Review of Health Impact Assessments Conducted under the Ministry of Health Learning by Doing Fund

A report prepared in 2010 by:
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University of Otago, Wellington
and
Quigley and Watts Ltd
for the Ministry of Health
Disclaimer:
The views presented in this report are those of the authors and do not necessarily represent the views of the Ministry of Health.
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1 INTRODUCTION

Overview
This paper was prepared in 2010 as a report of a review of those HIAs (including the WOHIAs) funded as part of the Learning by Doing initiative in 2007/08 and 2008/09. The review was based on the newly developed UK Review Package for Health Impact Assessment Reports of Development Projects (Fredsgaard et al 2009) (the ‘review package’).

The Learning by Doing (2007–2011) fund was administered by the Ministry of Health’s HIA Support Unit. It provided contestable funding to enable agencies around New Zealand to undertake and build skills and experience in health impact assessment. The review of the Learning by Doing HIAs was conducted by Quigley and Watts Ltd, and the findings of the review are presented in this report.

Aim of review
The aim of this review is to identify the overall strengths and weaknesses of the Learning by Doing HIA reports and develop recommendations for the commissioning, implementation, reporting and evaluation/review of future HIAs.

The overall success and usefulness of any impact assessment approach (including HIA) largely depends on the quality of the impact assessments conducted (Lee and Colley 1992). Therefore, quality control and continuous improvement are important aspects of HIA capacity building.

It should be noted that this review only evaluates the process and impact of the HIA based on the information given in each report. The review package includes questions about how well the HIA process is described, since a good HIA report should describe the methods and procedure in detail. However, a limitation of the current review is that where such detail has not been included in reports, it is impossible for reviewers to distinguish between poor reporting and poor process.
2 REVIEW METHODS

Background
Because HIA is a flexible tool, applied to a wide variety of proposals and settings, there is considerable diversity in the way it is practised (North American HIA Practice Standards Working Group 2009). Given such diversity, there are methodological challenges to developing a review template that is both flexible enough to accommodate a range of HIA styles and topics, and rigorous enough to guide an objective assessment of the quality of HIAs. These methodological challenges have been highlighted in the wider impact assessment literature (see, for example, Lee and Colley 1992; Morgan 2000).

A Review Package for Health Impact Assessment Reports of Development Projects (Fredsgaard et al 2009) was used to guide this review. The authors designed the Review Package to provide the basis for a critical review of HIA reports in the UK context, and specifically to assess HIAs submitted as part of the consent application process for development projects. They acknowledge that some modification may be required to apply the review package to a wider range of HIAs or in other jurisdictions. The work presented here did not include modification of the review package for the New Zealand environment as that was outside the scope of this project.

Overall approach
This review followed the procedures laid out in the review package as closely as possible. All 10 HIA reports were reviewed by the first reviewer (Judith Ball, Quigley and Watts) and four were also reviewed by a second reviewer (Matt Soeberg, Department of Public Health, University of Otago, Wellington) as a quality control measure. Both reviewers used the same procedure (outlined below).

The initial two HIA reports were reviewed by both reviewers so that grey areas and difficulties interpreting the review package were ironed out before the remainder of the reviews were completed. Towards the end of the process, a further two reports were reviewed by the second reviewer as a check on the consistency of ratings between reviewers and across the HIAs.

It was recognised at the outset that an iterative approach to developing the methods and procedures for the review would be required, as experience using the review package was likely to bring new issues to light.

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1 The UK review package recommends that two independent reviewers use the package to grade the HIA individually and then together reach consensus on the final grade for the HIA report. Due to budgetary constraints, this approach was not possible for all of the HIAs within the current review, and so a sample of four out of ten was reviewed by two reviewers.
**Inclusion**

A list of HIAs included is provided in Table 1. The review included all HIAs commissioned through the Learning by Doing fund before the end of June 2009, with reports completed and in the public domain by 31 January 2010. There were no Whānau Ora HIAs included in the review because none had been completed within the specified timeframe. Two HIAs were excluded because the accompanying report was not complete or had not been released publicly. A further report (*Oral Health and Fluoridation of the Water Supply*) was excluded after initial review because the project parameters had changed over the course of the work and the final report was not an HIA as such.

