

HEALTH IMPACT ASSESSMENT IN THE NEW ZEALAND POLICY CONTEXT

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Abstract

Assessing the health impact of policy outside the health sector is a key part of public health policy making. Policy makers use health impact assessment to improve, promote and protect the health of populations. This paper defines health impact assessment and provides justification for the use of formal health impact assessment tools. The New Zealand policy-making process and the mechanisms currently used within the public sector to assess health impact in New Zealand are discussed. Examples in the public domain from recent public policy making are used to illustrate the discussion. The paper then examines the opportunities that exist for public sector public health policy advisers assessing the health impact of policy in other sectors, given that policy can be a fiercely contested domain, and considers why the generic mechanisms are insufficient to achieve optimal influence. The supports needed for the successful application of formal tools, and the obstacles that exist, are analysed.

INTRODUCTION³

Health impact assessment (HIA) has been defined as “a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population” (European Centre for Health Policy 1999). We view it as a means to ensure healthy public policy – that is, as a means of putting health on the agenda of policy makers across government, assisting them to be aware of the health consequences of their decisions.

There is support for HIA internationally and in New Zealand. There has been increasing international interest (Lewis 2000, Scottish Needs Assessment Programme 2000). The

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Commission of the European Union has included HIA in its work (Commission of the European Communities 1995). In 1998, the UK Government proposed that “major new government policies should be assessed for their impact on health” (Secretary of State for Health 1998).

An early attempt to use HIA in New Zealand occurred at the Public Health Commission with the production of *A Guide to Health Impact Assessment* (Public Health Commission 1995). This guide for public health services focused on HIA only in relation to environmental issues. Subsequently, during consultation on the strategic direction for public health in 1996/97, it was proposed by the Ministry of Health that HIA be implemented at a high level across government, possibly at the Cabinet level in a similar way to Treasury compliance requirements. It was suggested that a formal HIA tool should be developed in cooperation with other sectors (Ministry of Health 1997b). Strong support was received for this proposal.

More recently, the National Health Committee (NHC) has proposed the adoption of HIA (Lewis 2000). This recommendation has emerged from the NHC's work on inequalities in health. The Committee has recognised the very real potential HIA has for addressing the health impacts of the determinants of health.

Further, the recently released draft *New Zealand Health Strategy* acknowledges the need to address the determinants of health and the important role the health sector has to play in intersectoral action to promote health (Minister of Health 2000). It argues that this role includes “assessing relevant public policies for their impact on health and health inequalities”. The first goal is “a healthy social environment”. The first objective under this goal is “to assess all public policies for their impact on health and health inequalities” (Minister of Health 2000:10). Clearly, there is support for HIA in New Zealand, but what does it actually involve and why is it needed?

WHAT IS HIA?

HIA provides formal tools to enable us to identify both direct and indirect impacts on health. It is a structured way of bringing together evaluation, partnership working, public consultation, and available evidence for more explicit decision making (Lock 2000:1396-1397). It has the potential to examine the direct impacts on health of policy in other policy arenas, and to look at the way policy in other arenas impacts on the determinants of health, and subsequently on health itself.

What would be the benefits of systematically undertaking HIA using formal tools? Formal tools provide the means to do systematic analysis of the health impacts of policy in other

policy arenas. They provide a means of strengthening what is currently done, doing it more effectively and more frequently.

The benefits, and the formal tools used, can best be illustrated by an example. Let us consider the impact of immigration policy on health, and particularly on the incidence of tuberculosis in New Zealand. The number of notified cases of tuberculosis in New Zealand has been declining for several decades, and reached a low point in 1988 when 295 cases were notified. Since then the annual number of cases has increased. Around 300-400 cases are reported each year. The rate of tuberculosis in New Zealand is almost double that in Australia. The proportion of New Zealand cases born overseas (such as in Malaysia, Hong Kong, Korea, Vietnam, Samoa and Tonga) has been steadily increasing, from 50% in 1993 to 66% in 1997 (Ministry of Health 1997a). *Guidelines for Tuberculosis Control in New Zealand* (Ministry of Health 1996) states that "immigration and visitation have been important factors contributing to the increase in tuberculosis in New Zealand since 1988" (p.6).

