Health Impact Assessment within the New World Economy

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Health Impact Assessment within the New World Economy

Abstract

The formalization of Health Impact Assessment (HIA) as a policy tool cannot occur as an exclusively academic endeavour; it must also take account of the political context within which the methodology will be applied. This paper explores the place of HIA within the "New World Economy", explaining and contrasting the notions of, so called, "tight focused" and "broad focused" HIA. We argue that HIA, in all its manifestations, is an inherently political device without claim to scientific objectivity. Broadly, we contend, that at a time when liberal democratic states are increasingly required to measure domestic policy against the demands of the global economy, national governments, for better or worse, will expand the application of tight focus HIA and limit the use of broad focus HIA. This requirement comes about because of the former's greater compatibility with the economic demands of global capitalism.

Introduction

Generally speaking, Health Impact Assessment (HIA) is a multi-disciplinary policy evaluation device the purpose of which is to appraise, anticipate and redress adverse health consequences of government policies and programmes on public health. As a process, it commonly involves five steps: screening for threats, scoping their hazards, appraisal of impacts, assembling options and implementing a solution.[1] HIA also assumes a range of social, behavioural and biological determinants of public health, which can include: income and social status, employment and working conditions, education, physical environment, biological and genetic endowment, access to social support mechanisms, personal health skills, and childhood development.

Today, there is increasing global interest in HIA. European policymakers, for instance, have become interested in developing principles for HIA and formalizing its methodology as a means of safeguarding their treaty obligations under the 1992 Maastricht Treaty, in order to ensure that EU policy is consistent with high levels of human health. Similarly, national governments in Britain, Australia, Canada and New Zealand have also developed their own models of HIA.[2] While some have applied HIA as both a monitor and a corrective device for existing government programs[3], others have used it to forecast the health implications of wider policy initiatives.[4] Although analysts generally agree that there can be no universal standard for HIA, they maintain that "key principles" should inform its

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[1] For a general description of HIA processes see Parry, J and Stevens, A. 2001: "Prospective Health Impact Assessment: pitfalls, problems and possible ways forward." British Medical Journal. **323**. pp. 1177-9.

[2] See, for example, Kwiatkowski, R. E. (1999). Canadian Handbook on Health Impact Assessment. Ontario, Health Canada; Enhealth (2000). Health Impact Assessment Guidelines. Canberra, Department of Health and Aged Care; King, A. (2000). New Zealand Health Strategy: Discussion Paper, Wellington, Ministry of Health; Scott-Samuel A., Birley, M., & Arden, K. (1998). The Merseyside Guidelines for Health Impact Assessment, Liverpool, Merseyside Health Impact Assessment Steering Group/ Liverpool Public health Observatory; and, Fleeman & Scott-Samuel, N. A. (2000). "A prospective health impact assessment of the Merseyside integrated transport strategy." Journal of Public Health Medicine **22**(3): 268-278. For a broad summary of the various models of HIA see, Ison, E. (2000). Resource for Health Impact Assessment, London, National Health Service.

[3] See for example, Dooris, M., & Cotterill, A. (2001). Hemsworth Coalfield Partnership SRB5 Programme Wellbeing Impact Assessment, Wakefield, Wakefield Health Action Zone, United Kingdom.

broader conduct. HIA, they suggest, should be systematic and academic. It should involve both key stakeholders and affected communities, and it should take local factors into account. Broadly, scholars contend that HIA should use methods and evidence appropriate to the impacts identified and the scope of the project, and make practical recommendations (Douglas, Conway, Gorman, Gavin & Hanlon 2001: 148-154).

The argument of this paper, however, is that the formalization of HIA cannot occur exclusively as an academic endeavour, but must also take account of the political context within which the methodology will be applied. In the past, analysts have glossed over the serious politico-contextual difficulties that limit the utility of HIA; and as a result, their formalizations of HIA methodologies have lacked substance. For example, it is meaningless to assert that a key principle of HIA is the use of "…evidence and methods appropriate to the impacts identified and the importance and scope of the policy" because the importance and scope of the policy, upon which the identification of impacts depends, is ultimately a political issue (Douglas, Conway, Gorman, Gavin & Hanlon 2001: 148-154). The necessity for political context is implicit within the assertion itself. Our point is that HIA is not conducted within a vacuum. HIA is a policy device; and policy is legislated under a framework of government, which is itself administered as a part of the global capitalist marketplace. Living within a global economic structure, the demands of the international economy limit the scope of policy options available to national governments. Thus, if HIA is to have meaning for national governments, or be given any key principles, it also must be conceptualised within the context of the global economy.

[4] See for example, Kemm J. (2000) Health Impact Assessment of the New Home Energy Efficiency Scheme, Wales, The National Assembly for Wales, United Kingdom.

