National Collaborating Centre for Healthy Public Policy

Canadian Round Table on Health Impact Assessment (HIA)

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Report

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The National Collaborating Centre for Healthy Public Policy (NCCHPP) seeks to increase the expertise of public health actors across Canada in healthy public policy through the development, sharing and use of knowledge. It is one of six centres funded by the Public Health Agency of Canada located across Canada, each with a mandate for knowledge synthesis, translation and exchange in a different area of public health.

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This is a preliminary document. We invite reader feedback, which can be sent to ncchpp@inspq.qc.ca

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1 PRESENTATION OF THE CONTEXT

1.1 HIA AS A VALUABLE APPROACH FOR SUPPORTING THE ADOPTION OF HEALTHY PUBLIC POLICIES IN CANADA

Health impact assessment, as defined internationally, is an approach that aims to support public policies by providing more information on the potential health consequences of decisions that government authorities are about to make. Drawing support from environmental impact assessment (EIA), the trend of using HIA to support the adoption of healthy public policies has been developing for a dozen years, especially in Europe. For that purpose, a standard process and certain methodological tools were developed to guide the practice. In Canada, HIA is especially well known in the field of environmental impact assessment, within which human health impact assessments are conducted for projects submitted for examination by virtue of different provincial and federal laws on environmental quality. So far, there is no reference centre in the Canadian context with regards to HIA being practised outside of EIA. The National Collaborating Centre for Healthy Public Policy (NCCHPP) believes it could play this role, considering the potential this approach appears to offer for supporting the adoption of healthy public policies.

1.2 THE ROUND TABLE

Some twenty people from Canada and abroad[1] were invited to discuss, with members of the NCCHPP, the various issues and possibilities in Canada regarding the development of HIA. The participants were invited to answer two major questions:

- What lessons can we draw from Canadian and international experiences in HIA?
- What opportunities and areas of development exist for this practice in Canada?

To answer these questions, the discussions were organized around four broad themes:

- Choosing HIA to work on healthy public policy at the local level.
- International and Canadian lessons from the past.
- What we can learn from current initiatives.
- The NCCHPP and support for this approach in Canada.

The presentation of three Canadian initiatives currently using HIA as a frame of reference for taking action on policies at the local level also stimulated discussion and brought out several issues and needs surrounding this practice in Canada. A brief description of these three initiatives is presented in the appendix.

This document presents the results of each discussion topic and the key points that can add new perspectives to current discussions on HIA.

[1] See the list of participants in the appendix

2 THEME 1
A) CHOOSING HIA AS A TOOL FOR PROMOTING HEALTHY PUBLIC POLICY
B) PUBLIC POLICY AT THE LOCAL LEVEL OF GOVERNMENT

2.1 HIA, A JUDICIOUS CHOICE, BUT…NOT A PANACEA

Despite the few known applications of this approach in Canada, several participants, notably those working at the local level, have seen many advantages of using HIA as a tool for promoting healthy public policy. The NCCHPP adheres to the current trend in viewing HIA as a process that goes beyond analyzing the health impacts of a policy option. HIA also aims to support the decision-making process. It is seen as a useful approach for promoting the meeting of the health sector with other sectors of society where decisions are made that could have an impact on health. When used by public health professionals, this approach helps them to work outside of their usual framework, which is a requirement for understanding the decision-making and policy development processes. It also offers public health actors who want to take action on the determinants of health a new way to influence policies other than advocacy, which is not always possible. The approach is therefore seen not only as a tool for sensitizing decision makers working outside the health sector to the determinants of health, but also as a powerful vehicle for leading public health and health promotion actors to consider the importance of the decisions they make outside their sectors in terms of impact on the population's health. Participants also reported that this practice would lead these actors to re-examine the context of the policy and development process and the role they can play in the process. Finally, discussions revealed that one of the strengths of this approach is that it offers a structured process for guiding actions and entering an intersectoral dynamic in an organized and credible way.

HIA's strengths:

- *Supports intersectoral action*
- *Entrusts a different and new role to public health actors*
- *Allows sensitization about the important determinants of health, both in the public health sector and in sectors outside of health*

However, participants strongly agreed that HIA is but one tool in the arsenal of strategies for influencing public policy. This strategy works particularly well when applied to a precise moment in the public policy development process – the moment when the policy is formulated, and in contexts when there is a will on the part of decision makers outside the health sector to collaborate with the health sector. Other approaches, such as advocacy, can also be useful and more relevant in other circumstances. It is therefore essential to situate this approach among other possible actions, and to distinguish them in terms of their usefulness as related to the different contexts and phases of the policy development process.

Recommendations:

- *Clarify the concepts and identify the different strategies for influencing policy;*
- *Do not neglect the various issues that emerge through this practice.*

International experience in both the environmental and health promotion fields provides information about the different issues associated with this practice. They can be classified in three major categories: methodological issues and the ability to reliably predict potential policy

impacts on the determinants of health; the demonstration of the value-added features of this practice, both for the health of the population and for the policy development process; and the potential consequences on the intersectoral relations that develop in contexts other than that of HIA. The members of the round table therefore strongly invited the NCCHPP to promote the monitoring and evaluation of this approach in order to contribute to answering these large questions.