**Table 1: HIAs included**

<table>
<thead>
<tr>
<th>HIA title</th>
<th>Funded organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Flaxmere Urban Design Framework HIA</td>
<td>Hawke’s Bay DHB</td>
</tr>
<tr>
<td>2  Implementation of Phase 1 of the Oral Health Strategy HIA</td>
<td>Hawke’s Bay DHB</td>
</tr>
<tr>
<td>3  Proposed Liquor Restriction Extensions in North Dunedin HIA</td>
<td>Otago/Southland DHB</td>
</tr>
<tr>
<td>4  Reorganisation of Secondary Schools / Makoura College Responsibility Model HIA</td>
<td>Wairarapa DHB</td>
</tr>
<tr>
<td>5  Hastings District Council Graffiti Vandalism Strategy HIA</td>
<td>Hawke’s Bay DHB</td>
</tr>
<tr>
<td>6  Wairoa Waste Management Plan HIA</td>
<td>Hawke’s Bay DHB</td>
</tr>
<tr>
<td>7  An Age-Friendly Community: Shaping the Future for Waihi Beach HIA</td>
<td>Bay of Plenty DHB</td>
</tr>
<tr>
<td>8  Health Impact Assessment on the proposed Air Quality Plan Change</td>
<td>Hawke’s Bay DHB</td>
</tr>
<tr>
<td>9  Manukau Built Form and Spatial Structure Plan HIA</td>
<td>Manukau City Council</td>
</tr>
<tr>
<td>10 Central Plains Water Scheme HIA</td>
<td>Canterbury DHB</td>
</tr>
</tbody>
</table>

**Templates**

To assist the review process, the authors prepared two templates onto which the review results were recorded: a spreadsheet, where the grades were recorded, and a Word template for recording justifications, discussion, conclusions and notes about the review package itself.

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2 The contract was held jointly between both DHBs.
Procedure

1 The items in the review package were addressed one by one. The reviewer recorded the grade (A–D) in the spreadsheet (see Table 2 below for a definition of grades), and justification was provided in each case and recorded in the Word template. Wherever possible and appropriate, the review items were applied literally. In some cases interpretation was required to make the item applicable to the New Zealand context. Following the advice in the review package, the reviewers avoided giving a ‘not applicable’ grade wherever possible.

2 Once the HIA report had been reviewed on all items, the reviewer gave a summary grade for each of the 12 categories. This grade was not simply an average of the letter grades but a qualitative reasoned judgment of the adequacy of performance based on specific issues identified by the reviewer and weighing their importance. For example, an HIA might have graded D on several items, but if these items were not seen as particularly relevant to that HIA (eg, they were relevant to project- but not policy-level HIA), then the overall grade for that category might be higher than the average of the item grades.

3 An overall grade for the HIA report was then allocated, based on the category grades and a qualitative assessment of the issues raised in the review. As with the item and category grades, the final grade was based on the scoring system outlined in the review package and reproduced in Table 2 below.

4 The main strengths and weakness of the report were noted, along with a discussion of mitigating factors where these were known to the reviewer (eg, timeframe, budget for completion).

5 Throughout the review process, impressions of the applicability of the review package were noted, along with perceived gaps and suggestions for adjustments to the questions. These ‘working notes’ are not summarised in the report, but will be made available to the Ministry and may be used subsequently to inform further work.

6 The steps above were also followed for the HIAs that were reviewed independently by a second reviewer. The first and second reviewers then discussed and compared each grade. There was strong agreement between the two reviewers: 100 percent agreement on the category and overall grades, with some divergence on individual item grades. The reviewers reached a consensus on grades for each item through discussion, and some of the item grades were adjusted as a result.

3 For example, item 2.2.2 regarding terms of reference for the HIA: in New Zealand HIAs do not normally have ‘terms of reference’ as such. This was interpreted to mean, ‘are the aims of the HIA clear, and has the scope been clearly defined?’.
Table 2: Definition of grades

<table>
<thead>
<tr>
<th>Grade</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Relevant tasks well performed, no important tasks left incomplete, only minor omissions and inadequacies.</td>
</tr>
<tr>
<td>B</td>
<td>Can be considered satisfactory despite omissions and/or inadequacies.</td>
</tr>
<tr>
<td>C</td>
<td>Parts are well attempted but must, as a whole, be considered just unsatisfactory because of omissions or inadequacies.</td>
</tr>
<tr>
<td>D</td>
<td>Not satisfactory, significant omissions or inadequacies, some important task(s) poorly done or not attempted.</td>
</tr>
</tbody>
</table>

Source: Review Package (Fredsgaard et al 2009: 4)

Managing conflicts of interest

Neither of the reviewers was involved in writing any of the HIA reports reviewed. Every effort has been made to conduct the review in an objective and independent manner.

