

Maritime Centre of Excellence for Women's Health

DRAFT:
**APPLICATION OF HEALTH IMPACT
ASSESSMENT TOOLS IN CANADA**

by

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APPLICATION OF HEALTH IMPACT ASSESSMENT (HIA) TOOLS IN CANADA (draft 10/08/98)

Overview

In this paper, a summary of Canadian Health Impact Assessment tools and is presented. The purpose of the summary is to develop a comparison between success stories and lessons learned between two Canadian and international initiatives-HIA and Gender Equity Lens (GEL) tools. This summary piece is only a beginning piece. The summary will be circulated to provincial ministries and otherwise to ensure it is current and accurate. In the future, lessons learned in HIA will be incorporated into a Gender Equity Lens Synthesis Paper.

The Maritime Centre

The Maritime Centre of Excellence for Women's Health is part of a national network of five policy research centres that focuses on the social factors that influence Canadian women's health. The Maritime Centre has adopted a targeted approach to 3 applied programs of research in the context of a . social determinants of health framework (see also Women's Health Framework, Health Canada 1995). MCEWH first program year focused primarily on the first two programs of research by funding projects on perceptions of determinants and the determinants of marginalized or groups of women not heard in previous health research. The third program's focus on the development and application of gender equity analysis tools and methods of policy, includes a Gender Equity Lens (GEL) project that is developing an educational framework for the development a Canadian curriculum for mainstreaming gender into the public policy process.

Discussion Purpose-Health Impact Assessment

The purpose of this discussion is to produce a summary document to circulate to current players in health impact assessment in Canada for their input and update on their current initiatives:

- Describe the development and implementation of health impact assessment (HIA) tools in Canada.
- Describe the challenges and benefits of HIA, and suggest next steps in the application of HIA tools.
- Identify next steps for determining the status of health impact assessment tools and initiatives in Canada in provincial ministries and otherwise.

Definition

The following definition of HIA developed by Frankish, Green, Ratner, Chomik, & Larsen (1996) has been adopted for this discussion: "Any combination of procedures or methods by which a proposed policy or program may be judged as to the effect(s) it may have on the health of a population" (p. 7).

Background

Current interest in HIA as a means to develop healthy public policy and the recognition that "there is more to health than health care" is not new. The landmark document the *Lalonde Report (1974)* set the stage by identifying four key factors (i.e., lifestyle, environment, human biology, and health services) that affect the health of a population. Although attention throughout the 1970's focused heavily upon lifestyle factors, during the 1980s it turned towards the influence of social, economic, and environmental factors on health status. Two key Canadian documents — *Achieving Health for All: A Framework for Health Promotion (1986)* and *The Ottawa Charter on Health Promotion (1986)* -- focused on underlying societal conditions that determine health, and, as a result, were "instrumental in focusing policy and program discussions on how health is created and health can be achieved by society as a whole" (Hamilton & Bhatti, 1996, p. 2). The health promotion framework outlined in *Achieving Health for All* described key health promotion challenges, mechanisms, and strategies. One of these strategies -- coordinating healthy public policy --

recognized the necessity of working with other sectors to ensure that all policies developed by governments support health. The *Ottawa Charter* outlined nine pre-requisites for health and five action areas necessary for ensuring access to the pre-requisites. Similar to the Framework, a key action area -- building healthy public policy -- recognized that access to the prerequisites for health cannot be assured by the health sector alone, and, therefore, coordinated action among all sectors of society is required (Hamilton & Bhatti).

The ideas and concepts from these documents have been synthesized in *Strategies for Population Health: Investing in the Health of Canadians (F/P/T ACPH, 1994)*. The “Green Book” as it is commonly referred, outlines a framework for population health based upon nine determinants of health. According to the framework, public policy is an important tool given its significant influence on people’s health and quality of life. Three broad population health strategies are also recommended in the Green Book. One such strategy -- “build understanding about the determinants of health and support for the population health approach among government partners in sectors outside health” (F/P/T ACPH, 1994, p. 36) -- involves making HIA of all government sector policies and actions a formal requirement¹ in the decision-making process to ensure that they are conducive to health (F/P/T ACPH). Much attention has focused on development of healthy public policy through intersectoral collaboration, particularly within and between governments as key strategies for fostering health and quality of life.