2.2 FROM THE LOCAL LEVEL TO THE CENTRAL LEVEL AND VICE-VERSA

The NCCHPP defines public policies as decisions made by authorities who have government legitimacy, in other words, by elected officials and decision-makers within the public administration. They work at several levels, from the international level to the local level, and all of them make decisions that could have an impact on the determinants of population health. In Canada, there is a trend toward the regionalization of government responsibilities in all sectors, including health. This trend, along with the desire of regional public health authorities to act on the public policies that develop at this level, led the NCCHPP to target this level of government for promoting the use of HIA. Participants reinforced this choice and made several arguments in its favour. At this level, population groups and decision-making bodies, whether municipal or regional, are closer to each other. Therefore, not only is access to the decision-making process easier, but the decision makers are better able to see the consequences of their decisions on the community. Sectoral responsibilities are also less compartmentalized at this level, which facilitates a holistic perspective of health, as it is generally experienced by the population. Moreover, public involvement in the HIA process is more feasible at the local level. The experience of *PATH* Projects in Nova Scotia and other Healthy Cities projects show that communities can play a role in the adoption of healthy public policies. Finally, participants noted that the majority of public health professionals work at the local level and, in this perspective, constitute an important critical mass with the ability to influence healthy public policies. Despite the consensus established on the importance of this strategy since the Ottawa Charter in 1986, work still needs to be done to better describe and structure the practice. HIA seems to be an appropriate tool for this task.

Each decision-making level has responsibilities towards population health. A mutual reinforcement dynamic is required.

Participants also mentioned that the local level is a relevant one for taking action on the social determinants of health, since the conditions of life are affected by local factors as well as being subject to the repercussions of decisions made at higher levels.

It is recognized that although the policies developed at the provincial and federal levels are more complex and difficult to change, they have a considerable impact on population health because of their overall effect and the fact that they can generate levers, or to the contrary, barriers, to local decisions. Admittedly, certain large problems, such as poverty, arise from structural factors that are beyond the reach of local decision makers.

Participants felt that the local level has an ability to make higher levels of government take action. The case of restricting tobacco use in Ontario and that of the fight against pesticides on Quebec golf courses are two examples of local-level initiatives that prompted and even supported the central level to generalize regulations adopted by municipalities. Provincial and Canada-wide public health organizations, such as public health associations and foundations fighting chronic diseases, could be important knowledge-dissemination vectors on the practice of HIA because of their visibility with higher levels of government decision-making.

The different levels of government can thus question each other and support each other in their practices promoting healthy public policies which require the involvement of public health actors at every level.

3 THEME 2
WHAT WE CAN LEARN FROM THE PAST

3.1 TO INTEGRATE OR NOT TO INTEGRATE HIA IN ENVIRONMENTAL IMPACT ASSESSMENT AND OTHER TYPES OF IMPACT ASSESSMENT

EIA is a strategic framework for looking at health impact.
But beware of the pitfalls: A divided vision and a tendency to stray from its original purpose.

Canada is recognized for successfully integrating the practice of environmental impact assessment (EIA) within decision-making processes as much at the federal level as in the provinces and territories. Most jurisdictions have also adopted measures to integrate the human health impacts of projects submitted for environmental assessments, and a great deal of effort was made in the 1990s to foster this integration. On the international level, it is often noted that the best way to develop HIA is to work within the EIA field. The central argument supporting this thesis was presented during the meeting – the field is well developed and can potentially ensure the quality of assessments as well as the sustainability of the practice. However, observers of the Canadian experience drew attention to the limits of EIA and its actual ability to effectively integrate the health perspective. At the federal level, despite the broad definition given to the concept of health in government documents, and the official recognition of the importance of its integration into EIAs, this integration is difficult to accomplish in practice. It rests on the few HIA agents who, more often than not, are in a position of competition with other professionals engaged in environmental studies.

The weak legitimacy of the health sector in EIA, a vague definition of health in the federal environmental protection law (CEPA) and the observed tendency for a vision of health restricted to physical aspects led the participants to conclude that Canada has more notoriety in this sector outside the country than within it. A few individuals played a leadership role in the 1990s to broaden the perspective of health impact assessments by considering the social aspects and getting this perspective discussed in a federal-provincial dynamic. Changes in government structures and the departure of HIA promoters led to the loss of this leadership, and today, while the social dimensions of health are sometimes integrated into EIAs at the federal and provincial levels, this is more the exception than the rule.

More generally, participants discussed the fact that while EIA's project approach facilitates analysis by reducing the reach of the impact studies to a precise territory and a well-defined population, this has the disadvantage of providing a fragmented vision of population health. Applying HIA to policies, outside the procedures governed by current EIA mechanisms, would allow action to be taken upstream of projects and action plans, encouraging a more coherent overall vision that includes the perspective of population health.

One of the dangers of the mandatory regulation of HIA, which came up in the discussion, is the trap in which EIA can occasionally find itself, where the process itself can override its final goal.

Several obstacles were mentioned, including: self-limiting to projects that meet the normative criteria established for undertaking an EIA and, following that, operating within an EIA framework that does not admit all relevant factors (among which are human impacts). Moreover, the reach of an environmental assessment is sometimes diminished by, for example, splitting up or fragmenting the project under study.