Many models of HIA exist, but most can be described in terms of two fundamental categories: broad focus HIA and tight focus HIA (Kemm 2000: 431-433).[5] Broad focus HIA constitutes an holistic approach to health policy. Typically, it is prospective, qualitative and inclusive. Usually applied as a forecasting device, broad focus HIA assumes that policy decisions made outside the health sector are of as much significance to public health outcomes as those made within it. Moreover, broad focus HIA is predominately qualitative, it rarely attempts to calculate risk, and welcomes the input of popular and professional advice. By contrast, tight focus HIA is typically retrospective, quantitative and technocratic. Generally applied as policy evaluation device; tight focus HIA accentuates the quantifiable aspects of public health, is sceptical of artless public participation, and favours the input of key interests groups and stakeholders using empirical models of public consultation.[6]

Policy makers, however, make political decisions; and, as a policy evaluation device, HIA's pretensions to scientific rationality are denied by association. The consequence is that although the categories of broad and tight focus HIA might be useful for describing the characteristics of HIA models, both the categories and the different models they describe are of small utility to policy makers precisely because policy makers are political.

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[5] See also, Kemm, J. & Breeze C. (1999) Developing Health Impact Assessment in Wales, Health Promotion Division, National Assembly for Wales; and, Ison, E. (2000). Resource for Health Impact Assessment. London, National Health Service.

[6] For Kemm the key divides between broad and tight focus HIA are: holistic-scientific, sociological-epidemiological, vague-precise, and democratic-technocratic. He argues that broad focus HIA takes a "holistic view of health", and has "disciplinary roots in sociology". Alternatively, tight focus HIA adopts a more exact approach to public health, having its origins "in epidemiology and toxicology" (Kemm 2000:431-2). The point for Kemm is that the two categories describe broadly different methodological approaches. Broad focus HIA lays emphasis on the social determinants of public health and rarely attempts to "quantify risk". Largely qualitative, it assigns "great weight to popular and lay concerns". A broad focus assessment confers with affected individuals and communities, and incorporates their concerns into the report as necessary and reliable evidence. Tight focus HIA, on the other hand, accentuates aspects of health "which are measurable, or at least observable", and develops "quantified estimates of risk". Although tight focus HIA recognizes the social determinants of health, it considers them selectively. Tight focus HIA attempts to modify the social determinants only where it has the capacity to effect a change for the good. Where it lacks the capacity to alter individual determinants, it removes them from its analysis (Kemm 2000:431-2). As our main purpose lies elsewhere, we have simplified Kemm's divisions as prospective-retrospective, qualitative-quantitative, and inclusive-exclusive, acknowledging that, in practice, HIA applications can both transgress the boundaries between categories, and, reflect each classification to different degrees.

We contend that models of HIA are most useful to policy makers when described within systems of political thought. Our point is that for HIA, the scientific is political. Accordingly, we contend that while the themes of broad focus HIA reflect the political ideas of the new left, the themes of tight focus HIA reflect neo-liberal political thought. As liberal capitalist states will find the characteristics of tight focus HIA more compatible with the demands of the international economy, we conclude that, for better or worse, where policy is subject to global market forces, HIA will be broadly retrospective, quantitative and technocratic.

Two Categories of HIA

There is no universal standard for HIA. Analysts have applied a variety of methodologies to an assortment of policy questions.[7] However, in the absence of recognized standards the terms broad and tight focus HIA become useful shorthand for distinguishing between fundamentally different approaches.[8] The key divides between the broad and tight focus categories are the classifications of prospective-retrospective, qualitative-quantitative, and inclusive-exclusive. In practice, however, HIA applications can transgress the boundaries between the two categories, reflecting each classification to different degrees. For example, an assessment might be retrospective, yet also be qualitative and broadly inclusive. Thus, rather than two distinct models, the broad and tight focus categories represent a continuos

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[7] For a useful, although incomplete, summary of the various models of HIA see, Ison, E. (2000). Resource for Health Impact Assessment, London, National Health Service.

[8] Kemm argues that the two categories produce different results. Having an inclusive and democratic ethos, broad focus HIA involves the general public in the policy-making process, and delivers outcomes based on the community's self-identified and self-spoken needs. Alternatively, having a technocratic culture, tight focus HIA informs the public of its procedures, but delivers outcomes on the basis of expert recommendations. As Kemm describes, broad focus HIA uses qualitative, or "vague quantifications" together with evidence drawn from the advice of "key informants" and the general public to deliver "low precision" outcomes. In contrast, tight focus HIA employs more defined quantifications derived from epidemiological and toxicological models and statistics to return "high precision" outcomes. For his part Kemm suggests that the main challenge confronting HIA is to formalize its methodology, and to improve the quality of its results. At a time when policy making is a complex process, and when policy makers are required to balance public health against other policy goals, he argues that HIA, whatever its category, must ensure that it makes a genuine contribution to policy development, and that it leads "to better decisions". As matters stand, he concludes, "a cynic

spectrum of HIA within which the various models fall. For example, Kemm suggests that approaches to HIA in Canada, Sweden and the United Kingdom fall towards the broad end, whereas examples from New Zealand and Germany fall towards the tight end of the spectrum (Kemm 2000:431-2).[9]