While acknowledging the range of recommendations that were made to the Government by the Ministry of Health and the New Zealand Immigration Service, and subsequently accepted, a group of clinicians were still highly critical of what they perceived as inadequacies in immigration policy, and the health response, in relation to tuberculosis. These were detailed in a paper published last year in the *New Zealand Medical Journal*. Their criticisms ranged from the length of time students or visitors from high-tuberculosis incidence countries should be allowed to stay in New Zealand before being screened for tuberculosis (they recommended a reduction in the length of time from two years to six months) to improvements in New Zealand's commitment to tuberculosis control in Pacific countries (Harrison et al. 1999).

From the perspective of other sectors, students, visitors and migrants bring needed skills, capital and revenue to New Zealand. It is perceived that, if New Zealand places higher health requirements on these groups than is the practice in other countries, these potential immigrants will go elsewhere – to the detriment of New Zealand's economy and social diversity. New Zealand also has humanitarian responsibilities to displaced persons who may seek refuge here and to those who may seek asylum. The interface between immigration policy and health is clearly a contested domain that is bedevilled by ideology, opinion and differing world views. The generic mechanisms that have been used by the Ministry of Health, which are employed by every government department to influence other sectors' policies (in this instance, immigration policy), are clearly perceived as inadequate by key players in the health sector.

Perhaps immigration policy would benefit from the application of formal health impact assessment tools – screening, scoping, health impact analysis, consideration of alternative

options, consultation with those likely to be affected, and action on the results. It would pass an initial **screening** that would demonstrate the significant relationship between immigration policy and health. Policies subject to screening may be identified as a result of a checklist developed for use by policy advisers in all sectors, or as a result of “case finding” based on accepted criteria (Scottish Needs Assessment Programme 2000). Further information could be gathered as part of **scoping**, which employs key informants to identify the direct and indirect health effects of the policy, the populations affected, and the methods that should be used for the HIA process.

Health impact analysis in this situation would need to be multi-disciplinary, and use a combination of methodologies, particularly epidemiological and economic modelling. It would assess the impact of immigration policies on the prevalence and incidence of diseases in New Zealand, and the health service consequences that are affected by immigration policy. Using such a model, it should be possible to test the impact of **alternative options** to maximise the positive and to minimise the negative impacts. The report that arose from this work would be the basis for public **consultation** to make sure that those who are likely to be affected by any adjustments in immigration policy have the opportunity to express their views, so that their views can be taken into account in the final analysis.

The use of these formal HIA tools would result in policy advice that was well grounded in the best available evidence, but additional costs would be incurred and the timeframes extended. For example, two pilots of formal HIA tools in Scotland, one on city transport policy and the other on a local housing strategy, required the employment of a research assistant and a facilitator for focus group discussions. The HIAs took six to eight months to complete, and a further five to eight months to write up (Scottish Needs Assessment Programme 2000).

Rapid appraisal and health impact reviews are additional methods, besides health impact analysis, which can be considered at the scoping phase when decisions are made on the methods to use for the HIA (European Centre for Health Policy 1999). Rapid appraisal methods are a systematic assessment of the health impact of a policy by a number of experts, decision makers and representatives of those potentially or currently affected by the policy (Ong 1996). These methods are based on the exchange of existing knowledge, as compared with health impact analysis that generates new knowledge. They are, therefore, quicker and less resource intensive than health impact analysis. Health impact review is used for more diffuse clusters of policies where it is not possible to disaggregate the precise impact of various parts of a cluster of policies, but it is possible to create a convincing summary estimation.

WHY DO WE NEED TO PROMOTE THE USE OF HIA?

Internationally, the demand for health services grows continuously and, in general, expenditure on health services grows faster than GDP (Ministry of Health 1999). In response to this pressure, and to shifts in demographic and epidemiological trends in diseases and in the prevalence of risk and protective factors, new technologies for health care, and communication and information technology, many governments (including New Zealand's) have been reforming their health systems. In the past, health reforms have paid greater attention to controlling growth in demand for personal health care services, and therefore controlling costs, than to improved health outcomes. The overall population benefits of personal health care services are often low, but the perceived individual benefit is high, and this perception underpins political and community pressure for a focus on personal health care services (Fries et al. 1998, Yach 1996). There are signs in New Zealand and internationally that this apparent neglect is being reversed (World Health Organization Regional Office for Europe 1996, Minister of Health 2000, World Health Organization 2000).