This way, according to observers of the field, over the years and with the consolidation of regulatory mechanisms that govern the launching and application of EIA, the practice tends to stray from the original ideal – the preservation of the physical environment – becoming instead a technocratic mechanism.

The discussion also highlighted the development of the environmental health sector. The practice first consisted of a risk assessment approach based on pre-established standards, and over time, in certain provinces, integrated a larger vision of health into the process, while facing the methodological challenges this involves. According to one of the participants, the sector must now move towards a third phase of development by integrating social determinants and inequalities.

HIA within EIA: moving towards a third phase of development.

In light of this information, participants suggested strengthening the practice of HIA within EIA when applicable. Despite the limits and problems discussed, the field of health impact assessment within EIA is well established and is a reservoir of many years of experience, which the development of HIA as applied to policies can and must use as a basis for support. However, in this field, there is a need to support the development of methodological capacities for integrating the social considerations of health and to encourage recognition of the contribution of social sciences to a practice based on natural sciences. It is therefore important to capitalize on the field's existing strengths while attempting to meet the methodological and interdisciplinary challenges.

The question of integrating HIA with other forms of impact assessment does not only concern EIA. In fact, the pressure on public decision makers to take an ensemble of other intersectoral considerations into account, such as sustainable development, social impacts and still others will continue to grow. This situation requires awareness about the reality of the decision makers without sacrificing the HIA emphasis on health and inequalities.

3.2 IMPLEMENTING HIA ON GOVERNMENT POLICIES

Two experiences characterize the use of HIA on policies at the provincial level in Canada: that of British Columbia, which lasted several years, and that of the province of Quebec, which launched this practice in the framework of its new *Public Health Act* adopted in 2001. Among the contextual factors that favoured the first tentative government implementation of the practice of HIA in British Columbia in 1993 were the establishment of public health objectives that allowed a larger vision of the health system's mission, as well as the presence of both government and academic promoters who devoted time and effort to encourage and develop this approach. The departure of these leaders and the problems associated with using an unproven approach contributed to its not surviving the change of government. Health impact assessment applied to policies, which are complex interventions, requires the consideration of a variety of factors that unfold according to a complex causal chain, and because of this, it is compromised by methodological problems that the practice has not yet had time to solve. To be implemented at this level, HIA needs to consolidate new capacities based on methodological tools other than those used to evaluate individual health projects or interventions.

- *The importance of champions from different sectors*
- *Long term health objectives*
- *Success measured in small steps*

It was mentioned that in 1996, a first HIA report ordered by Health Canada concluded that developing this approach through the provinces would be greatly facilitated by the establishment of health policies endowed with population objectives and a long-term vision. In fact, policy impacts on health can only be envisaged on a long-term horizon, and taking them into account implies a broad and social vision of health. In the presence of such policies, it is easier to develop an argument in favour of HIA that is coherent with the government vision

The Canadian health experience also demonstrates that paradigm shifts take time. Over thirty years after the Lalonde report and over twenty years after the Ottawa Charter, health systems still focus on medical care. This is what prompted the observers of the national scene who were at the meeting to say that we must consider the introduction of such a practice with patience and determination, since the danger is to give up when confronted with problems and to move on to another application, making HIA a passing phenomenon. The successes of HIAs should therefore be measured in small steps. One suggestion was to take inspiration from theoretical models of behaviour change. Success could be measured through evaluating modifications in the intentions and attitudes of public health actors and decision makers working outside the health sector to whom this approach is offered, for the purpose of making a detailed follow-up of the appropriation of this new way of seeing their roles and responsibilities in relation to population health.

4 THEME 3
WHAT WE CAN LEARN FROM CURRENT INITIATIVES

To date, the NCCHPP has identified three initiatives using the HIA frame of reference to influence public policies at the local level[2]. They were presented during the meeting, demonstrating the flexibility of the HIA approach by bringing out three different application models: the community model with Nova Scotia's *PATH Project,* in which communities in the eastern part of this province developed their own guide (e.g.: *Community Health Impact Assessment Tool - CHIAT*); the model based on the contribution of public health experts in which HIA is seen as a tool for updating their mandate for health protection and providing the population with information (Toronto, Ontario); and the intersectoral collaboration model used in Montérégie (in Quebec) in which the HIA approach is used in the framework of intersectoral actions between the health sector and the municipal sector to support the decision-making process. Exchanges about the presentation of these initiatives allowed the discussion of a variety of dimensions related to these practice models, identifying strengths and different issues.

- *A common base – three different models*
- *HIA practice highlights several components of action on healthy public policies.*

4.1 PATH PROJECT: AN ILLUSTRATION OF THE MODEL BASED ON COMMUNITY DEVELOPMENT

The model based on communities taking charge, as described by representatives of the *PATH Project*, proves to be a strong community empowerment approach that draws its strength from the development process of an HIA guide. The recommended approach places as much importance on the process of developing a tool (CHIAT) as on obtaining the tool itself. The process for making a guide requires a collective reflection about what community factors create health, along with the development of a shared vision for long-term health objectives. This approach gives communities a greater understanding of health issues, giving them more of a chance to provoke better alignment between decisions and the major objectives for community health. The major challenge associated with this model is the durability of the approach, which relies on voluntary participation and community groups whose financing is often precarious. This model responds to the warning by some of the international literature of HIAs becoming overly professionalized or specialized.