The use of Environmental Health Impact Assessment (EIA) tools and interest in assessing the health implications of development projects also significantly influenced the movement toward HIA. See Appendix C for a brief discussion.

Current Status

- Commitment to building and coordinating healthy public policy through HIA, including the use of tools has been articulated in all provincial government jurisdictions.
- Approaches to HIA vary widely across jurisdictions and no single model exists. Some provinces link HIA with the policy development process, while others couple HIA with provincial health goals or consider health within the context of EHIA (Frankish et al., 1996). To date British Columbia and Nova Scotia are the only provinces to develop specific HIA tools for use within the government and/or non-government sector. See Appendix A for a detailed discussion of Canadian approaches to HIA. See Appendix D for a list of HIA tools and contact persons.
- There is some debate about what actually constitutes an HIA tool (J. Frankish, personal communication, June 18, 1998). Some provinces such as Newfoundland and Prince Edward Island have created “tools” that while are intended to facilitate the development of healthy public policy, are more along the lines of a planning guide.
- The Nova Scotia Department of Health (NS DOH) is in the process of developing a “Quality of Life Impact Assessment Tool” (QOL Tool). Tool development has been a collaborative effort. The Population Health Steering Committee consulted not only with its own senior level staff, it brought discussions of the population health approach and operational plan several times to interdepartmental forums. These consultations significantly influenced the course of the population health strategy, particularly the development of the QOL tool. The tool was actually the result of efforts to make the abstract concepts of population health and healthy public policy tangible to those in non-health departments. The term “health” was also substituted with the broader “quality of life” (QOL). It has also been piloted internally and within a non-health department. Results from these are not yet available, but will be used to refine the tool.
- Three Community HIA tools were also developed in Nova Scotia through the *PATH Project*. At a

time of dramatic reform to Nova Scotia's health system, the Project was designed to foster greater community participation in health planning. The Project was unique because communities (rather than government) were involved in identifying broad factors that determine their health and in developing tools to assess the impact of programs and policies on the health of their communities. Project partners consulted extensively with members of the three communities via community steering committees. The tools reflect the participant communities' concerns and vision for a healthier community, and are intended for use by community groups, organizations, and local government. The Guysborough County Eastern Shore committee has received funding from the Community Health Promotion Fund to support continued use of the tool, and have formed CATCH — Citizens Towards Community health — to carry out the work. Links have also been made with the newly formed Community Health Board (CHB) in that area. In St. Ann's Bay, the tool is being used by the local health centre and in health planning in collaboration with the local CHB. In Whitney Pier, the tool is being used only by those involved with the PATH Project (CHB for Industrial Cape Breton has not yet been established).

- British Columbia's Ministry of Health and Ministry Responsible for Seniors developed an HIA Tool Kit and guidelines. The toolkit and guidelines, however, are rarely used in practice. The MOH is now revising its HIA instrument to fit more closely with its health goals and to be a more systematic guide to thinking.
- The role of gender varies within these tools. Nova Scotia's QOL Tool is not a gender lens, however, it contains questions and prompts that would require considerations of gender implications. For the PATH Project, gender issues were addressed within a community context as many of the stories told at community meetings reflected the reality of women's lives and the factors that determine their own health and the health of their families. This significantly influenced the development of the tools and resource document (see Appendix A). In BC, gender implications are rarely considered in practice. Finally, the Liverpool tool considers gender only in a general sense.

Monitoring and Evaluation

- Nova Scotia QOL tool is still being developed and no monitoring mechanism or plan has been established. As was previously mentioned, it has been piloted internally and within a non-health department. Results from these are not yet available
- Regarding the PATH Project, draft tools were tested on current issues at workshops in each community during 1997 and suggestions for improvement were given. Strategies for using the tool and working together to build a healthy community were also provided. No further evaluation has been conducted, however, Project participants along with two other Health Canada funded projects are involved in a project looking at best practices.² The community steering committees within each of the three communities are responsible for monitoring the implementation of the tools.
- In B.C., except for the evaluation of a series of workshops conducted across the province to provide training on using the toolkit and guidelines, no evaluation has been conducted on the efficacy of the toolkit and guidelines. There has also been no mechanism to monitor implementation of the tool. The MOH is now revising its HIA instrument to fit more closely with its health goals and to be a more systematic guide to thinking. A monitoring mechanism will also be forthcoming.

