Promoting social responsibility for health: health impact assessment and healthy public policy at the community level*

MAURICE B. MITTELMARK
University of Bergen, Bergen, Norway

SUMMARY
The 1997 Jakarta Declaration on Health Promotion into the 21st Century called for new responses to address the emerging threats to health. The declaration placed a high priority on promoting social responsibility for health, and it identified equity-focused health impact assessment as a high priority for action. This theme was among the foci at the 2000 Fifth Global Conference on Health Promotion held in Mexico. This paper, which is an abbreviation of a technical report prepared for the Mexico conference, advances arguments for focusing on health impact assessment at the local level. Health impact assessment identifies negative health impacts that call for policy responses, and identifies and encourages practices and policies that promote health. Health impact assessment may be highly technical and require sophisticated technology and expertise. But it can also be a simple, highly practical process, accessible to ordinary people, and one that helps a community come to grips with local circumstances that need changing for better health. To illustrate the possibilities, this paper presents a case study, the People Assessing Their Health (PATH) project from Eastern Nova Scotia, Canada. It places ordinary citizens, rather than community elites, at the very heart of local decision-making. Evidence from PATH demonstrates that low technology health impact assessment, done by and for local people, can shift thinking beyond the illness problems of individuals. It can bring into consideration, instead, how programmes and policies support or weaken community health, and illuminate a community’s capacity to improve local circumstances for better health. This stands in contrast to evidence that highly technological approaches to community-level health impact assessment can be self-defeating. Further development of simple, people-centred, low technology approaches to health impact assessment at the local level is called for.

Key words: health impact assessment; healthy public policy; social responsibility

INTRODUCTION
The 1997 Jakarta Declaration on Health Promotion into the 21st Century called for new responses to address emerging threats to health. The declaration placed a high priority on promoting social responsibility for health and identified equity-focused health impact assessment as a priority. Continuing on this theme, it is argued here that comprehensive implementation of equity-focused health impact assessment is the essential building block in constructing socially responsible policy and practice. An especially important arena for healthy public and private policy development is the local community and its settings, such as schools and workplaces.

There are several compelling reasons why local level policy-making is an important ingredient in the mix of health promotion strategies. Policy-making at macro levels may not
be sensitive to the diversity of local conditions that directly affect the health and well-being of residents of different communities. Beyond that, important health-related planning, policy-making and action originate at the local level. Also, the motivation of local leaders to practise healthy policy-making should be high, since they are affected by their own decisions. 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.

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 well-being 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 1970s. More than 6000 people living in Iraq were hospitalized 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 of only one-fifth that of the limit recommended by the World Health Organization (WHO) (although there is evidence that twice the WHO-recommended maximum dose is safe). Public health workers in Alaska strongly questioned the wisdom of this move 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 well-being 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 well-being occurs at the community level. For an example of this, consider public sector schools. National policies in many countries 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 of 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 workplace 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. Hancock pointed out long ago that at the local community level there are important social ties between public policy-makers and those affected by policy (Hancock, 1985). 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.

HEALTH IMPACT ASSESSMENT

Health impact assessment is an essential tool for healthy policy-making and practice. Health impact assessment addresses 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 policymakers 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 cooperation and coordination 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 that has the following five elements.

1. Health impact assessment 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).
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, including those living in difficult conditions. 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. 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, as in the information technology field, which has demonstrated how very complex technology can be made universally accessible through appropriate interfaces. 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.

At certain levels, developments in the health impact assessment arena 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). In Australia, a national framework for health impact assessment has existed for several years (National Health and Medical Research Council, 1994). 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 has been established and has begun to conduct methods seminars to develop the tools required.

There are positive developments also at the community level. For example, the Newfoundland and Labrador Heart Health Program (http://www.infonet.st-johns.nf.ca/providers/nhpp/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. Many Healthy Cities initiatives around the world include some form of impact analysis among their strategies (WHO, a).

**THE PEOPLE ASSESSING THEIR HEALTH (PATH) PROJECT**

A particularly stimulating exemplar comes 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 (CHIATs) tailored to the special needs of each of the communities. All three CHIATs 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 CHIATs in such a way as to:

- examine a broad range of factors that determine health, rather than only specific interests;
- identify what community members consider important in building a healthy community;
- encourage all community members to become involved in decisions about local programmes and policies;
- reflect community concerns and priorities; and
- 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 then selected a local person to coordinate 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 pre-determined list compiled by public health ‘experts’.

In the third step, steering committees designed their CHIATs 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 CHIATs incorporated this feedback.

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

The 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 CHIATs 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; coordination and cooperation 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 CHIATs 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 a particularly good example of how ordinary citizens can have a place at the very heart of local decision-making, with the CHIAT process as a central element for positive change. 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 health impact assessment need not take place at the community level, as in PATH, but could be focused in settings such as schools and workplaces. Inevitably, some communities/settings need impact assessment as a tool to help fight unwelcome change that threatens community well-being (new industry located in the wrong place, for example).

CONCLUSION

This paper makes the claim that a key activity required to promote healthy policy-making at the local level is health impact assessment. 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 WHO’s Healthy Cities networks that have been established around the globe are a solid basis upon which to advance this agenda (WHO, a). 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 ~1100 cities and towns involved in the programme, both the 1990 Milan Declaration on Healthy Cities (WHO, b) and the 1998 Athens Declaration for Healthy Cities (WHO, c) emphasize 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. describe some of the difficulties and barriers that have been encountered in Healthy Cities’ attempts to develop health impact assessment (Frankish et al., 1996). 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 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 Healthy Cities and outside, the development of practical approaches to community health impact assessment should have a place high on the health promotion agenda in the coming period.

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Address for correspondence:
Professor Maurice B. Mittelmark
Christiesgt. 13
5015 Bergen
Norway
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