4.2 TORONTO: AN ILLUSTRATION OF THE MODEL BASED ON PUBLIC HEALTH EXPERTISE

The model based on public health expertise integrated into municipal decision-making bodies, as is the case in the province of Ontario, ensures a continuous scientific platform and the possibility of integrating health concerns into the municipal decision-making process in a routine and eventually mandatory manner. It aims to provide solid information about the different projects and policies proposed by the municipal authorities so that the Public Health Director can fulfill the mandate of providing information to the population when there are concerns about possible health impacts. However, this model is demanding because of high expectations for the production of evidence-based knowledge which is not always available. This model is based on the quality of scientific data obtained, so the HIA must therefore be entirely conducted by the

[2] A summary of these presentations appears in the appendix.

public health sector. The challenges are methodological (e.g accessibility to relevant data) but can also be organizational and political, when public health notices hinder projects that arise within the same organization. Finally this model requires technical skill and sufficient resources to sort and identify proposals that require an HIA from among all of the projects or policies in development in a municipality as large as Toronto.

4.3 MONTÉRÉGIE: AN ILLUSTRATION OF THE MODEL BASED ON INTERSECTORAL COLLABORATION AND SUPPORT FOR THE DECISION-MAKING PROCESS

Finally, the model based on intersectoral collaboration and support for the decision-making process, such as that of Montérégie in Québec, offers an important potential for influence since it is focused on the process of developing the policy or project. Close proximity between the decision makers allows both a good understanding of the various dimensions of the decision and provides a level of public health information appropriate to the context and the nature of the project at the right moment, thus maximizing the potential for influence. However, this model must take into account possible tension between supporting the decision-making process and scientific judgement. Since it relies on consolidating existing intersectoral relations between the municipal sector and the health sector, it presents two specific issues. Firstly, this model is dependent on the will of municipal decision makers to integrate the process, motivated by the presumption of added value to the decision-making process. Secondly, a situation involving a controversial subject could have a negative impact on the intersectoral relations that public health actors are attempting to consolidate, which could affect other projects conducted in partnership between these two sectors.

The presentation of these three types of HIA models clearly illustrates the flexibility of this approach while identifying the different strengths and weaknesses of each. .

5 THEME 4
THE ROLE OF AN ORGANIZATION LIKE THE NCCHPP IN SUPPORTING HIA PRACTICE IN CANADA

Foster the climate and develop skills and knowledge

The National Collaborating Centre for Healthy Public Policy plans to promote and support HIA among public health actors who want to promote health through public policies. Its main mandates are the synthesis and exchange of knowledge for strengthening public health skills as well as networking support for researchers, practitioners and decision makers. As the first and only public health organization dedicated entirely to this theme in Canada, it was essential to find out what role the members of the round table felt the NCCHPP could play in terms of HIA. The suggestions that emerged can be classified in four broad categories: development of knowledge from practice; support for skill development; access to scientific information; and the creation of a general climate favourable to the deployment of this practice.

5.1 KNOWLEDGE DEVELOPMENT

Knowledge needs vary according to the type of HIA practice. In the framework of EIA, needs are mostly related to methodological approaches that assess the effects of development projects on the social aspects of health. For other types of HIA at the local level, the needs expressed are more about the overall HIA process and its relationship with the decision-making process for policies. The knowledge needs mentioned involve screening tools for policies or projects, citizen participation, understanding policy development contexts, good practices with respect to partnership and intersectoral dynamics, as well as finding possible ways to deal with the inevitable conflicts of values in this process.

Three routes were suggested. The first is that of knowledge synthesis on best practices, based on what is being done, first internationally where this practice is more common, and then nationally, as it becomes better known and more widely used. It seems necessary to put the concepts and practices developed in Europe and the United States into a Canadian context. In fact, beyond the common discourse on HIA, which allows the field to develop its own identity and to which the Canadian practice can adhere, there are cultural, historical and organizational realities that must be considered, if only to avoid conceptual confusion and ambiguities about this practice, which still exist.

- *Contextualized synthesis*
- *Demonstration projects.*
- *Crossover between practices*

The second route is that of supporting Canadian pilot projects and formal assessment studies. This path would allow current experiences to be documented so that we can learn from them, both to find possible ways of solving the challenges of this practice and to bring out aspects of HIA that could make it attractive to decision makers. Cases illustrating the value-added features of HIA, both within and outside EIA, could serve as references to gain recognition for the benefits of this practice.

Finally the third route consists of sharing knowledge through combining practices, favouring, among other methods, exchanges between projects and sharing these experiences with as many people as possible.

5.2 SUPPORTING SKILL DEVELOPMENT

If the integration of HIA in the basic training curriculum for public health professionals – in schools or programs of public health for example – were used as a way to sensitize and equip the health sector to act on policies, participants warned against making HIAs the exclusive domain of public health. It is clear that evaluative work in itself is only one part of the HIA process. And according to the model adopted, this work can sometimes be done by non-public health experts. If fact, when the target objective is sensitization to the broad determinants of health, stakeholders from fields other than public health can conduct HIAs. Defenders of the HIA practice who approach it from this angle consider that entrusting HIA uniquely to public health experts would greatly reduce the ability to spread this practice, while at the same time, also reducing its potential to create changes. Moreover, the skills required to understand and act upon the context of policy development processes are numerous and diffuse. It was mentioned that the best way to acquire the skills is through practice. European training experiences warn against gaining false confidence from taking courses, and call for prudence regarding the tendency to overly formalize training through an accreditation process. Training courses provide basic knowledge, but considering the complex contextual nature of the policy development process, effective skills are developed through practice.

