

GLOSSARY OF TERMS USED IN HIA

Best available evidence

Conclusive evidence of the links between, for example, socio-environmental factors and health or the effectiveness of interventions is not always available. In such cases, the best available evidence – that which is judged to be the most reliable and compelling – can be used, but with caution.

Community participation

Involving the community in an activity such as the planning of projects or carrying out a HIA. There are a number of models of community participation, some of which are outlined in the Gothenburg consensus paper on HIA (WHO, 1999). Levels of participation vary. Manipulation and co-optation can masquerade as participation.

Comprehensive (maxi) HIA

A comprehensive or “maxi” HIA is a much more detailed rigorous exercise than either a rapid or intermediate HIA. It usually involves the participation of the full range of stakeholders, an extensive literature search, secondary analysis of existing data and the collection of new data. “Control” populations may also be used (Parry and Stevens, 2001).

Concurrent HIA

Concurrent HIA is carried out while a policy, program or project is being implemented.

Cost-effectiveness Analysis

Systematic comparison of the relative value of different interventions for producing desired effects (i.e. better health and/or longer life, where the denominator reflects the expected gain (e.g. deaths-prevented, quality-adjusted life-years (QALYs) or numbers of individuals meeting health recommendations) and the numerator expresses the expected cost of the intervention (Gold et al., 1996). CEA can offer a valuable adjunct to HIA when there is sufficient evidence to generate discrete, credible estimates of the health effects and costs of different policy options.

Decision making

The process of reviewing the findings and recommendations of a HIA and making choices about how they should be taken forward.

Determinants of health

Determinants of health are factors which influence health status and determine health differentials or health inequalities. They include biological factors (e.g. age, gender and ethnicity), behavior and lifestyles (e.g. smoking, alcohol consumption, diet and physical activity), physical and social environment (e.g. housing quality, workplace stressors, and air pollution), and access to health care. (Lalonde, 1974; Labonté 1993) All of these are closely interlinked and differentials in their distribution lead to health inequalities. Analysts conducting an HIA will typically start by asking which of these determinants of health are affected by the proposed policy or project.

Disadvantaged / vulnerable / marginalized groups

These terms are applied to groups of people who, due to factors usually considered outside their control, do not have the same opportunities as other, more fortunate groups in society. Examples might include unemployed people, refugees and others who are socially excluded.

Economic impact assessment

Economic impact assessment involves exploring and identifying the ways in which the economy in general, or local economic circumstances in particular, will be affected by a policy, program or project.

Environmental impact assessment

Environmental impact assessment (EIA) is a well developed discipline, both in terms of theory and practice, having been in operation for nearly 30 years in the United States. Its origins lie in the U.S. National Environmental Policy Act of 1969 (NEPA). In the same way that HIA explores the health effects of policies, programs and projects on health, EIA does the same in terms of environmental effects. Some states have their own statutes, such as California's Environmental Quality Act (CEQA) governing environmental impact assessment. Because they are often subject to numerous mandates and legal challenge, EIAs are often long, complex documents that may take years and millions of dollars to complete. While ambient levels of health risks in the physical environment (e.g. air and water pollutants) are considered in EIAs, human exposure levels and health outcomes are usually not specifically addressed in EIAs, except for a consideration of certain environmental carcinogens and toxins in CEQA. An analysis of the social determinants of health may be touched on in some parts of EIA, (e.g. traffic congestion, employment levels, environmental justice), but it is not a major emphasis.

Equity in health

Inequity – as opposed to inequality – has a moral and ethical dimension, resulting from avoidable and unjust differentials in health status. Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential if it can be avoided. (WHO EURO, 1985) More succinctly, Equity is concerned with creating equal opportunities for health and with bringing health differentials down to the lowest possible level. (Whitehead, 1990). HIA is usually underpinned by an explicit value system and a focus on social justice in which equity plays a major role so that not only both health inequalities and inequities in health are explored and addressed wherever possible (Barnes and Scott-Samuel, 1999).

Evidence base

The evidence base refers to a body of information, drawn from routine statistical analyses, published studies and “grey” literature, which tells us something about what is already known about factors affecting health. For example, in the field of housing and health there are a number of studies which demonstrate the links between damp and cold housing and respiratory disease and, increasingly, the links between high quality housing and quality of life (Thomson et al., 2001).

Health impact

A health impact can be positive or negative. A positive health impact is an effect which contributes to good health or to improving health. For example, having a sense of control over one's life and having choices is known to have a beneficial effect on mental health and well being, making people feel “healthier” (Wilkinson, 1996). A negative health impact has the opposite effect, causing or contributing to ill health. For example, working in unhygienic or unsafe conditions or spending a lot of time in an area with poor air quality is likely to have an adverse effect on physical health status.