Peer review

Professor Richard Morgan (Department of Geography, University of Otago, Dunedin, and co-director of the Health Wellbeing and Equity Impact Assessment Research Unit, University of Otago, Wellington) acted as peer reviewer, reviewing the methodology and project plan at the outset of the review. He also reviewed the draft report, providing advice and suggestions where relevant. The aim of peer review was to ensure that the outcomes of the review were achieved and that the review package was applied in a robust and appropriate manner. At the final draft stage, Quigley and Watts staff provided additional internal review and editing.

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4 The peer review report is available on request.
3 REVIEW FINDINGS

The results of the review are summarised in Table 3. Seven out of ten HIAs were judged to be good or satisfactory overall, with one receiving an A grade and six receiving a B grade (satisfactory despite omissions and/or inadequacies). Three out of ten HIAs received C grades, indicating that parts were well attempted but the HIA was considered unsatisfactory overall because of significant omissions or inadequacies. None of the HIAs received an overall grade of D.

Table 3: Summary of review findings

<table>
<thead>
<tr>
<th>Review areas</th>
<th>No. of HIAs receiving grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
</tr>
<tr>
<td>Summary grade for CONTEXT</td>
<td></td>
</tr>
<tr>
<td>Site description and policy framework</td>
<td>2</td>
</tr>
<tr>
<td>Description of project</td>
<td></td>
</tr>
<tr>
<td>Public health profile</td>
<td></td>
</tr>
<tr>
<td>Summary grade for MANAGEMENT</td>
<td></td>
</tr>
<tr>
<td>Description of screening, scoping and data gathering methods</td>
<td>5</td>
</tr>
<tr>
<td>Governance</td>
<td></td>
</tr>
<tr>
<td>Engagement</td>
<td></td>
</tr>
<tr>
<td>Summary grade for ASSESSMENT</td>
<td></td>
</tr>
<tr>
<td>Description of health effects</td>
<td>0</td>
</tr>
<tr>
<td>Risk assessment</td>
<td></td>
</tr>
<tr>
<td>Analysis of distribution of effects</td>
<td></td>
</tr>
<tr>
<td>Summary grade for REPORTING</td>
<td></td>
</tr>
<tr>
<td>Discussion of results</td>
<td>5</td>
</tr>
<tr>
<td>Recommendations</td>
<td></td>
</tr>
<tr>
<td>Communication and layout</td>
<td></td>
</tr>
<tr>
<td>OVERALL GRADE</td>
<td>1</td>
</tr>
</tbody>
</table>

The following sections highlight the overall strengths and weaknesses of the Learning by Doing-funded HIAs as a whole. It also identifies review areas of variable qualify and provides some additional comments on the reports.

\(^5\) The aim of the review was to identify overall strengths and weaknesses rather than to judge the HIAs individually. Therefore the results have been aggregated.
Strengths

Engagement of stakeholders

Engagement of a range of stakeholders was a strength of nearly all the HIAs reviewed. The engagement strategy generally involved identifying relevant agencies and the representatives of vulnerable groups, and extending invitations to participate in HIA appraisal workshops or interviews. It was apparent that the engagement process was facilitated in many cases by the existing networks of the organisations and individuals directly responsible for the HIA. In most cases it was clear that the input of community stakeholders had been taken seriously and contributed to the conclusions and recommendations of the HIA. Many HIA reports provided lists of those who had participated (often in an appendix) and details about how information had been gathered from stakeholders.

There did not appear to be any HIAs where stakeholder participation had been overlooked, or where engagement was token. However, documentation of the engagement process was sometimes poor. For example, in some HIA reports the number and type of participants were not given, nor any detail about how they were engaged, their role in the process, what questions were asked of them, or how many workshops/interviews were undertaken. This made it difficult to judge whether the process itself had been poor, or whether it was only the reporting of the process that was poor.

There is wide agreement in the recent HIA literature and guidance (see Chadderton et al 2008; Kemm 2007; Institute of Public Health in Ireland 2009; North American HIA Practice Standards Working Group 2009) that local stakeholders are valuable sources of evidence that is not available elsewhere, and that meaningful and inclusive stakeholder participation can support HIA quality. However, stakeholder engagement is resource intensive and there is evidence in the current review that, in some cases, the strong focus on wide engagement may have detracted from the overall quality of the HIA because insufficient time appears to have been left for subsequent analysis and report writing. So although engagement can be seen as a strength of current practice, the review also raises questions about whether the resources allocated to stakeholder workshops were appropriate and proportionate in the HIAs reviewed.

