FIFTH GLOBAL CONFERENCE ON HEALTH PROMOTION

Mexico City, Mexico

5-9 June, 2000

Promoting Social Responsibility for Health:
Health Impact Assessment and Healthy Public Policy

at the Community Level

By

Maurice B. Mittelmark

Research Centre for Health Promotion

University of Bergen

---

1 An earlier version of this paper was presented at the 5th Global Conference on Health Promotion, Mexico City, Mexico, June 5-9, 2000, under the title "Promoting Social Responsibility for Health: Progress, Unmet Challenges and Prospects."
EXECUTIVE SUMMARY

The purpose of this paper is to suggest a path of action to further promote socially responsible planning and decision-making (healthy policy-making) at the community level. Commitment to socially responsible behaviour at all levels, including the community level, is vital to the goal of bridging the equity gap in health. It is argued that if equity-in-health is to be pursued with success, policy- and decision-making must occur in an environment in which citizens, business and government view equity-in-health as a prized and serious goal. The paper contends that the health gap can be narrowed significantly. The principle means for doing so are healthy policies that aim to improve equality in:

1) opportunities for education and employment,
2) access to a safe, nurturing physical and social environment,
3) opportunity to participate in the governance of society, and
4) access to health care and social support services.

The paper advances a number of arguments for focusing on healthy policy-making at the local level. This is not to say that the local level is of greatest importance. For many problems, e.g. air pollution, an effective policy structure requires action at all levels, from international to local. However, many healthy policy initiatives are national or international in scope, and do not explicitly include a focus on local action for healthy policy.

There are several compelling reasons why highly participatory, local level policy-making is important, and should receive greater emphasis than it does today. Policy-making at macro levels may not be sensitive to the diversity of local conditions that directly affect the health and wellbeing of communities. Important health-related planning, policy-making and action originate at the local level. Local leaders should be highly motivated to practice healthy policy-making, since they are affected by their own decisions. Additionally, experience with hundreds of research and demonstration programmes world-wide confirms that through the use of tried and proven community development techniques, communities are capable of achieving important improvements in health conditions and of strengthening their capacity to respond to new challenges and opportunities (Mittelmark, 1999).

There is also evidence that a participatory community health development process can shift peoples' thinking beyond the illness problems of individuals to consideration of how programmes and policies could support or weaken community health, and illuminate a community's capacity to control and improve local conditions for a healthier society.

The paper concludes with the claim that the key activity required to promote healthy policy-making at the local level is health impact assessment. Health impact assessment is in fact essential to healthy policy-making at all levels of society and the development of more effective HIA approaches should be a high priority. Thus, the present focus on health impact assessment at the local level should not be misinterpreted as meaning that the community level is the most important arena for this work. In fact, policy development and action at the local level, to be most effective, should happen in concert with national and international policy and action developments. However, health impact assessment at the community level is relatively
underdeveloped as yet, and that is the main rationale for the special emphasis it has received here.

The paper presents evidence that highly participatory, local health impact assessment can be used to identify negative health impacts that call for policy responses, and to identify and encourage practices and policies that promote health. Socially responsible decision-making for improved equity-in-health is stimulated by community-level health impact assessment, because it is a practical tool to help communities come to grips with local conditions that need changing if better health for all is to be realized.

The paper defends this agenda on the basis that high-sounding, general calls to improve social responsibility for health are not sufficient to stimulate action. At the same time it is recognized that there are many possible arenas for - and levels of - action to promote social responsibility for health. Which paths will lead to the best outcomes is a matter for debate, but evidence suggests that one very promising path is to stimulate local healthy policy and practice through widespread implementation of community-based health impact assessment.
INTRODUCTION

The 1997 Jakarta Declaration on Health Promotion into the 21st Century (WHO, 1997) called for new responses to address the emerging threats to health. The Declaration placed a high priority on promoting social responsibility for health and identified five policies and practices that show commitment to social responsibility:

1. Avoid harming the health of others,
2. Protect the environment and ensure sustainable use of resources,
3. Restrict production and trade in inherently harmful goods and practices, and in unhealthy marketing practices,
4. Safeguard people in the marketplace and the workplace, and
5. Include equity-focused health impact assessment as an integral part of policy development.

