The Positioning of Health Impact Assessment In Local Government in Victoria

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## Acronyms and Glossary

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<tr>
<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>BV</td>
<td>Best Value</td>
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<tr>
<td>CCT</td>
<td>Compulsory Competitive Tendering</td>
</tr>
<tr>
<td>CHP</td>
<td>Community Health Plan</td>
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<tr>
<td>CP</td>
<td>Council Plan</td>
</tr>
<tr>
<td>CPTED</td>
<td>Crime Prevention Through Environmental Design</td>
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<tr>
<td>DHS</td>
<td>State Department of Human Services</td>
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<tr>
<td>DOI</td>
<td>State Department of Infrastructure</td>
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<tr>
<td>DSE</td>
<td>State Department of Sustainability and Environment</td>
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<td>DVC</td>
<td>State Department for Victorian Communities</td>
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<td>EU</td>
<td>European Union</td>
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<td>EES</td>
<td>Environmental Effects Statement</td>
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<td>EIA</td>
<td>Environmental Impact Assessment</td>
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<td>HIA</td>
<td>Health Impact Assessment</td>
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<td>HuIA</td>
<td>Human Impact Assessment</td>
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<td>LGA</td>
<td>Local Government Area</td>
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<td>LPPF</td>
<td>Local Planning Policy Framework</td>
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<td>MAV</td>
<td>Municipal Association of Victoria</td>
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<tr>
<td>MBA</td>
<td>Master of Business Administration</td>
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<tr>
<td>MPHP</td>
<td>Municipal Public Health Plan</td>
</tr>
<tr>
<td>MSS</td>
<td>Municipal Strategic Statement</td>
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<tr>
<td>N&amp;WMR</td>
<td>North and West Metropolitan Region</td>
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<td>NMR</td>
<td>Northern Metropolitan Region</td>
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<tr>
<td>PIA</td>
<td>Planning Institute of Australia (Victoria)</td>
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<tr>
<td>Sea/Tree Change</td>
<td>Voluntary, permanent relocation of large numbers of people from metropolitan areas to the seaside or to rural or regional areas, in search of a better lifestyle</td>
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<td>SIA</td>
<td>Social Impact Assessment</td>
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<tr>
<td>SPPF</td>
<td>State Planning Policy Framework</td>
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<tr>
<td>STAKES</td>
<td>Finnish National Research and Development Centre for Welfare and Health</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>VicHealth</td>
<td>Victorian Health Promotion Foundation</td>
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<td>VLGA</td>
<td>Victorian Local Governance Association</td>
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<td>VPP</td>
<td>Victorian Planning Provisions</td>
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<td>VCAT</td>
<td>Victorian Civil and Administrative Tribunal</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>WMR</td>
<td>Western Metropolitan Region</td>
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Executive Summary

This 12 month research project which was funded by the State Department of Human Services, explored the potential positioning and application of health impact assessment (HIA) within the local government sector in Victoria. The contextual and operational conditions needed for its inclusion within Victorian local government planning processes were examined, and the enablers and barriers to its use were identified. The rationale for this research arose from a growing interest in HIA as a tool which can both predict potential health impacts of proposed policies, strategies and programs, and assist government decision-making, at a time when the state government was seeking a new method of putting health on the Victorian local government agenda. At this point in time, there is no legislative requirement mandating the application of HIA in the Victorian local government sector, although the current review of the Victorian Health Act is proposing such legislation as part of a flexible framework that would support future directions for public health.

In those countries where HIA is being applied either strategically or routinely at the local government level, it has directly improved local area planning and public policies, and has indirectly:

- encouraged key decision-makers in non-health departments to consider unanticipated health impacts of their decisions, particularly differential impacts across the municipality;
- facilitated intersectoral collaboration within local government;
- provided a systematic mechanism for evidence-based planning;
- encouraged ownership of local government decisions by utilising civic intelligence; and
- identified and made transparent trade-offs in local government decision-making.

Although the current political climate at all levels of government in Australia is very different to that which exists in these countries, the concept of HIA has strong support in Victoria: from senior managers in the State Department of Human Services, from several non-government agencies and from some staff in some councils. There is a strong synergy between this concept and the integrated approach to government thinking which is currently being discussed at state government level. HIA appears to reinforce the intent of the state legislation which determines the roles and responsibilities of Victorian councils and complements several frameworks that guide their day to day operation.

The project uncovered many factors that will influence the decision of each of the seventy-nine councils in this state to voluntarily position and apply HIA. Although their decision will primarily be influenced by their understanding of local government’s role in health, it will equally, if not more so, be determined by their ability and willingness to include a new initiative into an already overcrowded work agenda. Many of the identified barriers to the application of HIA in this sector appear to be based on a combination of fear and confusion about HIA, while others relate to the day to day operation of a local government. Although some barriers cannot easily be removed, fear and confusion could be dissipated by the provision of information about HIA, if the information was relevant to the Victorian local government context and available in a format that met the needs of this audience. Ongoing discussion and debate about the role of HIA in Victoria and the implementation of HIA demonstration models within the Victorian local government sector would inform local government's understanding of both the efficacy of this tool and the relevance of applying it in this sector.
At this point in time, rather than positioning HIA across the entire sector, the project found that it would be more effective and efficient to target those councils that have shown a level of enthusiasm about HIA and have the resources and skill base to apply such a new method of getting health considerations on their agenda. Building capacity for HIA in these councils will need to focus on both individual capacity and organisational capacity. Council staff will require initial education and ongoing support to understand the range of different HIA methods that could be used to address the different needs of different councils. Different organisational characteristics and the broader local context should be acknowledged to ensure that the positioning of HIA does not create an additional and unnecessary burden for council staff or councillors.

The state government and the local government sector have a unique opportunity to develop their own approach to HIA, if they so desire. Given the synergies between HIA and the goals of government to ‘maximise wellbeing’, ‘improve quality of life’ and provide for ‘a pleasant and safe working, living and recreational environment’ for all Victorians, intersectoral discussions should be brokered between key stakeholders in government and relevant non-government agencies. By working together and sharing the lessons learnt about the process and the outcome, these two levels of government in Victoria can contribute to the creation of better public policies, and ultimately to an improvement in the public’s health.

To seize this opportunity, it is recommended:

1. **That a plain language brochure about HIA and the project findings be published**

   Much of the fear and confusion surrounding the positioning and application of HIA could be diffused by publishing the findings of this project in a plain language brochure. Such a brochure should explain the potential role that HIA could play in getting health considerations on the agenda in the Victorian local government sector in a format that would meet the needs of multiple audiences.

2. **That opportunities to raise awareness of HIA amongst professional planners in local government be sought**

   As this project has generated widespread interest amongst planning professionals in the Victorian local government sector, a range of opportunities should be sought to raise awareness of HIA and disseminate information about the project findings, such as the state wide Good Practice Program Conference. Existing partnerships between regional staff in the State Department of Human Services and staff in regional councils should be utilised to explore the potential role that HIA could play in these regions.