Consideration of the wider determinants of health

All of the HIAs reviewed used a broad definition of health and considered potential impacts on the wider determinants of health such as socioeconomic, physical and mental health factors. For example, the HIA on the Proposed Air Quality Plan Change HIA focused not only on air quality impacts, but also on issues such as household-level economic impacts and sense of control. The focus of the analysis in each HIA depended on the type of proposal being assessed. In almost all cases the reviewers judged the determinants on which the HIA focused to be appropriate, given the subject matter. None of the HIAs limited the analysis to direct health impacts or took a narrow risk assessment-type approach.

Clear recommendations

All of the reviewed HIA reports included a list of recommendations to facilitate the management or mitigation of negative health impacts and the enhancement of
beneficial effects. In most cases these were clear, well supported by the evidence presented in the report, and explicitly directed at a specific agency.

**Good layout**

The majority of HIA reports were well laid out, with information logically arranged in sections or chapters. Almost all had a table of contents and a logical hierarchy of headings for ease of navigating the report.

**Weaknesses**

**Public health profile**

About half the HIA reports included demographic information about the affected community (eg, population size, ethnic and age breakdown). A few of these (eg, the Makoura College, Manukau Structure Plan and Waihi Age-Friendly Community HIAs) included a more detailed community profile, with information on wider determinants of health such as physical activity levels, deprivation, income, employment and unemployment rates. Sometimes ethnic inequalities in these determinants were noted.

However, very few of the HIAs provided a public health profile with baseline measures of health outcomes of interest, or information about the particular health needs or concerns of the affected communities. This is a significant omission because ‘the first step in making predictions is to know from where you are starting’ (Kemm 2007: 11). Judgments about the severity of health impacts depend on a sound understanding of the underlying health issues of a population. For example, accurate assessment of the impact of an air quality plan change relies on knowledge about the current rates and distribution of respiratory illness. If respiratory illness is a significant local issue, or if it is a condition that disproportionately affects disadvantaged communities, then health impacts are likely to be more significant than in a community where this health concern is negligible. Similarly, the impact of locating an oral health clinic in a particular community depends significantly on the current oral health status of that community, relative to surrounding communities and/or national targets. Provision of baseline data is also important so that in future years the actual impact of the intervention and the HIA can be accurately assessed against baselines provided in the HIA.

Three reports (Wairoa Waste Management Plan HIA, Implementation of the Oral Health Strategy HIA and Health Impact Assessment on the Proposed Air Quality Plan Change HIA) stated that a community profile had been part of the appraisal approach but did not include a community profile in the final report. Where community/public health profile data was provided, its relevance to the HIA was seldom explicitly explained. Information seemed to be provided in an ad hoc manner, and was not generally well tied in to the main discussion and conclusions of the report. An exception was the Central Plains Water Scheme HIA, where a low unemployment rate was relevant to the discussion of potential economic costs and benefits, and this was clearly presented in the report.

Data often related to a wider population than that affected by the proposal (eg, regional population data provided for a local project), no doubt because of data availability limitations, but these limitations were seldom explained or acknowledged.
Most of the HIAs identified health determinants of particular interest. It would have been good to have background information and baseline measures of these determinants, but most reports did not include such information. For example, in the graffiti HIA, the community profile does not establish current levels of perceived safety or social/cultural connectedness, which were the determinants of health of interest for this HIA.

**Description of health effects and impact assessment**

Discussion of possible impacts was often loose and not obviously systematic. For example, although the majority of HIAs focused on particular population groups and determinants of health, few provided explicit and systematic analysis of how the proposal would affect each of these groups/determinants. Many of the HIA reports were not specific about potential health effects, how they might come about and who would be affected. Some presented conflicting evidence or opinions about likely impacts but did not weigh up the evidence and come to a clear conclusion. For example, one report gave no indication of whose health and wellbeing would decline and did not provide data about current health ‘declines’ that would supposedly continue.

Most HIAs made good attempts to explain the possible causal pathways leading to health effects and provided underpinning evidence. In many cases this exercise was challenging because of the number and diversity of the likely impacts and the complexity of the causal pathways. Some HIAs presented causal pathway diagrams, mapping out the possible positive and negative impacts. These explanations and diagrams are helpful, but a further stage of analysis is required: given the evidence, which of these outcomes is most likely and most important? In the reports reviewed, the various causal pathways and strands of evidence tended to be presented uncritically and without any weighting, so it is not clear to the reader whether a ‘causal pathway’ is based on a throw-away comment by one workshop participant or is based on solid scientific and/or local knowledge.