In this paper, these five policies and practices define the term “social responsibility”. This is of course a restricted perspective on social responsibility. The construct has different shades of meaning for the media (Shelton and Hasim, 1996), for academia (Brunner and Ascher, 1992), for health professionals (Duskin, 1995), for the corporate world (Kyambalesa, 1990) and as it relates to government (Milio, 1981; Hancock, 1985). Here, for reasons primarily of practicality, the focus is limited to social responsibility in the arenas of business and of government.

Commitment to socially responsible behaviour in the private and public sectors is vital to the goal of bridging the equity gap in health, the main theme of this conference. As a stark example of the need, the Global Forum for Health Research (1999) estimates that of the 50 to 60 billion dollars spent annually on health research and development, only 10% is used for research on the health problems of 90% of the world’s people. The decisions by businessmen and government officials that have led to this situation do not demonstrate socially responsible behaviour, and contribute to a widening gap between the health of a lucky few and that of the rest of society. If equity-in-health is to be pursued with success, policy- and decision-making must occur in an environment in which both business and government view equity-in-health as a prized and serious goal, alongside other important goals such as being competitive, efficient and profitable.

Equity-in-health is admittedly an idealised goal, describing a world in which each person enjoys the best health that his or her genes and individual predisposition permits. Although perfect equity-in-health can never be achieved, much of the present inequity is avoidable and the gap between those with the best and the worst health can be narrowed significantly. The principle means for doing so are to improve equality in opportunities for education and employment, equality in access to a safe, nurturing physical and social environment, equality in opportunity to participate in the governance of society, and equality in access to health care and social support services. The principle means, in short, are to promote equality in life’s chances. Perfect equality in life’s chances is also an idealised goal, of course, but striving for better equity-in-health through improving equality in life’s chances is worthy, feasible, and socially responsible.
The example from the Global Forum for Health Research is but one of many which illustrate a situation of inequality (in this case in the distribution of research resources) that, if reduced, could improve equity-in-health. It is a particularly useful example, because it shows so clearly were the responsibility lies. The 1.3 billion people of the world living in extreme poverty have little or no access to health care, they do not have the education and other resources needed to move out of extreme poverty and they have no control over many decisions that affect their lives. The shift in priorities, resources and actions that is needed to begin closing the health equity gap is dependent entirely on socially responsible decision-making by those who do have the power.

The challenge is greatest in the poorer regions of the world that are trying to ‘catch up’ economically with the mature market economies. The drive to be competitive in international business causes inevitable conflicts with well-intentioned goals to protect health. Long working hours, poor working conditions, low wages and weak to non existent social safety nets are seen in many developing economies as unfortunate but essential costs of economic progress. In some societies child labour is seen as the only avenue to competitiveness in the global economy. Increasingly, the peoples’ guardian, government, is called on by business to prioritize economic development, too often at the cost of human development and health.

All this contributes to a well documented and growing health equity gap (Benzeval, Judge and Whitehead, 1995; Whitehead, 1990). Even in countries long thought to have tackled this problem with success -Norway for example - the health equity gap is evident when comparing the health status of people in highly skilled versus relatively unskilled employment (Dahl, 1993). Thus the equity-in-health issue affects virtually all societies regardless of their relative economic standing.

**TAKING ACTION**

Strategies for the public sector to tackle inequalities that produce health inequality have been identified (e.g., Dahlgren and Whitehead, 1992), and some of these are showing promise of reasonable effectiveness where they have been tried (Black and Mittelmark, 1999). A inspiring example is that of Costa Rica, where a serious commitment to improving equity in health was mounted in the early 1980’s despite very challenging economic conditions, producing gratifying improvements in population health status, including reduction of the health equity gap (Eriksson, 1999).