- The Liverpool tool (see Appendix B) has undergone internal evaluation, however, details are not available for circulation.³ In 1994, the first official example of prospective health impact assessment (PHIA) was piloted on a proposed new runway at Manchester airport, and the resulting recommendations were incorporated and implemented (Winters, 1997; Scott-Samuel, 1997)

Expected Challenges and Benefits

Efforts to develop and implement HIA tools are often difficult. A summary of the challenges were identified through the literature and consultation with tool developers:

- Non-health sectors have traditionally not given sufficient consideration to potential health implications of proposed and existing policies;
- Lack of collaboration and cooperation on common issues and policy initiatives and competing interests between and within sectors;
- Lack of understanding of the broad meaning of health, healthy public policy, and/or determinants of health (e.g., policies in non-health sectors are often not recognized as relevant to health).
- A related challenge is the resistance within some sectors to see their policies as “health policies” because of what is perceived as encroachment by the health sector (Frankish et al., 1996).
- The complex and interrelated nature of the determinants of health, and often long latency periods between causes and the resulting impacts on health status (Frankish et al.)
- Lack of time and resources (financial and human).
- Lack of political will (e.g., political cycles) and/or high level accountability and commitment to HIA .
- Apathy (e.g, lack of interest, belief that it would not make difference)
- Lack of available relevant data (particularly qualitative) and uncertainty over appropriate population health indicators (Frankish et al.) to do accurate HIA prospectively and monitor health impacts.
- Possible perception that HIA is not valuable or too simplistic.

Conversely, the benefits of doing HIA are:

- Improved collaboration between and within sectors (e.g., government, organizations, individuals) and, thus, increased effectiveness and efficiency in addressing common and complex issues.
- Enhanced ability of governments to ensure that their policies and programs are congruent with established health goals (Frankish et al., 1996).
- Improved population health status and outcomes through increased action on the determinants of health.

General Impressions and Next Steps

Efforts to mainstream the use of HIA tools are more likely to succeed if:

- The development and implementation process is collaborative.
- Commitment to HIA from senior bureaucrats, deputy ministers, cabinet, and policy analysts is secured.
- Communities are enabled to actively participate in and consulted on policy decisions that affect their health. The PATH Project is an excellent example of how communities can come together and develop strategies for participation in the decision-making process.
- Training focusing on the rationale behind their use and how to incorporate HIA tools in the policy analysis and development process must also be provided, especially within non-health sectors.
- Mechanisms for ensuring accountability and monitoring of their application, as well as for tracking (both short and long term) health impacts are established.

While all five points are important, the latter is particularly significant. Without a process to ensure the proper application of HIA tools and to monitor the efficacy of tool use and impacts of initiatives on population health, HIA will not become part of the policy/program-making process. This discussion, therefore, strongly recommends that in addition to the first four points, a system of accountability and monitoring be incorporated into any plan to establish HIA tools and processes.

Future Steps-What is the Status of Health Impact Assessment in Canada?

- Need to update and identify who is responsible for health impact assessment in provincial ministries of health and otherwise. This scan focused on existing provincial tools and contacts, outlined in Frankish et al 1996: Appendix B. Direct contact was made with NS, British Columbia, Newfoundland, Liverpool and Sweden.

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Endnotes

1. BC's HIA Toolkit, published in 1994, was required to be used by policy analyst as a standard step in the preparation of Cabinet Submissions in all government ministries. (BC Ministry of Health and Ministry Responsible for Seniors, 1995).

In 1994, Newfoundland's Social Policy Committee of the Cabinet informed all government deputy ministers that applicable health implications be identified in all cabinet submissions.

In Nova Scotia, the *Report of the Nova Scotia Royal Commission on Health(1989)* recommended that all government policy initiatives include an assessment of their impacts on the health of the population.

In Manitoba, all major government actions and policies are evaluated for their health implications (Frankish et al., 1996). Attempts to obtain further details have not been successful thus far.

In Saskatchewan a Population Health Impact Assessment (PHIA) process and tool has been recommended to the Ministry of Health for all departments (Franksih et al.).

2. For information on the status of this project, contact Margie MacDonald, Health Canada, Atlantic Region.
3. Contact person in Liverpool has been contacted to determine when and if details will be made public. Response is pending.