Don't let HIA become an exclusive domain of public health

Considering the number of tools and resources that have been developed in recent years in several countries and for different contexts and clients, participants suggested that the NCCHPP could identify them and highlight their respective contributions in order to help Canadian practitioners. Establishing a taxonomy of different guides and practices according to contexts and realities, and building upon diverse experiences, would be a better way to meet the needs of the practice at the field's current stage of development.

5.3 ACCESS TO INFORMATION AND SCIENTIFIC DATA

The acquisition of relevant scientific data is often a big challenge for conducting prospective assessments and the NCCHPP was invited to facilitate access to this data. Nonetheless, it is clearly difficult for one organization to keep abreast of the broad spectrum of information required for the scientific process. This refers as much to data linking the determinants of health to the state of health as it does to linking policy projects to the determinants of health. Access to repertoires that are available and at the very least, reports on HIAs conducted in Canada and elsewhere in the world, would make it possible to meet part of this need.

5.4 CREATING THE CLIMATE

Implementing the practice of HIA throughout Canada is a considerable challenge. Besides the methodological issues associated with prospective assessments and those related to public health actors' needs for knowledge and skills, there are also the needs related to the intersectoral dynamic, of which HIA is necessarily a part. Action in favour of healthy public policy and HIA involves going into areas of responsibility other than health. Not only must public health actors be informed and be made aware of this approach if we want it to spread and make it a strong link for healthy public policy actions, but other public decision-making sectors must also be informed of what public health can bring them. The NCCHPP was therefore invited to establish links with these other sectors and act as a public health ambassador. The Federation of Canadian Municipalities is cited as an example of an organization where such a message would open the door to intersectoral relations. Circulating ideas is a good way to promote

innovation. The NCCHPP occupies a privileged place for doing this and contributing to creating a climate and a terrain conducive to deploying this practice on the national level. It was also invited to participate in international discussions that could stimulate interested Canadian networks.

6 KEY MESSAGES

The quality of the discussions and the impact of the ideas that people from different backgrounds inspired at the round table highlighted a number of themes for reflection, which we feel are important enough to be given a special place in the NCCHPP's follow-up work. We have retained five of these ideas.

6.1 THE IMPORTANCE OF DEFINING THE CONCEPT AND CLARIFYING ITS REACH IN TERMS OF OTHER PRACTICES

Admittedly, HIA outside of EIA is still a young field, and because of this, it always suffers from a certain amount of conceptual confusion. We have seen that HIA can be perceived differently depending on the country, and that the notion of influence inherent in this practice is sometimes associated with that of advocacy. In fact, it has been established that both of these conditions are necessary for obtaining healthy public policies – the production of public health information, and influencing the policy development process. Without its pillar of influence, HIA does not play a role in promoting the adoption of healthy public policy. However, HIA is not the only public health practice that can contribute to these two conditions. Research, for example, allows the production of evidence, while advocacy is a strategy that aims to use this data to promote a particular option, at times in a dynamic of confrontation. The distinctiveness of HIA is that it supports the decision-making process, which must take many alternatives into consideration, each with its advantages and disadvantages, along with a host of other considerations, health being one element among many. It was therefore suggested that HIA cannot be reduced to research or advocacy, but instead, that it falls somewhere between the two. Using this process with decision makers opens perspectives and promotes dialogue, which in itself constitutes a certain form of influence that still needs to be conceptualized.

In light of these reflections, the NCCHPP was invited to participate actively in discussions that would allow any remaining conceptual confusions to be cleared up, since this is important to HIA promotion efforts.

6.2 THE HYBRID ROLE OF PUBLIC HEALTH ACTORS ENGAGED IN HIA

In parallel with the first theme, the theme dealing with the role of public health actors in the framework of the HIA process took up part of the round table discussions. With the HIA process, there seems to be a possible conflict of roles between research and supporting the decision-making and influence processes. It turned out that this potential conflict seems to be mainfested differently depending on the decision-making level (central or local) and according to which institution the people who are conducting the HIA belong (government or community group). At the central level, in the framework of government policies, where the scope of projects makes impact analyses more complex, expert roles and supporting and influencing roles can be played by different people. This situation exists, for example, in the Quebec government model, where public health experts from the ministère de la Santé et des Services sociaux (Department of Health and Social Services) and the Institut national de santé publique provide scientific information which is put into context and adapted to the targeted policy by health department agents who are involved in interministerial relations.

It seems to be more difficult to separate the two roles at the local level because of the scarcity of the resources generally assigned to this practice and the proximity of the decision-making locations. In the framework of a controversial policy proposal, it is possible, for example, that the

same public health organization supports a group of citizens in their claims, but challenges this group's data if it is not considered valid.