3. **That an intersectoral committee be established with key stakeholders at state government level**

   Given the synergies between HIA and the intent of the state legislation that defines the roles and responsibilities of Victorian local governments, discussions should be brokered between senior staff from:
   
   - state government departments, namely the State Department of Human Services, the State Department of Sustainability and Environment and the State Department for Victorian Communities;
   - local government associations, namely the Municipal Association of Victoria and the Victorian Local Governance Association;
This intersectoral committee should urgently address the following issues:

**The need to seek and nurture HIA champions and allies**

The three HIA research projects that have recently been undertaken in Victoria have resulted in the formation of a loose network of champions and allies for HIA. This network should be formalised to become an action based group that provides a forum for ongoing discussion and debate about the use of HIA as one method of getting health on the agenda of local government in Victoria.

**The need to include a ‘health’ overlay or equivalent instrument in the Victorian Planning Provisions.**

Although some Victorian councils have expressed interest in developing HIA policies for inclusion in their respective Local Policy Planning Frameworks, the most effective and efficient strategy to ensure consideration of health impacts in land use planning in Victoria would be to include a ‘health’ overlay or similar instrument in the State Policy Planning Framework of the Victorian Planning Provisions.

4. That capacity for HIA be built in interested councils

A strategy, which utilises the Continuum Model for consideration of health impacts as described in this report, should be developed to assist the Victorian councils that have shown interest in positioning and applying HIA in their organisations.

5. That resources be allocated to undertake HIA demonstration models

An effective method of demonstrating the role that HIA could play at the local government level and the efficacy of such a tool in this sector would be to undertake local demonstration models. Interested Victorian councils should be the lead agencies in at least two HIA demonstration models. Ideally, one demonstration model should link to a proposed strategic plan and the other would be the application of HIA to a proposed program or project that is in some way associated with one or more determinants of health.
1. Introduction

In recent years there has been a growing recognition of the role of policy in both health and non-health sectors, as a determinant of health (Scott-Samuel, 1996; Kemm, 2000; Whitehead, 2000). As a result, the application of health impact assessment (HIA) to policies, strategies and programs is increasingly being encouraged as a means of ascertaining the nature, scope and extent of their impacts on both population health and specific groups within the population.

HIA is being applied to perform different roles in different levels of government around the world. Its positioning at these different levels is very important as each level provides an opportunity to engage differently with health, and with key stakeholders whose decisions can potentially affect health. In the European Union (EU), for instance, HIA is applied at a strategic whole-of-policy level with consideration being given to the ways in which the EU’s policies affect health within and between each of the member states (World Health Organisation, 1999). In contrast, HIA has been institutionalised in Sweden and it is routinely applied at the County Council level (The Federation of Swedish County Councils).

There is increasing agreement that the application of HIA at local government level is crucial in putting health considerations on broader policy and planning agendas. If local decision-makers can think about the effect that their decisions might have on health when planning investment in a range of areas (e.g. amenities, buildings, or the location of services), then the greater and more direct the health gains are likely to be.

This research project, which was funded by the State Department of Human Services (DHS), explored how HIA could be positioned and applied within local government in Victoria for the purpose of assisting in the promotion of public health and the reduction of health inequalities. The contextual and operational conditions needed for its inclusion within Victorian local government planning processes are discussed, and the enablers and barriers to its use are identified.
2. Background

2.1 Health Impact Assessment

HIA has its origins in environmental impact assessment (EIA), where HIA is one of a collection of tools that determines the impacts of a development project on the natural environment, on the community, and on risks to human health. However, the scope of HIA has broadened from this traditional risk/environmental/health protection model to public health/health promotion applications that can be routinely applied to all activities which have a potential impact on human health. During the past few years, much innovative research has been undertaken to incorporate the aims of sustainable development, which underpins the work of many governments worldwide, with those of all impact assessments, including health impact assessment (Northern Lincolnshire Community Planning Support Unit, 2005). This new integrated impact assessment concept and associated tools, includes a whole range of social, economic and environmental objectives for improved quality of life and sustainable development. It promotes a very broad integrated approach to decision-making to ensure long term, efficient solutions that also contribute to improving quality of life. At this point in time, integrated impact assessments have been used by only a few government authorities and are essentially still a work in progress.

HIA is a multidisciplinary activity that is defined as:
“a combination of procedures, methods and tools by which a policy, program or project may be assessed and judged for its potential, and often unanticipated, effects on the health of the population, and the distribution of those effects within the population”.
(Lehto & Ritsatakis, 1999; Mahoney & Morgan, 2001).

The goal of HIA is to attempt to predict the potential impacts of an action and to try to minimise the negative and maximise the positive impacts that might arise from it. It is clear from published research on HIA, and from reports of completed HIAs that the two main benefits it provides are that it assists in putting health considerations on the agenda where it currently is not considered and that it provides a mechanism for evidence-based planning. Currently there is a tension in the HIA literature between the use of HIA as a discrete and systematic process to assess health impacts, and its use as an advocacy tool to assist in getting the issue of health on the non-health agenda (Joffe, 2003). As HIA is a relatively new concept, its effectiveness in fulfilling these roles in different settings has not yet been fully evaluated. The results of a three-year EU multi-country study which is currently examining the effectiveness of HIA across Europe will provide long awaited answers to these crucial questions (Wismar, 2004).

Local governments in many countries, including Australia, are playing an increasing role in prioritising health in planning and HIA has been shown to be an effective tool to assist in this process. The Luton Borough Council guide, An Easy Guide to Health Impact Assessments for Local Authorities describes HIA as “a corporate planning tool to be used when writing policies” and “a mechanism within the local government to improve health and tackle inequalities” (Egbutah & Churchill, 2002, p.56). The report, HIA: a tool for policy development in Australia, states that governments around the world need to develop their own approaches to HIA which suit their cultural, historical, economic, political and social imperatives:
“By sharing information about what works and does not, what is known and what is not known and what conditions are needed for HIA to work best we can work together to contribute to increasing population health gains through better-evidenced and healthier public policies”. (Mahoney & Durham, 2002, p.96)

Australia has a long history of applying HIA within environmental impact assessment processes linked to new projects and developments. However, there is increasing interest in exploring the potential for the broader application to policy, with research being conducted by the Commonwealth Department of Health and within the states, particularly in NSW, Queensland, Victoria and Tasmania. Given the legislated commitment to putting health on the local government agenda in Victoria, HIA could assist by:

- identifying health impacts related to the processes by which initiatives are developed and the outcomes of these processes;
- influencing health outcomes through input to policy development and implementation; and,
- building partnerships by raising awareness of health issues and providing a mechanism for partner organisations to identify joint objectives and common agendas (Barnes & Cooke, 2001).

In 1999, the first short course that introduced the concept of HIA and taught methods to apply HIA was offered as a postgraduate subject in one Victorian university. Since its inception, the number of participants in this short course has doubled, with many potential participants being refused registration due to lack of spaces. It is particularly noteworthy that the number of representatives from the Victorian local government sector continues to increase.

### 2.2 Local Government in Victoria

Since the advent of municipal public health planning seventeen years ago, Victorian councils have slowly broadened their focus beyond the traditional environmental health issues of sanitation and infectious diseases, to encompass the social determinants of health. However, for a number of reasons, not all councils have progressed in this direction at the same pace. An exploration of the possible positioning of HIA into the Victorian local government sector requires an understanding of noteworthy past events and of the present environment in which this diverse sector operates.