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Appendix A

Approaches to HIA in Canada

Newfoundland. In 1994 the Social Policy Committee of the Cabinet informed all government deputy ministers that applicable health implications be identified in all cabinet submissions. To assist government in this regard, the manual *Making Public Policy Healthy [MPPH] ... a vision for our community health (1995)* was developed by the Newfoundland Heart Health Program (NHHP) of the Department of Health. MPPH (now supplemented by the determinants of health developed by Health Canada) integrates HIA with community health as communities are to assess the potential impact of government policies against defining community characteristics (e.g., economic conditions, basic services) that may be positively or negatively impacted after a proposed policy has been implemented. It is intended for individuals/groups wanting to *create* policy to benefit the health of community members; or *support/oppose/advocate* for change in policy that may have health impacts for the community. The NHHP offered a seminar in October 1995 to government policy makers, government representatives, health professionals, health related agencies, and community groups interested in the development of policy that affects the health of the population. The purpose was to create an awareness of health and stimulate action on the making of healthy public policy. In addition, as part of their health strategy, the Department of Health developed health goals as discussed in the document *Newfoundland Department of Health: Provincial Health Goals (1994)* (Frankish et al., 1996). HIA, however, has not yet been mainstreamed within the Newfoundland government, and few departments participated in the NHHP's seminar. Discussion of gender-based analysis (GBA) have arose via the Women's Policy Office, but application of GBA, like HIA, has not been happening.

Prince Edward Island. A group of PEI health providers and community representatives developed the *PEI Health Promotion Framework: Circle of Health (1996)*. This framework provides a visual image -- an integrated three dimensional rainbow-coloured circle -- of what makes and keeps people healthy. The centre rings depict *what* determines health, *who* is involved, and *how* to maintain and improve health. The purple core & base represent health promotion values (individual and societal), which are the underpinning of the entire framework. The framework can be used to (a) promote a common understanding of health promotion; (b) locate links, relationships, and contributions in health promotion work; and (c) provide direction for strategic planning for health promotion. It can be used by health promotion program planners, health providers, individuals and groups, and health promotion researchers and evaluators to interpret their findings. The Department of Health and Social Services also developed five broad health goals and objectives to track and monitor the health status of the population. Development and monitoring of measurable goals & objectives is the responsibility of a Health Policy Council (comprising community members & professionals) (Frankish et al., 1996).

Nova Scotia. The draft *Quality of Life Impact Assessment Tool (NS DOH, 1998)* currently under discussion is a generic tool for individual government departments to adapt it to their individual needs. The tool and the substitution of the term "population health" with the broader "quality of life (QOL)" was the result of efforts to make the abstract concepts of population health and healthy public policy tangible to those in non-health department, the DOH took the unique step in. Part one is a checklist based on the health determinants to help policy and program developers consider potential impacts of initiatives on QOL, particularly for disadvantaged groups. Each item is accompanied by marginal prompts to help tool users consider various population groups and/or social or economic situations in their analysis. Part two asks how other public policy sectors may be affected. Part three asks what other partners might be affected and/or have an interest in collaborating in the development process. The tool has been piloted internally and within a non-health department. The tool was also presented at a government forum in January and at the Canadian Public Health Association conference in Montreal this past June. There has also been international interest in the draft, and it has been distributed widely.

Preceding the development of the tool was the *Report of the Nova Scotia Royal Commission on Health (1989)* which recommended that all government policy initiatives include an assessment of their impacts on the health of the population; the development of *Health Goals for Nova Scotia (Nova Scotia Provincial Health Council, 1992)* to guide the measurement of policy impact, and *Government By Design (versions 1993-1998)* -- the planning document for government. *Government By Design* includes the government's mission, goals — i.e., the pillars of public policy — (*fiscal stability, economic growth, social responsibility, & responsive gov't*), priorities, outcomes, measures and departmental plans. QOL tool developers viewed government's goals/pillars as congruent with the determinants of health/QOL and the health goals. The QOL tool, therefore, is designed to help government achieve its goals.

Community Health Impact Assessment (*Path Project, 1997*). At a time of dramatic reform to Nova Scotia's health system, the Project was designed to foster greater community participation in health planning. Community HIA was seen as a strategy to enable communities to become effective participants in decisions that affect their health. The Project was unique because it involved community members (rather than government) in identifying broad factors that determine their health, and in developing tools to assess the impact of programs and policies on the health of their communities.

