the RLTS on public health and community wellbeing.

An HIA workshop presented snap-shots of the evidence regarding transport and wellbeing, a description of the populations of interest in the region, and a description of the draft strategy. Participants focused on the potential positive and negative impacts of the strategy on community health and wellbeing.

Determinants of health chosen for this HIA were physical activity, accessibility to services and

the community, accident rates and changes in injuries and fatalities, reduced community connectedness (community severance) as a result of roads and/or traffic, and stress and anxiety. It focused on four expected outcomes:

- public transport (scheduled train and bus services) infrastructure improvements
- public transport (scheduled train and bus services) ease of use improvements
- travel demand management, walking and cycling
- roading, the Grenada to Gracefield link.

A brief assessment of the objectives of the Regional Land Transport Strategy was also undertaken.

The main conclusions of the HIA approach were:

- the draft RLTS objectives have the potential to positively impact on public health and are supported
- overall the draft RLTS is unlikely to protect and promote public health for the region's population
- the draft RLTS is likely to increase inequalities in health, particularly between socio-economic groups
- increasing modal share for public transport use and walking and cycling, and reducing private motor vehicle modal share are the best ways for transport to promote health,





and the draft RLTS is not predicted to achieve these changes. If the RLTS is to meet its objective of protecting and promoting public health it must shift its focus to increasing public transport and TDM use

- individual investments in the RLTS that promote public transport infrastructure and services, and access for people with disabilities are applauded. However, on balance their positive public health impact is likely to be overshadowed by the impact of the emphasis on new roading
- an increased focus on equity is recommended in the RLTS objectives, policies, and packages
- the draft RLTS displays a mismatch between the public health protecting and aspirational strategy objectives, with the public health-damaging 'advanced roading' funding allocation
- assumptions that increased allocation of funds to public transport are likely to increase congestion and negatively impact on economic and regional development must be strongly challenged.

The major recommendations of the HIA approach were:

- incorporate social equity and affordability into the RLTS objectives and outcomes
- investigate changes in fare-pricing structures and fare boundaries to improve equity and affordability
- increase the proportion of funding for public transport, walking and cycling, and reduce the proportion of funding for new roading, as new roading is not likely to promote health, while other modes of transport are
- make trade-offs explicit with regard to the mis-match between objectives and funding allocations
- initiate HIA in projects that flow out of this RLTS, and initiate HIA earlier in future RLTS planning processes

- strengthen the aims of the RLTS towards increased mode share for public transport and active modes and reduced dependence on private motor vehicles.

The Regional Council Transport Committee will consider the recommendations of the HIA, a strategic environmental assessment, and submission on the draft strategy. The Council will finalise the strategy early in 2007.

For the full HIA report see http://www.gw.govt.nz/story_images/3662_HealthImpactAssess7334.pdf

5. Mangere *Let's Beat Diabetes* HIA

This HIA focused on the implementation of the Mangere Growth Centre plan – a plan linked with Auckland's Regional Growth Strategy, which aims to better manage population growth in the region. The HIA was commissioned to be linked with the Counties-Manukau *Let's Beat Diabetes* campaign and aimed to highlight aspects of urban design that 'might contribute to a reduction of obesity levels in the district'. In particular, the HIA examined the proposed regeneration plans for housing and parks within a social housing precinct in Mangere, and the proposed Arts Centre, and how they might affect the health and wellbeing of the local population. There was a particular focus on the link between urban design and physical activity/nutrition, along with five other determinants of health: social connectedness, personal and community safety, access to services and employment, housing and community spaces

The key agencies involved were: Auckland Regional Public Health Service, Manukau City Council, Counties Manukau District Health Board (DHB) and Housing New Zealand Corporation. Local community leaders and health workers were also involved on the steering group and in the appraisal process, and contributed to the formulation of the recommendations made in the final report.



The HIA report included a community profile and an evidence review of the links between urban development and health, along with a series of recommendations to the Manukau City Council, Housing New Zealand Corporation and Auckland Regional Public Health Service. These recommendations ranged from high-level policy and practice recommendations (eg, Manukau City Council regulations around building standards should be tightened to reflect best practice in the region), to detailed project level suggestions (eg, design of public spaces and social housing in the Housing New Zealand Corporation's Pershore Precinct should support active living and recreation).

The final report was presented to senior management of Manukau City Council and Housing New Zealand Corporation in August 2006. Final decisions regarding the implementation of the Mangere Growth Centre plan have yet to be made, but Auckland Regional Public Health Service has commissioned an implementation plan for the recommendations made in the HIA, to ensure the issues are considered by key agencies throughout the ongoing planning and decision-making process.

Planners and community members involved in the HIA were enthusiastic about the process, particularly about the ability of the HIA to collect information and opinions from a range of stakeholders in a systematic way, and feed them into the planning process.

For the full report of this HIA see <http://www.quigleyandwatts.co.nz/>

Other examples of New Zealand HIAs include:

6. Wairau/Taharoto Transport Corridor

A plan to widen a four-lane road to include a cycleway, a walkway and a bus lane. The HIA included North Shore City Council, Auckland Regional Transport Authority, Auckland Regional Public Health Service and observers from Transit New Zealand. For the full report of this HIA see <http://www.quigleyandwatts.co.nz/>

7. Drinking Water Capital Assistance Programme

This assessed the potential impact of the drinking water subsidy scheme on Māori health. It was sponsored by the Ministry of Health and was used to pilot whānau ora assessment tools.