Strengthening the focus of governments on health and health outcomes, rather than on personal health care, means that inevitably governments recognise the need to take a "whole of government" approach to health outcomes. However, this approach has to be tempered by the need to consider competing policies to promote the well-being of people. The use of formal HIA tools introduces a more rational basis for considering these policy dilemmas, and for anticipating future policy considerations, than the current approaches used by the public sector. HIA is likely to legitimise the assessment of a broader range of public policy in areas where health has not traditionally had a role. It would enable inequalities in the determinants of health to be assessed, which is important as a way of assisting the current Government to "close the gaps". This is a key issue for Māori and a government responsibility in terms of honouring the Treaty of Waitangi. Mason Durie argues, in relation to Māori health development, that "health authorities have a role to play in advocating that all policies should be assessed for their health impact" (Durie 1998:182).

What could be the consequences of using formal HIA tools? Had HIA been undertaken for the impact of housing policy on health, would we have been able to adjust housing policy, and prevent the impact of household crowding which has proven to be a major risk factor for the epidemic of meningococcal disease that New Zealand has been experiencing for the last nine years (Baker et al. 2000)? What would be the impact of paid parental leave on maternal, family and child health?

We shall now consider the policy context in New Zealand, the generic mechanisms that currently exist to assess the health impact of policy in other sectors, why the generic mechanisms are not sufficient to influence other sectors' policies, the obstacles to overcome and the support that would be needed to introduce effective HIA within the policy-making process.

POLICY CONTEXT

Assessing the health impact of policy outside the health sector is a key part of public health policy making. Policy makers use health impact assessment to improve, promote and protect the health of populations. What they do not do is use formal, standardised tools to assist them in this process. Instead, they use a combination of research, analysis and persuasion in various ways in order to argue the case for health.

The Policy Process

The policy process has a number of key phases:

- Problem identification – determining which issues get on the policy agenda, and why;
- Policy formulation – determining who develops policy and what it consists of;
- Policy implementation – asking how policies are implemented, what resources are available and how it will be enforced; and
- Policy evaluation – determining how policy is monitored, whether it achieves its objectives and whether there are any unintended consequences (Walt 1994).

Ideally the outcome of HIA would be used at each phase of policy making. For example, problem identification would draw on the **scoping** phase of HIA and the **health impact analysis**. Policy formulation would include consideration of the **alternative options** analysed as part of the HIA and the outcome of the HIA public **consultation**, which would also contribute to policy implementation. The methods used in the **health impact analysis** could also be applied to policy evaluation. This is not always done. The health consequences of policy are often not identified until implementation or even evaluation of policy.

Approaches to Understanding Policy Formulation

There are a number of different views on how policy is formulated. How we understand the process influences the potential we see for HIA.

There are three key approaches:

- The rational-deductive approach is based on the notion that policy makers start with a problem and work through to its solution in a rational and linear way;

- The incremental approach is an opportunistic one that recognises that all implications are never known at the outset and so there is a constant need to reflect and amend. Lindblom characterised this approach as “muddling through” (1959); and
- The mixed-scanning approach aims to combine the best features of the previous two approaches. Etzioni suggests that an overall scan of the policy environment is useful to identify those decisions that can be taken incrementally and those which are strategic (1967).

From our experience as policy advisers, we see the mixed-scanning approach as the best characterisation of what actually occurs. The pressure is always there to be reactive and deal with immediate problems. However, by stepping back, it is also possible to be strategic. We believe HIA has something to offer to both processes. Rapid-appraisal instruments would be very useful to ensure a systematic analysis of the reactive work of policy making and resource-intensive health impact analysis and reviews would be useful at the strategic level.

Nature of Government

New Zealand’s unitary state means the use of HIA is relatively simple. Only one level of government is involved with health policy making and all other key policy arenas. In Canada, where health is a provincial responsibility, it is necessary to involve all the provinces and the federal Government. Ratner et al. discuss this Canadian problem and argue for a federal health strategy to frame HIA of federal programmes and policies (Ratner et al. 1997). Similarly, in Australia, responsibility for health is split between the Commonwealth, states and territories and local government.

The Treaty of Waitangi plays a key role in the New Zealand policy context. Any use of HIA must take account of the Crown’s obligation to honour the Treaty and ensure partnership with Māori, their participation in all aspects of policy making and protection of their rights. Clearly, if formal tools were to be agreed upon, Māori must be closely involved in the process to ensure they meet their needs.