In the private sector, it has been demonstrated time and again that it is possible to balance economic interests with a sense of obligation to people and their wellbeing, and still make a profit (Hopkins, 1999). Despite evidence that socially responsible actions are quite feasible in both the public and private sectors, such practices are not widespread. Thus, the challenge is twofold. First, to highlight the success stories to demonstrate what is possible. Second, to pinpoint areas where improvement is required. Here, the focus is more on need for improvements, but conference participants will undoubtedly provide many examples of existing good practice that will inspire adoption elsewhere.
A special challenge for the World Health Organization and its partners at the Fifth Global Conference on Health Promotion is the need to move beyond calls for action, to plans for action that are implemented, and for which people are willing to take responsibility. As a stimulus for effective action, the priorities set by the Jakarta Declaration are too broadly conceived. The conference participants in Mexico should set a few focused priorities for moving the social responsibility agenda forward, determine a framework for action and monitoring, and commit to accountability.

HEALTHY PUBLIC AND PRIVATE POLICY

The foundation for socially responsible action is healthy public and private policies that set standards for conduct, guide decision-making, and ensure accountability. Considering the five policies and practices of social responsibility listed at the beginning of this paper, and minding the call for focus and action, it is argued here that comprehensive implementation of equity-focused health impact assessment is the essential prerequisite for moving forward. Health impact assessment is the linchpin to healthy public and private policy and practice, just as environmental impact assessment has been the linchpin to growing success in the environmental protection movement. The other four policies and practices of social responsibility listed at the beginning are stimulated and supported by health impact assessment. Health impact assessment is the essential building block in constructing socially responsible policy and practice.

There will be critics to point out that this is a very narrow agenda, ignoring many important social responsibility issues. However, if we are to move beyond rhetoric and on to action, a step-by-step approach that creates a series of ‘small wins’ has much to recommend it (Weick, 1984). As we gain experience and confidence, the agenda can be expanded.

HEALTHY POLICY AT THE COMMUNITY LEVEL

An especially important arena for health impact assessment and healthy public and private policy is the local community and its settings such as schools and workplaces. This is not to say that the local level is of greatest importance. For many problems, air for example, an effective policy structure requires action at all levels, from international to local. However, many healthy policy initiatives are national or international in scope, and do not explicitly include a focus on local action for healthy policy. There is a tendency to think of policy-making as a large, very complex enterprise, and to think of policies as being ‘handed down’ by experts.

However, there are several compelling reasons why highly participatory, local level policy-making is also important, and should therefore receive greater emphasis than it does today. Policy making at macro levels may not be sensitive to the diversity of local conditions that directly affect the health and wellbeing of residents of different communities. Important health-related planning, policy-making and action originate at the local level. Also, the motivation of local leaders to practice healthy policy making should be high, since they are affected by their own decisions. Additionally, experience with hundreds of research and demonstration programmes world-wide confirms that through the use of tried and proven
community development techniques, communities are capable of achieving important improvements in health conditions and in strengthening their capacity to respond to new challenges and opportunities. There is evidence, too, that a participatory community health development process can shift peoples' thinking beyond the illness problems of individuals, to consideration of how programmes and policies could support or weaken community health, and illuminate a community's capacity and control to improve local conditions for a healthier society. Each of these points is taken up below.

When the subject of healthy policy is raised, thinking automatically turns to the large arenas of national and even international policy-making. Indeed, globalization of the economy is in many ways erasing national borders and concerted action to protect health is essential at the international level. However, even the best-intentioned national or international healthy public policy initiatives may fail to have the intended impact at the local level, and may even result in serious harm because of ignorance of local conditions. National policy-makers cannot anticipate with a high degree of confidence how their health-related policy will affect life and wellbeing at the community level. Local level analysis of social and health impacts could prevent policy ‘boomerangs’ by suggesting reasonable modifications to policy so that implementation fits local conditions and needs.

