



Whither HIA in New Zealand....or just wither?

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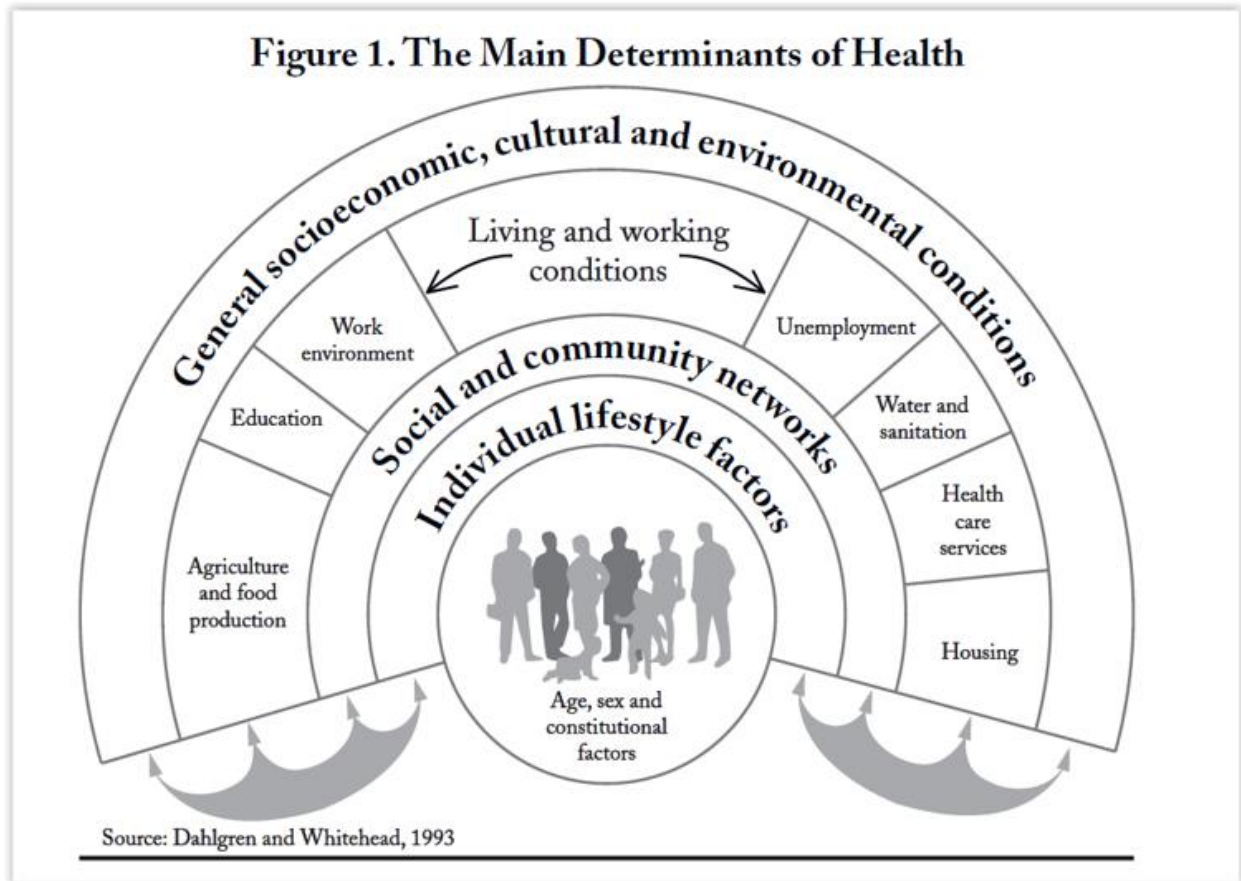
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Health impact assessment (HIA) has had mixed fortunes in New Zealand. Following a fitful start in the 1990s, HIA finally gained a level of recognition and political acceptance as a policy appraisal tool that saw it being practised across the country, until political support, and funds, faded. Does HIA still exist in New Zealand, perhaps under other labels or guises, or has it just withered? Is there room for a comeback given current social and environmental concerns, and the opportunities provided by ongoing reviews of environmental, health and disability legislation?

Health has been a part of impact assessment practice internationally since the passing of the National Environmental Policy Act in the US in 1970. However, for 15-20 years the emphasis was on environmental health, and especially the potential for environmental pollution of air, water and land to affect human health. This emphasis was supported by work at the WHO to develop environmental standards based on human health considerations: for example, recommended maximum levels of PM10 and more recently PM2.5 are levels of particulate matter in air that directly reflect concerns over human health due to air pollution. This approach recognised changing environmental conditions can affect a person's health, especially if they have a genetic condition that makes them vulnerable to certain factors.