#### 2.2.1 Third Tier of Government

In Australia, local government is the third tier of government which historically has been guided by the state and national governments’ legislation and policies. During the past decade, there has been a move away from enacting prescriptive legislation for local government, to providing more enabling frameworks within which councils have some degree of discretion in initiating their own policy directions (National Office of Local Government, 2005).

Australian local government now has roles in governance, advocacy, service delivery, planning, community development and regulation (National Office of Local Government, 2005). There is no longer a standard definition of ‘core’ local government services such ‘roads, rates and rubbish’. Local government now delivers a greater range of services, broadening its focus from ‘hard’ infrastructure provision to include spending on social services such as health, welfare, safety and community amenities. However, unlike local government in many other member countries of the Organization for Economic Cooperation and Development, including the United
Kingdom (UK), the United States of America (USA) and Canada, Australian local governments do not have primary responsibility for services such as health (hospitals), education, policing and public housing.

Currently, there are 79 councils in the state of Victoria, comprising one capital city council, 21 metropolitan councils, 25 regional city councils, 10 fringe councils, 21 rural councils and one interim authority (VicUrban) which has local governance responsibility for the newly developed Docklands precinct in Melbourne (Department of Infrastructure, 2005). It is envisaged that Docklands will become part of the municipality of Melbourne in the near future, and will thereafter be governed by the capital city council, City of Melbourne. Although there are obvious similarities between the roles and responsibilities of each council, their respective priorities will be determined in large part by their geographical location, demographics and socio-economic profile.

2.2.2 Local Government Act
The Victorian Local Government Act 1989 states that the primary goal of a council “is to endeavour to achieve the best outcomes for the local community having regard to the long-term and cumulative effects of its decisions” (Victorian Legislation and Parliamentary Documents, 2005a). One of local government’s most important responsibilities is, therefore, to develop a vision for its municipality and to plan for the future realisation of this vision in partnership with its community. This Act also specifies a number of “facilitating” objectives that will guide a council in achieving this goal:

- To promote the social, economic and environmental viability and sustainability of the municipal district;
- To ensure that resources are used efficiently and effectively and services are provided in accordance with the Best Value Principles to best meet the needs of the local community;
- To improve the overall quality of life of people in the local community;
- To promote appropriate business and employment opportunities;
- To ensure that services and facilities provided by the council are accessible and equitable;
- To ensure the equitable imposition of rates and charges; and
- To ensure transparency and accountability in council decision-making.

The Local Government (Democratic Reform) Act, which was passed in November 2003, requires all Victorian councils to develop and approve a Council Plan (CP) with community consultation after each four-yearly council election (Department of Infrastructure, 2005a). CPs, which will replace councils’ previous Corporate Plans, are essentially a statement of a council’s strategic objectives for the next four years and include a four-year strategic resource allocation plan which is updated annually. A convention that seems to have developed in the local government sector is the embedding of council policies within its various strategic plans, rather than a clear separation of these two elements, as occurs at other levels of government in Australia. In fact, the term ‘policy’ is often used interchangeably with ‘strategic plan’.

2.2.3 Local Government Amalgamations
In 1993, there were 210 councils in Victoria, while today there are only seventy-nine. The massive restructuring of the local government sector that occurred in the mid-1990s, was particularly noteworthy, because only two prior amalgamations had occurred between Victorian councils during the previous one hundred years (O’Connor, 2000). During his first fifteen months in office, the then Premier appointed a Local Government Board, dismissed over one thousand councillors and created 78
new councils. This bold act was considered undemocratic by many people, particularly in regional and rural Victoria, and a further example of a State Government that would act without consultation with those affected by its decisions. However, it must be acknowledged that the need to rationalise councils, which at that time were described as outdated and inefficient, had been discussed by several preceding Premiers, who had been unable or unwilling to take appropriate action.

Mike Hill, past Executive Officer of the Victorian Local Governance Association (VLGA) has described these years of local government reform (1992 to 1999) as a period which brought both benefits and chaos (Hill, 2003). He agreed that Victorian councils needed to be reformed, as they were “parochial bodies that lacked the capacity, vision and strategic perspective to be seen as being in government” (Hill, 2003, p.2). The positive legacy of this traumatic period, from Hill’s perspective, has been the emergence of a stronger local government sector that has rediscovered advocacy and has become a formidable political lobbyist. According to Hill, most councils today are better managed, plan more strategically and have broadened their staff skill base. However, not all councils have grasped the new opportunities that were presented by these reforms. Many are very defensive and suspicious of the State Government and its proposals. Some are still mourning the passing of a time when a council’s role was simpler and thus more clearly defined.

While this organisational upheaval was underway, each new council was also being forced by State Government legislation to subject half of its operating costs to a new tendering process. Compulsory Competitive Tendering (CCT), which was a classic neo-liberal idea borrowed from Thatcher’s Government in the UK, resulted in more than half of council’s permanent employees being forced to re-apply for their own work. The then State Minister for Local Government was empowered to force the CCT agenda if the State Government targets were not met and councils were threatened with dismissal if they did not strictly apply this policy.

O’Toole asserts that this period in local government was driven by a new discourse of governance in Victoria, which represented local governments as “corporate entities”, where the roles of councillors were redefined as “directors of the board” (2003, p. 1). A separation was created between “steering” or setting the policy framework and “rowing” or providing the services. Local government bureaucracies were transformed “to meet the needs of a corporate enterprise” and local citizens became “customers” whose relationship to their local government was redefined as that of “share-holders in enterprise local government.”

### 2.2.4 Best Value

With the election of the Labour State Government in 1999, the Local Government Act was amended to remove the requirement for CCT and to introduce Best Value (BV) Principles (Department of Infrastructure, 2004). This amendment removed the inflexibility of CCT while ensuring that councils remained accountable for their expenditure. Councils are now permitted to determine the most effective means of providing a service to the community whilst obtaining value for money. The Government’s objectives in introducing the BV legislation were to foster:

- local accountability;
- a whole-of-organisation response;
- consultation on performance;
- best value outcomes;
- benefits not costs; and

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1 The 79th local authority, which governs the Docklands precinct, was created after these local government amalgamations.
• innovation.

In 2004 the BV Commission in its Annual Report concluded that for most Victorian councils, BV has become an important component of their management system and their style of governance (Department of Infrastructure, 2005). An important outcome of BV has been a better understanding amongst councillors of the complexities and impact of local government services, thus enabling improved policy-making. Although the BV Principles will sunset in state legislation after December 2005, it is envisaged that the reporting requirements for BV will be dovetailed with other State Government reporting requirements.

2.2.5 Community Plans

Currently, the DHS, the DVC and the MAV are discussing possible options for streamlining the strategic planning required of local governments by State agencies, and providing for more integrated planning between these two tiers of government at a local area level (Kelly, M, 2005). One element of this proposed work is to develop an integrated planning framework for the Victorian local government sector, based on three central plans: the Community Plan, the Council Plan and the Municipal Strategic Statement. Issues currently addressed through separate plans could be incorporated within one (or more) of these key documents or could be addressed through Council determined and generated strategic or business plans.