Health inequality and inequity

Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes. It is important to distinguish between inequality in health and inequity. Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case it may be impossible or ethically or ideologically unacceptable to change the health determinants and so the health inequalities are unavoidable. In the second, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair, so that the resulting health inequalities also lead to inequity in health.

Healthy public policy

Healthy public policy is a key component of the Ottawa Charter for Health Promotion (1986). The concept includes policies designed specifically to promote health (for example banning cigarette advertising) and policies not dealing directly with health but acknowledged to have a health impact (for example transport, education, economics) (Lock, 2000).

Impact assessment

Impact assessment is about judging the effect that a policy or activity will have on people or places. It has been defined as the “prediction or estimation of the consequences of a current or proposed action” (Vanclay and Bronstein, 1995)

Integrated impact assessment

Integrated impact assessment brings together components of environmental, health, social and other forms of impact assessment in an attempt to incorporate an exploration of all the different ways in which policies, programs or projects may affect the physical, social and economic environment. New Zealand and Australia have particularly noteworthy examples of integrating HIA into existing EIA processes.

Intermediate HIA Monitoring and evaluation

An intermediate HIA may combine a workshop with key stakeholders followed by desk-based work to build up a more detailed picture of the potential health impacts than those which would be identified during a rapid or “mini” HIA. It may involve a limited literature search, usually non-systematic, and is mostly reliant on routine, readily available data (Parry and Stevens, 2001).

Monitoring and evaluation

Monitoring is the process of keeping track of events. For example, the monitoring of a project may involve counting the number of people coming into contact with it over a period of time or recording the way in which the project is administered and developed. Evaluation involves making a judgement as to how successful (or otherwise) a project has been, with success commonly being measured as the extent to which the project has met its original objectives. Both the “process” (activities) and “outcomes” (what is produced, for example in terms of changes in the health of those targeted by the project) can be monitored and evaluated.

Multidisciplinary

HIA is not the preserve of any one disciplinary group. Instead, it draws on the experience and expertise of a wide range of “stakeholders”, who are involved throughout the process. These may include professionals with knowledge relevant to the issues being addressed, key decision makers, relevant voluntary organizations and – perhaps most importantly – representatives of the communities whose lives will be affected by the policy (Barnes and Scott-Samuel, 1999).

Neighborhood

The term neighborhood usually refers to a local area which is defined in some way physically (for example, an estate or an area bounded by major roads) or by people’s perceptions of what constitutes their local area. Neighborhoods are usually fairly small. For example, neighborhoods designated for New Deal for Communities funding are usually made up of around 4,000 households or around 10,000 people.

Outcomes

The effect the process has had on the people targeted by it. These might include, for example, changes in their self-perceived health status or changes in the distribution of health determinants, or factors which are known to affect their health, well-being and quality of life.

Outputs

The products or results of the process. These might include, for example, how many people a project has affected, their ages and ethnic groups or the number of meetings held and the ways in which the findings of the project are disseminated.

Policy

A policy can be defined as an agreement or consensus on a range of issues, goals and objectives which need to be addressed (Ritsatakis et al., 2000). For example, “Saving Lives: Our Healthier Nation” can be seen as a national health policy aimed at improving the health of the population of England, reducing health inequalities and setting objectives and targets which can be used to monitor progress towards the policy’s overall goal or aims.

Program

The term program usually refers to a group of activities which are designed to be implemented in order to reach policy objectives (Ritsatakis et al., 2000). For example, many Single Regeneration Budget programs and New Deal for Communities initiatives have a range of themes within their program – often including health, community safety (crime), education, employment and housing – and within these themes are a number of specific projects which, together, make up the overall program.

Project

A project is usually a discrete piece of work addressing a single population group or health determinant, usually with a pre-set time limit. Usually (but not always), the term refers to “bricks and mortar” projects involving construction of a discrete structure or group of structures, such as a power plant, highway, or housing development.

Prospective HIA

Prospective HIA is carried out before any action has been taken, either in terms of drafting a policy, putting together an action plan or implementing it so that steps can be taken, at the planning stage, to maximize the positive health impacts of a policy, program or project and to minimize the negative effects (Scott-Samuel et al., 1998).