For our purpose, Kemm's important point is that most examples of HIA can be described in terms of the broad and tight focus categories, and their respective characteristics. Indeed, practical applications of HIA in the European Union and Great Britain can be differentiated as prospective-retrospective. For example, researchers in the European Union have used prospective, or broad focus methods to project the results of EU policy initiatives.[10]. With the Maastrich Treaty outlining that "health protection requirements shall form a constituent part of the communities other policies", European researchers are required to forecast the health consequences of EU initiatives across a range of disciplines—in effect they are asked to conduct broad focus HIA. In the UK, the first prospective HIAs concentrated on individual projects rather than on national policy. For example, in 1994 the proposed second runway at Manchester Airport was subjected to

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could frequently question how much new knowledge the [HIA] report contained or how it contributed to the decision-making process" (Kemm 2001: 432).

[9] For New Zealand see, Public Health Commission (1995). A Guide to Health Impact Assessment, Wellington, Department of Public Health. For the United Kingdom see, Scott-Samuel A., Birley, M., & Arden, K. (1998). The Merseyside Guidelines for Health Impact Assessment, Liverpool, Merseyside Health Impact Assessment Steering Group/ Liverpool Public health Observatory. For Canada see, Kwiatkowski, R. E. (1999). Canadian Handbook on Health Impact Assessment, Ontario, Health Canada; & Population Health Resource Branch. Health Impact Assessment. Ministry of Health, British Colombia: Vancouver, 1994. For Sweden see, Swedish Association of Local Authorities (1998) Focussing on Health. http://www.lf.se/hkb/engelskversion/enghkb.htm

[10] The integration of eastern European states to the EU demands significant policy changes across a variety of sectors in many individual eastern nations. As these changes may impact upon public health, HIA has become a useful analytical tool over and above EIA. Hoping to establish a consensus on HIA, in 1999 the World Health Organisation released the Gothenburg paper. The Gothenburg paper represents HIA as a broad policy analysis device rather than as extension of EIA used in regard to specific projects. Emphasising social determinants of health rather than physical and environmental health determinants, the Gothenburg Paper argued that four principles should govern the introduction of HIA: democracy, the right of people to participate in the assessment of policies that affect their lives; equity—the need to assess the distribution of impacts across different community groups; sustainable development, emphasising both the short and long time scale of impacts; ethical use of evidence—the rigorous use of both qualitative and quantitative evidence based on different scientific disciplines to get as comprehensive assessment as possible. See European Centre for Health Policy, World Health Organization Regional Office for Europe (1999). Health Impact Assessment: main concepts and suggested approaches, Brussels, WHO.

prospective HIA.[11] Similarly, and perhaps less well-known, in 1995 the Victorian Government carried out a prospective HIA on a proposed freeway development in Melbourne (see Dunt, Abramson, Andreassen 1995).[12] In Britain, it was only following the Blair government's *Saving Lives: Our Healthier Nation* initiative that policy makers began to subject major government strategies to HIA prior to their implementation.[13] In 1998, for example, the Liverpool Health Authority commissioned the Liverpool Public health Observatory to conduct a prospective assessment of the Merseyside Integrated Transport Strategy (Fleeman & Scott Samuel 2000: 268).

By contrast, other HIA applications in the United Kingdom have been retrospective. For example, agencies in London and Wales have developed the Health Inequality Impact Assessment (HIIA) as a refinement of HIA (Lester, Griffiths, Smith & Lowe 2001: 272). HIIA has the advantage of allowing authorities to direct health services to the most disadvantaged members of the community. Accordingly, the aim of HIIA is to reduce existing inequalities in health, "or, at the very least, to avoid making the situation worse". HIIA is essentially a retrospective evaluation device. Although HIIA can also be prospective, insofar as is it undertaken at an early stage in the policy development process, it generally conducted against the background of a national government commitment to reduce the existing health inequalities—higher morbidity, lower life expectancy—of those living under disadvantaged circumstances. Indeed, devices like HIIA are typically retrospective, in that they require policymakers *to evaluate* the causes existing inequalities,

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[11] See Will, S., Arden, K., Spencely, M., Watkins, S. (1994) Application by Manchester Airport PLC for the development of a second main runway (part) and associated facilities; construction of new highways at Manchester Airport. Proof of evidence of Stockport Health Commission, in accordance with the rule of the Town and Country Planning Rules 1992.; prospective health impact assessment, Stockport: Manchester and Stockport Health Commissions, 1994. cited in (Fleeman & Scott-Samuels 2000: 268).

[12] Investigating the "future effects" of the proposal "on the local community's physical and mental health", the study found that the reduction of traffic injury and noise out-weighted that small risk of respiratory problems associated with pollution. However, it also acknowledged that, on the basis of the data, "others may arrive at a different conclusion", arguing that a post-constructional analysis of the freeway would be necessary to confirm the assessment's projections. See Dunt, D., Abramson, M., Andreassen, D. 1995: "Assessment of the Future Impact on Health of a proposed freeway development", Australian Journal of Public Health, **19**(4)pp. 347 & 355.

whereas broad focus applications require policymakers *to forecast* the results of policy across a wide range of areas.