A case study illustrating this problem has its starting point in the early 1970’s: more than 6,000 people living in Iraq were hospitalised and 400 died after eating bread made from wheat flour containing a high dose of mercury from a fungicide (Egeland and Middaugh, 1997). This extremely serious poisoning episode aroused substantial concern internationally. In the United States, national officials reacted quickly, setting a recommended maximum daily dose of mercury only one-fifth that of the limit recommended by the WHO (though there is evidence that twice the WHO recommended maximum dose is safe). Public health workers in Alaska strongly questioned the wisdom of this move. That is because many public health officials base their fish consumption advisories on mercury consumption recommendations from the national government. However, from the community perspective, severely limiting the consumption of seafood may do more harm than good. Aside from the known beneficial health effects of eating fish, people in many areas of remote Alaska rely on subsistence fishing. Restrictive advisories could damage the social, economic and personal wellbeing of entire villages. The point here is not to enter the debate on what levels of mercury in the food chain are safe or not, but merely to illustrate the importance of the local perspective on health-related decision-making that happens outside the community.

Another part of the rationale for an emphasis on health promoting policy-making at the community level is that much of the critical decision-making affecting health and wellbeing occurs at the community level. As but one example of this, consider public sector schools. National regulations may dictate the required health curriculum, the formal training and competency levels of teachers, the examination procedures and so forth. But only policy-making in the schools can determine what the learning culture and environment will be. Will the very serious mental health problem of bullying be tolerated as inevitable, or will the teachers, parents and students develop policies and practices that sanction bullies in a serious way? Will the routines of the educational process, the food served in school, and the school facilities support, or be a detriment to, the health of staff and students?
For those who are far removed from school days, consideration of the work environment makes the point equally well. Many countries today have national policies to protect workers’ health. Nevertheless, many people have been in (or know about) a workplace where the culture ‘grinds’ people down, destroying morale, lowering productivity, and causing excessive turnover, sick leave, and burn out. Alternatively, enlightened management in many workplaces realizes that the path to sustained productivity is (policy resulting in) worker participation in decision-making, provision of training for advancement, development of working conditions that actually improve health, and so on. No amount of policy-making at the national level can affect the culture of work environments to the degree that policy at the local level can.

Moving up from the level of schools and workplaces to the community level, the case is equally strong that local healthy policy-making is essential for success. Trevor Hancock (1985), a leading Canadian public health physician credited with coining the term “healthy public policy”, pointed out long ago that at the local community level, there are important social ties between public policy-makers and those affected by policy. Community policy-makers live where they work. They are identifiable with their policies. They (and their families and friends) are affected by their own decisions. The bureaucracies of communities are less complex than at national and regional levels, and there is greater likelihood of inter-sector collaboration at the local level.

Indeed, experience with hundreds of research and demonstration programmes world-wide confirms that through the use of tried-and proven community development techniques, communities are capable of achieving important improvements in health conditions and in strengthening their capacity to respond to new challenges and opportunities (Mittelmark, 1999). Restrepo (2000) provides much insight into the potential for strengthening community capacity for health and well being, capacity that could be brought to bear to improve healthy public policy action at the community level.

HEALTH IMPACT ASSESSMENT

The case being built here thus has two elements.

- One practical strategy for advancing social responsibility for health is the stimulation of local-level healthy policy-making.
- Health impact assessment is the essential tool for healthy policy-making and must therefore be developed and deployed in a form that is acceptable and functional in local communities and their settings.