8. Screening of National Environmental Standard for Drinking Water

This shows the impact on population health. This was sponsored by the Ministry for the Environment. For the full report on this HIA screening exercise see <http://www.quigleyandwatts.co.nz/>

International examples

The international history of policy-level HIA is longer than in New Zealand, spreading over the past 15 or so years. The following section gives examples of the HIAs undertaken in different countries.



European Union

Across the 25 member countries of the European Union (EU) there is increasing recognition by governments of the social, economic and environmental determinants of health. This is reflected in Article 152 of the Amsterdam Treaty for Member States which encourages the use of HIA to ensure human health is protected in the development of EU policy (Quigley 2004). The voluntary status of HIA in the EU contrasts with the statutory requirement to carry out assessment of the environmental impact of high-level policies (Strategic Environmental Assessment). This means the use of HIA is patchy in the EU. There are however, some excellent examples of its use, some of which are summarised in Table 2.

Table 2 Selected examples of how HIA has been applied in EU member states

Country	Policy sectors using HIA	Administrative level
The Netherlands	<ul style="list-style-type: none"> Housing policy, employment, environmental energy tax, national budget 	Health impact screening of national policy
England	<ul style="list-style-type: none"> Burglary reduction initiative, national alcohol strategy London Mayoral strategies Regeneration projects, farmers' markets 	National Regional Local
Wales (equity focus)	<ul style="list-style-type: none"> Home energy efficiency, tourism, economic development Power station development, landfill sites, housing renewal 	National Local
Sweden	<ul style="list-style-type: none"> EU common agricultural policy (Swedish Institute of Public Health) Agriculture, alcohol policy 	EU-wide National
Lithuania	<ul style="list-style-type: none"> Toxic substances policy 	National
The Netherlands	<ul style="list-style-type: none"> Anti-smoking policy, licensing legislation, housing forecast 	National
Slovenia	<ul style="list-style-type: none"> Agriculture policy - to prepare for entering the EU 	National

Source: (based on Lock and McKee 2005)

The EU has recently developed a standard generic methodology for conducting HIAs on EU policies, at Europe-wide level, regionally (northern, southern or eastern Europe) or at nation state level.



Thailand

Thailand has carried out over 30 HIAs on policies, programmes and projects, having adopted HIA as a tool to improve trust between the government and civil society. Although the government sector is the key user of HIA, the academic community and civil society have been recognised as key stakeholders in the drive for healthy public policy (Quigley 2005). Thailand is one of the few countries that has successfully institutionalised HIA by formally integrating it into policy-making processes. HIA has enabled trust to be rebuilt between the government and the people by involving the community and stakeholders in the transparent HIA process.



Australia

For several years some parts of Australia have used a risk-assessment based HIA within an

environmental impact framework.

Tasmania has made this form of HIA compulsory for large developments. However, it rarely considers the social determinants of health that operate indirectly and have greater linkages with policy development rather than projects.

HIA at a policy-level, based on a social model of population health, is emerging strongly in some states of Australia. Equity as a fundamental value of HIA has a strong focus, with a collaboration across states and with New Zealand producing a toolkit for Equity Focused Health Impact Assessment. Associated with the development of this toolkit were a number of pilot HIAs carried out in the health sector. HIA activity has since moved into non-health sectors such as the HIA on the Victorian Drought Relief Program.

The international experience of institutionalising policy-level HIA, is discussed in Appendix Three.

Getting the best from HIA

4 Chapter Four

Individuals in policy agencies surveyed after HIA were strongly positive about their experience. They found that HIA introduced new information to the policy and improved the understanding and use of information already gathered. It was a more effective means of engaging stakeholders than had been used in the policy process previously and as such, improved understanding of participating organisational roles and responsibilities.

Previous experience of HIA will influence an agency's decision to undertake other HIAs. But there are other factors that influence agencies to use HIA as a routine part of decision-making. This chapter outlines the ideal environment for HIA, how to make HIA routine and the roles of various sectors.

The ideal environment for HIA

The findings from PHAC reviews of HIA experience and uptake in New Zealand build up a picture of the ideal agency environment for HIA. Agencies are more likely to undertake HIA where at least some of the following conditions exist:

- access to public health and HIA technical expertise
- agency understanding of a broad definition of health and wellbeing and the social and economic determinants of health
- agency understanding of the potential impact their activities have on health and wellbeing (through the wider determinants of health) and interest in and use of HIA
- a commitment to equity issues and an understanding of the need to focus attention on population groups with lower health outcomes such as Māori, low income and Pacific peoples
- 'champion(s)' of the public health approach, including HIA
- recognition that the HIA process might assist in meeting statutory responsibilities, for example, the local authority requirement to promote and protect community wellbeing



HIA introduced new information to the policy and improved the understanding of information already gathered. It was a more effective means of engaging stakeholders.





- ability to see how HIA would fit into the policy-making process and contribute positively to the policy
- confidence to undertake the HIA process; this was most often gained by HIA training and access to public health and HIA technical expertise
- a previous positive agency experience of HIA
- support from senior management (and local body politicians in the case of local authorities)
- access to funding and staff resources; funding and expertise provided by the public health sector (the PHAC and public health units) was critical in getting HIA started. Policy agencies were more likely to provide resources after they had an experience with HIA. This is consistent with international findings which show a correlation between the establishment of an HIA support unit and the sustainability of HIA
- access to a locally-based tool. There was a positive response to the PHAC tool in the PHAC reviews
- statutory recognition or requirement for HIA; shown internationally to be significant for making HIA last and put forward in response to the survey as an important incentive that should be put in place in New Zealand.

Not all of these factors need to be in place for an HIA to be initiated. Many will be realised as a result of an HIA or even in the initial stages of an HIA. The starting point will be the understanding of how the HIA will assist in the development of the policy.