HIA applications can also be classified as inclusive-exclusive. For example, several applications in Britain and the EU have sought a comprehensive appraisal of health impacts, and have thus gathered opinions from both the general public and key stakeholders, placing as much importance on the views of each as upon quantitative public health statistics (Morrison, Petticrew & Thompson 2001: 219).[14] By contrast, other HIA applications in Britain have been more technocratic and elitist. Recent applications of HIIA in London and Wales, for instance, have informed rather than consulted with the general public (Lester, Griffiths, Smith & Lowe 2001: 272-276). Indeed, some policymakers in the UK argue that there should be five guiding principles to HIIA: the process should be introduced in the planning stage, the appraisal team should be multidisciplinary, the appraisal should be evidence based, it should recognise the broader determinants of health; and, what is most significant, the process should allow participants *to see* how decisions are made. Accordingly, the ordinary individual may observe the HIA process, but not become an active participant.

Similarly, UK policymakers have also experimented with the Rapid Health Impact Assessment (RHIA). Used in a number of urban regeneration programs in East London, RHIA seeks largely expert opinion to the exclusion of wider public opinion (Lester, Griffiths, Smith & Lowe 2001: 272-276). The RHIA process is co-ordinated by a facilitator whose duty is to liaise with key stakeholders rather than directly with the public. The facilitator makes an initial cost-mechanism-outcome summary of the project, and gathers preliminary evidence from documented plans, public health statistics and key informants.

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[13] see, http://www.ohn.gov.uk/ohn/ohn.htm

[14] For a broad summary of HIA applications see, Ison, E. (2000). Resource for Health Impact Assessment, London, National Health Service.

Secondly, the facilitator convenes a workshop of stakeholders, in which stakeholders brainstorm and assess the possible impacts before deciding upon options and implementations. The facilitator maintains the stakeholder network so as to assist in the monitoring and refinement of the implementation. Thus, where broad focus HIA welcomes public participation in the decision making process; RHIA and HIIA endeavour to explicate the process but control participation with the intention of making it more rigorous and scientific. Herein, HIIA practioners argue that the assessment of impact should be a largely evidence-based appraisal of *inequalities* so as to "avoid wasting money on actions that might be popular or easy but ineffective" (Lester, Griffiths, Smith & Lowe 2001: 272-276).

Lastly, HIA applications can also be classified as quantitative-qualitative. For example, HIA applications in the UK and abroad have differed in terms of their commitment to social determinants of health and to risk assessment of health impacts. Under its *Saving Lives: Our Healthier Nation Initiative*, the Blair government encourages health authorities to conduct HIA, recognizing that "population health is the outcome of a range of social, economic and environmental factors" (Fleeman & Scott Samuel 2000: 268). Nevertheless, where some HIIA practioners have thought themselves unable to influence policy in a particular social, economic or environmental sector, they have removed that particular sector from their analysis (see Lester, Griffiths, Smith & Lowe 2001: 272-276). Similarly, some RHIA applications have emphasized scientific results over the qualitative processes. RHIA uses quantitative public health data and the 'insider knowledge' of key stakeholders, stressing "the relation between the context of an intervention, the mechanisms by which the intervention aims to have an effect, and the outcomes that are expected to result". The RHIA process involves three steps: screening and scoping, considering how expected outcomes might affect health determinants, and, feedback, implementation and monitoring; however, its more general strategy is to develop a cost-mechanism-outcome approach

(Cave & Curtis 2001: 12). Accordingly, some RHIA practioners adopt a largely evidence, or risk analysis based approach to the assessment against the qualitative determinants of public health.

Thus, although there is no universal standard for HIA, the broad and tight focus categories offer a useful way to describe the multitude of HIA applications. However, the utility of the categories should not be overstated. In itself, Kemm's categorization is of no substantial value: it may help us understand how current applications of HIA differ from one to the next, but it neither tells us why they differ, nor does it help us understand which model will be suited to what purpose. The point is that we can only make ground in this regard by understanding HIA as a tool in the service of more general political ideas. For HIA, the scientific is political; and it is only by unpacking the broad and tight focus categories, and identifying their major components with more general systems of political thought that we can gain some understanding as to why policymakers have recently become interested in HIA, why the different categories of HIA exist, and even, what kind of future the different models of HIA can expect to enjoy.