In some HIAs, credibility was undermined by a lack of precision in the description of effects. To protect and uphold the reputation of HIA as a method, reports must be careful to present evidence accurately and avoid sweeping statements or overstating causality.

There was generally no attempt to quantify impacts, assess the likelihood of an impact occurring, its severity, the number of people affected, or the political, ethical or public health importance of the impact. None of the HIAs distinguished between long-term and short-term effects or defined these time scales. Only one HIA made any attempt to state the level of certainty or uncertainty attached to the predictions of health effects.

The continuity between the different sections of the report and the stages of the HIA was poor in many of the HIAs reviewed. For example, HIA guidance suggests that the population groups and determinants identified at the scoping stage would guide the public health/community profile and subsequently the analysis of potential health effects, which would highlight key findings in relation to those populations and determinants and draw on the community/public health profile. This was seldom the case, and it was rare for the description of health effects to refer back to the priorities set at the scoping stage, or to use these as an organising principle for the description of health effects. Similarly, the findings of the community profile and literature review
Most of the HIAs focused on discussing factors that could influence the success of the proposal from a health perspective and on developing recommendations to maximise success. Analysis and presentation of potential positive and negative health effects were rarely the main focus, and most of the reports did not come to explicit conclusions about the likely health impacts of the proposal. The majority of the reports reviewed did not have a 'conclusions' section at all, and where conclusions were included, these were seldom systematically organised conclusions about potential health impacts.

**Analysis of distribution of effects**

Almost all of the reviewed HIAs made some comment about inequalities, either in the introduction, the community profile or the discussion. Many of the HIAs engaged representatives of vulnerable groups in the HIA process and provided some analysis of how Māori needs and/or concerns might be addressed in the policy being assessed. A few HIAs did explicitly consider the potential impacts on vulnerable groups. However, in most HIAs, identification of who would be affected by each identified impact tended to be vague, and implications for equity were seldom explicitly stated.

None of the HIAs presented a systematic analysis of the distribution of impacts, or presented conclusions about the likely impacts for each of the population groups identified at the scoping stage. None drew explicit conclusions about whether the proposal was likely to increase or decrease inequalities overall. So while equity issues were certainly 'on the radar' in the HIAs reviewed, the actual analysis of the distribution of effects was generally weak.

**Review areas of variable quality**

There were a number of review areas of variable quality, where some HIA reports performed well against the review package criteria and others were weak. In general, weaknesses could be easily remedied, as discussed below.

**Description of scope and methods**

Most of the HIAs included a brief description of the screening and scoping stages, and reported the outcomes of the scoping stage (ie, the aims and focus of the HIA). However, only a few covered ‘geographical, temporal and population scope’ (item 2.2.2 in the review package). The timeframe for the proposal’s implementation and the timeframe for the impacts (eg, short-term versus long-term impacts) were not well covered in the HIAs reviewed, and consideration of the temporal scope of the HIA was rare. Despite this omission, clarity of scope was a strength of most of the reports reviewed.

Another point to note in relation to scope is that the population and determinants identified at the scoping stage were not always carried through to the subsequent stages of the HIA. Clarity of scope becomes somewhat irrelevant if not followed through.
According to the review package, an HIA report should describe how the quantitative and qualitative evidence were gathered and analysed and their relevance to the HIA should be justified. Most reports provided an outline of the methods used in the literature review, and a few described in detail the methods for the appraisal workshops: the participants, the agenda, the questions asked, etc. However, some HIA reports provided little or no description of methods, and this is an aspect that could be improved overall.

**Site description**

Although the phrase ‘site description’ clearly belongs to project-level HIA, policy-level HIAs still need to briefly define the geographical area affected by the proposal and describe its physical and social characteristics and current usage of the area. The HIAs where this was completed well were generally urban design HIAs where the site description was completed by the policy agency (or consultants) as part of the proposal development and simply ‘cut and pasted’ into the HIA reports. Most other HIA reports were weak in this area. This was not seen as a major shortcoming, but one that could be quite quickly and simply remedied in most of the HIAs with the inclusion of a map and/or a short context-setting paragraph.