Moody and colleagues make a strong case for the importance of appropriate infrastructure to support health promotion practice (Moody, et al, 2000). Useful tools are needed if such infrastructure is to function as intended. The Investment for Health process described by Ziglio and colleagues (Ziglio, et al, 2000) provides just such a set of tools, and health impact assessment provides another useful tool.
There is no consensus as yet on what exactly health impact assessment should consist of, nor are there any authoritative statements indicating what approaches to health impact assessment are essential if equity is to be in focus. However, in one way or another, all approaches to health impact assessment address the basic question “how are existing or planned policies, programmes or projects actually affecting, or likely to affect, people’s health, for good and for bad?” Answers to this question could help policy makers and programme managers make the decisions and changes needed in order to perform their work in the most socially responsible manner possible.

The arena of health impact assessment is young and developing very rapidly (Scott-Samuel, 1996). International co-operation and co-ordination are being stimulated by, among others, the WHO European Centre for Health Policy (Lehto and Ritsatakis, 1999). They describe a general approach to health impact assessment (HIA) that has five elements:

1. HIA examines direct and indirect impacts on health of policies, strategies, programmes or projects
2. The initial stage is screening using available information to determine if there is confidence that impact is negligible, or if more information is needed
3. If more information is needed, scoping is done to determine what level of resources and expertise are required to develop the needed information (ranging from a rapid appraisal using additional expertise, to an in-depth impact analysis, or an extensive impact review)
4. Generation of assessment report
5. Modification of the policy/project if indicated

Despite the jargon (screening, scoping), models such as this should (with appropriate user interfaces) be useable in almost any setting and be accessible to any group of interested citizens, regardless of level of formal training. Science, business and government should have access to the technology, but so should average citizens, even those living in difficult conditions.

Even when “big science” research methods are not feasible, useful local level (and participatory) analyses are possible. Some examples are presented below. However, the trend of ever more technical and complicated methods of impact assessment threatens to exclude average citizens from participation. In the best of worlds, science develops knowledge and some of that knowledge can be put to use by average people to solve practical problems. That is technology born from science. Too frequently however, as the technology becomes more complex, elites take over and the technology transforms into quasi-science.

This has happened in the environmental impact assessment arena and threatens to happen to health impact assessment if we are not vigilant. The jargon is becoming inaccessible to the average person and the methodology is becoming very complex. However technological development and user-friendliness can co-exist. We can learn from the information technology field, which has demonstrated how very complex technology can be made universally accessible. User interfaces of the simplest kind are needed if health impact assessment is to reach where it is most needed. Health promotion should strive to build an
approach to health impact assessment that any person or group with average education and intelligence can master with some study and practice. We must be alert to and defend against the natural tendency to permit professionals to take technology out of the hands of the people.

This section, which might have been sub-titled the “world of the desirable”, has focused on a call for action, advanced some recommendations, and raised several warnings about what should be avoided. The next sections illustrate the “world of the possible”, pointing to some positive developments in both the business and the public sectors, to make the case that the recommended actions are feasible.

THE PRIVATE SECTOR
The world of business has in the last decade begun to take the idea of corporate social responsibility (CSR) very seriously, for reasons of both altruism and enlightened self-interest. Today, virtually all of the major international companies have made a formal commitment of their resources to the social responsibility agenda. However, health promoters have not done as well as might be hoped in connecting to the corporate world’s social responsibility movement. In this regard, health promoters need to learn from the success of other “green” movements, especially the environmental protection movement.

A very large proportion of corporate social responsibility action is tied to the environmental protection movement. This movement has succeeded in putting forth a clear and compelling case for specific protective actions, and is expert at keeping environmental issues on the front burner of public discourse. Environmental protection is health promoting, of course, but more can and should be done. The unique contribution of health promotion is the equal emphasis on social and physical environment, especially community development for health.

Also, health promoters need more and better collaboration with existing CSR alliances. Not only do virtually all major corporations have CSR policies and programmes, many have joined CSR networks and made CSR alliances. But one example of many that could be offered is the Social Venture Network Europe, part of a world wide network including more than 400 companies and business leaders working together for solutions to environmental and social problems (Social Venture Network Europe, 1999). Among the initiatives of this network is the development of CSR standards and practical tools to help companies assess the suitability of members’ actions in a wide range of areas including corporate governance, community involvement, employee development and sustainable development.