The Politics of HIA

Generally speaking, public policy may be understood as a means by which governments institutionalize the things they value. It concerns what governments do, why they do them, and ultimately, the consequences of their interventions (Fenna 1998:3). Policy is the result of complex interaction between politicians, the electorate, political activists, interest groups, public servants, the media, corporations and other competing interests, only to name a few. The business of formulating public policy draws these interests together in a complicated pattern of decision making that makes understanding the final determination of policy difficult given its manifold influences (Bridgman & Davis 2000:1-3). Rationality is atypical of policy. In the chaotic, quasi-political world of public policy, rational decision-making is

the result of underlying agreement on objectives and methodology. Such agreements are rare in politics (Fenna 1990: 47). Thus, as both an evaluation device and a policy-making tool, HIA is inherently political—its association with policy denies it any pretensions to firm methodological foundations. Accordingly, and notwithstanding the fact that both share the procedures of screening, scoping, appraisal, decision-making and implementation, HIA cannot be regarded as a development of Environmental Impact Assessment (EIA). EIA is an assessment of environmental degradation upon which there is general methodological consensus; HIA, however, is assessment of policy impacts on public health regarding which there is no such agreement. As we have seen, there is no universal standard for HIA, only a multiplicity of models. In many ways, HIA's association with public policy is responsible for this lack of consensus: if there can be no consensus on policy, there can be no consensus on methods for policy evaluation and development. Thus, whatever its method, HIA will always be as political and unscientific as the policies it seeks to develop and evaluate. Accordingly, we contend that HIA, conceptualised within a political context, is less an extension of EIA to public health, and more a policy device that supports the theoretical tenets of the new left. Indeed, among the most distinctive features of HIA are the inclusive-exclusive and qualitative-quantitative divides—the emphasis on democratic engagement and the social determinants of public health. As discussed in the previous section, HIA applications in the UK and around the world—although to different degrees—assume that high levels of community health are connected to the notions of socio-economic status, education, employment, support mechanisms, personal health skills, and childhood experience. Herein, HIA is indebted to leftist political theory.

Leftist thinkers question whether individuals are actually free and equal in modern society. While liberal theory assumes that individual citizens, regardless of race, class or gender, have equal access to protection under the law, and are therefore free and equal, leftist thinkers dispute that the formal existence of rights under the law guarantees freedom

and equality.[15] For leftists, any evaluation of the extent of individual liberty must be made on the basis of material rather than constitutional freedoms. For instance, individual citizens might have theoretically equal access to protection under the law, and yet be unable to take their grievances to court for lack of knowledge, education or material wealth. Similarly, women might have equal access to positions of employment, but find that family responsibilities still limit their career options. The point for leftists is that if constitutional liberties have no social application, they are irrelevant to everyday life. In order to be genuinely free, leftists maintain that individuals must be capable of deploying their liberties both under the law and within society. Accordingly, leftists argue that there can be no separation of social and political freedom: the personal is political (see Held 1996: 121ff).

The point for public health professionals is that HIA, and particularly its broad focus category, assumes something rather similar. Just as leftists believe that inequalities of class, sex and race obstruct the degree to which individuals can exercise their liberties, broad focus HIA assumes that inequalities in socio-economic status, education, working conditions, physical environment-and in biological and genetic endowment-affect the health of individual citizens. As with leftist accounts of freedom, broad focus HIA's understanding of public health is social and contextual in nature. Just as freedom is as much dependent upon social determinants—class, race and gender—as it is upon formal constitutional mechanisms, so too is individual health as much dependent upon social determinants—socio-economic status, education, working conditions—as it is on upon equal access to health care. Thus, with the major thinkers of the new left, HIA challenges the neo-liberal argument for the separation between state and society.

For both leftists and broad focus HIA, the personal is political: both conclude that the state must recognize its responsibility to intervene in society. Pateman, for example, argues

[15] Marx and Engles, for example, contested the idea of a neutral state, arguing that individual opportunities were dependent on their position in the class structure.

that the state is inexorably linked with the maintenance of social inequalities (Pateman 1985:173). The state's systematic reproduction of inequalities diminishes the meaning of freedom for the greater part of society. Moreover, individuals will never be free and equal until governments recognize their responsibility to intervene in society. For leftists, citizens are not free when they suffer for the want of opportunities and resources. Similarly, broad focus HIA directly implicates the activities of the state in the health of its citizens. For example, it suggests that although individuals enjoy equal access under the law to hospital treatments and procedures; their health might yet suffer given their inability to meet the costs of treatment, or a lack of knowledge that that treatments for their condition exist. Thus, it is not enough for government to provide equal access to health services. Inequalities in education, income, status and employment affect health in similar way to that in which class, gender and race restrict individual liberty. While the point for leftists is that government must curb the restrictions imposed by class, race and gender in order to guarantee meaningful individual freedom for its citizens; the point for broad focus HIA is that citizens will never enjoy equal levels of health until government addresses those health limitations imposed by social determinants. Thus, broad focus HIA emphasises qualitative determinants of health and inclusive democratic participation because the personal is political.