**Policy context**

Item 1.1.3 in the review package states: ‘The report should describe the policy context and state whether the project accords with significant policies that protect and promote public health and reduce inequalities’. Several HIAs explicitly stated how the current proposal aligned with regional, national or international public health policies or standards. However, most of the HIA reports did not comment on the policy context in this way. Again this is not seen as a major omission, but one that could be easily rectified with a few sentences about how the proposal aligns (or not) with key public health policies.

**Description of the project**

Item 1.2.1 of the review package states: ‘The aims and objectives of the project should be stated and the final operational characteristics of the project should be described.’ For policy-level HIA this means a description of the aims and objectives of the proposed policy (including a brief discussion of the problem it is intended to address) and details of the policy interventions being considered, including options where relevant. Several of the HIAs did this very well and the reader gained a clear understanding of what was being proposed and why.

However, other HIA reports gave scant or confusing information about the proposal(s) being assessed. In the liquor restrictions HIA, the current situation was described (crime, disorder, litter, etc) and the proposal was said to be a response to the current issues. However, the aims and objectives of the liquor restriction proposal were not spelled out explicitly, nor was the nature of the restrictions or the area they would cover. A clear description of the proposal is necessary in HIA reports and should not be difficult to do.
**Referencing**

Over half of the HIA reports were well referenced, but some reports were weak on referencing. Poor referencing undermines the credibility of the report, and this is an area where consistent high quality is important.

**Other comments**

Some of the reports had other features that are worth commenting on, even though they are not specifically covered in the review package.

**Glossary**

Some of the HIAs included a glossary. This was helpful to the reader and was particularly useful when placed at the front of the document.

**Introduction to Whānau Ora**

Two HIAs had a foreword that introduced the concept of Whānau Ora. This scene setting was helpful, and would have been particularly valuable for readers from non-health sectors seeking to understand the wider context for the HIA.

**Writing style and clarity**

A clear and easy-to-read writing style made a big difference to the comprehensibility of the reports. Reports that had many long, complex sentences, or used words that had not been carefully chosen, were sometimes hard to understand.

**Errors and inconsistencies**

It was evident that some of the HIA reports had been completed under considerable time pressure, and in some cases this led to errors and inconsistencies that should have been picked up in a final edit. Such inconsistencies can mar the overall credibility of the HIA.

**Use of visual aids**

Where photographs and maps were used, these helped to bring the HIA to life and quickly gave the reader an impression of the area under consideration and/or the issues being discussed. Although inclusion of photographs or maps is not always appropriate or possible, it is something to be considered for future HIA reports.
4 DISCUSSION

When critically reflecting on the technical adequacy of the HIA reports under review, it is important to bear in mind the overall purpose of and context for HIA practice. HIA has emerged because the health and wellbeing implications of policies have not always been carefully considered as part of the policy-making process. HIA aims to fill that gap and ‘inform and influence decision making on proposals and plans, so health protection and health promotion are effectively integrated into them’ (Quigley et al 2006: 2). The ultimate test of an HIA is whether or not it effectively informed and influenced decision-making for the benefit of population wellbeing.

In practice this is very difficult to judge, and it is widely agreed that critical appraisal of HIA reports (using a review package or similar) serves valuable functions and should be a routine part of the HIA process (Quigley et al 2006: 3). However, it is also acknowledged in the literature that the capacity and tools for conducting such appraisals of HIA reports have been limited (ibid.). The recent publication of the UK Review Package (Fredsgaard et al 2009) goes some way towards addressing this deficit, as does the development of the North American Practice Standards for Health Impact Assessment, also published in 2009.

This review clearly demonstrates that, when judged against the criteria of the UK review package, the process and routine aspects of the Learning by Doing HIAs tended to be carried out well. However, widespread weaknesses in some of the core analytical components were also identified; specifically, in the description of health effects, analysis of the distribution of effects, and impact assessment.

Are these really ‘weaknesses’?

It could be argued that many of the apparent weaknesses of the reviewed HIA reports simply reflect differences between project-level and policy-level HIA and the fact that the review tool was not designed for policy-level HIA. This review acknowledges that HIAs of high-level policies or strategies are different from project-level HIAs, and that the UK review package (in its original form) may not be the most appropriate benchmark against which to measure New Zealand practice. However, although there are many items in the UK review package that have little relevance in the New Zealand context, this has been considered in the final judgment on the adequacy, strengths and weaknesses of each HIA report. For example, it may be methodologically impossible for a high-level policy HIA to make concrete predictions about health effects, and therefore analysis of likely impacts on health determinants may be more appropriate in many policy HIAs. This has been taken into account in the review.

