The need for strategic health assessment

Hilary Thomson provides a useful critical review of Health Impact Assessment (HIA). As she says, HIA could in principle provide a structured mechanism to promote healthy public policy outside the healthcare sector, but she is sceptical of its ability to deliver that. She identifies the main issues as the extent to which HIA actually influences practical policy, and the quality of the evidence base that is used to conduct HIA.

She somewhat understates the ability of HIA to influence decision makers, in the short-term by improving the intervention, and in the long-term through raising awareness of health and its determinants, as the experience of London shows. The first mayoral strategy was on transport, and was subject to an HIA that suggested some additions that were incorporated in the final policy, as shown by a changes audit.1 In addition, with subsequent mayoral strategies, the HIA happened at ever earlier stages, and officials became progressively more open to working with health people and more knowledgeable about the determinants of health involved in their area of work. So sometimes at least, HIA can be successful in these terms.

She is right to stress the need for high-quality evidence in assessing health impacts. Peer-reviewed literature is the most reliable way to achieve that, and I agree that research evidence has been seriously underused in HIA, although the situation may be improving now. A major improvement is needed in the availability and the use of relevant high-quality evidence, especially concerning ‘upstream’ pathways connecting policy options with proximal health determinants.

An alternative approach: strategic health assessment

As Thomson says, HIA has its limitations. What could be done about them? One suggestion is to apply a similar concept at a more strategic level— ‘strategic health assessment’ (SHA).2 This would resemble HIA in examining the health impacts of current measures, policies and strategies, including both positive and negative impacts and unintended as well as intended consequences, and in having a broad definition of health. The difference is that it would have a global, regional or national perspective, and would be undertaken by people with specialized expertise in the topic area, e.g. academics, enabling it to focus more thoroughly on the scientific evidence. It would lack the extensive consultation element of the local HIA process, which can have positive effects including giving a voice to the voiceless, if done well—not an easy task. The roles are therefore complementary: SHA analysing the overall relationship between health outcomes and their determinants in that policy area, including upstream ones, with HIA as an additional process that could be undertaken for specific projects, based on the SHA’s sound and updatable evidence base.

The underlying values would be similar to those of HIA: (i) maximizing health gain and minimizing health loss; (ii) aiming to reduce social inequalities in health; and (iii) helping to achieve the best overall trade-offs between health and other dimensions of sustainable development, including competitiveness and non-health aspects of the environment. Responsibility and accountability would be clearly assigned and ethical aspects as well as uncertainties made explicit. It would be carried out by experts who are independent of vested interests.

SHA would aim to provide evidence to inform decision makers at all levels of government, and including the private and voluntary sectors as well as the public sector. This could prove more efficient than HIA in the analysis of health impacts, as the same result might be achievable with fewer resources. It would identify trade-offs, as well as synergies for example that replacing car dependency with active modes of transport would reduce greenhouse gas emissions while increasing physical activity. It would also pay particular attention to social inequalities in health and to vulnerable groups. SHA could also explore the health impacts of key policy options, whether or not they have a primary health motivation. It would take into account employment, competitiveness, economic costs and the socioeconomic environment. A priority need is information on the effectiveness and the cost-effectiveness of interventions. In all these ways it would contribute to healthy public policy and to joined-up policy.

Causal diagrams

This could fit well with Thomson’s suggestion that HIA needs to map the pathways explicitly. As she says, as well as being useful practically, this could help to set a research agenda. It could involve not only intervention studies and epidemiology as she suggests, but also other types of evidence, for example on what policies produce a modal shift in transport—in other words, on the upstream pathways. The systematic involvement of topic experts in these complementary disciplines would be essential, breaking down the barriers between ‘silos’ of different types of expertise.

Diagrams of this type have been used for some time, e.g. in the context of climate change,3 urban transport4 and food/nutrition.5 They are a powerful tool, which make assumptions explicit, and can provide a framework for statistical analysis and modelling, generate testable predictions and explore the effects of intervention.5 They are highly intuitive, and this also carries the danger that they can be misused.

The starting point is a structure of the main causal processes that could be involved. This summarizes the empirical evidence, but necessarily also incorporates judgements based on subject knowledge where the evidence is
inadequate. As the research results accumulate, the status of the diagram progresses from relatively tentative to soundly evidence based. This is a stronger philosophical position than the naı¨ve inductivism of much epidemiology, for example it makes it harder to confuse ‘evidence of absence’ with ‘absence of evidence’.

Acknowledgements

The term ‘Strategic Health Assessment’ emerged from discussions with Professor Anil Markandya and Dr Bettina Menne.

References


Conclusion

Humanity faces a number of crises, some ancient such as absolute poverty and hunger, and some new such as global climate change, and obesity and related conditions that are due to poor diet and inadequate physical activity. There are also numerous other important issues that need to be addressed. I propose that SHA is one tool that could be developed to assist in the knowledge base required for the tasks we face.

Michael Joffe,
Department of Epidemiology and Public Health, Imperial College London, St Mary’s Campus, Norfolk Place, London W2 1PF

Correspondence:
e-mail: m.joffe@imperial.ac.uk
doi:10.1093/eurpub/ckn088