Making HIA routine

Access to HIA, or even experience of HIA, will not necessarily mean that health and wellbeing will be routinely considered. If policies from across public sectors are to have a positive impact on health, consideration of wellbeing, health and equity needs to be a

routine part of policy development processes. Currently, consideration of potential health impacts tends to either take place in an ad hoc way by relying on informal consultation with individuals in other sectors, or not at all. International experience has shown that an explicit and systematic process, such as HIA, is needed to ensure the availability of technical information on the expected impacts on health and wellbeing is sufficient to influence decision-making. It also ensures that health is broadly defined and that equity issues are well-addressed.

However, access to the HIA process will not in itself be sufficient to provide adequate information on potential health impacts. Organisational support is crucial for ensuring new policies are systematically screened for their suitability for HIA, and that assessments are adequately resourced.

In September 2006, the Prime Minister announced funding for government agencies to be supported to carry out HIA on new policies and legislation. An HIA support team will be established, located initially in the Ministry of Health, with the aim of establishing it later within an agency that already has a cross-government focus. The support team will be backed by an intersectoral external reference group which will identify public sector opportunities for HIA. Local government support will continue to be provided by the public health units within DHBs, backed by the central HIA support team.

What individual agencies can do to make HIA routine

Each agency's response to the expectation that their policies will need to be systematically assessed for potential impacts on health and wellbeing will be driven by their own imperatives. Some of these are anchored in legislation or strategic direction, and others in the recognition of the overall benefit to their policy processes and to the population at large.

Whatever the drivers, each agency will need to find a way to make HIA a routine part of the policy-development process.

For an agency to establish HIA routines, it first of all needs to recognise that HIA can enhance policy goals. This recognition will not come by itself. It will need a public health or HIA 'champion' in the organisation to bring the benefits to the policy development table. If this 'champion' heads the organisation, routine health assessment will be a natural result. However, it is more likely that the 'champion(s)' will be further down the hierarchy and options for embedding HIA in the policy development processes will be a challenge. Having a vision and taking small steps until the first HIA is completed, with the benefit established in the eyes of the decision-makers, will be necessary before HIA can become routine. From there a plan needs to be developed with some or all of the following components:

- include HIA tools and encouragement in policy manuals, intranet links etc
- provide staff with access to HIA training
- make contact with the regional public health service or HIA support unit
- develop a Memorandum of Understanding with relevant health agencies that includes the recognition and encouragement of HIA
- second staff from the public health sector, possibly jointly funded, to assist the agency to identify the potential health outcomes of its activities (Christchurch City Council and Whangarei District Council have done this)
- establish a group within the agency to screen new policies for their suitability for HIA.

What Government can do to make HIA routine

Making HIA routine would be aided by the processes the Government puts in place.

Options for **central government** include:

- establishment of a central HIA support team with a 'whole of government' focus (this is happening under the recent Government announcement)



- statutory recognition of the use of HIA in the proposed Public Health Bill, the Local Government Act 2002 and other relevant legislation
- provision of incentives in a range of legislation such as those that already exist in the public health objectives of the New Zealand Land Transport Strategy 2002, reflected in the Land Transport Management Act 2003, and the purpose and principles of the Building Act 2004 which are required to be reflected in the revised Building Code
- development of supportive and administrative frameworks that support any legislative recognition, eg, a mix of centrally and locally-based support teams, memoranda of understanding, Cabinet Office guidance, training and access to locally-based tools
- recognition and support for HIA from public sector oversight agencies such as the State Services Commission, Office of the Auditor General and Treasury.

Options for **local government** include:

- linking HIA with the Long Term Council Community Plan process (LTCCP)
- establishing a relationship with the local public health unit as a source of public health information and expertise
- building capacity in the organisation; this could include training existing staff, appointing a health planner or seconding public health expertise from elsewhere
- including HIA into policy development and planning manuals.

What the health sector can do to support HIA

It is important the health sector models good practice. There are many health sector policies that would benefit from an assessment of the potential impacts on health and wellbeing. HIA identifies unintended effects, especially on particular groups of the population that may be missing out.

The health sector also has a role in crossing a language divide between sectors, brokerage and public health input, and in building capacity in both the health and other public sectors.



Develop a common language

‘Health’ means different things to different sectors. It is important that a common understanding is developed to avoid agencies who are working together ‘talking past each other’. This does not mean that the health sector imposes its understanding of health on other sectors, but that it provides opportunities for a negotiated understanding before health impacts are assessed.

A broad definition of health has currency in the health sector and the PHAC recommends the use of the *whare tapa wha* model of health (Durie 1994). This model includes physical wellbeing (*te taha tinana*), mental wellbeing (*te taha hinengaro*), spiritual wellbeing (*te taha wairua*) and community wellbeing (*te taha whānau*). When the health of the population

is phrased in terms of these ‘wellbeings’, rather than in terms of disease status, it is clear that other sectors besides the health sector have responsibilities for it. The word ‘wellbeing’ is used across sectors, especially local government and social development, and encompasses a broad definition of health and its determinants.

Provide public health and HIA expertise

A key finding from the PHAC HIA work, which is strongly supported by international experience, is the need for public health support and HIA expertise in promoting and undertaking HIA. The recent government announcement of funding for HIA will include the establishment of a central HIA support team which will provide agencies with public health and HIA expertise and information. Some public health units have been providing this expertise at a regional level.

Effective HIA assumes an understanding of the wider determinants of health and the linkages with health outcomes. It also relies on experienced practitioners to broker and guide the process, at least initially. (For instance, the nine London mayoral strategies required public health and HIA expertise for the first few HIAs, after which local government had acquired sufficient expertise to continue unaided).