However, the environmental perspective was only part of the picture and, during the 1980s, public health practitioners drew attention to the wider scope and complexity of factors that affect human health. In simple terms this added a social determinants component to the existing environmental determinants model of health and is often summarised using the Dahlberg-Whitehead diagram:

Figure 1. The Main Determinants of Health



Source: Dahlgren and Whitehead (2007)

The notion that health can be affected by a breadth of factors, many potentially altered directly or indirectly by policies, plans and projects, led to the emergence in the late 1980s and early 1990s of health impact assessment as a vehicle for bringing these considerations into relevant decision-making processes.

In New Zealand, the enactment of the Resource Management Act 1991 at that time integrated impact assessment into the resource consent process and, given the reference in s5 to enabling "...people and communities to provide for their social, economic, and cultural well-being and for their health and safety...", hopes were high that health would be treated as a natural, integral part of that impact assessment process. This intention prompted the Public Health Commission (an independent advisory body set up in 1993) to develop a guide on health impact assessment that could be used in the context of the RMA consent processes (PHC, 1995). The HIA process envisaged in that guide was based on a risk model, so a complementary guide on health risk assessment, covering the technical core of the HIA, was also released (PHC, 1995). For various reasons (one perhaps being that the PHC being abolished in 1996), these initiatives seemed to have little lasting influence on the assessment of environmental effects under the RMA. In the absence of formal government guidance on the process of assessing



environmental effects until 1999, and without further advice on how to address health issues, impact assessors largely fell back on familiar environmental health considerations that were a feature of planning applications under previous planning processes, such as the reliance on environmental standards.

In 1998, New Zealand hosted the annual conference of the International Association for Impact Assessment (IAIA) in Christchurch, organised by Nick Taylor and Martin Ward. To take advantage of the presence at the conference of a number of international experts on HIA (such as Martin Birley, an international HIA consultant, and Roy Kwiatkowski from Health Canada) the author organised a one-day pre-conference workshop on HIA, with the morning given over to international perspectives, and the afternoon to presentations and discussion about the current state of HIA in New Zealand (Morgan, 1998). This event was followed up by presentations and discussions on HIA at the Public Health Association annual conferences that year and the next. Together, these activities renewed interest in a more broadly based HIA that would serve wider public health aims. Staff working for the National Health Committee researched the use of HIA at the strategic (policy) level in other countries, especially in Europe, and undertook a pilot study to allow staff to explore possible approaches to the use of HIA for the assessment of government policies (Lewis, 2000).

This work was ultimately reflected in the New Zealand Health Strategy 2000 which identified “*A healthy social environment*” as its leading goal, and “*Assess public policies for their impact on health and health inequalities*” (NZHS, 2000, p. 10) as the first objective for that goal. To meet that objective, the Public Health Advisory Committee (established in 2001 and working under the National Health Committee) was tasked with developing a new health impact assessment guide. So “*A Guide to Health Impact Assessment: A Policy Tool for New Zealand*” was released in 2004 (PHAC, 2004) and was very much aimed at the assessment of non-health policies. This was followed in 2007 by the release of *Whānau Ora Health Impact Assessment* (MoH, 2007) to help policy makers anticipate the potential health effects of a policy on Māori and their whānau. An HIA support unit was set up within the Ministry of Health to promote the use of HIA for policy assessment in central, regional and local government, to organise short training courses on HIA, and to administer a Learning by Doing fund.

In broad terms, central government departments did not take up HIA to any great extent despite these efforts. In contrast there was much greater take-up by regional and metropolitan councils and the district health boards. The 36 completed HIAs available on the MoH website, mainly from the years 2006-2014, reflect this regionalism: the majority concern urban development strategies or plans, with transport (including three Regional Land Transport Strategies) also prominent. The MoH website also has seven whānau ora HIAs, typically involving DHBs and local iwi, examining the implications for Māori health of a range of proposals.

The period from 2004-8 marked the high point for this form of HIA in New Zealand. A change of government in 2009 saw the dis-establishment of the HIA Support Unit and a wind-down in training activity. District health boards, however, maintained an interest in HIA, including working with policy and planning staff in regional and local authorities on issues such as urban

growth strategies. But over time the interest in HIA seems to have been largely superceded by a Health in all Policies (HiAP) approach, which is oriented very much towards the achievement of desired health outcomes in non-health policies (e.g. reducing health inequalities; encouraging higher levels of physical activity through changes in urban design or transport modes; etc.). This trend has seen less emphasis on the analysis of proposed policies and plans for their unintended consequences for health, a key part of any impact assessment process.