Whereas broad focus HIA, on the one hand, leans toward the qualitative and inclusive ends of the spectrum; tight focus HIA, on the other, leans toward the quantitative and exclusive ends in terms of it readiness to abandon individual determinants of health over which it has no control, and its subjection of democratic participation to scientific rigour. The point is, however, that herein the scientific is also political. While broad focus HIA can be associated with leftist political thought, tight focus HIA can be associated with the neo-liberal critique of leftist welfare politics. For example, leftist thinkers believe that as the public and private sectors are intermingled, elections are insufficient mechanisms by

which to ensure the accountability of government to the people. Accordingly, leftists seek more meaningful participation in politics. McPherson, for instance, insists that although the problems of engaging the community in the policy process of a complicated and heavily populated society are substantial, individual freedom can only be realised through the ongoing participation of the community in the management of the state apparatus (McPherson 1977). For Macpherson, participatory democracy is essential to the resolution of social problems. Participation develops a collective concern for social troubles, which cultivates a sense of mutual responsibility that assists in their resolution. Broad focus HIA welcomes public participation in policy development for related reasons. Participation ensures that government programs are responsive to popular needs, and produces a "community-owned" sense of health. For example, and contrary to the views of experts, a community might decide that safer footpaths constitute a healthier neighbourhood (Mahoney & Morgan 2001: 11). Participation in HIA develops a shared concern for the community health in which the personal experiences of citizens become integral to the determination of policy. As with the major thinkers of the left, broad focus HIA attempts to maintain higher levels of public health through a participatory process that creates an atmosphere in which the health and welfare of each individual is accepted as being compatible with the health and welfare of the community as a whole. In turn, democratic involvement and concern for equality and collective outcomes in public health supports the leftist notion of a compassionate and engaging state, in which policy is designed to promote fairness and equality throughout the community as a whole.

Recoiling from broad based community participation, tight focus HIA reflects the political thought of the new right. For example, the key thinkers of the new right argue that political and economic life should be matters of individual freedom. New right thinkers advocate *laissez-faire* economics and a minimal state, seeking to extend the influence of unfettered markets to all departments of human life. In the 1980s the

Thatcher and Reagan administrations in Britain and the United States began rolling back the apparatus of the welfare state, insisting that the rise in bureaucracy and the dominance of interest groups had compromised individual freedom. Essentially, the major thinkers of the new right champion the cause of individual liberty and equality of opportunity against equality of participation, by limiting the democratic use of state power (Held 1996: 254). Generally speaking, theorists of the new right seek equality in the domain of individual liberty and opportunity, while theorists of the left seek it in equality of participation.

The point is that tight focus criticisms of broad focus HIA reflect new right criticisms of the old welfare state.[16] In the 1970s and 1980s, theorists of the new right made ground against the welfare state by highlighting the uncertain and authoritarian outcomes of its democratic and participatory style of politics. Hayek, for example, argued that there could be no guarantee that the views of democratic majorities would be good or wise. Democratic majorities are neither infallible nor certain, and democratic procedures do not forestall the arbitrary use of government power by virtue of their existence (Hayek 1976: 52-53). For Hayek, the problems of arbitrary democratic power were compounded by the modern welfare state, through which representatives and bureaucrats had attempted to reshape society by redistributing resources in the name of the common good. Hayek argued that any attempt to regulate the lives of individuals in the name of social ends constituted an attack on their liberty. Regardless of the aim, the result of social engineering was always coercive government (Hayek 1976:42).

The language of recent critics of broad focus HIA reflects that of the critics of the welfare state. Both the new right and broad focus critics maintain that qualitative democratic procedures produce arbitrary, subjective and political motivated results. For example, critics argue that "it will be a challenge for HIAs to be seen as representative of

communities' health and not as conspirators with those who fund them, political agents employed to justify decisions with health rhetoric" (Morrison, Petticrew & Thompson 2001: 220). Again, just as critics of the welfare state suggested that democratic consultation produced 'red-tape' and bureaucracy, critics of broad focus HIA argue that the opening up of the policy process to democratic participation produces "consultation fatigue". They suggest that through excessive consultation "a variety of health concerns may be identified that the policy or project has no capacity to resolve". Excessive consultation promotes "anxiety and unrealistic expectations" to the extent that consultation can become "harmful" and "unethical" (Morrison, Petticrew & Thompson 2001: 220). Where thinkers of the new right argue that, although the welfare state had well-meaning aims, it produced ambiguous and wasteful results, critics of HIA suggest that broad focus assessment produces little but "results of discussions with affected communities" and "qualitative data on projected impacts" which do not "evaluate the actual outcomes" (Morrison, Petticrew & Thompson 2001: 219-220).