Qualitative and quantitative

HIA tries to balance qualitative and quantitative evidence. It involves an evaluation of the quantitative, “scientific” evidence where it exists but also recognizes the importance of more qualitative information. This may include the opinions, experience and expectations of those people most directly affected by public policies and tries to balance the various types of evidence (Barnes and Scott Samuel, 1999). Generally speaking, quantitative evidence is based on what can be counted or measured objectively whilst qualitative evidence cannot be measured in the usual ways and may more subjective, for example, encompassing people’s perceptions, opinions and views.

Population (Affected population)

Groups of individuals defined by locality, biological criteria (e.g. age, gender, health condition, or common exposure), or social criteria (e.g. socio-economic status or cultural affiliation). How a population is defined in an HIA will depend on the proposed project/policy being considered, health issues of most concern, the extent and classification of existing evidence on those health issues, and what information is of most value to the policy-making process.

Population Health

The health of groups, families and communities, defined by locality, biological criteria (e.g. age, gender or health condition), or social criteria (e.g. socio-economic status or cultural affiliation). The population health approach, which provides a foundation for HIA, emphasizes health as a resource or capacity, not simply a state.

Rapid (mini) HIA

A rapid or “mini” HIA, as the name suggests, is done quickly. It may be a “desk top” exercise, reliant on information which is already available already available “off the shelf” (Parry and Stevens, 2001), or through a half day or one day workshop with key stakeholders (Barnes et al., 2001). In either case, there is usually a minimum quantification of the potential health impacts which are identified.

Retrospective HIA

Retrospective HIA is carried out after a program or project has been completed. It is used to inform the ongoing development of existing work.

Risk Assessment (risk analysis)

The quantitative approach to HIA incorporates many of the elements of risk assessment laid out in environmental impact assessment and engineering. The risk assessment paradigm prescribes a sequence for four steps for assessing risks: (1) hazard identification, (2) exposure assessment, (3) dose-response assessment, and (4) risk characterization (i.e. evaluation of impact of changing exposure levels. Usually, but not necessarily this process is quantitative. Despite apparent objectivity, it is dependent on a series of assumptions and analytic choices (Nurminen, Nurminen and Corvalen, 1999).

Risk, Attributable

The proportion of new events or cases in a given time period attributable to exposure to a risk factor (Kleninbaum, Kupper, Morgenstern (1982).

Relative Risk (Risk Ratio)

The ratio of the probability of an event occurring in an exposed group versus an unexposed group. A relative risk of 1 indicates that there is no difference in the two groups' risk of the event. A relative risk of 2 indicates that the exposed group has double the risk of the unexposed group.

Scoping

Scoping refers to the process of identifying the potential health impacts of a policy, program or project before they are quantified, as in a rapid HIA. It may include reviewing the relevant literature and evidence base and collecting the views of key stakeholders (those with expert knowledge of the project, those involved and those potentially affected) followed by the tabulation of the potential health impacts (Parry and Stevens, 2001).

Screening

In relation to HIA, screening usually refers to an initial step being taken in order to determine whether a policy, program or project should be subject to a HIA. The criteria used for this process may include, for example, the size and cost of the activity in question, the extent of any obvious or immediate health effects or the perceived extent of longer term effects. A new road transport policy, for example, might meet these criteria in view of its potentially high financial cost, the possibility of immediate health effects in terms of road traffic accidents and likely longer term effects in terms of air quality.

Social impact assessment

Social impact assessment is "the process of assessing or estimating, in advance, the social consequences that are likely to follow from specific policy actions or project development, particularly in the context of appropriate national, state or provisional policy legislation" (Vanclay and Bronstein, 1995). It is based on the assumption that the way in which the environment is structured can have a profound effect on people's ability to interact socially with other people and to develop networks of support. For example, a major road cutting across a residential area can have the effect of dividing a community with implications for social cohesion (Hendley et al., 1998).

Strategic environmental assessment

SEA has been defined as "the environmental assessment of a strategic action: a policy, plan or program (Therivel and Partidario, 1996). SEA developed out of the recognition that the environmental impact assessment of specific projects, whilst an extremely valuable device, does not allow sufficient scope for the examination of the effect of a combination of projects. A commitment to sustainable development requires that a strategic approach to the environment be adopted. (Wood, 1995).

Uncertainty

HIA is fundamentally about clarifying uncertainty – pointing out and attempting to minimize specific areas of uncertainty about the possible health impacts of a proposed policy. There are actually many types of uncertainty, including "model uncertainty" (uncertainty about the logical and mathematical representation to

explain phenomena) and “parameter uncertainty” (certainty about the value, variation, accuracy, etc. of a specific relations or conditions in a model). High levels of uncertainty (especially model uncertainty) may preclude HIA, but at the same time the value of information from an HIA tends to be highest when there are high levels of uncertainty.

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