Taking a position against a project for which negative impacts on health or its determinant were identified can also be difficult for stakeholders who are employed by the government, which is often the case for public health actors at any level of government. In fact, it can be uncomfortable and even impossible for these actors to maintain a firm position against a policy proposal put forward by a government decision- making body. The central question about this situation is to find a way to conform to the expected roles for their jobs while maintaining responsibility towards society and the health of the population. Sometimes one must choose the best people to deliver the message, and they can be found in civil partnership groups. In this respect, it was mentioned that NGOs are often in the best position to venture into controversial situations.

These reflections have led the NCCHPP to take a look at the different roles of public health actors with regards to public policy by taking into account a variety of political realities, the nature of policies, and partners from outside the health field and government institutions.

6.3 RECOGNIZING THE DIVERSITY OF HIA PRACTICES - THE SWISS KNIFE METAPHOR

One of the characteristics of the HIA process is its flexibility, which allows it to adapt to different forms, as shown in the description of initiatives currently underway in Canada. It can be designed to put the emphasis on the quality of scientific data, as is the case for the Public Health team from Toronto, for example; or it could be oriented more to supporting the decision-making process and to making the determinants of health easier to understand. In the latter case, HIA generally does not involve long, in-depth studies.

The diversity of HIA practices is also associated with the different functions of public health. From the perspective of health protection and prevention of possible harmful effects, it is part of an approval dynamic, similar to the methods now being used in EIA. From the perspective of health promotion, where both positive and potentially negative health effects are investigated, HIA focuses on the sensitization of decision makers to the non-medical determinants of health. The choice of what type of HIA to use is a function of an ensemble of factors, often linked with the practitioners' particular context.

The Canadian diversity shows that this process is flexible and must adapt to different influence capabilities. The Swiss knife metaphor also seemed like a useful way to illustrate this necessary flexibility. In fact, as with a Swiss knife, HIA provides a common base for diverse applications.

The challenge now is to preserve the diversity of practices that allows HIA to adapt to different contexts, but without stretching the concept to the point that it loses its own specificity. If this were to happen, the confusion around HIA would remain, and there would be a reduced capacity for participating in international discussions.

6.4 A NEW KNOWLEDGE DEVELOPMENT TERRITORY LOCATED BETWEEN THE PUBLIC HEALTH SECTOR AND OTHER GOVERNMENT DECISION-MAKING SECTORS

Among the key messages that were generated by the exchanges at the round table was the perspective of envisioning HIA practice in a new territory, located between that covered by the public health sector and other sectors in which decisions of a public nature are made. Participants noted that HIA training could take place in this new territory to guard against its

becoming the exclusive domain of public health, confirming that HIA is located at the convergence of societal responsibilities towards the health of the population. Thus, the public health sector brings useful information to decision making while the other sectors bring knowledge of their own domains and about the reality of the decision-making process. In this intersectoral dynamic, public health actors must share their knowledge and thus their power with other sectors, which agree to give up some of their prerogatives linked to the decision-making process. HIA practice therefore implies a different positioning of public health actors in relation to their traditional roles.

6.5 GREAT DIVERSITY AMONG CANADIAN PROVINCES

Finally, looking more specifically at the Canadian reality, concern about the wide diversity among Canada's provinces and territories was often highlighted. The differences are as much related to structures of the public health sector and its role as to government decision-making mechanisms and the number of community organizations that can play a role in establishing policies and the place they occupy. The strategies for influencing healthy public policies, and therefore the implementation and updating of a practice like HIA, must necessarily adapt to these different realities. In Ontario, for example, public health structures are integrated into the municipal sector, which gives them direct access to municipal decision-making mechanisms. In Quebec, the public health sector is well-developed, structured into three levels, and benefits from a number of years of experience in influencing public policy in several different sectors.

A challenge therefore exists for a centre like the NCCHPP to adapt to this diversity and meet a variety of needs. A single model to fit all needs is unthinkable.

7 CONCLUSION

Health Impact Assessment as an approach for taking action to influence healthy public policies appears to be both an important and a relevant niche for the National Collaborating Centre for Healthy Public Policy. Alongside five other centres which are part of the network of National Collaborating Centres for Public Health, financed by the Public Health Agency of Canada, its mission is to contribute to strengthening the skills of public health actors through knowledge synthesis and utilisation. The work to make public policies favourable to health takes many forms and can be approached in many different ways. The HIA process appears to be a promising strategy. It allows the combination of two basic dimensions of this work, which are obtaining evidence and influencing the decision-making process. The strategy benefits from active development on the international scale, which could nurture Canadian practices. It also offers the potential to meet the needs expressed by the groups with whom the NCCHPP met during consultation meetings held across Canada to establish an orientation for its work. There was an obvious need for tools and ways of approaching HIA to allow the healthy public policy strategy promoted in the Ottawa Charter to become concrete and operational.

The HIA field applied to policies has been steadily developing for about fifteen years in Europe and its popularity is growing, since several countries outside the continent are also interested in this practice, as the proliferation of scientific and grey literature on this subject shows. The background paper produced in preparation for the round table meeting[3] brought out the strengths and challenges associated with this practice. It became important to join this knowledge development with the panorama of the Canadian reality.