In this framework, the Community Plan would be the central long-term integrating plan, comprising common domains such as health and wellbeing, sustainable economic development and safety. While there are a legitimate range of approaches to Community Planning, the type of Community Plan being promoted here is that which is facilitated by local government to identify and articulate community aspirations, priorities and needs across a local government area. The Community Plan would provide direction for council, and the Council Plan would then reflect the broad priorities of the Community Plan, as well as outline specific actions to address them.

2.2.6 Planning and Environment Act

Planning is a term that creates some confusion in the minds of professionals outside the planning sector. Planning, as commonly understood in the Victorian local government context, is about the use, development and protection of land in the present and long-term interests of all Victorians. The Municipal Association of Victoria (MAV) asserts that local governments’ planning decisions “shape communities and influence the environment, thus affecting peoples’ livelihood and quality of life” (Municipal Association of Victoria, 2002, p. 7). In most Australian states, planning has been compartmentalised into statutory planning and strategic planning. The former refers to the “formulation and administration of controls on the use and development of land”, while the latter is concerned with the “research and policy development aspects of the planning process” (Eccles and Tannetje, 1999, p.15). Ideally these two functions should be integrated to ensure that a council’s decisions about land use and development are made on the basis of considered policies and sound evidence, rather than “local political pressure and inventive legal argument” (Eccles and Tannetje, 1999, p.16). However, as the organisational structure in most Victorian councils isolates statutory planners from their research-based colleagues, planning at a local level can sometimes be an anomaly.

The Victorian Planning and Environment Act 1987 is the legislative basis for the planning system in Victoria (Victorian Legislation Parliamentary Documents, 2005b). The State Department of Sustainability and Environment (DSE) manages the
regulatory framework for land use planning and land subdivision across the state, and provides advice and information about planning policy, urban design, strategic planning, land development and forecasting.

The Act stipulates that each council must develop a Municipal Strategic Statement (MSS) to provide a strategic planning vision, objectives for land use and development in the municipality, and policies and programs to achieve these. The MSS must be integrated with council’s other objectives, policies and programs which are not directly associated with land use and development, as identified in its Council Plan (CP). Ultimately, these integrated documents should aim to achieve the objectives of land use planning in Victoria, which are to:

- provide for the fair, orderly, economic and sustainable use, and development of land;
- provide for the protection of natural and man-made resources and the maintenance of ecological processes and genetic diversity;
- secure a pleasant, efficient and safe working, living and recreational environment for all Victorians and visitors to Victoria;
- conserve and enhance those buildings, areas or other places which are of scientific, aesthetic, architectural and historical interest or otherwise of special cultural value;
- protect public utilities and other assets and enable the orderly provision of public utilities and co-ordination of public utilities and other facilities for the benefit of the community;
- balance the present and future interests of all Victorians; and
- facilitate development, in accordance with these objectives.

The use and development of land in Victoria is controlled by the Victorian Planning Provisions (VPP) that comprises seventy-nine different planning schemes, each of which contains:

- the State Planning Policy Framework (SPPF) which is the State Government’s over-arching strategic land use plan;
- a Local Planning Policy Framework (LPPF), which is a council’s MSS and other local policies that are not directly associated with land use; and
- zone and overlay provisions.

The objective of the SPPF is “to ensure that the effects on the environment are considered and provide for explicit consideration of social and economic effects when decisions are made about land use and development of land” (Victorian Legislation Parliamentary Documents, 2005b). The SPPF principles describe the factors that influence good decision-making, one of which states that “land use and development planning must support the development and maintenance of communities, with adequate and safe physical and social environments for their residents, through the appropriate location of uses, and development and quality of urban design”.

The VPP requires all public and private developers to submit planning permit applications to the relevant council before they use and develop land in Victoria. According to the MAV (2002, p. 9), a council decides to grant a planning permit “based on an assessment of the proposal, the strategies, policies and decision guidelines in the planning scheme, and the planning merits of any objections received”. The Act stipulates specific matters which a council ‘must’ or ‘may’ consider before approving a planning application. Any significant effects of the proposed use or development for which the application is made, on the environment ‘must’ be considered by councils, while councils ‘may’ consider any significant social and economic effects. Therefore, each council decides whether it will identify any
significant social or economic effects, if it will exercise its discretion to consider them and how it will consider them. A council’s decision to grant or disallow a planning permit can be reviewed by the Victorian Civil and Administrative Tribunal (VCAT), which is an independent body that is administered by the State Department of Justice. The President of the VCAT has recently estimated that only 9% of council decisions about planning permits have been challenged and required a judgment by the VCAT (Morris, 2005).

During the past few years, many planning professionals in Victoria have expressed concern that the VPP are too cumbersome and too confusing. In 2004, the Victorian branch of PIA completed a review of the VPP with a particular focus on the changes that had occurred since the election of the current State Government (Cousin, 2004). The review noted that although there is evidence of much progress towards a more streamlined scheme, some promised modifications are not being undertaken.

Cousin proposed that a major reason for this slow rate of change is the legacy of the reforms that were enacted by the previous State Government. She stated that it appears that the VPP are currently being strained due to the: "sheer volume of applications, the rich new array of value-based as well as standard-based considerations for decision-makers, coupled with substantial downsizing and budget reductions across state and local governments, and difficulties in attracting skilled professionals into the statutory planning arena" (Cousin, 2004, p. 11).

Cousin (2004) concluded with a number of recommendations to improve the performance of the VPP which are particularly relevant for local governments.

- Develop tools for strategic impact assessment -
  - Include economic, social, health and environmental impacts in an Impact Assessment Statement.
  - Monitor performance of land use/development, after approval, to ensure conditions set during impact assessment are fully met.
- Strengthen and reinforce the local governance component of the VPP -
  - Those who develop policy (particularly State Government Departments) have an obligation to ensure that there are adequate resources for policy implementation, delivery, monitoring, feedback and corrective action across all components of the VPP.
  - New policy must be accompanied by an impact assessment statement including detailed implementation provisions.
- Education, skills and capacity building -
  - All bodies in the VPP must make an ongoing commitment to build staff skills and organizational capacity to manage difficult policy issues and stakeholder engagement in decision-making processes.

In August this year, a special interest group of the PIA convened a forum where it was concluded that “there appears to be considerable policy support in Victoria for an approach to planning which integrates environmental, social and economic considerations” (VLGA Community and Social Planners Network, 2005). This special interest group has organised a workshop in November 2005, to explore the links between the following:

- the legislative basis for considering social impacts in the planning system;
- social policy objectives, for both the State Government and local governments;
- desirable social outcomes, in the context of local communities; and
- the effect of planning decisions on those social outcomes.
2.2.7 Sustainable Neighbourhoods Project

The Sustainable Neighbourhoods project, which is due for completion by the end of 2005, aims to update the residential subdivision provisions in Clause 56 of the VPP (Department of Sustainability and Environment, 2005a). Although the DSE is currently preparing a draft report for public consultation purposes, the project outcomes are envisaged to be a new clause in the VPP that supports:

- residential subdivisions which provide networks of compact and walkable neighbourhoods, where neighbourhood centres support local services and facilities;
- reduced car use because public transport is easy to use, and walking and cycling are promoted;
- environmentally friendly development where lot layout and design support more energy efficient dwellings;
- integrated water management that conserves our drinking water, reuses and recycles water, and locally manages the quality and quantity of urban run-off; and
- future community housing needs by providing diverse lot sizes and a range of lot types.