The structure of the public service in New Zealand is quite complex, as Boston et al. note: “By international standards, New Zealand has a large number of departments, many of which are very small” (Boston et al. 1996:87). This increases costs and makes coordination difficult. In turn, this can result in more territoriality and conflict, and less willingness to examine broader interests. However, Boston et al. warn that “a simple, neat, consistent organisational framework is probably impossible to devise” (p.95). This complexity makes the successful use of HIA more difficult. We need to be mindful of this when developing formal tools and implementing their use.

Palmer and Palmer discuss the mechanisms for government decision making. They argue that the mechanisms tend to be “extremely complex and the pattern of decision-making differs markedly from one kind of decision to another, depending upon the type of decision, the importance of the issue, and the interests at stake” (Palmer and Palmer 1997:16). It is in this complex and varied context that we are discussing the use of HIA.

Policy is usually generated from four different sources: political parties, pressure groups, the public and public servants. We believe political parties and public servants are key sources of HIA. Political parties tend to agree on a broad approach to public policy and present this to the public at election time in their party manifestos. Palmer and Palmer rightly predicted that, under MMP, specific policy commitments in manifestos would be reduced in favour of general political philosophy and image (Palmer and Palmer 1997). Public servants, on the other hand, tend to control much of the detail of policies, and are in a strong position to suggest changes. We believe that, ideally, HIA should be broadly supported by political parties/government and that the detail should be addressed by public servants in some guise or other.

GENERIC MECHANISMS

What are the generic mechanisms available to policy makers and advisers to assess the health impact of policy in other sectors? Different administrations institute varying arrangements of the following mechanisms to develop policy advice, make decisions and implement policy. What follows are examples of some of the generic mechanisms available to the health sector to influence the policies of other sectors. The mechanisms have not been evaluated in terms of their effectiveness, partly because this depends on the quality of links and relationships, which in turn are dependent on the people and personalities involved.

It is in Cabinet that decisions occur and policy is made. Cabinet Ministers represent their portfolios and argue the case from their perspective. The Minister of Health can therefore argue the health case for policy in any other policy arena. When Ministers have strategic dual roles – for example, Simon Upton was Minister of Health and Minister for Crown Research Institutes – this helps to ensure that each policy arena considers the interests of the other. Further, when developing Cabinet papers, government departments are obliged to consider all the implications for other government agencies and consult them at the earliest possible stage. When making submissions to Cabinet, departments must certify on a CAB 100 form that they have followed the required consultation process.

Underpinning Cabinet is a system of Cabinet committees. Boston et al. (1996) note that:

¶It may be argued that this is where real power lies in the New Zealand political system. ...In principle, the cabinet committee system should encourage a more coordinated approach to policy development. (p.46)

The Social Policy and Health Committee includes health, education and social welfare, so coordination between these policy sectors should be easier than with a sector such as the environment which has a separate committee.

Policy advisers can influence the coordinating role of the Department of the Prime Minister and Cabinet on a particular issue. For example the Crime Prevention Unit is based in this Department⁴. One of its key roles is to coordinate government activity in relation to crime prevention. The health consequences of crime are significant, when the impacts on mental and physical health are taken into consideration. For example, the homicide mortality rate is higher than the mortality rate from asthma in New Zealand, and although the hospitalisation rate for asthma is higher than that for assault, influencing policy in relation to crime prevention still has important outcomes for health (Wickens et al. 1998, Coggan et al. 1995). The health sector has always participated in the work of the Crime Prevention Unit, thus enabling health input to the decision making.

Many statutory bodies, such as the Environmental Risk Management Authority (ERMA), have a statutory duty to consult. Hazardous substances and new organisms have to be assessed for their impact on health, and the health sector has been closely involved in the development and implementation of ERMA's policies. In the example of ERMA, the health sector is potentially able to exert leverage because of its role in the enforcement of the Hazardous Substances and New Organisms Act 1996. For other statutory bodies, such as the Land Transport Safety Authority, there is no apparent reason why health issues should receive priority over other important societal outcomes.

Ministerial committees have been established to achieve coordination between the relevant sectors in policy and implementation on specific issues. The Ministerial Committee on Drugs, for example, chaired by the Minister of Health, includes the Ministers of Corrections, Customs, Justice, Police, Māori Affairs, Youth Affairs, Transport and Education. It meets a number of times a year to review progress on minimising drug-related harm and to decide which policy initiatives should be recommended to government. A Ministerial Committee chaired by the Minister of Health can be expected to provide especially influential health-sector input for other sectors' policies.