Although variations from the project-level gold standard for HIA are acceptable and necessary in policy-level HIA, it is widely agreed in the HIA literature that it is important for an HIA report (whether policy level or project level) to be explicit about its methodological limitations and specific about its aims. This was not generally the case in the HIA reports reviewed, but was done well in one report.
It is also widely agreed that HIAs at any level should be as rigorous, transparent and conclusive as possible, and should demonstrate careful analysis and interpretation of evidence. This is vital if HIAs are to be credible to a wide audience and robust enough to stand up to scrutiny. Based on the review findings, it appears there is room for improvement in these aspects in many of the HIAs reviewed. There is a range of possible underlying causes of the weaknesses identified, and further exploration is warranted so that HIA practice can be strengthened and weaknesses addressed.

It is worth considering the fact that the availability of funding via the Ministry’s Learning by Doing fund may have encouraged agencies to designate work as ‘HIA’ that might more appropriately have been carried out using a different framework or methodology (such as community consultation or evaluation). Three of the reviewed reports did not involve assessment of a draft policy or plan, and in some cases it is questionable whether the gap being addressed was a need for public health input. The work undertaken was no doubt of value to the agencies involved, but it does raise the question of whether HIA was the right tool for the job and whether the screening stage of the HIA process is being applied appropriately. Based on the findings of this review, it is proposed that the screening stage should identify perceived needs or gaps in the policy-making process and/or key unanswered questions, and consider whether HIA is the most appropriate tool for addressing those needs or answering those questions. Greater clarity in the reports about why HIA was chosen as the most appropriate approach would also be useful.

In most of the HIA reports reviewed, the stated aim of undertaking the HIA was to ‘assess the health and wellbeing impacts of the proposal’ (or words to that effect). This is a broad aim and gives little attention to how precise such an assessment might be. It allows a more general policy appraisal of the potential impact on the determinants of health rather than an HIA that includes an impact assessment stage. More specific and detailed aims would be helpful. General policy appraisals are likely to be helpful to the decision-maker. However, HIA reports should: maintain their internal validity by being explicit about the analytical techniques used to draw together information, have a clear and separate discussion from the findings, be clear about the potential health impacts, and provide information about the magnitude and severity of those impacts (whether quantitatively or descriptively). Most of the reviewed HIA reports did not do this well.

The question of what defines HIA and whether HIA is ‘fit for purpose’ have been widely debated in the international literature over the last decade. Now that HIA practice in New Zealand has reached a certain level of maturity, perhaps it is time to explore some of these questions in relation to the specific New Zealand context and our HIA practice here.

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6 Most definitions of HIA state that a defining feature is prospective assessment of a proposed project, plan, or policy. However some include ‘retrospective HIA’ (of an existing project or policy) in the definition of HIA, if the aim is to inform future decisions about the project or policy in question.
Resource limitations

It is important to acknowledge that most HIAs completed in New Zealand are done so on a limited budget, often with little time available, and (under a ‘learning by doing’ approach) are often undertaken by new or relatively inexperienced practitioners. Expectations of HIA reports must be fair and reasonable given the resources available for their execution. At the same time, quality and rigour in HIA reports are vital if HIA is to be seen as a valid and worthwhile method. Given limited resources, HIAs need to be scoped and managed appropriately, and adequate time and resources (including skilled personnel) need to be allocated to the impact assessment and report writing stages.

As noted in this review, engagement is a particular strength of the reviewed HIAs, and this is a resource-intensive aspect of the HIA process. It is likely that in some cases limited resources were focused on getting the engagement process right – sometimes to the detriment of the quality of the final report. From the reviewers’ perspective, several of the reports appeared to have been written quickly (although information on timeframes was not available to confirm this), and these reports would have benefited from a thorough editing process. It is also possible that lack of time may have contributed to some of the analytical weaknesses discussed above. This suggests that more appropriate resource allocation across the stages of the HIA and careful project management may be areas for improvement.

Guidance limitations

It is also important to acknowledge that very little guidance or training has been provided in New Zealand on some of the review package criteria. For example, the Public Health Advisory Committee (PHAC) guide provides very little information about how or why the policy context or the public health profile should be presented, so it is perhaps not surprising that these tasks are poorly or inconsistently executed in HIA reports. As noted above, the guidance is also unclear about the respective roles of stakeholders and HIA practitioners in the HIA process.