In addition to the already accepted and expected forms of socially responsible behaviour, business is becoming interested in the idea of ‘social audits’, that measure social and environmental impacts and help guide improvement in such areas as community and customer relations and employment practices (Hopkins, 1999). Social audit is thus very close in practice to impact assessment, and indicates the potential to further expand the promotion of social responsibility for health in the private sector.
As the business world becomes more adept at carrying out and using the results of social audits, they can and should be encouraged to meet two challenges. Firstly, to include specific attention of health issues in social audits. Secondly, to commit to sharing the techniques and practices of effective social and health impact assessment with local communities. Business-government alliances already exist in many communities world wide, and these could easily be extended in the direction suggested here.

THE PUBLIC SECTOR

The term social responsibility is not often explicitly used in conjunction with good government, perhaps because the universal ideals of responsible and representative government might seem synonymous with the concept of social responsibility. However, from a health promoter's perspective, it can be easily argued that the social responsibility of government goes beyond the provision of services and protections that citizens need and want. The case has long been made that the social responsibility of governments should include the development and practice of healthy public policy, emphasising the health impact of decisions that are made in public policy areas outside the health sector (Draper, 1991).

At certain levels, developments are gratifying. There exist today a number of stimulating examples of national and international level inter-sector collaborations for healthy public policy and health impact assessment. The European Regional Office of WHO, for example, is beginning work with European partners to build capacity for health impact measurement and monitoring and health policy development (Lehto and Ritsatakis, 1999). This model could and should be emulated in other regions. In Australia, a national framework for health impact assessment has existed for several years (National Health and Medical Research Council, 1994), and states such as Queensland have begun to expand traditional environmental impact assessment to include social - including health - impacts (Dale, Chapman and McDonald, undated). An impressive example of action at the national level is the National Assembly of Wales’ recent formal commitment to health impact assessment as a central strategy in tackling determinants of health that cut across policy areas (Health Promotion Division, 1999). The Scottish Council Foundation’s Healthy Public Policy Network has developed a vision for health improvement that includes explicit recognition of the health effects of policy-making in non-health sectors such as housing and transport (Stewart, 1998).

In Canada, the Federal/Provincial/Territorial Committee on Environmental and Occupational Health has published a very comprehensive handbook on health impact assessment (Minister of Public Works and Government Services Canada, 1999). In the United Kingdom, a network to promote impact assessments of government policy is established and has begun to conduct methods seminars to develop the needed tools. At the community level, the Newfoundland and Labrador Heart Health Program (http://www.infonet.stjohns.nf.ca/providers/nhhp/docs/policy.html) have produced a practical “Making Public Policy Healthy” guide book that citizens and community groups can use to create, support or oppose local policies.

It is of course important to acknowledge the obvious barriers that must be overcome. As usual there are pathfinders to show the way. Particularly useful insights have been reported by
workers in the Social Impact Assessment Unit of the Queensland (Australia) Department of Families, Youth and Community Care (Dale, Chapman and McDonald, undated). They have identified a range of factors that have limited the speed of development of social impact assessment in Queensland, and offer their lessons to others that seek to implement social (including health) impact assessment initiatives. This is a summary of their experience:

(1) Traditional environmental impact assessment is a highly technocratic and rationalist endeavour relying on physical and engineering sciences, and limiting the importance of community participation.
(2) Impact assessment has shown a marked disciplinary bias against the social and economic sciences, constraining the quality of advice provided to decision-makers.
(3) There is the perception among some decision-makers that physical sciences and their 'hard' data are more useful than social and economic sciences and their 'soft' data. This contributes to the perception that social impacts are difficult to define and measure.
(4) There is a lack of appropriate institutional and administrative structures for social impact assessment, thus marginalising the area.
(5) There is a lack of skilled social impact assessment practitioners, a record of some poor social impact assessment practice, and a resultant conflict between developers and communities about the meaning/usefulness of social impact data.