The PHAC secretariat, together with consultants, and individuals from the University of Otago, has in effect fulfilled the role of a small HIA support team at a central level. The experience within the support team has included strategic policy, academic/teaching experience, and technical expertise (including impact assessment experience and public health knowledge). With backing from an intersectoral external reference group providing advice on agency entry points, the team has been effective in spite of being a relatively small resource. The PHAC has recommended this model for the recently-announced government HIA support to sustain HIA in New Zealand.

At a local level, some public health units have been providing the functions of HIA support teams. Strong leadership in this area has come



from public health units in major centres, especially Auckland, Hutt Valley, and Christchurch.

The PHAC acknowledges that it is the larger local authorities supported by equivalently large public health units which have had the capacity and flexibility of funding to support HIA. Further work needs to be done to find ways to encourage and support HIA in the smaller centres to ensure geographical equity.

Build capacity and capability for HIA

Capacity building needs to occur both within and outside the health sector. Because policy HIA is a relatively new discipline, confidence and experience needs to be built, along with professional development pathways.

The PHAC and partners has trained more than 250 people across sectors in HIAs. This training has increased professional confidence and competence and has resulted in some HIAs being undertaken. HIA training can be accessed through the Wellington School of Medicine and Health Sciences (WSMHS) Summer School in February each year, at both introductory and advanced levels. At other times of the year, training is provided through a recently announced research and training collaboration between WSMHS and Quigley and Watts Ltd – the Health, Wellbeing and Equity Impact Assessment Research Unit (HIA Research Unit).

Check the PHAC website for the next training opportunities. <http://www.nhc.govt.nz/phac>

After initial training, the greatest learning takes place in HIA practice and it is vital that capacity is built in this area.

HIA in local government

Local government in New Zealand has some important legislative drivers that give HIA status in assisting local authorities to meet their public health obligations. The Health Act 1956 states that it is the ‘...duty of every local authority to improve, promote, and protect public health



within its district’. The Local Government Act 2002 recognises the wider determinants of health in its purpose which is ‘to promote the social, economic, environmental and cultural wellbeing of communities’ The Local Government (Auckland) Amendment Act 2004 provides a recent example of the translation of the Government’s strategic goals for regional sustainable development into law. The Act promotes the integration of Auckland’s transport infrastructure and land use planning.

These pieces of legislation position wellbeing/health as a core local government responsibility. In addition, HIA fits well with the ‘normal’ routines of local government that seek to engage communities. Other incentives for local government include its requirement to identify community outcomes by consulting with the community. Ideally, the HIA process is participative and inclusive, providing local government with a tool and incentive to include communities and other key stakeholders. For example, Greater Christchurch succeeded in engaging Māori in the Urban Development Strategy discussions by using the HIA process.



In spite of these legislative incentives, substantive action at the local and regional level based on intersectoral collaboration, is still in its infancy, with HIA having been largely confined to the urban areas that have access to more resources and staff capacity. But with the sharing of case studies and other local government actions, it is expected that the current increasing interest in HIA will continue. Local government actions related to HIA include creating health planner positions (Auckland City Council, Whangarei District Council), public health secondments (Christchurch City Council) and moves to include HIA in policy manuals.

HIA in a resource management context

In New Zealand, the purpose of the Resource Management Act 1991 promotes a sustainable management approach to environmental management. The Act makes specific reference to health, its purpose referring to the 'protection of natural and physical resources in a way, or at

a rate which enables people and communities to provide for their social, economic and cultural wellbeing, and for their health and safety'. Assessment of health impacts should therefore be an explicit part of any impact assessment. However, experience has shown that the link between environmental quality and human health is either not expressed well or is sidelined within the resource consent process.

If an explicit legislative requirement for resource management to include HIA is not feasible at this point, other means of encouragement should be put in place. The Ministry of Health published guidelines about the use of HIA in the resource management process in 1998 (Ministry of Health 1998). A key role for the Government's HIA support team will be to work with the Ministry for the Environment to develop a protocol or guidance specific to the environment sector. HIA within the environmental policy context was not a focus of the PHAC work and further analysis is required.





Sources of evidence

Appendix One

Sources of evidence linking transport and health

Public Health Advisory Committee. 2002. *Intersections between Transport and health*. <http://www.nhc.govt.nz/phac/publications>

Kjelstrom T, Hill S. 2002. *New Zealand evidence for the health impacts of transport*. A report for the Public Health Advisory Committee. <http://www.nhc.govt.nz/phac/publications/>

London Health Observatory. http://www.lho.org.uk/HIL/Determinants_Of_Health/Transport.aspx

World Health Organization website. <http://www.euro.who.int/transport>

Sources of evidence linking housing and health

Housing and Health – He Kainga Oranga. <http://www.otago.ac.nz/wsmhs/academic/dph/research/housing/index.html>

Centre for Housing Research. <http://www.hnzc.co.nz/chr/index.html>

Auckland Regional Public Health Services. *Housing and Health – A summary of selected research* http://www.arphs.govt.nz/publications/HealthyHousing/Healthy_Housing.asp

London Health Observatory http://www.lho.org.uk/HIL/Determinants_Of_Health/Housing.aspx

Sources of evidence linking social environments with health

Income and health

Blakely T, Fawcett J. 2005. *Decades of Disparity II: Socioeconomic mortality trends in New Zealand 1981–1999*. Public Health Intelligence Occasional Bulletin Number 25.

Blakely T, Wilson N. 2005. *Shifting Dollars, Saving Lives: What might happen to mortality rates, and socioeconomic inequalities in mortality rates, if income was redistributed?* <http://www.treasury.govt.nz/academiclinkages/blakely/tgls-blakely.pdf>

Ecob R, Davey Smith G. 1999. *Income and health: what is the nature of the relationship?* Social Science and Medicine. 48:693-705.