2.2.8 Planning for Health Project

Over recent years the Victorian Division of PIA has become increasingly aware of the direct relationship between planning decisions and the health of our community. In 2002, this Division received short term funding from VicHealth to undertake a project that would promote this clear link to planners (Planning Institute of Australia 2002). The project has been very successful in achieving the following objectives, and further funding is currently being sought from VicHealth:

- increase the number of planners aware of and advocating for the integration of planning and health;
- increase the capacity of planners to influence local urban design so that health is "planned in" rather than "planned out";
- gather evidence of good planning for health and well being, including literature and case studies, collated and disseminated to planners; and
- identify key planning and design elements that will lead to greater health and social benefits for the community.

2.2.9 Safer Design Guidelines for Victoria

In July 2005, the State Minister for Planning launched the Safer Design Guidelines for Victoria, which aim to facilitate the planning and design of safer urban environments for all Victorian communities (Department of Sustainability and Environment 2005b). The Guidelines are a response to two key State Government initiatives:

- Melbourne 2030 (a strategic plan, which was developed in 2000, for managing the growth of Melbourne over the next 30 years); and
- Safer Streets and Homes 2002-2005 (a crime and violence prevention strategy for Victoria).

The objectives of the Safer Design Guidelines are to:

- increase community usage of public places, in the daytime and evening;
- achieve connection and integration of streets and public places;
- reduce opportunities for crime and anti-social behaviour;
- improve the quality of life for the community by improving perceptions of public places; and
- create more liveable and sustainable environments.
As these Guidelines are referenced in the State Planning Policy Framework, all councils must now consider them when assessing a planning application to ensure that the design of all urban environments enhance personal safety and property security.

2.2.10 Healthy by Design

*Healthy by Design* is a resource for planners in Victoria that has been developed by the Victorian Division of the Heart Foundation in response to local government requests for practical guidance in designing walkable, and ultimately more liveable, communities (Heart Foundation 2004). The guide facilitates the creation of healthy places in which people can live, work and visit, by encouraging planners to include:

- well planned networks of walking and cycling routes;
- streets with direct, safe and convenient access;
- local destinations within walking distance from homes;
- accessible open spaces for recreation and leisure;
- conveniently located public transport stops; and
- local neighbourhoods fostering community spirit.

The guide also provides a matrix which highlights the fact that health, safety and access in the built environment, can all influenced by the same range of design features. This matrix supports an integrated approach to planning and assists council planners to develop “value-added” local structure and area plans.

2.2.11 Environmental Impact Assessment

Assessment of environmental impacts is driven by several pieces of legislation in Victoria, including the Planning and Environment Act 1987, the Environment Effects Act 1978 and the Environment Protection Act 1970. The State Minister for Planning is responsible for the first two of these Acts while responsibility for the third rests with the State Minister for Environment (Department of Sustainability and Environment, 2005c).

In considering planning permit applications as well as planning scheme amendments under the Planning and Environment Act, all councils must have regard to the effects of a proposal on the environment. Documentation of environmental impacts for this purpose is the most common form of EIA in Victoria.

The Environment Effects Act 1978 empowers the State Minister for Planning to require the application of an EIA to large private or public works proposals with potentially significant effects on the environment (Department of Sustainability and Environment, 2005d). This EIA is developed by the proponent and is presented to the State Government in the form of an Environment Effects Statement (EES). Although the Minister usually advises the DHS of such proposals, there is no systematic process to ensure comprehensive and timely input from the DHS. The assessment procedures under this legislation have recently been reviewed and both the DSE and the DHS are currently discussing new mechanisms to ensure that these EIAs adequately consider health impacts.

The Environment Protection Act requires the DHS to assess the likely impacts on the public’s health of applications for industrial works approvals, and new or amended licensing of certain industrial premises. The DHS must provide a written report within 21 days of receipt of an application, clearly stating any objections to the proposed works or licences, and recommending any changes. Although the legislative requirement for DHS input into the EIA processes under this Act appears to allow for some consideration of potential health impacts, the DHS has noted that the response
timelines may need to be reconsidered to permit adequate consideration of any potential health impacts and to allow the concerns of affected communities to be properly assessed.

2.2.12 Municipal Public Health Planning

In 1988, two additions were made to the Victorian Health Act 1958. The first introduced a requirement for each Victorian council to develop and implement a Municipal Public Health Plan (MPHP) at three yearly intervals, while the second required councils to prepare environmental health impact statements (Victorian Legislation Parliamentary Documents, 2005c). The latter of these was never proclaimed and has since been removed from the legislation.

The Act stipulates that each council’s MPHP should:
(a) identify and assess actual and potential public health dangers in the municipality; and
(b) outline programs and strategies which the council intends to pursue to prevent or minimise those dangers, to enable the people in the municipality to achieve maximum well being and provide for the periodic evaluation of those programs and strategies, as well as annually reviewing the public health plan.

The National Public Health Partnership (2002, p. 60) states that the introduction of this planning requirement “recognised the increasing importance of local government in public health issues and attempted to provide a method for integrating State Government and local area planning to promote high quality services”. The proponents of this new initiative envisaged that both councils and service providers would become increasingly aware of the health impacts of all council planning decisions by adopting a broadened perspective of health. However, such municipal public health planning processes required the development of a new mindset within Victorian councils and a culture of thinking holistically using a social model of health, in an environment that had not traditionally had to consider it.

After more than a decade of municipal public health planning of varying standards, it was clear that some councils had changed their thinking, while others had not. In 2001 the DHS released a new municipal public health planning framework, Environments for Health (Department of Human Services 2001), which provided a practical guide to assist in the integration of public health considerations into council’s broader planning responsibilities. It clearly described how existing council actions across the built, social, economic and natural environments could potentially have an impact on the public’s health. The DHS also provided a small stream of funding, the Good Practice Program, that aimed to facilitate best practice municipal public health planning and to showcase the most successful initiatives across the sector. Since the launch of this framework, there has been a growing commitment to supporting integrated municipal public health planning processes in Victoria, through a range of activities by organisations such as the Victorian Health Promotion Foundation (VicHealth) and the PIA (refer sections 2.2.8 and 2.2.9).

It is noteworthy that the Victorian Health Act is currently under review with the final draft of the new Act being expected within the next 12 months. The review aims to ensure that Victoria has a modern legislative framework that is “sufficiently flexible to support current and future directions for public health, and is consistent with modern legislative thinking” (Department of Human Services, 2005, p. 4). One section of the review, which explores the potential role for HIA at both state and local government level, suggests that a legislative requirement for HIA could be advantageous as it may assist in:
• raising awareness of HIA amongst decision-makers, proponents of a project and the public;
• aiding consistent application of HIA requirements;
• setting a standard for compliance; and
• providing a strong basis for clarifying roles, responsibilities and working relationships between agencies conducting EIAs and health agencies.

