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SUMMARY OF DISCUSSIONS | OCTOBER 2013

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ABOUT THE NATIONAL COLLABORATING CENTRE FOR HEALTHY PUBLIC POLICY

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. The NCCHPP is one of six Centres financed by the Public Health Agency of Canada. The six Centres form a network across Canada, each hosted by a different institution and each focusing on a specific topic linked to public health. In addition to the Centres' individual contributions, the network of Collaborating Centres provides focal points for the exchange and common production of knowledge relating to these topics.

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INTRODUCTION

Without a doubt, interest in HIA is growing all over the world. Ever since the first International Conference was held in Liverpool in 1998, the number of participants and countries represented has risen steadily. The 12th International Conference on HIA, which took place in August 2012 in Québec City, drew close to 400 participants from 42 different countries. This large turnout in a difficult economic climate attests to the growing interest in this practice and its universal appeal. As Dr. Carlos Dora of the World Health Organization (WHO) stressed in his opening address, these conferences have played a significant role in consolidating HIA practice and in establishing an international community of practice.

Since it was first introduced in the 1970s within the context of environmental impact assessments, HIA has broadened its scope and shown flexibility in adapting to different objectives and decision-making contexts (Harris-Roxas et al., 2012). International conferences on HIA, each one in its own way, are a testimony to this evolution, providing a forum for the various practice-related issues of the day. The 2012 Conference was aimed more specifically at exploring HIA practice in the context of the Health in All Policies approach that international health authorities have been advocating during the past few years.

The 2012 Conference addressed the themes of **Health in All Policies** and **HIA institutionalization**, and took stock of the **diversity of the practice** and what we have learned so far about its **effectiveness**. Naturally, in addition to these four main themes, participants were also given plenty of scope to make proposals. Discussions were held on themes that have run through all the conferences, including training, health inequities, citizen participation, environmental health and political aspects of HIA, to give practitioners and their partners an opportunity to share their respective experiences and discuss the current state of research.

1 IS HIA THE MEANS OF CHOICE FOR INTEGRATING HEALTH INTO ALL POLICIES?

Since 2006, the movement to establish a Health in All Policies (HiAP) approach within governments has generated more and more interest. The concept was advanced by Finland when it assumed the presidency of the European Union in 2006 (Ståhl et al., 2006) and, since then, it has frequently been the focus of recommendations. Dr. Carlos Dora reminded participants that the approach was recommended in the WHO Commission on Social Determinants of Health report (Commission on Social Determinants of Health, 2008), at the WHO World Conference on Social Determinants of Health in October 2011 in Brazil, at the United Nations Summit on Non-Communicable diseases in New York in 2011, and at the Conference on Sustainable Development (Rio+20) in Rio de Janeiro in June 2012 (Dora, 2012).

For the public health sector, the idea is not new. The importance of intersectoral action and healthy public policies has been promoted for many years, having been brought to the forefront in 1986 by the Ottawa Charter for Health Promotion (WHO, 1986). However, the escalation of complex problems, such as chronic diseases, obesity and climate change, is a challenge requiring integrated responses. Increased awareness of the impact of such problems on the quality of life of populations and on the prosperity of countries has put this urgently needed approach back on the agenda. The HiAP approach will in fact be the main topic addressed at the next WHO Global Conference on Health Promotion, to be held in Geneva, Switzerland, from the 2nd to the 4th of October 2013.

HiAP is considered to be a collaborative approach that helps decision makers in all government sectors take health, welfare and inequity issues into account in their processes for developing, implementing and assessing projects, programs and policies (Ståhl, 2012). According to speaker-panellist Timo Ståhl, the relevance of the approach is no longer in question, and the issue now is how to implement it in concrete ways. This will be the challenge in coming years.

HIA is often presented as a practice that helps make the HiAP approach work. However, the particular context of this approach, embedded in the government's politico-administrative system, means that standard HIA practice will no doubt have to be adapted. The HiAP approach is characterized by a concern for achieving a mutually beneficial situation for stakeholders, by decisions arrived at by consensus and by a long-term vision (Broderick, 2012; Rudolph, 2012). For the health sector, this means developing intersectoral relationships based on trust, recognizing specific objectives pursued in other sectors and proposing ways to achieve them while taking health issues into account. Linda Rudolph of the California Department of Public Health likened the situation to a quest for mutually beneficial opportunities.