Howden-Chapman P, O'Dea D. 2001. Income, income inequality and health in New Zealand. In: Eckersley R, Dixon J. Douglas B.(eds) *The social origins of health and wellbeing*: 129-148. Cambridge University Press.

London Health Observatory website. http://www.lho.org.uk/HIL/Determinants_Of_Health/Income.aspx

Public Health Advisory Committee. 2004. *The Health of People and Communities – A way forward: public policy and the economic determinants of health*. Report to the Minister of Health. Wellington.

Employment and health

National Occupational Health and Safety Advisory Committee website <http://www.nohsac.govt.nz/>

Department of Labour Occupational Safety and Health website <http://www.osh.govt.nz/index.htm>

Health Development Agency, NHS. 2005. *Worklessness and Health – what do we know about the causal relation? An evidence review summary*. <http://www.renewal.net/Documents/RNET/Research/worklessnesshealthwhat.pdf>

London Health Observatory website. http://www.lho.org.uk/HIL/Determinants_Of_Health/Employment.aspx

Family and community safety and health

New Zealand Family Violence Clearing House.
<http://www.nzfvc.org.nz/PublicationArea.aspx?topic=Health>

Vic Health. 2004. The health costs of violence. Measuring the health burden caused by intimate partner violence. A summary of findings.
<http://www.vichealth.vic.gov.au/assets/contentFiles/ipv.pdf>

Sources of evidence linking urban design and health

Ministry for the Environment. 2005. *The Value of Urban Design. The economic, environmental and social benefits of urban design*. Wellington: Ministry for the Environment.

Auckland Regional Public Health Service. 2006. *Improving Health and Wellbeing: A public health perspective for local authorities in the Auckland region*. Auckland: Auckland Regional Public Health Service.

Ewing, Reid, Frank Lawrence, Kreutzer Richard. 2006. *Understanding the relationship between public health and the built environment. A Report prepared for the LEED-ND Core Committee*. Available at www.usgbc.org/ShowFile.aspx.

Jackson R, Kochtitzky C. *Creating a Healthy Environment: The Impact of the built environment on public health*. Centers of Disease Control and Prevention. Sprawl Watch Clearinghouse Monograph Series.

Kelly-Schwartz A, Stockard J, Doyle S, Schlossberg M. 2004. Is Sprawl Unhealthy? A multilevel Analysis of the Relationship of Metropolitan Sprawl to the Health of Individuals. *Journal of Planning Education and Research* 24: 184-196.

London Health Observatory website
http://www.lho.org.uk/HIL/Determinants_Of_Health/Environment/PlanningAndHealth.aspx

Duhl LJ, Sanchez AK. 1999. *Healthy Cities and the urban planning process. A background document on the links between health and urban planning*. World Health Organization.

World Health Organization. 2006. *Promoting physical activity and active living in urban environments - the role of local governments*. Healthy Cities 21st Century. Europe.



More about Health Impact Assessment

Appendix Two

Where has HIA come from?

In 1986, the Ottawa Charter outlined five important strategies for the improvement of population health. One of these strategies was the importance of building healthy public policy, which has since become an important component of public health action, mostly through political advocacy. Building healthy public policy requires anticipating the impacts different policy options will have on health, and opportunities to influence the policy process. HIA offers a practical way of addressing both of these conditions.

The history of HIA at a strategic policy level is a short one, but is well grounded in other forms of impact assessment that have a much longer history, for example, Strategic Environmental Assessment, Social Impact Assessment and Environmental Health Impact Assessment. The latter form of HIA is risk-based and focuses on health protection in the context of proposed developments and projects (Mahoney 2001). These other forms of impact assessment are summarised in Chapter three.

In New Zealand, Environmental Health Impact Assessment was introduced under the provisions of the Resource Management Act 1991 (RMA). In 1998, the Ministry of Health published guidelines for its use including a systematic process for HIA and risk analysis within the context of the RMA. However, without an identifiable constituency among practitioners for this form of HIA, it has not been widely practised in New Zealand (Morgan 2005).

Internationally, HIA at policy level has a 15 year history in about 15 jurisdictions including the European Union. It is strongest in Europe but also strong in countries like Thailand, while still developing elsewhere, such as Australia and New Zealand. International HIA activity is

summarised elsewhere in this report. The definition of “health” in this context incorporates general wellbeing and some countries call the process Wellbeing Impact Assessment.

What are the values of HIA?

As Scott-Samuel (1999) points out, HIA is not value neutral and therefore its values should be explicitly stated. Some HIA values listed below were reached under international consensus (the Gothenburg Consensus 1999) and others are specific to New Zealand. The following list includes both of these sources.

Equity

Throughout this report there are references to health equity and health inequalities. These terms are often used interchangeably and although have overlaps, are different. This report has used the term ‘health inequalities’ as a statement of difference that might include both avoidable and unavoidable differences in health status. ‘Health equity’ refers to differences that are avoidable and unfair. Equity incorporates an element of social justice. Ensuring that public policy does not result in widening health inequities is a core value of HIA.

In New Zealand, there are wide inequities in health between population groups. Many people experience significant and avoidable ill-health, which although distributed across the population, is disproportionately borne by specific groups such as Māori, people with low incomes, and Pacific people. Public policy has the potential to reduce or widen these health disparities with unintended and unanticipated negative impacts on groups within populations, while having a positive



effect on the health and wellbeing of the general population. A key role for HIA is to predict those differential effects and to make recommendations to eliminate or reduce avoidable inequalities.

