

## Short commentary

### Health Impact Assessment and advocacy: a challenging combination

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Local authorities, national governments (UK Department of Health, 2004) and the EU (article 152 Amsterdam Treaty) have committed themselves, to put it simply, to the aim to “see to it that any decision taken by the (...) Council is in line with (...) the population’s health” (Simos 2006, this issue). Increasingly, health impact assessment is used as a tool to reach that goal. Every policy tool needs some degree of institutionalisation to become effective. This forum provides us with interesting pitfalls and problems concerning the institutionalisation of HIA (Litzistorf Spina 2006, this issue). Yet, the evidence for the (potential) success of HIA, which should convince policy-makers to institutionalise HIA as a tool, still remains obscure. Policy makers question the effectiveness of the HIA: has the policy or plan actually been changed to protect or improve health and if so, was that change the result of the HIA? Most evaluations, however, are limited to the process and product of the HIA.

As for the process of HIA, there is as yet limited consensus on how HIA should be conducted. Most definitions emphasise two elements: predictions of health effects and advising policy (Kemmer 2003). We may distinguish between broad scope HIA, which considers the perceived risks by the population as evidence; and tight scope HIA, which is based on epidemiological and risk analysis traditions and considers quantitative data mainly (Kemmer 2000) (table 1). Some of the broad scope HIAs consider community empowerment and democratisation through participation as their main objective. This is in line with the Gothenburg Consensus which considers four values to underpin HIA: democracy, equity, sustainable development and ethical use of evidence (European Centre for Health Policy 1999). These values are derived from the health promotion movement, which has adopted political modes of advocacy for health, such as mobilizing public support.

The “broad scope” form of HIA seeks power foremost from public support. An example of this is the Brighton and Hove HIA of smoke-free public places (Scanlon et al. 2006, this issue). The “tight scope” form seeks to derive power from scientific evidence, of which the HIA on the Energy from Waste plant in North Quay is an example.

In a four-year evaluation project of HIAs in the Netherlands, we have found that marginally institutionalised HIA lacks the resources to make a difference and mainstream health into decision-making procedures. The obvious solution of mobilizing public support, may be effective in the short term but counterproductive in the long run: in case of potentially adverse impacts on health, HIA might become a “blocking power” to the non-health policy plan but decision-makers may experience HIA in a negative way and disapprove of future cooperation, as has happened in one of the local Dutch cases. Instead, early consultations and a constructive attitude will lead HIA to a brighter future. The non-health sectors that are asked to make “healthy decisions” need convincing argu-

**Table 1** Distinction between “broad scope HIA” and “tight scope HIA”

	“Broad scope HIA”	“Tight scope HIA”
<i>Source of power</i>	Public support	Scientific evidence
<i>Main source of inspiration</i>	Health promotion	Environmental impact assessment
<i>Evidence</i>	Indirect: perceptions of risk and health	Direct: measurements of risk and health
<i>Prime value</i>	Democracy, equity	Ethical use of evidence
<i>Aim</i>	Empowerment Change policy	Accuracy and credibility of predictions Change policy
<i>Philosophical view</i>	interpretative	Positivist

ments of the existence and severity of health impacts, which scientific research aims to provide. Scientific evidence, however, is in some cases not enough to change decisions. Decision-makers need to know how these impacts may obstruct or improve their own non-health policy goals in the long run. They need to feel ownership in order to act in the interest of health. We therefore argue to focus HIA on the delivery of an evidence base for health impacts, and embed the HIA in a broader health policy that adopts strategies to bridge the several gaps between the different sectors, interests, positions, procedures, cultures and languages. In other words, health policy officials and servants need to coordinate intersectoral cooperation, in the process of which HIA can provide valuable evidence.

In addition, mixing advocacy with HIA may lead to obvious methodological problems. An example of HIA partially turning into advocacy is the anti-smoking HIA in Brighton and Hove, in which the public survey was mixed with a promotional campaign. If promotion and survey were closely connected, the responses to the survey are likely to be biased. Properly conducted, such a poll would try to collect responses from a representative sample of the population in a neutral way, and then still it would be an opinion poll and not an HIA. It is an attempt to show public support for health-favourable policy, not an estimation of what health effects would ensue of different policy options. However useful for influencing

policy, we would argue that this should not be called HIA. We would argue that HIA needs to primarily derive its power from credibility, and that HIA loses this credibility if it is mixed with advocacy. Thus, advocacy needs to be uncoupled from HIA, at least when it comes to making predictions of health effects. This does not mean that advocacy is not needed; quite on the contrary. In some cases it may make sense to separate the present HIA-practice into an impartial assessment of evidence and an advocacy effort that is biased in favour of health, so that the estimation of health effects gains in credibility but popular concern can also be used to influence policy. The evidence-based HIA report can be promoted by the research director or other "liaison officers" that have the position, competence and means to use political sources for influencing policy. It also does not mean that only evidence from quantitative sciences needs to be included in HIA; qualitative studies can certainly play a role if conducted impartially and in agreement with the pertaining scientific quality criteria. To enhance the implementation of the HIA recommendations and make decisions health-sensitive, structural involvement of the users at an early stage is required. The HIA needs to be built on some degree of consensus about the problem, the assessment and the alternative solutions. But if HIA is to succeed and gain long-term credibility, its predictions must be seen as impartial and scientifically valid.

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