What of HIA at the project level? Despite the early work of the PHC in the 1990s to develop an HIA model, there are few examples of distinct, named, project-level HIAs in New Zealand. Ironically there was one attempt to use the 2004 PHAC HIA model on a major project. It came about through the Learning by Doing fund of the Ministry's HIA support unit, when a team from Community and Public Health at the Canterbury DHB carried out an HIA on the Central Plains Water Scheme in 2008, to make up for the perceived lack of a significant health component in the AEE of that proposal. An evaluation of the HIA for the Ministry of Health (Morgan, 2011, p. 26) concluded that:

in the end, the decisions on the resource consents were rather unsympathetic to some of the key messages of the HIA, such as the inequality arguments, and the commissioners regarded the HIA as less than objective.

The information contained in the HIA, and the way the issues raised were argued at the consent hearing, emphasised the distance between policy HIA and project HIA.

The tools developed for policy-level HIA tend to focus on broader issues, which provide the basis for negotiated change to proposed policies. In contrast, HIA in the RMA context has to focus much more specifically on cause–effect pathways that link particular project actions to direct and indirect environmental changes, which in turn lead to potential impacts on the health of individuals and communities. Consequently, HIA in the RMA context has to be focused more directly on generating specific impact information that can be defended in public hearings if necessary (Morgan, 2011, p. 26).

The other main problem noted in the evaluation was that by undertaking the HIA, the Public Health Unit was unable to perform its role as the health advocate/advisor to proponents and decision-makers. The CPWS HIA was seen as a “one-off” process, due to particular circumstances, and the evaluation recommended that it should not be seen as model for future project HIAs.

Despite the lack of named HIAs at the project level, health impacts have not been ignored in AEEs for resource consents under the RMA. However, as noted earlier, the treatment has generally been dominated by environmental health considerations. A common practice has been to use environmental standards, based on human health considerations, for issues such as water and air quality, noise, and land contamination. These can be applied by environmental scientists without public health training, an important consideration with the low numbers of public health practitioners working in impact assessment. On the other hand the use of standards leads to health being treated implicitly, to the extent that decision-makers and the

public may not always make the connection to health. In addition, as the standards will usually be applied to separate environmental sectors, the treatment of health is disaggregated, making an overall assessment of environmental health consequences difficult and an overall assessment of community health outcomes impossible. In particular, the combined health effects of various forms of environmental pollution are often problematic, especially for vulnerable individuals and communities, when exposed to combined effects even when separate standards are predicted to be met or single effects are determined as less minor. In terms of the broader social determinants of health, the more important ones have tended to be picked up in social impact assessments, if carried out, but usually without the substantive investigation a public health professional would conduct.

As a consequence, there is rarely any overall assessment of the total burden of health impacts on individuals, families, or communities, taking account of both environmental and social determinants. This is where project level HIA has a role to play. Working with environmental scientists, ecologists, social scientists, and building on their investigations, the HIA practitioner would provide an integrated analysis of the health impacts that might be experienced by various sectors of the community. This is not a role the public health units and DHBs can take up: it needs independent practitioners with public health training, who are familiar with impact assessment methods and processes, from biophysical/ecological to social and cultural. And it needs non-health practitioners who understand the complexity of conducting an HIA alongside the other components of an AEE. There is room for new HIA guidance along these lines from the Ministry of Health and Ministry for the Environment once the new Natural and Built Environment Act has been passed.

What of policy level HIA? The *Health and Disability System Review – Final Report – Pūrongo Whakamutunga* released in March 2020 contains just one comment on HIA, in a section on HiAP:

International experience has found that without an explicit process, such as health impact assessments (HIA), the availability of technical information on the expected health and wellbeing impacts is unlikely to be sufficient to influence decision-making to any significant degree. (p. 86)

Despite this positive recognition of the value of HIA, there does not seem to be any intent in subsequent government documents to return to the heady days of the early 2000s when HIA was a central policy tool. Yet faced with major decisions such as those associated with climate change mitigation and adaptation in coming decades, decisions that could lead to fundamental changes for New Zealand communities, HIA should be a key part of the analytical toolkit to ensure unintended consequences for health from those decisions are minimised or avoided altogether.

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