Participation of decision-makers and affected communities

Because the strongest influences on health come from the social, cultural and economic environments in which people live their lives, it is essential that people have the opportunity to participate in social and economic policy development at central and local level. It is also essential that there is cross-sectoral collaboration of decision-makers in building healthy public policy that is likely to affect all or large sections of the community.

Community participation and cross-sectoral collaboration are core HIA values, as they are for all public health action. Effective HIA involves key stakeholders in the proposal being assessed, including community participation. The extent of participation is often constrained by timeframes imposed by the decision-makers, such as timing of Council meetings etc. If this is the case, good practice would ensure community representation and reference to previous related consultations in the community. For example, by the time the Avondale Liveable Communities rapid HIA was carried out (see earlier in this report), the Council had involved the community in extensive meetings to discuss the proposed intensification of the town centre. This material was then fed into the HIA process to avoid “community consultation burn-out”.

Commitment to sustainability

HIA values include the need to use resources in a way that protects them for future generations (sustainability). The sustainability framework in New Zealand requires policy-makers to consider social, economic, environmental and cultural impacts of any

proposed policy, programme or plan. These four impacts are in fact the wider determinants of health, which are assessed in the HIA process. This is of particular interest to local government which is required to ‘promote the social, economic, environmental and cultural wellbeing of communities in the present and for the future’.³ HIA is a tool to assist in this.

Ethical use of evidence

Evidence used in HIA includes published literature, local data and stakeholder experience. To use evidence ‘ethically’ means to use all the evidence available, both quantitative and qualitative, ensuring the evidence is rigorous and based on different scientific disciplines. Evidence collected from the community through qualitative means, such as surveys and focus groups, should be valued along with quantitative data and other published material. Stakeholder experience may conflict with published material, in which case it is important to be explicit about the source and to fully explore the reasons for the conflict (Joffe and Mindell 2005). See also Chapter 3 for a further discussion of the use of evidence in HIA.

Broad definition of health

HIA is based on a broad definition of health that includes physical, mental, emotional and spiritual wellbeing.⁴ It also includes people’s relationships with each other and with the environment. In New Zealand, the PHAC suggests in its Guide to HIA that the ‘*whare tapa wha*’ model of health is adopted which includes physical (*te taha tinana*), mental (*te taha hinengaro*), spiritual (*te taha wairua*) and community (*te taha whānau*) wellbeing.

In some non-health sectors, it has been customary to define health in terms of disease

³ Local Government Act 2002.

⁴ “spiritual health/wellbeing” has been described by Alistair Campbell (Professor of Ethics at the University of Singapore) as people’s sense of meaning in their lives, which can include religion but not exclusively.

status, in which case only the direct health impacts will be taken into consideration. When health is defined broadly, indirect impacts on health will be considered - impacts mediated through social, economic, environmental and cultural influences.

Treaty of Waitangi

Aspects of participation and equity are made particularly salient by the Treaty of Waitangi. HIA in New Zealand highlights the need to assess policies for their impact on Māori health through the principles of the Treaty as defined by the Royal Commission on Social Policy – partnership, participation and protection. Partnership involves working with Māori to develop strategies for Māori health gain; participation means involving Māori at all levels of decisions-making (including HIA); and protection means working to ensure Māori have at least the same level of health and wellbeing as non-Māori, safeguarding Māori cultural values and practice. Access to cultural resources and events is one of the key determinants of wellbeing for Māori.

Integration with other forms of impact assessment

In some countries there is a trend towards integrating HIA with other forms of impact assessment, as another way of putting health on to the policy agenda. In Finland, impact assessments on health and on social outcomes have been merged to focus on Human Impact Assessment. This approach has merit for time efficiency and because the term 'Human Impact Assessment' may be more acceptable to non-health sectors.

Other options may be to merge HIA with Strategic Environmental Assessment (the environmental policy-level equivalent of HIA) or to combine health, social, environmental and economic impact assessments. However, the greater the combination, the larger the risk that health impacts will be subsumed by the other issues. The PHAC believes that if an integrated assessment model is attempted in New Zealand then it is important to ensure that the health and wellbeing component is an explicit part of the model.

International experience of making HIA routine – some case studies

Appendix Three



British Columbia, Canada (BC).

BC provides one of the first systematic examples of policy-level HIA in the world, instituted in 1989. By 1999 HIA was no longer active due to lack of political support after a change of government and key individuals having left the agency. The lesson learned was that key individuals can set up a flourishing process, but without partnerships and institutional support, momentum is unlikely to be sustainable. BC is now successfully rebuilding HIA on a stable base with key partnerships and a dedicated HIA support unit.



Quebec, Canada

The Quebec Public Health Act requires a policy HIA process independent of Environmental Impact Assessment (EIA) on all public policy known to have significant health impacts. The Act requires the Minister of Health to be consulted on any Act or regulation [of any Ministry] that could have significant impact on the health of the population.

To implement the Act, Quebec has set up an HIA support unit with two full-time equivalents to support HIA, including a research and evaluation component.

Also in Quebec, a Memorandum of Understanding established in 1987 between the Ministries of Health and Environment has been key to subsequent systematic HIA within EIA practice.



Sweden

While there is no statutory requirement for HIA in Sweden, public health legislation has placed HIA on a strong footing by linking it to the National Public Health Strategy which has been

agreed across sectors. Swedish public health legislation contains eleven public health objective domains based on the determinants of health, and specifically promotes HIA to address health inequalities. An institute has been established with a mandate to support HIA. There has been little evaluation of impact, but at the local level civil servants and politicians view the achievements of HIA positively. At the national level HIA-type screening has been included in the Swedish policy process.