What is perhaps of greater concern are weaknesses in HIA aspects that are well covered in New Zealand guidance; for example, analysis of the distribution of effects (pp.52–53 of the PHAC guide) and impact assessment (pp.54–56 of the PHAC guide). Overall, there is little evidence that the PHAC guide to appraisal (pp.33–56) was widely followed in the HIAs reports reviewed. The reasons for this are not clear, though they may relate to some of the issues discussed above. For example, if HIA is not the most appropriate tool to address the policy development gap identified, or if HIA is being applied too early in the policy development process, the matrices in the guide may not be applicable. Or, if stakeholder engagement is prioritised in project planning and resource allocation, it may be perceived that adequate resources are not available to undertake detailed analysis according to the PHAC guidance. Further investigation of current training and guidance needs and the usefulness of the PHAC guide appear to be warranted.
5 CONCLUSIONS AND RECOMMENDATIONS

When judged against the review package criteria, the majority of HIAs were judged to be good or satisfactory. This review has highlighted several strengths common to almost all of the reports, in particular good engagement with stakeholders and consideration of the wider determinants of health.

However, the review also highlighted various areas for improvement across the HIA reports, some of which may relate to the fundamentals of HIA practice, such as the impact assessment stage and analysis of the distribution of effects. Further investigation into the explanations for the strengths and weaknesses identified in this review is warranted to support quality improvement in HIA reports in New Zealand and to promote continuous learning. This is consistent with the ‘learning by doing’ approach.

It is hoped that that this review will serve as a catalyst for critical reflection and constructive debate within the HIA sector in this country. Further discussion within the HIA sector may be necessary to reach agreement about which issues need to be addressed as a priority and the appropriate next steps. Specific recommendations are provided below, aimed at building on current strengths, as well as addressing identified weaknesses, in current HIA practice in this country.

Recommendations

Workforce development and capacity building

- Dissemination of good ideas (eg, the inclusion of a glossary) and examples of good practice in specific aspects of policy-level HIA (eg, through analysis of the distribution of effects) is recommended. Where good practice examples are not available within New Zealand, overseas policy-level HIA reports may be useful.

- Further exploration of the underlying causes of the strengths and weaknesses identified in the current review is recommended, including investigation into the extent to which the PHAC guide is used by HIA practitioners (and if not, why not).

- Further guidance and/or training may be required on some aspects of HIA that are important but not well covered in current New Zealand guidance documents (eg, how and why to complete a public health profile or community profile, how and why to outline the policy context, and what to include in the description of the policy being assessed).

- Although the PHAC guide covers analysis of the distribution of effects and assessment of the significance of impacts, the current review suggests that these aspects of HIA are not generally well executed. Further guidance or training may be necessary in these specific areas.
**Commissioning**

- When appraising applications for HIA funding, consideration should be given to whether the scope of the proposal clearly matches the resources available (including time, funding and skilled personnel). The scope may need to be revised if resources are insufficient.

- When appraising applications for HIA funding, consideration should be given to the stage and level of the policy or project to be assessed, and the nature of the ‘gap’ the HIA is intending to fill. Whether HIA is the most appropriate tool for providing the required input should be determined.

- When writing contracts for HIAs, agencies should set clear expectations for what should be covered in the HIA report, particularly in relation to areas of weakness identified in the current review (e.g., public health profile, analysis of the distribution of effects).

- Contracts for HIA projects should explicitly state the criteria the HIA will be evaluated against when monitored/evaluated.

**HIA practice**

- The Ministry should encourage and support HIA practitioners to critically reflect on their own practice and consider how the future quality and reputation of HIA can be improved and optimised in the New Zealand context. This could be achieved through a regular forum (annual or biannual) convened for this purpose, for example.

- Sufficient resources (including time and skilled personnel) need to be allocated by HIA project managers to enable thorough analysis after data collection is complete. The analysis stage should bring together all the information collected (i.e., the public health profile, literature review and stakeholder workshops/interviews) to provide conclusions about potential health impacts.

- Sufficient resources (including time and skilled personnel) need to be allocated for report writing to ensure the writing is clear, succinct and well argued; any errors or inconsistencies are identified; the report is thoroughly referenced; and the report is a coherent whole.

- Attention needs to be given to a more systematic presentation of HIA conclusions; for example, organising these according to the key population groups and determinants of health on which the HIA focused.

**Evaluation**

- The review package should be adapted to the New Zealand context so that the items, categories and weighting reflect good practice in policy level HIA.

- Benchmarking of New Zealand HIA practice against international best practice is recommended to ensure that New Zealand practice standards are consistent with internationally accepted HIA standards and definitions.
REFERENCES