It is also worth noting that critics of broad focus HIA, just like neo-liberals, do not seek to exclude democratic influences; but only to apply democratic evidence in a more rigorous and scientific manner. For Hayek, as for classical liberal theorists like J. S. Mill, democratic majorities were capable of tyrannising communities in the similar manner to authoritarian regimes. However, whereas Mill met the tyranny of the majority with the liberty principle, Hayek met the uncertainties of democratic society with the constraint of law. For Hayek, the rule of law prevented majorities from becoming tyrannical (Hayek 1960: 103). With Locke, Hayek maintained that where the law ends tyranny begins, arguing that citizen participation in government must be subject to legal restrictions that protect individual liberty (Held 1996:258-9). In a similar way, Parry and Stevens, for example, recently

[16] See for example, Morrison, D., Petticrew M. & Thomson, H. (2001). "Health impact assessment and beyond." Journal of Epidemiol Community Health **55**(4): 219-220; Parry, J., Stevens, A. (2001). "Prospective Health Impact Assessment:

questioned the accuracy of broad focus HIA because it applies qualitative participatory evidence—stakeholder interviews, focus groups, surveys and literature reviews—in unsystematic ways. As broad focus methodology currently stands, Parry and Stevens argue that consultation with the community has four main problems: firstly, "conducting the consultation in a manner that is balanced and reliable..:"; secondly, "relying on the opinions of stakeholders to predict the effect of a policy…"; thirdly "that the very process of undertaking an health impact assessment may have an impact (positive or negative) on community health"; and fourthly, even that "the involvement of the community could be seen as a way in which unpalatable political decisions are offloaded from the decision makers" (Parry & Stevens 2001: 1179). They recommend that if consultation is to "usefully and reliably inform the estimations of health impacts, the process of consultation itself needs to be rigorous and its impacts as an intervention in its own right need to be recognised" (Parry & Stevens 2001:1179). For Parry and Stevens, HIA practioners need to embrace the methods of classical epidemiology, and subject citizen participation and consultative evidence to the laws of social science.

We are not suggesting that critics of broad focus HIA are agents of neo-liberalism; only that their calls for a more rigorous scientific approach to qualitative evidence reflect new right political theory insofar as they limit direct participation through scientific structures for the analysis of qualitative data. Our point is that the scientific is political: just as neo-liberals limit and define community participation in politics through the law, structured democratic elections and indirectly representative institutions, broad focus critics admit democratic participation only within the rigorous structures of empirical social science. Indeed, the similarity of language between neo-liberal critics of the welfare state and the recent critics of broad focus HIA should not be passed over. For example, whereas Hayek suggested that "there has often been much more cultural and spiritual freedom under

pitfalls, problems and possible ways forward." British Medical Journal **323**: 1177-1182.

autocratic rule than under some democracies" (Hayek 1976:53); broad focus critics suggest that there are more authoritative—viz. objective, apolitical, conclusive—outcomes under a scientific approach to democratic evidence, than under the open and unscientific participatory approach of broad focus consultation:

> The scientific evaluation of health effects that result from policies, plans and programs needs to be uncoupled from the promotion of health in communities and non-health sector agencies, and from the political process of decision making. All these activities have important contributions to make to improving public health but we believe that public policymakers, planners and—most importantly—the communities they serve will be better served by such refinements in the current approach (Morrison, Petticrew & Thompson 2001: 220).

The scientific is political because it limits and confines democratic participation within rigorously defined structures. Thus, although critics of broad focus HIA might be able to claim scientific rationality, they have no more claim to political objectivity than the advocates of broad focus HIA.

The Future of HIA

HIA is political; and as such, its future prospects are as difficult to predict as the course politics itself. However, perhaps the most significant influence of the course of twenty-first century politics is the development of the global economy. Although liberal constitutional democracy is emerging as the preferred model of government for the twenty-first century, the liberal capitalist economy places stringent constraints on national policy, several of which have dire consequences for broad focus HIA. Now more than ever, the activities of national governments are confined by the requirement to encourage commercial investment. The development of international communications technology

has made domestic markets more responsive to the global capitalist system, and forced most western governments to balance social and economic policy with the demands of international business. As such, among the primary tasks of modern government is to secure international investment (Beresford 2000:80). Failure to obtain investment produces a downturn in economic activity that can be fatal to government. Reduced economic activity diminishes the national tax revenue, thereby limiting the ability of government to fund its policies. Furthermore, economic downtown increases unemployment, which comprises government in both the opinion polls and at the ballot box. Indeed, for a government to pursue policies that have a negative impact on business profitability runs counter to the logic of capitalist democracy. Policies that favour society over the market run the risk of producing a capital strike, and in many cases government might have little alternative but to allow the requirements of the international political economy to trump social policy initiatives in the name of economic survival (Dryzek 1996: 25).