At the same time, the Queensland group points to developments that are providing solutions to many of these problems. Good case studies are now available which show that community development projects’ viability can be enhanced when good social impact assessment is conducted, and improvements in practice mean that better quality social impact assessments are becoming the rule rather than the exception. Also, social impact assessment is becoming institutionalised and community groups scrutinise impact assessment reports to be sure that social impact assessment has been included properly. In Queensland, there is increasing awareness of the need for social impact assessment and there are improved legislative and administrative arrangements under which social impact assessment can function.

These problems and solutions are to a certain extent dependent on the situation and some are probably not meaningful in a wide range of other settings. Nevertheless, the Queensland experience indicates that the “natural history” of developing and deploying community-based health impact assessment is a rocky road and the track taken may be somewhat different according to cultures and contexts.

A CASE STUDY OF SUCCESSFUL COMMUNITY-BASED HEALTH IMPACT ASSESSMENT

There are as yet few published studies documenting community health impact assessment, but among the few, there is one excellent exemplar from Eastern Nova Scotia, Canada (Gillis, 1999). The People Assessing their Health (PATH) project was undertaken in a region of Canada that is geographically isolated and faces difficult socio-economic circumstances. Community health impact assessment was used to increase public understanding of the
determinants of health and empower citizens to play an active part in decisions influencing their health.

The first stage in the work was the local development of community health impact assessment tools (CHIAT’s) tailored to the special needs of each of the communities. All three CHIAT’s were intended to provide answers to the same question: What does it take to make and keep our community healthy? Other objectives were to develop the CHIAT’s in such a way as to:

1. examine a broad range of factors that determine health, rather than only specific interests;
2. identify what community members consider important in building a healthy community;
3. encourage all community members to become involved in decisions about local programmes and policies;
4. reflect community concerns and priorities;
5. provide information useful to community health boards to guide decisions about the organization of primary health care.

The process used included four steps. At the first step, public meetings were held to determine who in the community was interested in becoming involved; a local committee selected a local person to co-ordinate the project; teams were trained in communication and group facilitation techniques; and local steering committees were formed.

In the second step, facilitators conducted citizen meetings, starting from the premise that community people know what it takes to make their community healthy. The process included measures that encouraged community members to consider the broadest possible range of determinants of health, and they were not steered (or distracted) by a predetermined list compiled by public health “experts”.

In the third step, steering committees designed their CHIAT’s based on data collected during step two. Information typically included was a statement of the values and principles that guided the work, a vision statement for a healthy community, a summary of key determinants of health, a list of factors important in building and sustaining a healthy community and priorities for action. Community workshops were used to obtain feedback on drafts and the final CHIAT’s incorporated this feedback.

In the final step, steering committee members worked with local community leaders to ensure that the CHIAT’s were used in decision-making undertaken by community health planning groups and municipal decision-makers.

Outcomes were quite similar in each community. The most important health determinant identified in all three communities was jobs/employment opportunities. Other determinants identified were healthy child development, lifelong learning, lifestyle practices, physical environment, safety and security, social support, stable incomes and good health services. The CHIAT’s also pointed to factors thought to be key in building healthy and sustainable communities. These included: good communication; community involvement; local control; opportunities for leadership development; confidence in one’s community; co-ordination and
co-operation in service delivery; ethics, values and spirituality; and respect for one’s culture and history.

The key lessons learned through the PATH experience are very likely applicable to other communities. The highly participatory process helped many people shift thinking beyond the illness problems of individuals to consideration of how programmes and policies could support or weaken community health. In all three communities, the process brought to light local socio-economic inequalities and illuminated community capacity and control to improve conditions for a healthier community. Finally, PATH demonstrated the value of developing CHIAT’s as a strategy to support community action on health.