Officials' committees are established to coordinate advice and ensure that officials look beyond their own departments. Whereas these committees can be used as a mechanism to

⁴ The Crime Prevention Unit is now part of the Ministry of Justice.

influence the evolving policies of other sectors, Boston et al. argue that “officials’ committees encourage compromises and pragmatic recommendations to ministers” (1996:46). The Officials’ Committee on Food Administration, for example, met regularly and frequently to reach compromises in the sometimes-competing health and trade issues related to food regulation.

Written comment on draft papers from other government departments is a relatively frequent and cheap mechanism for influencing policy in other sectors. Its influence is probably dependent on the seniority and credibility of the person making the submission, and the degree of follow-up that occurs to ensure that the submission is adequately considered amongst the competing views generated from the submission process. Maintaining a watch on Cabinet and Cabinet committee agendas is one follow-up method that can be implemented. Senior officials have the opportunity to peruse Cabinet committee agendas for items on which health should or has been consulted, and follow them up. The window of opportunity is very small, but opportunities can be created to influence decisions even at a very late stage. Another follow-up method is using the informal opportunities that arise, such as lunch, waiting outside Cabinet committee meeting rooms, or even the street!

Finally, the health sector can influence other sectors’ policies by working with select committees. Departments have two main roles in relation to select committees. Firstly, they service select committees that are considering bills within their sector. The role of the department in this instance is to analyse the submissions that the committee receives, provide advice on the basis of the analysis, and provide any other information and advice as requested by the committee. Secondly, and more importantly, departments may be invited to appear before a select committee as a witness to the committee. In rare instances, a department may request permission from its Minister to make a submission on a matter that it considers to be of major significance.

People working in the health sector have the same access to select committees as the general public. However, as Boston et al. point out, select committees are not the usual place for significant policy change: “by and large, rather than making major changes to bills, select committees have ensured that the bills better achieve their stated objectives” (1996:51).

In summary, within the public sector there are a number of generic mechanisms that the health sector can use to influence the policies of other sectors. These generic mechanisms can be applied in a timely manner as part of the normal work of the health sector and so do not require additional resources.

WHY AREN'T GENERIC MECHANISMS SUFFICIENT TO INFLUENCE OTHER SECTORS' POLICIES?

Policy can be a fiercely contested domain. Other sectors may not see health as a legitimate player and therefore influencing policy in their domain will be more difficult. Environmental policy has traditionally had health involvement because of the direct impact on health of environmental issues such as gas emissions. Income policy influences a key determinant of health, but not health directly. It is therefore harder for health to participate in this policy domain. HIA would provide increased legitimacy for health involvement in other policy arenas.

It may be that there is a lack of political support for health input into some policy arenas. However, an agreed government HIA policy would provide the mandate for analysis and action.

Time pressures that are a normal part of government processes mean that the extent and quality of gathering the evidence, appraising it, and developing robust arguments in favour of addressing health impact in the policies of other sectors can be compromised. Rapid-appraisal HIA methods provide timely but systematic ways to assess policy, and these methods could be used as part of the generic policy-making process. The use of full HIA in an anticipatory fashion also avoids this weakness of generic mechanisms.

Because of the complexity of the bureaucracy, it can be difficult finding out what is on the policy agenda of other sectors. Once again, agreement to HIA would increase the likelihood of transparency, at least in areas that were agreed as high priorities for analysis.

SUPPORTS NEEDED FOR EFFECTIVE FORMAL HIA

The use of formal HIA tools takes resources and time. The outcome of the process may directly challenge ideological positions, and thus it is very important that there is political will to incorporate HIA into the policy-making process. The use of government priorities for departments can assist interdepartmental coordination by ensuring attention to key intersectoral linkages.

Strategic frameworks for health in New Zealand have used a broad definition of health. This legitimates the assessment of the health impact of specific policies in other policy arenas. The draft *New Zealand Health Strategy* also appears to be going to provide this legitimacy (Minister of Health 2000).

Officials need to lead the process, and recognise the positive influence of HIA on their role as policy advisers. In working with Ministers, they need to manage the time lag between Ministers' need for advice and the timeframe within which a formal HIA can produce results. Depending on the complexity of the issues to be considered, the quality and accessibility of the evidence and skills to support the HIA, and the methods used, current experience suggests that the timeframe to undertake a useful formal full HIA is likely to be at least six months, with a further six months needed for the write-up. This timeframe is obviously considerably different from the six weeks, six hours, or even six minutes within which some advice to Ministers has to be formulated. This is where anticipatory HIA and rapid-appraisal methods are needed.