2.2.13 Leading the Way

In 2000, VicHealth, in collaboration with the DHS and the MAV, developed a resource package which targeted the Victorian local government sector. Leading the Way aimed to explain the social model of health and to effectively equip councils to respond with practical solutions to their local circumstances (VicHealth 2002). Particular focus was placed on providing strategies designed to simultaneously address the social determinants of health and the objectives of MPHPs and of councils’ other core plans. It was vital that the materials produced would be read by councillors and senior managers with a view to influencing policy development across all work areas of the council. The resource package was designed to complement the Environments for Health framework and was launched to coincide with the release of the framework. By December 2003, 74 (94%) of Victorian councils had been directly exposed to this resource package in at least one format and 275 councillors from 62 (78%) councils had attended Leading the Way presentations in a council meeting or at a MAV Councillor Development Weekend.

2.2.14 Primary Care Partnerships

Since April 2000, over 800 service providers across Victoria have established 32 voluntary alliances or Primary Care Partnerships (PCPs) to address the issue of fragmentation of primary health service delivery (Austin, S. et al, 2004). Victorian local governments are leading members of all PCPs, as they provide and fund a range of primary care services, and play an important role in local area public health planning, advocacy and community development. PCP Community Health Plans (CHPs), which encompass locally identified health issues, are annual plans that report each PCP’s strategies and achievements.

Essentially council’s MPHPs and CHPs are complementary plans that both focus health planning on local areas and aim to empower local communities to work together on key health and wellbeing issues (Department of Human Services 2003). MPHPs are intended to be local strategic health plans which are underpinned by an understanding of the many factors in the local built, social, economic and natural environments that could impact on the public’s health. In contrast, the CHPs are operational plans that are informed by the MPHPs but which contain specific collaborative strategies to strengthen the primary care service system (e.g. health promotion activity, service coordination, advocacy, community needs and capacity building). In most Victorian councils, the staff member who has been allocated responsibility for developing council’s MPHP, is also council’s representative on PCP committees and working parties. Although this decision regarding work responsibilities ensures continuity of ideas and better coordination of strategies, it often also results in work overload for the relevant staff member.

2.2.13 Department for Victorian Communities

The election of the Labour State Government in 1999 brought a change in the dominant discourse within state government circles to include aspects of community governance and community building (O’Toole, 2003). While much of the corporate culture still remains, new terms such as ‘civic engagement’ and ‘community
ownership’ are appearing more frequently in government documents and emphasise the importance of social capital in building stronger and more equitable communities.

Strengthening communities is a key priority of the current State Government which is aiming to improve social, economic and environmental well-being for all Victorians and develop new partnerships to address inequality and disadvantage (Department for Victorian Communities, 2005a). The establishment of the Department for Victorian Communities (DVC) represents this State Government’s determination to deliver government services in a way that supports and strengthens communities across Victoria through a more integrated approach to planning, funding and delivering services at the local level. DVC has embedded the following principles within the design of all its policies and programs:

- building social networks;
- promoting local leadership;
- encouraging local ownership and control; and
- facilitating innovation, creativity and sustainability.

The capacity of local government to meet the needs of communities and to deliver services on behalf of both State and Federal Governments is being enhanced by the Local Government Victoria division of DVC (Department for Victorian Communities, 2005b). This division works cooperatively with each of the 79 councils and supports good governance, continuous improvement, intersectoral administration, intersectoral relationships and intra-government coordination. In May 2005, DVC facilitated a conference at which a range of local and state government staff discussed the implementation of a series of actions that local and state government will undertake in the near future to increase the community strengthening role and capacity of Victorian councils.
3. **Methodology**

3.1 **Reference Group and Working Group**

Due to the high level of interest that this project raised within a range of organisations in Victoria, the project team decided to establish two groups that would provide guidance during the research period. Firstly, a Reference Group provided assistance in matters related to broad issues with state-wide implications. This group, which met four times, comprised representatives of a number of state government departments (health and non-health sectors), several organisations with an interest in local government planning, academia and two Victorian councils that have recently adopted an integrated approach to planning (Appendix 3). Secondly, a Working Group addressed the day-to-day aspects of the project which had relevance to regional and local matters. This group, which met seven times, comprised representatives of the DHS, two Regional Offices of DHS, the two case study councils and one local government social planner with extensive experience in impact assessments (Appendix 4).

3.2 **Data Collection**

3.2.1 **Literature Search**

The data sources for the literature review were derived from the collection of scientific articles held by the HIA Research Unit at Deakin University, from materials (e.g. reports, published documents and ‘grey’ literature) collected from HIA professionals worldwide, who had worked in or had commissioned work on HIA at local government level, and from searches on the Internet via pages known as the HIA gateway.

Due to the longstanding interest in HIA within Scandinavian countries, the project team commissioned the services of a Danish research assistant to conduct a specific search and review of the Scandinavian literature using the native languages of these countries. This search was partly guided by knowledge of the history of HIA in Scandinavian countries and the sites where HIA reports were likely to be placed (e.g. the National Institute of Public Health or the Ministries of Health), and used the search strategy described by Pennington (2002).

The search of the Scandinavian literature revealed that, although the Swedish National Institute of Public Health is currently researching HIA methodology at the local authority level, their website did not provide information about their research findings or about any HIAs that had been applied at the local level in Sweden. However, it was found that twenty Swedish local authorities have applied HIAs - ten municipalities and ten county councils. An extensive search on the websites of Sweden’s 289 municipalities, found twelve websites that provided relevant information for this project. The website of only one municipality, Helsingborg, provided reports of six completed HIAs, and these have been reviewed. In addition, the literature search found an evaluation report of the implementation of HIAs by the Stockholm Health District Authority, which described the HIA tools that had been used and the lessons that were learnt.

In Finland, the search revealed that the Finnish have combined HIA and Social Impact assessment (SIA) to develop another form of impact assessment, Human Impact Assessment (HuIA), which has been applied at all three levels of government. The main source of information about the application of HuIA at the local government
level was the website of the National Research and Development Centre for Welfare and Health (STAKES). Short descriptions of six HuIAs were found on the STAKES website, and three of these, Kajaani, Kerava and Turku, were reviewed.

No published reports of HIAs that have been applied at local government level in Denmark were found. However, personal communication with academics in that country indicated that, although no HIA tools have been developed in this country, some municipalities have conducted HIAs but have not reported their findings in the literature or on any local websites (Bistrup, M.L., 2004; Gulis, G., 2004).

Little HIA activity was found in Norway, but recent correspondence with Norwegian public health experts indicates that the Norwegian government has commissioned a report on the potential positioning of HIA within government. At the time of writing, the outcome of this report is unknown.