If HIA is political, and if the realities of the global market constrain and define the course of twenty-first century politics, then HIA cannot remain aloof from the same economic limitations. The consequence is that governments might begin to favour tight focussed models of HIA given their better compatibility with economic requirements. Indeed, broad focus HIA is poorly matched with the thesis of global capitalism. To recapitulate, broad focus HIA seeks pervasive intervention in society, and requires government agencies to smooth variations across a broad range of social determinants. Broad focus HIA is largely a collective device, underscored by a strong sense of egalitarianism and democratic engagement, which attempts to soften the effects of capitalist markets through Keynesian style policy development and management. Global capitalism, and its capacity for rapid movement of services and finance across the world marketplace, produces difficulties for broad focus HIA, particularly its qualitative and participatory

dimensions. Firstly, broad focus HIA might recommend solutions that have negative impacts for business. Ranging across an already wide domain, the qualitative determinants of health include employment and socio-economic status. Accordingly, broad focus HIA runs a real risk of clashing with commercial interests. A broad assessment might require government to smooth the adverse effects of the free market by restricting business activity, which, however, would contradict the logic of the market state. Secondly, broad focus HIA faces an era that shuns grand and visionary politics. It seeks community participation at a time when many citizens lack interest in, and are disenchanted with politics. The community itself might see little point to participation in HIA. Again, democratic participation might also run counter to the interests of business. In addition, given their task of maintaining the nation as a profitable centre for investment, governments will be less inclined to facilitate participatory influences on policy where there is a risk of a clash between popular and commercial interests. Thirdly, broad focus HIA is costly and labour intensive. Democratic engagement and qualitative research requires time, resources and a strengthening of state bureaucracies. Thus, broad focus HIA enlarges the role of the public sector in policy development at a time when most western democracies are attempting to reduce the size of the public sector. Today, bureaucracies are considered as cumbersome, expensive and inefficient. If this trend continues twenty-first century market states are unlikely to welcome a policy device that expands the role of public sector agencies, which most national governments are already determined to shrink. Lastly, as market rationality widens to penetrate the individual consciousness of citizens, notions of equality, social justice and civil society—upon which devices like broad focus HIA depend—will be under as much threat from *homo economicus* as democracy and participation are already from "economically rational" governments (Dryzek 1996:143). Indeed, the decline of collectivism and the rise to dominance of rational economic behaviour, on the

part of both governments and individual citizens, might prove fatal for social democratic policy devices like HIA.

Nevertheless, the prospects for HIA are not altogether bleak. The global economy might impose restraints on social policy, but some form of HIA will still be a necessary accompaniment to capitalism. Some scholars argue that the rise of the Keynesian welfare state in the post-war era was essential to capitalism's survival (Dryzek 1996: 30). HIA being political, and twenty-first century politics being subject to the global economy, the future of HIA might lie as an inequalities assessment tool. For example, some form of HIA might be required to smooth the health inequalities created by the market and thereby maintain of the legitimacy of global capitalism. Indeed, the rapid expansion of HIA in the UK is a direct consequence of third-way initiatives like *Saving Lives: Our Healthier Nation*, which are themselves a consequence of social degradation engendered by the economically rational Tory administrations of the 1980s & 1990s. HIA might even function as a necessary adjunct to global capitalism, and be triggered when communities are deemed to have slipped through the welfare safety net and require additional assistance. Accordingly, future governments might favour tight focus HIA over broad focus HIA. While tight focus HIA is capable of meliorating the adverse effects of capitalism, it is also better equipped to meet the demands of the market. Tight focus HIA seeks limited community participation, and is largely risk-based assessment of policy loosely connected to the social determinants of health. Where unable to influence health impacts across a particular social determinant, tight focussed models remove the determinant from the analysis. In addition, tight focus HIA recognises that government interventions are often wasteful and unproductive, and restricts community participation within consultative methods of social science, which may even be more to the liking of individual citizens themselves. Indeed, just as the decline of collectivism and the rise of rational economic behaviour might prove

fatal for social democratic policy devices like broad focus HIA, it might actually work to the advantage of economically rational devices like tight focus HIA.

Conclusion

Global capitalism produces many benefits, but it produces as many inequalities. HIA, as means by which these can be evaluated and redressed may become a necessary adjunct to the international economy. Moreover, as tight focus HIA is capable of ameliorating inequalities while remaining broadly compatible with the thesis of global capitalism, it seems the model best suited to the needs of twenty-first century government. Indeed, HIA is already finding favour with 'third-way' theorists in Great Britain, who value equality and protection for the vulnerable, but remain methodological conservative (Giddens 1998: 65-66). In a similar way, tight focus HIA is concerned with equity and social justice, but redresses health inequalities on the basis of quantitative health statistics and rigorous public engagement rather than qualitative determinants. The point is, however, that if HIA does become necessary to smooth the inequalities of the market, and, if governments do favour tight focussed over broad focussed models, the event will not have come about as a consequence of the greater scientific precision and objectivity of tight focus HIA, but because of its better compatibility with global economic requirements. To be sure, the scientific is political. But perhaps the most interesting question with regard to the future HIA is that if the tight focus model becomes the design of the future, will its market friendly methodology be capable of effectively redressing health inequalities? In many ways, the success or failure of HIA is the litmus test for third-way political theory. Indeed, having its origins in broad based leftist thought, HIA was intended as device through which the inequalities created by the market might be assailed; however, if modified and applied in its tight focus form, it might be found that HIA, and even the "third way" itself, has been captured, emasculated and paroled by the very same forces it set out to attack.

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NOTE

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