In fact, Canada has made important international contributions through its development of innovations and ideas for promoting health and population health. With regards to HIA and EIA, the province of British Columbia was a forerunner to the government policies plan in 1993, and the province of Quebec used this experience to institutionalize the practice of HIA through its *Public Health Act*. The round table on HIA also allowed participants to revisit this practice, which has evolved considerably since the first work was done for Health Canada in 1996. Over the last twelve years that separated the two events, HIA has at times lost ground, and has had some false starts, but has also seen advances that can be attributed in part to EIA, the strength of the idea of population health, the existence of an academic and research network that takes an interest in the determinants of health, the presence of new public health infrastructures, the strength of certain local communities and the fact that interest in HIA is still very strong.

The round table was a chance to take time to examine this development. Firstly, the discussions confirmed the consistency of an issue that is often discussed in the HIA field - the methodological problems associated with the prospective evaluation of policy projects. Other issues also came out, such as the persistent conceptual confusion that could detract from a clear understanding of this practice and the development of this field. The Centre must examine this problem and contribute ongoing reflections to clarify the concepts on practices favouring the adoption of healthy public policies. This conceptual issue was also linked to the historical, cultural and organizational differences that characterize different continents and countries. As an illustration, we can mention the difference in terms of partnerships between the public health sector and other sectors: these partnerships vary depending on countries and contexts, and this variation certainly colours the the way in which HIA practice is conceived.

[3] Available on the NCCHPP Web site

The practice of HIA implies a change in culture in both the public health and the public administration sectors. Recognition of the socio-economic determinants of health ("the determinants of the determinants"), the need for a long term vision, and horizontal governance are all conditions that favour the deployment of HIA. However, they require long term changes. Implementing HIA outside EIA can be considered an innovation. It takes time and a particular type of support, and persistence is key. As a pan-Canadian organization, the NCCHPP can surely play a facilitating role by creating a favourable climate.

The emergence of a new practice such as HIA also makes it necessary to circulate ideas and create connections between practice communities throughout Canada and beyond. The suggestion made at the roundtable to measure the success of the HIA practice not only in terms of the ability of the process to influence the decision-making process but also on the level of acceptance of the process by decision makers is certainly an original idea for the NCCHPP and its partners to explore. This new practice also inevitably involves the development of public health actors' knowledge and skills, which go beyond knowledge of the procedure and the ability to use the appropriate analysis models, but also involve the different dimensions linked to policy influence, such as, among other things, the policy development process, citizen participation and the different roles of public health actors among the other actors involved in the world of decision making. Moreover, the importance of considering the intersectoral dynamic of HIA is another key message to remember.

For most of these knowledge objectives, the information exists, whether in the EIA field or that of health promotion, population health, epidemiology, policy analysis or community development. Synthesizing this knowledge from the perspective of benefiting HIA practice is at the heart of the NCCHPP's mission. However, certain information requires recourse to research capabilities, notably, concerning the evaluation of HIA's effectiveness and the possible negative effects of this approach. In addition to support for academic research projects, participants recommended that the NCCHPP continue its efforts to document the existing cases using an in-depth approach. In fact, it was suggested that the NCCHPP study a few initiatives that carry lessons, counting on the fact that releasing the results to the many networks the centre can address would allow the results to spread quickly for the benefit of more people.

Finally, it is crucial to remember that this meeting was a discussion within the public health sector. Since the nature of HIA is intrinsically intersectoral and, as we were reminded many times by the content of the exchanges based on actual cases, we must consider taking the next steps in the strategy for a national discussion on HIA with stakeholders who work outside of the health sector.

APPENDIX 1
CANADIAN HIA INITIATIVES AT THE LOCAL LEVEL

PATH Projects

Presented by Colleen Cameron

The PATH 1 and PATH 2 projects and a community-developed HIA tool originated in the context of health services reform in Nova Scotia in the mid-1990s. The reform was to be based, among other issues, on needs expressed by the communities. The objective of the first project, *PATH Project 1* in 1995, was therefore to provide several communities in the province's eastern health region with a way and a means to actively participate in reflections about the decentralized organization of health services. The project, financed by Health Canada, was based on an adult education and community development approach, which allowed the communities to identify the main factors that affected their health and well-being. This process resulted in the creation of a tool entitled Community Health Impact Assessment Tool (CHIAT) to be used for different projects and governmental or organizational decisions, and the creation of a network called the PATH Network. A second project (*PATH Project 2*), also financed by Health Canada in 2000, allowed the same appropriation process to be repeated, this time with the community health council of the town and county of Antigonish.

The development process of these guides aimed to strengthen the skills of individuals and communities and provide them with better appropriation of their health, and this was the focus of the experience. It includes six steps. The first step aims to collectively establish what it would take to maintain a healthy community. This step unfolds with a structured dialogue based on story learning. The second step consists of developing a prospective vision of a healthy community, and the third is to identify the factors that contribute to this vision. The final steps are to develop a tool (step 4), test it (step 5) and make a utilization plan for it (step 6).

The tools that were developed have been used several times, notably to counteract decisions related to the closing of services.

Three broad findings were revealed with regards to these experiences. The first concerns the fact that the development of abilities and knowledge for individuals and groups was not enough to create changes. The systems that head them would have to get involved in the same sensitization process on the determinants of health and in the establishment of a broad and long-term vision of health. The second finding refers to the time and resources needed in the community development process. Even if actions take place at a very local level, they still need resources. Finally, the third finding is that to benefit the community, these new abilities and tools must be put into a context in which citizens are encouraged to participate in decision making.

