

International Health Impact Assessment – a personal view

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For these personal reflections on Health Impact Assessment (HIA) I start with the multilateral development institutions, such as the Asian Development Bank (ADB) and the World Bank in Washington. I'll use the ADB as an example of some mixed experiences.

A few years ago, the ADB commissioned a two-year programme on HIA from a team, of which I was a member. The origin of the programme was, perhaps, a little bit unusual as it came from special funding for malaria control in Southeast Asia. The malaria control programme had most of the usual components such as drug development, bed nets, rapid diagnosis and treatment, mapping resistance, and mosquito control. As the ADB is mainly concerned with large infrastructure development, there was a final small component – HIA.

Large infrastructure development changes the physical and social environment, and this can promote the conditions under which malaria infection rates either rise or fall. But HIA is a holistic discipline, intended to consider all the possible health outcomes of a development, and not just a single disease. Furthermore, malaria in Southeast Asia tends to be restricted to the edges of forests zones while the infrastructure development is often urban or in deforested zones. Therefore, the HIA programme had a wider remit than just malaria.

One of the main outputs of the programme was a free publication entitled "Health Impact Assessment: a good practice sourcebook" (2018), to which I was the main contributor. The report is an update, in some ways, of the HIA Guidelines produced by ADB in 1992. Following the completion of the programme, and the publication of the report, is there evidence of the ADB producing many HIA statements? I would suggest that the answer is no. If not, why not? I cannot provide a direct answer as I do not have access to the thinking within the ADB institution. What I can offer is an analysis of the ADB's Consulting Services Recruitment Notices. These are published weekly by the consultant management system. There is rarely, if ever, a call for a HIA specialist. Instead, there are calls for environmental or social safeguards specialists. These safeguards specialists are assumed to have the capability to consider the health impacts as part



of the other impacts of the project. They usually do not have any education or training in public health, environmental health, or in health impact assessment.

I see something similar in other institutions, for example the oil and gas corporations. These often carry out an Environmental Social and Health Impact Assessment (ESHIA), but again, the health component is subsumed under the social component. There are also Environmental Impact Assessments (EIA) that include a health chapter. I have observed this work being done by bright generalists who do not have any specific education or training in a health-related discipline. They can read the book and cut-and-paste from earlier reports. But in my opinion they do HIA a disservice and do not provide innovative thinking on impact identification, significance, or mitigation.

As this piece is being written for a New Zealand publication, some information about the situation in the United Kingdom is of interest. I won't try to address all the activities in the devolved nations of England, Scotland, Wales, and Northern Ireland. Wales, as many will know, has a very active HIA unit and many associated publications.

England and Scotland do not generally have a statutory requirement for a HIA, either stand-alone or as part of an EIA. Many will know that the updated European Commission Directive on EIA pays more attention to population health than the previous version. There is debate about the implications of this guidance, but I have no clear picture.

I had a recent project in Scotland where a health chapter was required as part of an EIA for a residential development of more than 50 houses in the administrative district called West Lothian. The owner of the land was seeking outline planning permission for the development. This would increase the value of the land and the owner would then sell it on to a developer at a profit. West Lothian Local Authority has issued non-statutory planning guidance on HIA and the pre-application had produced a response from the planning office indicating that an HIA chapter was advisable. The guidance was based on a checklist of 25 simple questions divided into the categories of physical infrastructure, connections, and services and facilities. In my view, the key part of an HIA is to make justifiable recommendations for healthy design. The justifications came from a review of Scottish national policy, public health priorities, standards, and West Lothian policy and guidance. For example, there is a West Lothian Strategic Environmental Assessment that has the objective of improving the quality of life and human health of communities. As the project was at the outline planning stage there was very little detail, so the recommendations were general. I divided my recommendations into environmental, social, and cumulative categories. I identified both local and global cumulative impacts. For example, I referred to the contribution the project would make to global carbon emissions and the consequent health impacts of climate breakdown. The source of the emissions would be fossil fuelled vehicles, poorly insulated homes, and poorly designed domestic heating and lighting systems. The recommendation was to minimise fossil fuel use for transport, cooking, heating, and lighting; and to maximise insulation. One of the other chapters in the EIA was a transport assessment. But this was largely stating that the development would not add significantly to car density on the local roads. It had little to say about active transport. I tried to engage with the

consultants writing the transport assessment, but they weren't interested. This is a common challenge.

An interesting current example is an initiative taking place in the County of Essex, on the edge of London. Essex has long had a Design Guide to encourage high quality development. The latest iteration encourages developers to become accredited to the Livewell scheme. Accredited developers will presumably have an enhanced reputation and be more competitive. Under the scheme developers are encouraged to undertake a stand-alone rapid HIA at an early planning stage. Essex has produced a checklist of questions representing the determinants of health in the built environment. There are approximately 143 questions, which is about twice the number in the well-known HUDU guidance. The questions fall into the following categories: active environments and active design principles; design of homes and neighbourhoods; access to open green and blue space; supporting community participation and lifetime neighbourhoods; access to healthier food environments and locally sourced food; education, skills development and employment; access to health care infrastructure; and environmental sustainability. Essex officers have advertised a contract to produce a very short HIA training course for an audience of developers, urban designers, consultants, investors, public health professionals, and planners.

In conclusion, HIA struggles on as it has over the last 40 years with advances and retreats. In some settings there is evidence of health being buried in environmental and social assessments. This is likely to promote the medical model and reduce the quality of reports and recommendations. On the other hand, planners in the UK are taking a renewed interest in healthy urban design and see HIA as a useful promotional tool.

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