The speakers addressing the topic asked the following question: Is HIA practice, as it is currently defined and implemented, adapted to this context? The question still remains unanswered. In both South Australia (Broderick, 2012) and California (Rudolph, 2012), the ways in which partners outside the health community view HIA is an obstacle to using it as an HiAP integration strategy. HIA is perceived as a long process, as producing information that is hard to access and use, as likely to hinder policy development and as more likely to produce judgments than recommendations; in short, HIA is seen as not very compatible with the HiAP philosophy. To avoid this pitfall, panellists raised the possibility of calling HIA by another name, such as a

"health lens" or "health analysis." They also stressed the need for altering standard practice to meet the requirements of the context in which government decisions are made, and they mentioned that health sector stakeholders run the risk of placing the "health" objective above other government objectives. Mr. Ståhl warned against the proliferation of impact assessments within governments, and said he would prefer to see either the integration of HIAs into integrated impact assessments or other types of impact assessments in which health issues have been taken into consideration.

Clearly, the debate is still wide open. It was mentioned that HIA can be adapted to a variety of contexts, as shown by the emergence of an application model known as the "decision-making support" model (Harris-Roxas & Harris, 2011). This model is in keeping with the principles of collaboration and mutual gains that underlie the HiAP approach. For the time being, then, HIA can be considered as an appropriate practice for supporting the HiAP strategy, provided that it is designed and understood as an *organized dialogue* (Dora, 2012) and not as a strategy presented in the form of expert judgments, far removed from the policy development process.

2 HIA INSTITUTIONALIZATION AND POLITICO-ADMINISTRATIVE ISSUES

Institutionalization has often been cited as the best way to ensure the continuity of HIA in public administration and thereby promote a bona fide "health culture" within governments (Banken, 2001; Morgan, 2008). HIA institutionalization means that the practice is used routinely in administrative processes and as a result has become a systematic, ongoing process. A handful of countries have succeeded in institutionalizing HIA, and the conference provided a forum for reviewing those experiences and discussing the key issues and challenges this represents. Three different models were presented: those used in Québec, Thailand and the United States. In these three jurisdictions, HIA institutionalization is rooted in legislation. In Québec, the renewal of the *Public Health Act* in 2001 served as an opportunity to make it a requirement for all government departments and bodies to ensure that the legislation they pass does not have negative public health impacts. An intragovernmental mechanism was established to supervise the progress and treatment of consultation requests submitted to the Ministère de la Santé et des Services Sociaux (MSSS – Québec's ministry of health and social services). This mechanism also established a clear division of the roles and responsibilities of each body, including the government's Executive Council. In the past ten years, the MSSS reported 528 consultation requests made by a range of government sectors, and a study conducted from 2002 to 2007 suggested that 80% of legislative initiatives for which HIAs were conducted during this period had taken into account notices issued by the health sector. A recent independent study concluded that institutionalization led to greater awareness of the impact of actions taken in other sectors on public health and of organizational and cultural changes on horizontal management (Denis & Smith, 2012). However, several challenges remain. Among those cited were the need to act with a longer lead time before decisions are made in order to be able to influence the process at the outset and the need to continue outreach efforts with regard to government departments with an economic vocation (Poirier et al., 2013).

In Thailand, HIA is required under two legislative measures, both adopted in 2007. The first concerned the reform of the health system and the law that governed it. The reform was aimed at reorienting the system to bring it in line with public health objectives and not just with health care. A section of this new act empowers groups and individuals to demand that an HIA of a policy be undertaken as well as to participate in the process. In the same year, the amended Constitution of the Kingdom of Thailand specified the responsibility of project promoters regarding impact assessments on the environment and on the health of the population affected. According to Dr. Sukkumnoed (Poirier et al., 2012), this combines the two core ideas of promoting collective learning about better public policies and protecting public health through a mandatory approval process for major public or private projects. Advantages and disadvantages for both were cited. For instance, it was not possible using either of the approaches to avoid divisiveness and opposition, which slowed down the development of some policies and projects. However, community participation in HIAs promoted a better understanding of health determinants at the local level and greater participatory democracy, as well as the identification of innovative policies (Poirier et al., 2012).

In the United States, HIA practice has grown dramatically. Two factors account for this: more funding is provided by the federal government and private foundations; and some U.S. states,

such as California, Oregon, Alaska and Washington, have adopted measures supporting HIA practice, either within or outside the framework of environmental impact assessments. According to Dr. Aaron Wernham (Poirier et al., 2012), these support measures for HIA implementation were passed as the result of pressure from community groups. At the federal level, the *Environmental Protection Act* and the *National Environmental Policy Act*, in force since the early 1970s, provide a platform for HIA institutionalization. Dr. Wernham remarked that while legislation is a major factor in HIA institutionalization, it is not enough if groups of citizens are not truly committed and if the public health sector is not involved, which runs along the same lines as what Dr. Sukkumnoed said about the Thailand experience.

It is worth noting here that experiences in the Swiss canton of Geneva and in British Columbia, Canada, appear to support this claim. In both of these cases, governments have adopted legislative measures permitting HIA practice in the past years, but they have yet to be implemented. Conversely, in Québec, legislation was the foundation on which HIA institutionalization was built. The same situation now prevails in the autonomous community of Andalusia in Spain (Rivadeneyra, 2012). In South Australia, a measure similar to the one adopted in Québec will be included in its new public health act. This measure is seen as a way to ensure that the Health in All Policies approach will survive changes in government (Broderick, 2012).