Because of extensive community-wide consultation and participation, the tools reflect the participant communities' concerns and vision for a healthier community, and are intended for use by community groups, organizations, and local government. . The tools are: 1) *Voices of St. Ann's: Building a Healthy, Healing Community*; 2) *Guysborough County Eastern Shore: Our Community Health Impact Assessment Tool*; and 3) *Whitney Pier Working Together: Our Hope for the Future*. These tools and the process, results, lessons of the Project are described in the resource *PATHways to Building Healthy Communities in Eastern Nova Scotia: The PATH Project (1997)*.

New Brunswick. A specific HIA tool has not been developed. Related initiatives include *Health 2000: Toward a Comprehensive Health Strategy (1990)* which defines health goals and encourages government ministries, health care providers, community groups and consumers to transfer the health goals into objectives, targets & action strategies (Frankish et al., 1996). A parallel initiative was *Public Health Service: Vision, Mission, Goals and Objectives (1993)* wherein goals by health priority area to track and monitor health status were established (Frankish et al.).

Quebec. Impact evaluation of health care reform in Montreal is occurring (*Impact de la reconfiguration du réseau sur la santé et le bien-être de la population (Tousignant, 1996)*). HIA is considered a tool "to evaluate the impact of health reform on health and to develop studies and a surveillance system to track the distribution and impact of funds allocated to various health activities and programs" (Frankish et al., 1996, p. 60). Five health improvement goals and ten health promotion objectives related to four life cycle phases are outlined in *The Policy on Health and Well-Being (1992)* (Frankish et al.). Quebec health regions are also expected to translate goals into regional plans emphasizing the health needs of citizens vs. health services and resources (Frankish et al.).

Ontario. A specific tool HIA has not been developed. Working groups of experts developed objectives and targets for health goals between 1991 and 1993. These have been used to evaluate provincial health reform initiatives. Regarding HIA, the goals and targets have influenced provincial policy direction and development process (Frankish et al., 1996). *Health for All Ontario (1987)* set the goal setting process in motion and lead to the definition of five broad health goals outlined in *A Vision of Health: Health Goals for Ontario (1989)* (Frankish et al.).

Manitoba. A specific HIA tool has not been developed. Health goals and objectives have been developed to track the health status of Manitobans., and all government programs have been reviewed for their contribution to health. All major government actions and policies are also evaluated for their health

implications (Frankish et al., 1996). In addition, *Quality Health for Manitobans: The Action Plan (1992)* outlines a health strategy, including a comprehensive health measurement system within a healthy public policy framework (Frankish et al.).

Saskatchewan. A specific HIA tool has not been developed. According to Frankish et al. (1996), “a Population Health Impact Assessment (PHIA) process and tool has been recommended to the Ministry of Health for all departments, in the development of policies and programs, and for evaluation of grant and funding proposals” (p. 57). Population health goals and measurable objectives have also been established. *Population Health Goals for Saskatchewan (SK Provincial Health Council, 1994)* outlines a framework for improving the health status of people and communities in SK. Health goals recognize the broad range of factors that determine or influence health. A PHIA would be linked to the goals (Frankish et al.). *Working Together Toward Wellness: A Saskatchewan Vision for Health (1992)* proposes a health reform strategy including a wellness vision, principles and wellness goals.

Alberta. A specific HIA tool has not been developed. Alberta links HIA to healthy public policy, sustainable development and provincial health goals (Frankish et al., 1996). *The Rainbow Report: Our Vision for Health (1989)* recommended that policies be reviewed and legislation, regulations, and procedures introduced to ensure that the health of Albertans is fully and equally considered in regard to economic development, diversification and job creation; and that the impact of environmental policies on health is considered (Frankish et al., 1996). Also, the *Health Goals for Albertans: Progress Report (1993)* outlines nine broad health goals and related objectives and strategies. Goals are to support decision making for resource investment in health (Frankish et al.).