Although many HIAs have been applied at local government level, reports of their findings are not freely available for review. A review of the literature found a number of reports about HIAs that have been applied at local authority level in the UK. The following ten HIAs that have been applied to a range of plans or strategies were reviewed and are summarized in Appendices 1 and 2:

1. HIA of Aylesbury Plus New Deal for Communities (NDC) Delivery Plan applied by an independent public health specialist and commissioned by a health authority in partnership with a local government (Barnes 1999)
2. HIA of Determinants of Child Health in Bro Taf applied and commissioned by Bro Taf Health Authority (Lester, Griffiths, Smith, & Lowe 2001)
3. HIA of Structure Plan (land use plan) applied by external HIA consultants and commissioned by Cambridgeshire County Council and Peterborough Unitary Authority (France 2003)
4. HIAs of Edinburgh City Council’s Local Transport Strategy and North Edinburgh Area Renewal Housing Strategy respectively, applied by an external public health consultant (Scottish Needs Assessment Programme) and commissioned by Scottish Executive Health Department (Douglas, Conway, Gorman, Gavin & Hanlon 2001; Gorman, Douglas, Conway, Noble & Hanlon 2003)
5. HIA of London’s Spatial Planning Strategy applied by a Steering Committee comprising representatives from local health and government authorities, and commissioned by Greater London Authority (Bowen 2004)
6. HIA of Local Plan (land use) applied by environmental health facilitators and commissioned by Luton Borough Council (Egbutah & Churchill 2002)
7. HIA of Merseyside Integrated Transport Strategy applied by Liverpool Public Health Observatory and commissioned by Liverpool Health Authority (Fleeman & Scott-Samuel 2000)
8. HIA of Redevelopment of Service Delivery at Salford Royal Hospitals Trust applied by University of Salford and commissioned by Capital Development Directorate of Salford Royal Hospital NHS Trust (Douglas, Higgins, Dabbs & Walbank 2004)
9. HIA of Proposed Housing Development in a former mining village in South Wales applied by Cardiff University and commissioned by Welsh Assembly Government (Elliott & Williams 2003)

3.2.2 Key Informant Interviews

The literature search and review was supplemented by telephone and face-to-face interviews with two groups of key informants. The first group comprised HIA practitioners who have undertaken HIAs in local government, while the second group
were local government experts who have extensive knowledge of and experience in the Victorian local government sector.

A selection process and an interview questionnaire were developed (Appendices 5 and 6) for both groups of key informants. The project team, in consultation with the Reference and the Working Groups, selected a total of 19 key informants - 7 HIA practitioners and 12 local government experts (Appendix 7). Before each interview, consent forms were distributed and permission was obtained from the key informant to tape record the interview. For the purposes of this project, a verbatim transcription of each interview was not considered necessary, but rather, each interview was summarised to reveal the major issues that had been raised by the key informant. After the interview, each key informant was provided the opportunity to alter their interview summary as appropriate to avoid any misrepresentation of their comments.

Another ten people, who had experience in the application of HIA in local government, expressed strong interest in contributing to this project, but were not interviewed because the Reference and Working Groups and the research team believed that they could not offer sufficiently detailed information which would add to the findings of this project.

### 3.2.3 Regional Focus Groups

In order to answer questions about the potential positioning and future application of HIA in local governments, it was important for this research project to be linked to the current work of local government. HIA is a relatively new concept and anecdotal evidence suggests that each local government is at a different stage of development in their understanding of their role in promoting health. Therefore, it was not possible, nor sensible, to involve all Victorian local governments in this project. In consultation with the then Director of Partnerships at the DHS Central Office, two DHS Regions were selected as the basis for the applied component of the research because they:

- provided a mechanism for accessing a range of local government authorities;
- had structures in place to facilitate consultation and discussion;
- were interested to be part of this research; and
- were linked into local area issues, despite being removed from the day-to-day business of local councils.

The DHS Regions provided an ideal mechanism or base for undertaking the necessary consultation processes. Additionally, as the needs of local governments are very different across rural and urban Victoria, and even within different kinds of urban councils, it was important for the project to include Regions that could provide different insights into the development of local councils in respect to planning for health, different levels of experience, different levels of readiness, and that were willing to consider or try new approaches to planning for health.

As every Victorian council is required to produce various plans, each of which encompasses different strategic planning issues, consideration was given to including:

- one DHS Region where councils have well developed policies linked to all of these plans; and
- one DHS Region where councils do not have well developed policies linked to all of these plans.

The first Region selected was the former Western Metropolitan Region (WMR) which comprised seven Local Government Areas (LGAs) spanning from the City of Melbourne to the urban fringe. Each LGA in the DHS WMR was at a different level of
development in respect to public health planning, and the DHS WMR Regional Office facilitated the WMR Local Government Health Planners’ Network which met on a monthly basis. This network was to be consulted using focus group methodology, to identify important lessons about the positioning of HIA at local government. However, during the period between the submission of the project application and the commencement of this project, the DHS WMR merged with the Northern Metropolitan Region (NMR) to form the North and West Metropolitan Region (N&WMR). Consequently, the focus group consultation that was to have originally comprised members of the DHS WMR Health Planners’ Network was expanded to include members of the equivalent Health Planners’ Network in the DHS NMR. The second selected Region was the Gippsland Region, which contains 6 rural LGAs that had not developed their thinking about broader public health planning. Although the regional Municipal Health Planners’ Forum met only on an irregular basis, it was used as the basis for consultation in this Region.

Agreement was obtained from the DHS Regional Manager of Public Health in both DHS Regions to participate in this research project and to assist as appropriate. Both managers were committed to the application of HIA at local government level and understood the tensions that currently existed in their region. Preliminary meetings were held to consider the appropriate structure for the consultation and the case studies.

Before each consultation, a paper by Douglas et al (2001), which describes the principles of HIA, was distributed to each member of the Network and the Forum respectively. Each consultation comprised a 30-60 minute presentation which introduced the concept of HIA and clarified any aspects, followed by a 2 hour focus group with eight planners representing 6 and 8 LGAs respectively (Appendix 8). Before the meeting, permission was obtained to tape-record the focus groups and consent forms were distributed. The series of questions which guided the focus group discussions (Appendix 9) was developed after reviewing the findings from both the literature and the key informant interviews.

Broad themes which were covered in the focus group consultations included:
- factors which indicate readiness to consider health at local government level;
- level of interest in inequalities at local level;
- barriers to considering health and inequalities as part of the core business of local government;
- awareness of the potential role and value of HIA in putting health on the agenda;
- issues linked to positioning of HIA;
- management issues to be considered (short and long-term); and
- suggestions for triggers for an HIA and approaches that should be used.

For the purposes of this project, verbatim transcription of these focus group discussions was not required, but rather, focus group reports summarised the major issues that had been raised in the discussion. After each focus group, each participant was provided the opportunity to alter the report summaries as appropriate to avoid any misrepresentation of their comments.

3.2.4 Case Studies

Two very different councils, one in the DHS Gippsland Region and another in the DHS N&WMR were selected as case study councils for this project. Individual consultations with a range of council staff and councillors in these councils provided
an in-depth exploration of the contextual factors that could influence the positioning and application of HIA in a Victorian local government.

The first case study council was East Gippsland Shire Council, which had been invited to participate because this council does not have health on its agenda and, at the time of the project application, had not developed a MPHP for more than a decade. This council as a whole has neither a clear understanding of the determinants of health nor a commitment to considering the impact of its plans and policies on the public’s health. However, it was envisaged that this council could provide valuable lessons about the potential positioning and application of HIA in what appears to be a non-supportive environment.