3 A DIVERSE PRACTICE

As a result of the growing body of knowledge about health determinants and the influence of various schools of thought in the public health field, HIA is now being adapted in a variety of ways, as befits the purposes of its practitioners. For instance, while the primary objective of an HIA conducted within the framework of an environmental impact assessment is to protect human health from the noxious effects of industrial facilities, we are now likely to encounter situations where HIA is conducted for the purpose of giving citizens a voice in the policy development process or reducing health inequities. While this diversity has the merit of meeting a variety of needs related to the establishment of healthy policies, it has also added to the confusion about HIA.

Ben Harris-Roxas presented the typology he developed of the various models of practice to reflect this diversity, helping conference participants put their own practices in context within this rapidly expanding field. Constructed from observations made in Australia and elsewhere in the world, the typology proposes four models of practice (Harris-Roxas, 2012). The oldest, known as the *mandatory* model, refers to HIAs conducted on a mandatory basis, including within the framework of environmental impact assessments. Such HIAs are usually included in development project approval processes, are conducted by experts for the purpose of identifying health risks, and mobilize knowledge in epidemiology and toxicology. In the so-called *decision-making support* model, HIAs are conducted on a voluntary basis with the consent of decision makers for the purpose of enriching the decision-making process. Decision makers, stakeholders and the community at large are urged to take part in the HIA process. This model is based on a social conception of health and strives as much to maximize positive outcomes as to minimize negative outcomes. The other two models proposed, the *advocacy* model and the *community-led* model, are also based on a social conception of health, and place a major focus on health inequities. In the *advocacy* model, HIAs are conducted by groups outside the decision-making process to pressure authorities into adopting a particular policy. *Community-led* HIAs are run entirely by non-experts, and their purpose is not so much to pursue any one particular option as to ensure that the concerns of the community that will be affected by the policy are heard and taken into consideration. One of the underlying principles of this model is that it should bolster the capacity of communities to participate in the decisions that affect them. According to this typology, the purpose and the epistemic posture that results from it are what distinguish the various HIA application models that can be seen today.

The production of this typology marks a turning point in the evolution of the HIA field. Until now, a great deal of effort has been devoted to developing methods and analytical tools (see, for example, Mindell et al., 2006), clarifying values and principles (European Centre for Health Policy, 1999) and setting practice standards (North American HIA Practice Standards Working Group, 2010). Clarifying the specific purpose of each model of practice and its associated theory of action makes it easier to study them and determine the processes involved in achieving results. HIA is at the crossroads of three scientific disciplines: public health (including epidemiology), social sciences and political science. Each offers theoretical tools capable of supporting the various aspects of HIA in a way that is consistent with the model of practice used. The third plenary session provided an opportunity to illustrate the advantages of borrowing theoretical models from outside the public health field. For example, Eva Elliot

observed that, in Wales, HIA practice favours a sociological approach that focuses on understanding interactions between the HIA process, the stakeholders involved and the context in which it is adopted, while making the most of lay knowledge (Elliot, 2012). Dr. Elliot also noted that "mandatory" models generally attach more importance to expert knowledge at the expense of lay knowledge. Dr. Monica O'Mullane has adopted a politico-administrative perspective to understand the reasons why government decision makers in Ireland make use of HIA results. Theoretical models derived from political science proved useful for illustrating the apparent dichotomy between the linearity of the HIA process and the nonlinearity of the decision-making process. By using theoretical political science models, it was also possible to better determine the contextual conditions that promote the use of HIA outcomes by decision makers; such conditions could even be considered before an HIA project is begun (O'Mullane, 2012). The idea of borrowing analytical tools from political science has already been proposed to shed light on the complexity of the process of developing a public policy in which an HIA procedure is used (Bekker et al., 2004; Putters, 2005). Judging from two major research projects currently underway, one in South Australia on the HiAP approach within government (Lawless & Baum, 2012), and one in Québec, where the impact of HIA institutionalization is being studied (Denis & Smith, 2012), the use of such tools still seems to be of interest in the study of HIA.

The proliferation of HIA models and its ability to evolve freely into new forms (Dora, 2012), however, pose a risk that the boundaries of HIA may become so blurred that it will lose its identity. Vigilance in this area is therefore in order. This concern has also been raised at previous conferences.

The usefulness of the typology proposed by Harris-Roxas and Harris will be confirmed in coming years. It will be useful not only to practitioners, enabling them to communicate their positions clearly, but also to researchers, who are urged to use theoretical frameworks rooted in public health-related sciences. In coming years, this development will serve to improve HIA practice, as reflected by the old adage: "nothing is more practical than a good theory."