British Columbia. The Ministry of Health and Ministry Responsible for Seniors developed *Health Impact Assessment Guidelines* and a Toolkit to be used by policy analysts as a standard step in the preparation of Cabinet Submissions in all B.C. government ministries. In *Health Impact Assessment Guidelines*, HIA is described as a process that can be applied to any program or service, and a resource to guide thinking and discussion (not a measurement tool). It can be applied at the planning, evaluation, and/or resource allocation stage. Steps are identified and questions to be addressed and factors to be considered in the HIA process are described. Worksheets are included as an aid to this process. A *Guide to the Cabinet Committee System* states that gender and health implications of policy options should be analyzed.

North West Territories and Yukon Territory. A specific HIA tool has not been developed. As of 1996, goal setting process was in progress (Frankish, 1996). In *Mandate and Goals: Department of Health (NWT, 1993)* priority areas for health are outlined, and development of goals and objectives supported (Frankish et al., 1996). In *Health Status Report (YN, 1992)* and *Yukon Health Promotion Survey(1993)*: These form the basis of the Yukon goal development process (Frankish et al, 1996).

Appendix B Non-Canadian HIA Tools

Liverpool

The Liverpool Public Health Observatory defines HIA as “the estimation of the effects of a specified action on the health of a defined population” (Scott-Samuel, 1997, p. 15). Ideally, HIA should be prospective (i.e., precede the implementation of any policy, program, or project) to avoid or reduce negative health impacts and/or enhance positive ones (Scott-Samuel), and incorporate more one than one method/model of HIA (Winters, 1997). The principles of their approach is similar to that of EIA (see Appendix D) and involves the following steps (Scott-Samuel, 1997, p. 16):

- Apply “screening criteria” to select policy/program/project for HIA.
- Profile affected communities, including “at risk” groups from ... a social equity perspective, noting environmental risk factors (e.g., water courses); and institutional risk factors (e.g., capacity of health protection agencies).
- Identify potential health impacts, in conjunction with key informants, including affected communities — using impact classification from the *Lalonde Report (Health Canada, 1974)* and from Labonte’s socio-environmental model of health.
- Risk assessment of health impacts — estimate probability of occurrence and the measurability of each potential impact
- Quantify potential impacts (where possible), including range of uncertainty and risk.
- Identify most important potential impacts and outstanding information/research needs for each health impact.
- Option appraisal
- Health risk management recommendations.

The tool has undergone internal evaluations within the University of Liverpool, however, details are not yet available for circulation. In 1994, the first official example of prospective health impact assessment (PHIA) was piloted on a proposed new runway at Manchester airport, and the resulting recommendations were incorporated and implemented (Winters; Scott-Samuel). Reports on this HIA pilot have yet been to be published. Gender implications are considered only in a general sense.

Sweden

Sweden’s HIA instrument comes in three versions or templates:

1. The Health Question -- a simple itemized list of health impacts (Federation of Swedish County Councils [FSCC], 1998a).;
2. The Health Matrix that shows how a decision may impact on various conditions or groups (FSCC, 1998b).; and
3. Health Impact Analysis — a foundation for HIA prior to decision-making (FSCC, 1998c).

Each version can be adapted to local conditions and needs. The version employed will depend upon the complexity of the proposed policy, its nature, and the time frame available. However, all versions are based on the same key question: “How is the health of different groups affected by the proposed policy decision at hand?” (FSCC, 1998da).

Sweden’s interest in HIA appears to stem from paradoxical health trends in that county (i.e., mortality and morbidity are decreasing, yet, people with even minor health problems are finding it increasing more difficult to cope and succeed in the labour market) (Diderichsen, 1998). To understand such trends, the consequences of diseases are described in terms of functional impairment and capacity to meet every day

challenges, i.e., how does disease impact on quality of life. Because health is influenced by broad interrelated factors, knowledge is needed to make well-informed decisions on, for instance, changing various welfare systems (Diderichsen).

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APPENDIX C: ENVIRONMENTAL (HEALTH) IMPACT ASSESSMENT

Definition

EIA is a tool to assess and mitigate adverse environmental and social consequences of development projects. In most Canadian provinces and in many other countries, EIA is a legislated requirement (Frankish et al., 1996; Winters, 1997). EIAs that address health issues are special form of HIA known as EHIA, and is a tool to assess the health implication of proposed development projects (Frankish et al.).

