

Perspectives on health impact assessment

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One stream of health impact assessment (HIA) can be seen as a natural development of environmental impact assessment, treating human communities as an important part of the ecosystems to be protected. This approach was first applied to construction projects in developing countries (1) but was soon influencing other countries (2–4). Another stream of HIA has its origins in the notions of determinants of health (5) and healthy public policy (6). One of its earliest applications was in Canada, but it has also been influential in Europe (7–9). Examples of both streams will be found in this theme issue. Two broad disciplinary approaches to HIA can also be specified, one based on epidemiology and toxicology, and the other on social sciences. In addition, it is possible to distinguish between HIA applied to projects and HIA applied to broad policy and strategy matters. Papers in this issue demonstrate all these approaches.

Until there is a shared understanding of terms, no debate is possible. HIA, like other fashionable expressions, has been used to name a wide variety of activities and is in danger of becoming so all-embracing as to be meaningless. Various definitions have been offered, but the two essential characteristics of HIA are that it seeks to predict the future consequences for health of possible decisions; and that it seeks to inform decision-making.

If one accepts these as the two necessary and sufficient characteristics of HIA, various conclusions follow. First all HIA is prospective, and the terms “retrospective HIA” and “concurrent HIA” (used in some of the papers in this issue of the *Bulletin*) should be dropped and replaced with others such as “evaluation”, “surveillance” and “monitoring”. Second, many activities, though they do not call themselves HIA, are. Prospective comparative risk assessment (10) is one of these. Third, many other activities, though they call themselves HIA (including the paper in this issue by Leonard (see pp. 427–433), are not. Activities such as needs assessment, community development, public health surveillance and

advocacy do not have these two defining characteristics and so are not HIA. In denying them the title of HIA, we are not, of course, denying that they are valuable contributions to public health.

Health impact assessment relies on understanding causal links so as to predict the consequences of proposed actions. Epidemiology and toxicology produce evidence for some causal links, but currently they are only able to consider a very limited set of causative agents and an even more limited set of outcomes. Sociology and psychology provide other means of predicting how humans and human societies will react to changing circumstances. HIA does not offer certainty in its predictions or seek to remove the need for judgement in decision-making. It can do no more than reduce the uncertainties and inform the judgements that decision-makers have to make. Any attempt to reduce all outcomes to a single metric so that options can be compared by simply summing their various outcomes is probably over-ambitious and certainly makes it impossible to include some important determinants.

Emphasis on the relation between impact assessment and decision-making is relatively new. Early models of HIA showed a linear process with a direct assessment directly linked to decision-making (7), but the real world is far more complex. An assessment will not influence the decision-makers unless it is designed to meet their requirements. Far too many health impact assessments have not been communicated to the decision-makers, or failed to be policy-relevant, or arrived too late to help.

Health impact assessments are most likely to inform decision-making if the decision-makers “own” the assessment and are closely involved in all the stages of the HIA, from scoping (defining all the elements involved) to report. One might logically conclude from this that decision-makers should make their own impact assessments. While this solution has much to recommend it, it is difficult to reconcile

with the principle of openness, and presents the risk that matters outside the narrow policy agenda will be neglected. The problems described in the paper by Jobin (see pp. 420–426) show why entrusting HIA to policy-makers could be dangerous.

The need policy-makers have for impartial advice may not fit with the values of public health. The role of an assessor, who has to consider the advantages and disadvantages of all options, is different from that of an advocate, who makes the case for the option favoured. Public health practitioners value health, equity and participation, and may find it difficult to switch from arguing for these to making an impartial assessment.

HIA has come a long way in the past 10 years, but if it is to go further it has to concentrate on its two key tasks of predicting the future and assisting decision-makers. ■

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