European Union

The Amsterdam Treaty for Member States encourages, but does not require, the use of HIA. A consensus on HIA methodology was needed, and then developed. Sustainable resources for HIA support units have been set aside in 14 of 22 member states.



England

HIA is quite widely practised in England with government commitment to the assessment of policies' impact on health and wellbeing, supported in government departments by non-mandatory directives and access to suitable assessment tools. Support units have been established across the country and are funded by regional health organisations. A public health 'observatory' is dedicated to the provision of evidence of HIA effectiveness and on specific topics of use to HIA practice.

While there is no current statutory requirement for HIA in England, the Government has indicated the potential of HIA to become a statutory requirement within the Health Select Committee's report on obesity. The report states:

'Major planning proposals and transport projects are already subject to environmental



impact assessment; we believe that it would be appropriate if a health impact assessment were also a statutory requirement. This would enable health to be integrated into the planning procedure and help bring about the sort of creative, joined-up solution which is required.'
(House of Commons, 2004, Third report, para 321)

In addition, England's Regulatory Impact Assessment (RIA) guidance has been strengthened so policy makers must now consider health impacts at all the appropriate stages of policy development within the RIA process.



Wales

Wales has strong support from the Welsh assembly and the Minister of Health and Social Services has established an HIA support unit that has developed a Guide to HIA, provides training and promotes more systematic use of HIA. The Welsh experience is strongly equity-focused.



Netherlands

The Netherlands Parliament has funded an HIA support and promotion unit. Parliamentary documents and advisory reports at the national level are screened using an HIA checklist. By 2005 25 policy-level HIAs had been carried out.



PHAC recommendations to the Minister of Health

Appendix Four

The following recommendations to the Minister of Health were developed by the PHAC based on its experience over nearly five years of implementation and review of HIA. The recommendations accompanied advice to the Minister of Health in August 2006.⁵

The recommendations are that you (the Minister of Health):

- (a) agree that the Ministry of Health take the lead in establishing an HIA support unit or team, with a 'whole of government' focus, utilising partnerships that reflect an appropriate mix of agencies and expertise, and configured to achieve the following functions:
- promote HIA to central government agencies⁶
 - support central government agencies outside health that choose to undertake HIA, with a focus initially on assessing policies that have the potential to impact on the obesity epidemic
 - support HIA brokers (most likely to be health agencies) at local government level by providing guidance and information
 - provide/co-ordinate HIA training courses
 - provide a public health evidence base for HIA
 - facilitate monitoring and evaluation.
 - establish an intersectoral external reference group with central and local government representatives to advise on appropriate entry points for HIA.

- (b) agree that the Ministry of Health develops a plan for embedding the formal consideration of health impacts (including institutionalising HIA) into public policy-making processes, which:

- takes a comprehensive approach and focus on a number of different levels
- includes elements of the recommendations listed below.

At a central government level

Legislation

The PHAC recommends:

- statutory recognition for policy-level HIA in the proposed Public Health Bill. Inclusion in the Public Health Bill would initially be enabling rather than enforceable but with a built-in review of the effectiveness (with performance measures) of voluntary uptake. (Note that you have agreed to this in principle in response to Committee Report 20061218)

Cabinet Office guidance

The PHAC recommends that:

- the Ministry of Health investigates the potential for Cabinet Office guidance as a means of ensuring that central government agencies take the health impacts of policies into consideration
- any Cabinet Office guidance on consideration of health impacts embodies a 'whole of government' ethos where potential health impacts are considered throughout the policy development process rather than a 'tick box' approach at the end of a Cabinet Paper.

⁵ The PHAC is required by statute to provide advice to the Minister of Health even though its public health work is across sectors.

⁶ The assumption is that public health units will perform this function at local government level.

Role of the Ministry of Health

The PHAC recommends that:

- the Ministry of Health shows that it takes wider health impacts into consideration when developing its policy, undertaking HIAs where appropriate. For instance, papers to Executive Team include a requirement to show the effect of any proposal on health and health inequalities
- the Ministry of Health develops a formal procedure for responding to other agencies' requests for input, to ensure all relevant aspects of health and health inequalities are covered. The PHAC favours a cross-directorate team with an agreed template to assess policy proposals.

Inclusion of HIA tools in policy development processes

The PHAC recommends that:

- HIA tools are included in the Ministry of Health's policy analysis toolkit ('the policy wheel')
- the Ministry of Health works with other agencies to see that HIA tools are included in policy analysis manuals and toolkits across sectors and are amended for agency-specific application where required
- the Ministry of Health works with the Ministry of Transport and Land Transport New Zealand to develop a protocol or Memorandum of Understanding to guide the inclusion of HIA in the development and review of strategies and policies
- the HIA Support Team works with the Ministry for the Environment to prepare guidelines for HIA application in the resource management context.

Role of the 'oversight agencies'

The PHAC recommends that:

- the Ministry of Health explores the feasibility of agencies with an oversight role for government agencies (such as State Services Commission, the Treasury, the Ministry of Economic Development [regulatory impact assessment], and the Office of the Auditor General), to require agencies to show how they have taken health and wellbeing into account in the development of their policies. This would include the feasibility of including consideration of health and wellbeing impacts in Statements of Intent across sectors.

Integration with other forms of impact assessment

The PHAC recommends that

- the Ministry of Health explores the feasibility of integrating HIA with other forms of impact assessment (for example social and environmental). In considering this approach, it is important that health is an explicit component of the integrated model
- the HIA Support Team give consideration to how HIA techniques can be better integrated into resource management procedures. This could involve inclusion of an explicit requirement or a principle in the resource management legislation.