The next steps will be to reflect on the way these developments can be used and maximized to influence public policies.

The Pilot Project in Montérégie

Presented by Jean-Pierre Landriault

The Direction de santé publique (DSP) for the Montérégie area (1.4 million inhabitants, located south of Montréal), is heading an HIA pilot project in collaboration with one of the eleven local Centres de santé et de services sociaux (Health and Social Services Centres—HSSC) of its territory and its municipal partners. This project aims to verify how much interest municipal decision makers have in this project and the organizational conditions and impacts related to the introduction of this new practice, as much for the municipal sector as the public health sector. This project forms part of the support for new responsibilities towards population health assigned to the HSSCs during the recent service organization reform. The HSSC must, in addition to clinical and individual health and social services, act on the social determinants of health with their partners. The introduction of the HIA practice seemed like an appropriate approach in this context.

Three projects identified by municipal actors have been the subject of HIA since September, 2007: a policy on senior citizens for a municipality of 60,000 inhabitants; a development project for a cooperative with the goal of revitalizing a small village (1,100 inhabitants); and a project to implement a small household waste composting plant for a regional county municipality (nine municipalities). One resource person has been hired full-time for one year to accompany the municipalities involved, along with the HSSC and DSP personnel. In the framework of this pilot project, the classic five-step HIA process[4] is being applied by public health actors in collaboration with municipal actors, with the idea that the latter can eventually appropriate it.

As of February 2008, the three municipal projects were at different steps in the HIA process. This pilot project benefits from the expertise of the NCCHPP, the INSPQ and the Ministère de la Santé et des Services sociaux du Québec (MSSS) which supports the HIA process within the government. The program should be completed by September 2008, and the DSP and HSSC will have to decide how to spread this approach more widely in the region.

At this stage of the pilot project, three broad questions have emerged. The first deals with the impact of this process on the relationship between the health sector and the municipal sector. Due to the fact that this model of HIA involves public health actors in the municipal decision-making process, it also depends upon good collaboration. The second question refers to the abilities, resources and roles of regional and local public health organizations to provide more support to the municipalities in conducting HIAs. Finally, the third question concerns the political or inter-organizational repercussions in case of a negative report following an impact assessment of a health proposal or policy.

[4] For illustration of the five-step model see Health Impact Assessment: a Promising Action Path for Promoting Healthy Public Policies -- Background Paper ,Appendix, p. 9.
http://ccnpps.ca/docs/BackgroundPaperHIA.pdf

HIA in Toronto

Presented by Ronald Macfarlane

The Public Health Branch of Toronto has been practising health impact assessments for many years on municipal projects but in an ad hoc manner. In recent years, based on the priorities expressed by the Toronto Board of Health, the Medical Officer of Health has been encouraging the public health team to use this practice in a more systematic and organized way in order to better respond to their mandate of supporting the adoption of healthy public policies. This practice is also becoming necessary because of growing public expectation for an opinion from the Medical Officer of Health on various issues. The implementation of HIA allows a body of quality knowledge and information to be developed so that Toronto Public Health can provide informed advice.

Since 2004, some HIAs were completed, mainly by the Environmental Protection Office, at the request of the Toronto Board of Health. This has allowed the team to become familiar with the issues associated with HIA. In 2005, Toronto Public Health submitted a report to the Board of Health on mechanisms allowing the identification of situations in which public health should be involved. This report indicated that additional resources would be necessary to conduct HIAs on a regular basis. Since the resources were not made available, the implementation of the HIA framework has taken longer than planned. Since 2007, the team has been involved in an HIA that is part of an environmental impact assessment of a waste management project.

The goal of Toronto's proposed HIA framework is to provide the Medical Officer of Health with quality information that will allow him or her to make a solid judgement on the impacts of a project or policy proposal. In this respect, the quality of the assessment responding to rigorous scientific criteria appears to be essential. This is why the health impact assessments must be conducted by public health experts and done to the satisfaction of the public health department. The framework puts a great deal of emphasis on the first step of the HIA process, which is the screening process. Since it is recommended that HIAs should be conducted under the direction of the public health team, the first step was to develop a screening tool that could sort the proposals that could be the subject of an HIA from among municipal proposals in Toronto. The screening tool is inspired by one developed in London, England. The HIA process that was developed using the standard HIA steps, points to how HIA can be integrated into environmental assessments undertaken in Toronto.

Several issues and challenges were identified at the current stage of development of this framework in Toronto. The first challenge consists of finding a way to reduce the number of proposals that would need to be screened A pre-screening process will likely need to be put in place to guide the team quickly towards the most important projects. There are also concerns about availability of resources and expertise required on the team, the development of methods to take long-term social impacts into account, access to evidence and the ability to evaluate the costs and benefits of HIA.

APPENDIX 2
LIST OF PARTICIPANTS

François Benoit	National Collaborating Centre for Healthy Public Policy
Pierre Bergeron	Institut national de santé publique du Québec
Élizabeth Boivin	Health Canada
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Lucie Lemieux	Direction de la santé publique de l'Outaouais
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Diane McClymont Peace	Health Canada
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Theresa Schumilas	Ontario Healthy Communities Coalition
Louise St-Pierre	National Collaborating Centre for Healthy Public Policy
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