As discussed in the introduction to this paper, it is at least five years since the proposition of using HIA in New Zealand was first put forward. Several bodies have recommended the HIA approach in the last five years, and yet formal HIA tools are still not in use, despite apparent support within the public sector for the concept. It is possible that this long gestation period is associated with various factors, including political will and concerns about resources and effectiveness.

HIA cannot occur without good quality, information-driven constructive networks and relationships within the public sector. The Scottish experience suggests that ownership should be shared so that the HIA is jointly owned by the decision makers, the investigators, the affected community and other stakeholders (Scottish Needs Assessment Programme 2000). Achieving joint ownership is a tall order, but the aim does signal the importance of paying due regard to the processes by which priorities are set for undertaking HIA, the methods chosen and applied, and the process of communication and feedback. There are examples in the New Zealand public sector where joint ownership has been attained, such as the Strengthening Families initiative (Ministry of Social Policy et al. website).

HIAs are evidence based, and therefore effective research and monitoring is essential to provide that evidence – this is where a goals framework, with monitoring of targets, strengthens the ability to do HIA. The annual monitoring of the previous New Zealand goals framework provided considerable evidence that could have been used to support HIA (Signal and Durham 2000, Ministry of Health 1998). The goals framework also meant that an argument could be made for new monitoring programmes to be put into place, such as the national nutrition survey and the national drugs survey (Russell et al. 1999, Field and Casswell 1999).

Public participation is likely to strengthen the argument for maximising the positive health

impacts and minimising the negatives, if the public is seen to support a particular issue. Communities have unique and diverse insights that can contribute to the scoping of the issues, the application of the methods, and the consideration of alternative options. The use of qualitative methods to tap these insights should be considered as part of the formal tools that constitute a useful HIA. A robust process for involving the public can increase political support for the results of the HIA. We anticipate that public participation in HIA could be successful, drawing on the experience of other participation processes, providing HIA was seen to produce results.

OBSTACLES

An important obstacle to the widespread uptake of formal HIA tools is the lack of evidence of effectiveness (Lock 2000). The effectiveness of applying formal tools for HIA – versus informal, opportunistic, generic approaches – is currently unproven.

The Institute of Medicine has defined policy development as the means by which problem identification, technical knowledge of possible solutions and societal values converge to set a course of action (Institute of Medicine 1988). Societal values are a critical part of HIA, and it is important to ensure that the policy process is not unduly weighted by technocratic inputs. Despite our earlier optimism, we consider that initial HIAs using formal tools have to be seen to be successful and produce results, if the public is to trust and participate in the process.

Officials and politicians will be concerned with how a formal HIA process can be resourced and the opportunity costs calculated. There are no answers to these concerns until the process has been trialed and evaluated, and an economic appraisal has been conducted.

If HIA is to be taken further, it will be essential that the early HIAs address and overcome these obstacles. The concept of trialling raises a further set of issues around setting priorities from amongst the vast array of public policy that a government is managing at any one time. For those policies that should be subjected to a formal HIA, how should we set priorities and what criteria should we use? The health sector has more experience with prioritising health issues and health services than other public policies, but it is likely that criteria already in use could be adapted for setting priorities for HIA from amongst the policies that have passed the screening process for health impact.

CONCLUSION

Formal tools for HIA have an important contribution to make in strengthening the assessment of the health impact of policy across government. There is increasing support in New Zealand for their use. Policy making is both strategic and reactive. Both long-term

investigation and rapid-appraisal tools are needed to support HIA in policy making. The tools need to be consistent with New Zealand's unique policy-making context. We need tools that take account of our unitary state, the Treaty of Waitangi, and the relative complexity of our public service and decision-making processes.

Currently, there are a number of generic mechanisms available through which the health impact of policies in other sectors is assessed. The adoption of more formal HIA tools has the potential to strengthen the work that is currently done in the often fiercely contested domain of policy making. Key supports such as political will, a strategic framework for health policy, and backing from effective research and monitoring, are vital for effective HIA. The draft *New Zealand Health Strategy* promises to provide some of these key supports (Minister of Health 2000). We are optimistic that now is the time to permanently weave formal HIA tools into the New Zealand policy-making context. We acknowledge that such an approach requires a careful evaluation of the risks and benefits, and the resources required, and that public participation is going to be a critical success factor.

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