At local government level

The PHAC recommends that:

- in any future review of the Local Government Act 2002 that consideration is given to including a statutory recognition of HIA or related process, as an additional Principle stated in the Act
- the Ministry of Health ensures that funding mechanisms for public health action, and other forms of support, facilitate the brokering and support of HIA at a local level.



Bibliography

- Ajwani S, Blakely T, Robson B, et al (eds). 2003. *Decades of Disparity: Ethnic mortality trends in New Zealand 1980-1999*. Wellington: Ministry of Health and University of Otago.
- Aldrich R, Mahoney M et al. 2005. Building an equity focus in health impact assessment. *NSW Public Health Bulletin*. Vol 16 No. 7-8.
- Banken R. 2001. *Strategies for institutionalising HIA*. WHO Europe.
- Blakely T, Fawcett J, Atkinson J, et al. 2004. *Decades of Disparity II: Socio-economic mortality trends in New Zealand 1981-1999*. Public Health Intelligence Occasional Bulletin Number 24. Wellington: Ministry of Health.
- Counties Manukau District Health Board. 2006. *The impact of housing improvements on acute hospitalisations at Middlemore*. Unpublished presentation.
- Davenport C, Mathers J, Parry J. 2006. Use of health impact assessment in incorporating health considerations in decision making. *J. Epidemiol. and Community Health*, 60:196-201.
- Davies H, Nutley S. 2001. *Evidence based policy and practice: moving from rhetoric to reality*. Centre for Public Policy Research and Management, University of St Andrews, UK. Paper to the Third International, Inter-disciplinary Evidence-based Policies and Indicator Systems Conference.
- Durie M. 1994. *Whai Ora: Māori Health Development*. Auckland University Press, Auckland.
- Institute of Public Health in Ireland. 2006. *Health Impact Assessment Guidance*. <http://www.publichealth.ie/index.asp?locID=489&docID=581>. Accessed 31 Oct 2006.
- Joffe M, Mindell J. 2005. Health Impact Assessment. *Occup. Environ. Med.* 62;907-912.
- Lock K, McKee M. 2005. Health impact assessment: assessing opportunities and barriers to intersectoral health improvement in an expanded European Union. *J. Epidemiol. and Community Health*. 59;356-360.
- Mahoney M. 2001. *Health Impact assessment: Environmental management versus healthy public policy perspective – exploring the nexus between the two*. Paper presented at the 28th National Environmental Health Conference, Perth.
- Mindell J, Boaz A, et al. 2004. Enhancing the evidence base for health impact assessment. *J. of Epidemiol. and Community Health*, 58; 546-51.
- Ministry of Health. 1998. *A Guide to Health Impact Assessment*. Wellington, New Zealand.
- Ministry of Health 2002. *Reducing inequalities in health*. Wellington, New Zealand.
- Ministry of Health and University of Otago. 2006. *Decades of Disparity III: Ethnic and socio-economic inequalities in mortality in New Zealand 1981-1999*. Wellington. Ministry of Health.
- Morgan R. K. 2005. *Institutionalising Health Impact Assessment: the New Zealand experience*. Centre for Impact Assessment Research and Training, University of Otago (unpublished).
- National Health Committee. 1998. *Social, cultural and economic determinants of health in New Zealand: Action to improve health*. Wellington.
- Office of the Parliamentary Commissioner for the Environment. 2006. *Healthy, wealthy, and wise. A health impact assessment of Future Currents: Electricity Scenarios for New Zealand 2005-2050*. Wellington.
- Public Health Advisory Committee. 2005. *A guide to health impact assessment: a policy tool for New Zealand*. 2nd edition.



Public Health Advisory Committee. 2004. *The Health of People and Communities – A way forward: Public policy and the economic determinants of health*. A report to the Minister of Health. Wellington.

Public Health Advisory Committee. 2006. *Health is everyone's business*. A report to the Minister of Health. Wellington.

Quigley R. 2005. *Review of international policy level HIA*. A Report to the Public Health Advisory Committee.

Quigley R, Ball J. 2006. *The Mangere Growth Centre Plan Health Impact Assessment*. Prepared for the Manukau City Council and the Auckland Regional Public Health Service. Quigley and Watts Ltd (unpublished).

Quigley R, Cavanagh S et al. 2004. *Clarifying health impact assessment, integrated impact assessment and health needs assessment*. NHS Health Development Agency. United Kingdom.

Scott-Samuel A. 1998. Health Impact Assessment – Theory into practice. *J. of Epidemiol. and Community Health*, 52; 704-5.

Signal L, Langford B, Quigley R, Ward M. 2006. Strengthening health, wellbeing and equity: Embedding policy-level HIA in NZ. *Social Policy J of NZ*. Issue 29.

Soeberg M. 2005. Hope for a (Public Health) Generation? – *Current and emerging issues in Health Impact Assessment*. A draft paper prepared for the Auckland regional Public Health Service.

Stevenson A. 2006. *Assessing the impacts on health of an urban development strategy: A case study of the Greater Christchurch Urban Development Strategy* (unpublished).

Ward M. 2006. *A review of agencies experience of HIA in New Zealand*. A report to the Public Health Advisory Committee.

World Health Organization – European Centre for Health Policy. 1999. *Health Impact Assessment – Gothenburg consensus paper*.

World Health Organization 2000 *Transport, environment and health*. Edited by Carlos Dora & Margaret Phillips. WHO Regional Publications, European Series, No. 89.

Wyllie A, Mulgrew L. 2006. *A review of the uptake of HIA in New Zealand*. A report for the Public Health Advisory Committee. Phoenix Research, Auckland.