4 THE EFFECTIVENESS OF HIA: AN ISSUE TO EXPLORE

Within the HIA community of practice, one area of discussion has always centred on the question of the effectiveness of HIA. When HIA was introduced into public policy in the early 2000s, the issue was concerned mainly with whether the analytical methods used could predict health outcomes correctly (Parry & Kemm, 2005). During the preparatory phase of the 12th conference, members of the international scientific committee unanimously expressed the view that the effectiveness of HIA remains a crucially important issue. Today, however, it is stakeholders outside of the HIA field—policy decision makers and administrators of health organizations or community groups—who are asking the question: Is HIA effective? Many acknowledge that it is impossible to establish a direct correlation between HIA outcomes and the health of a population (Wismar et al., 2009), so what can we say to the people we are trying to convince, about the merits of HIA?

Part of the answer was provided by Robert Quigley's presentation, which reviewed the principal evaluative studies conducted in Australia and New Zealand, where HIA has been practised for several years. Quigley claims that when the HIA process is considered from the standpoint of its ability to inform the decision-making process and promote changes to policy proposals to make them healthier, the effectiveness of HIA is no longer in question (Quigley, 2012). The other effects noted can be summarized as follows:

- HIA processes change the ways in which organizations think about health;
- HIA also helps develop methodological capacities for consensus building and consultation mechanisms;
- HIA helps deepen knowledge about social determinants.

The New Zealand experiences also showed that skills in building intersectoral relationships and leadership skills are just as important as technical skills. In this regard, Mr. Quigley reported that one does not need to be a seasoned veteran to undertake an HIA. In New Zealand, most HIAs were conducted by neophytes who nonetheless were able to take advantage of minimal outside support. For this speaker, the success of HIA is not based so much on the time factor or on the means granted as it is on the concern for making HIA an added value for decision-making processes.

The presentation given by Dr. Rajiv Bhatia, one of the pioneers of the practice in the United States, on the experience of the San Francisco Department of Public Health, confirmed the results seen in Australia and New Zealand. One interesting aspect of the experience in San Francisco, where HIA practice dates back more than ten years, is the development of mechanisms for collaboration between the public health sector and government decision-making spheres. Over time, as a result of successful HIA implementation, knowledge development, the establishment of mutual trust, and greater awareness about health determinants, HIAs became less frequent, giving way to ongoing interactions between the public health sector and municipal decision makers. As a result of this sea change in the ways the two sectors collaborated, the health sector became more involved in all stages of the public policy development process, from introduction to implementation and assessment (Bhatia, 2012).

To wind up the series of presentations on HIA effectiveness, André Fortier, Associate Secretary General of the ministère du Conseil exécutif du Québec (an executive branch of the provincial cabinet), expressed a third point of view, based on his vantage point from within a central governmental body that manages the interface between the administrative processes for developing legislative initiatives and those leading to the adoption of these projects by parliamentarians. In Québec, 400 to 500 legislative initiatives are submitted every year to the government for a ruling. At present, HIA is the subject of one of the sixteen "impact clauses" that various government departments must consider when developing legislative initiatives. In presenting this background, Mr. Fortier reported on compromises that were necessary when the time came to select impact analyses that appeared to be most relevant to a project. However, an estimated 75% of legislative initiatives submitted to the Executive Council took health impacts into account. Furthermore, the Executive Council may withdraw a project from the analysis process if it is thought that an HIA was not conducted in a satisfactory way or did not lead to an acceptable solution. One of the clear messages that this senior civil servant had for conference participants is that a policy is based on a compromise between several diverse interests and values. Public health cannot "win" in all aspects (Fortier, 2012).

CONCLUSION

The 12th International Conference on HIA was an opportunity to observe ongoing progress in this field, as reflected by the upsurge in the practice all over the world and the greater fund of knowledge about HIA. The diverse range of subjects discussed at each edition of this international conference is proof of the vitality of the movement and the enthusiasm of its participants.

One of the key ideas that ran through all the plenary sessions was the strategic planning of the future of HIA development. Now that the foundations of the practice are well established, now that it has demonstrated its adaptability to the wide range of contexts in which it has been adopted and has proved its worth, the challenge is to foster its growth so that health is considered more fully in all sectors where decisions affecting the population are made. Work remains to be done in this area (Massé, 2012), and this means that stakeholders must seize every opportunity to introduce the idea of HIA, even if only partially, they must build relationships based on trust with other sectors and they must work together with local communities and different groups in the field. The latter are potential allies in their efforts to demand governance that includes concern for public health (Massé, 2012).

In short, if efforts to consolidate HIA practice continue, and if its adherents demonstrate that they have a strategic vision, HIA has a tremendous potential for advancing the ideal of putting “health” in all policies.

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