PATH illustrates some core principles for community health impact assessment, and these are very consistent with community development strategies that have proven value (Mittelmark, 1999; Restrepo, 2000). PATH is, however, among the first attempts to place ordinary citizens at the very heart of local decision-making, and including the CHIAT process as a central element for positive change. It goes well beyond the fairly typical (in some places at least) participatory processes involving citizen boards and steering committees, and democratic representation. PATH is of course not the answer for all communities. Some communities need processes to evaluate specific proposals, for example road-building projects, public safety issues, or educational policies. Community impact assessment need not take place at the community level, as in PATH, but could be focused in settings such as schools and work places. Inevitably, some communities/settings need impact assessment as a tool to help fight unwelcome change that threatens community wellbeing (new industry located in the wrong place, for example).

Perhaps the main value of PATH outside the borders of the participating communities is that it puts “meat on the bones”, serving as a living, breathing example of the community-based, community-controlled health impact assessment strategy that is advocated in this technical paper.

**SUMMARY**

This paper makes the claim that the key activity required to promote healthy policy-making at the local level is *health impact assessment*. Indeed, health impact assessment is essential to healthy policy-making at all levels, from international to local, and the development of more effective approaches to health impact assessment should be a high priority at all levels. In other words, the present focus on health impact assessment at the local level should not be misinterpreted as meaning that the community level is the most important arena for this work. In fact, policy development and action at the local level, to be most effective, should happen in concert with national and international policy and action developments. However, health impact assessment at the community level is relatively underdeveloped as yet, and that is the main rationale for the special emphasis it has received here.

This paper presents evidence that highly participatory, local health impact assessment can be used to identify negative health impacts that call for policy responses, and to identify and encourage practices and policies that promote health. Socially responsible decision-making for
improved equity-in-health is stimulated by community level health impact assessment, because it is a practical tool to help communities come to grips with local conditions that need changing if better health for all is to be realized.

In defence of the admittedly narrow agenda suggested here, high-sounding, general calls to improve social responsibility for health are not sufficient to stimulate action. Focused objectives are needed if action is to follow. At the same time it is recognized that there are many possible arenas for - and levels of - action to promote social responsibility for health. It is open to debate which paths will lead to the best outcomes, but evidence suggests that one promising path is to stimulate local healthy policy and practice through widespread implementation of community-based health impact assessment.

The World Health Organization's Healthy Cities networks that have been established around the globe are a solid basis upon which to advance this agenda (http://www.who.dk/healthy-cities/hcn.htm#PhaseIII). Healthy Cities is a strong and growing movement that has long recognized the importance of systematic assessment of the health impact of local policies. In Europe, for example, with approximately 1,100 cities and towns involved in the programme, both the 1990 Milan Declaration on Healthy Cities (http://www.who.dk/policy/milan01.htm) and the 1998 Athens Declaration for Healthy Cities (http://www.who.dk/healthy%2Dcities/athens.htm) emphasise the importance of intersectorality and accountability. The Milan Declaration is quite specific on this point, stating participants' pledges to

"...make health and environmental impact assessment part of all urban planning decisions, policies and programmes."

Follow-up on the good intentions expressed in public declarations is, however, not easy. Frankish, et al (1996) describe some of the difficulties and barriers that have been encountered in Healthy Cities' attempts to develop health impact assessment. The main lessons appear to be that highly complex approaches to health impact assessment are self-defeating, and that in any case there is no simple and uniform way to conduct assessment. Relatively simple approaches, tailored in each instance to local circumstances, are called for. Healthy Cities and similar movements focused on villages, islands, prisons, and hospitals (among others!) will undoubtedly continue to be innovation laboratories for healthy public policy-making. It is urged here that both within in Healthy Cities and without, the development of practical approaches to community health impact assessment should have a place high on the health promotion agenda in the coming period.
REFERENCES