In the developed world, EIA was initiated in the United States after the National Environment Policy Act of 1969 made EIA a mandatory component in the planning of development projects. It was later complemented by social impact assessment and then HIA (Scott-Samuel, 1997). During the last decade, interest in EHIA spread within Canada, Australia and New Zealand (Scott-Samuel).

Steps for Environmental and Health Impact Assessment

Step 1: Screening Does this project need an E&HIA

Step 2: Scoping What issues must be addressed?

Step 3: Profiling What is the current status of the affected population and local environment?

Step 4: Risk Assessment What are the risk or benefits? Who will be affected?

Step 5: Risk Management Can risk be avoided or prevented? Are better alternatives available? How can benefits and risks be costed? How can differing perceptions of costs and benefit, nature and magnitude be mediated? Will predictions of future health risk be robust enough to withstand legal and public scrutiny?

Step 6: Implementation and Decision Making Does the assessment provide sufficient, reliable information for decision-making? Is there a conflict to be resolved? How will conditions be enforced? How will impacts be monitored? How will post-project management be resourced?

Step 7: Monitoring, Environmental, and Health Auditing, Post-Project Evaluation Is the project complying with its conditions? How will is the E&HIA process as a whole achieving its aims of protecting the environment and health?

Source (cited in Scott-Samuel, 1997): National Framework for Environmental and Health Impact Assessment, National Health and Medical Research Council, Australian Government Publishing Service, 1994)

Challenges to EIA and EHIA in Canada

- Although HIA are usually conducted if there is a health concern, attention to the health implications in EIAs within most Canadian jurisdictions have generally been sporadic. EIA policies and legislation do not require the assessment of health impacts, and, thus, procedures, guidelines and mechanisms to ensure adequate and consistent consideration of health issues are lacking (Simon, 1988, Davies, 1991 — cited in Frankish et al., 1996).
- Links between both provincial and federal health, environment, and labour ministries are weak. A lack of political will and resources (human and financial) to ensure communication have been identified as the cause (Simon, 1988, cited in Frankish et al., 1996).
- Most EIAs that have assessed health impacts are limited to qualitative analysis (Simon, 1988, cited in Frankish et al., 1996).
- Unlike the American public, Canadians cannot take government departments to court if it is perceived that a department has not addressed certain issues adequately. Perhaps that is why EIA in the U.S. are more comprehensive (Simon, 1988, cited in Frankish et al., 1996).

However, the likelihood of conducting an EHIA is increased when :

- The proposed development is near a human settlement.
- The estimated lifetime on the project is longer than 100 to 150 days.

- Perceived or actual health impacts are likely to occur. The nature of the project is often the strongest determinant of whether a EHIA is conducted (Davies, 1991, cited in Frankish et al., 1996).

Appendix D
List of HIA Tools and Key Contacts

Tool	Key Contacts (<i>*contacted</i>)
Quality of Life Impact Assessment Tool (NS DOH, 1998)	*Debra Keays, Director, Public Health & Health Promotion Nova Scotia Department of Health
PATHways to Building Healthier Communities in Eastern Nova Scotia (Path Project, 1997) - includes 3 community HIA tools	<ul style="list-style-type: none"> - *Doris Gillis, former PATH Project Co-coordinator, - *Peggy Mahon, Project Co-Coordinator, St. F. X. Extension Department - Lucille Harper, Director, Antigonish Women’s Resource Centre, - Madonna MacDonald, Supervisor of Nursing, Public Health Services, Eastern Regional Health Board, - Ruth Schneider, Consultant, PATH Project Evaluator,
Health Impact Assessment Guidelines (BC MOH & MRS, 1994) & Health Impact Assessment Guidelines (BC MOH & MRS, 1995)	*Cameron Lewis, Policy Development & Project Management, MOH, 5-2 1515 Blanshard St., Victoria, BC, V8W 3C8
Liverpool Public Health Observatory PHIA Tool	*Alex Scott-Samuel, Department of Public Health, University of Liverpool, Whelan Building, Quadrangle, Liverpool, UK, L69 3GB
Sweden HIA tool (3 versions): - The Health Question - The Health Matrix - Health Impact Analysis	<ul style="list-style-type: none"> *Karin Berensson, Federation of Swedish County Councils, - Asa Axelsdotter, Federation of Swedish County Councils, - Sam Miller, Association of Swedish Local Authorities