The second case study was Wyndham City Council which had been invited to participate because this council had been very keen to be involved in HIA research for several years. Their approach to planning is consistent with the principles of HIA and they have prepared a document which outlines how HIA might be positioned within their current planning frameworks. This council is ideally positioned to be the site of one case study because it has a commitment to integrating health considerations into policy and planning across the organisation. It has a growing population base, a clear understanding of the factors within the community that impact upon health, well developed and refined planning processes and a strong sense of the value that HIA can provide within its planning processes. It is also sufficiently advanced in its planning processes to provide lessons to other councils. During the period between the submission of the project application and the commencement of this project, a number of council staff members who had been involved in the original project planning discussions, found other employment. Consequently, other staff members, who now occupy positions of relevance for this project, were invited to participate and have welcomed the opportunity to contribute.

The research approach underpinning the case studies was based on the principles of action research, which involves both participants and researchers determining the research process and ongoing direction. Each case study site visit spanned a period of five consecutive days, during which time the project team consulted a number of council staff from different work areas of relevance to this project (Appendices 10 and 11). Individual consultations of at least 45 minutes’ duration were interspersed with half to one hour team meetings. The method of informal consultation that was adopted was essentially an organic process which examined the following broad areas:

- the political arm of council;
- the administrative arm of council;
- the organisation as a system;
- processes and structures within council; and
- the capacity for HIA.

Consultations were guided by a series of exploratory questions (Appendix 12) which had been developed from the advice provided by the Reference and Working Groups, and the findings from the literature review, the key informant interviews and the focus groups. One week before the time of their scheduled consultation with the project team, each relevant staff member in each of the two case study councils was sent a summary of the major findings from both the literature review and the key informant interviews (Appendix 13). This summary was distributed to provide an introduction both to the concept of HIA and to the project.
3.3 Data Analysis

3.3.1 Literature Review
The information gathered from the literature was reviewed with a view to answering the following questions:
- Who has used HIA at local/regional government levels?
- What links are there to the broader agendas of government?
- What has HIA been used for (i.e. critical questions it seeks to answer)?
- How has it been used?
- What tools/approach was used?
- Any information on barriers/limiting factors or enablers?
- What lessons have been learnt? and
- What links are there to other forms of IA?

3.3.2 Thematic Analysis
Qualitative analysis of the key informant interviews and the focus groups was essentially a distillation of the major themes that emerged. To ensure that all the major themes were identified from the key informant interviews, six interview summaries were subjected to the process of triangulation by four members of the Working Group and the Deakin University HIA Research Unit team. No new themes were proposed as a result of this process and it confirmed that the thematic analysis had been accurate and comprehensive.

3.3.3 Analysis of Case Studies
In addition to the scheduled consultations with specific individual council staff or teams, daily visits to the council offices created opportunities for informal discussions with a range of council staff. After each consultation, the members of the project team jointly conducted a qualitative review of the discussion that had occurred. Each of the two researchers reported their interpretation of the staff member's comments, as they related to each of a series of the exploratory questions (Appendix 12), before a joint final analysis was prepared. Any incidental informal feedback from council staff and any other issues that had been raised during the consultations were also analysed for their relevance to the major exploratory questions. To complement these consultations, a number of council's relevant strategic planning documents were also analysed. Each council's MPHP was reviewed for any evidence of an integrated planning approach to municipal public health planning. In addition, the project team jointly reviewed council's non-health related planning documents for any mention of the word "health" or the determinants of health, and for any articulation of the links between the type of planning described in the particular document, and the public's health.
4. Results

4.1 What did the published literature tell us?

As the reports about the ten HIAs that had been applied in the UK provided the most detail regarding the HIA process, the analysis in this section will focus primarily on these HIAs and the lessons learnt from their application at the local government level. A separate review of the HIAs that have been reported in the Scandinavian literature, will conclude section 4.1

In the UK there is an acceptance at national and regional levels of the social determinants of health and the fundamental principles of HIA. Indeed, the present UK government’s commitment to addressing health inequalities and the wider determinants of health has led to a recommendation that HIA is undertaken on all major policies that may have a direct or indirect effect on health. This national focus has resulted in HIAs being conducted at local government or local authority level.

The ten HIAs that were applied in the UK had an overall objective of reducing negative impacts of a proposed policy/project and maximising positive impacts, and one or more of the following primary goals:

- To address and reduce health inequalities;
- To embed health into the decision-making process and to influence decision-making at an early stage in the planning of policies, strategies, projects, and/or programmes; and
- To assist in the development of a toolkit for application in future HIAs.

A review of these HIAs revealed a number of broad themes which will be discussed within a framework developed by Milner (2004) in an overview specifically relating to HIAs undertaken by Northumbria University with local authorities in the North-East of England. This framework identifies some of the practical issues related to embedding HIA into local authority business and highlights the following key aspects about the integration of HIA into mainstream local policy-making and planning activities:

- Local authorities as key settings for HIA;
- Defining ‘health’;
- What should be assessed;
- When should the assessment be undertaken;
- Who should undertake the assessment;
- Acceptance of HIA;
- HIA is time and resource intensive;
- Participatory approach provides unique qualitative data;
- Improved communication, relationships and understanding; and
- The importance of context.

4.1.1. Local authorities as key settings for HIA

The HIAs under review were predominantly commissioned and/or conducted by local government authorities, regional development agencies or assemblies, and local health authorities.

Milner (2004) states local government organisations are instrumental in controlling the determinants of health and are well placed to act as key agents for improving local community health as they are:

- democratically accountable;
- participate in a consultative relationship with local constituents;
• are key players in multi-, single-focus, and cross-cutting strategic partnerships;
• have community planning responsibilities;
• have a legal power of ‘well-being’;
• are often legally empowered to promote or protect public health through systematic action;
• have scrutiny functions;
• have responsibility for governance of social care; and
• are well placed to monitor and evaluate interventions aimed to improve health.

The above points raised by Milner (2004) frequently appeared in the discussion section of the reports of the reviewed HIAs.

4.1.2. Defining ‘health’

Difficulties were acknowledged in defining and understanding health, and health-related terminology, across different organisations and teams. This resulted in confusion around identification of health impacts and their links to particular policy, and in measurement and quantification of impacts. A need for operational definitions of health was highlighted, particularly in relation to extending an understanding of health beyond traditional clinical service provisions and delivery perceptions to include consideration of social inclusion and activities associated with improving well-being for all communities. Milner (2004) discussed the difficulty associated with the conceptualisation of health and suggests that a shared ‘negotiated’ concept of health is required across sectors, professional groups and individuals, and that variation in perceived importance of health influences needs to be acknowledged in the HIA process.

4.1.3. What should be assessed

Milner (2004) states policy makers and planners should consider potential positive and negative impacts (including health impacts) when developing and initiating new policies and proposals. In the case studies reviewed both potential positive and negative impacts were identified in policies and programmes associated with urban land use (with a focus on housing policy), transport strategies and regeneration, and health related service delivery methods, with an overarching goal of identifying and addressing health inequalities.

Milner (2004) pragmatically cautions that it is not practical for all policies and programmes to be subjected to an in-depth assessment and that initial screening of policies and strategies is necessary to prioritise proposals for assessment. A systematic process of selection is recommended to identify proposed activities for more in-depth analysis. Evidence of the development or utilisation of screening tools was found in the majority of HIAs under review and utilisation of such tools alleviated the pressure of time and resource constraints resulting in a ‘rapid appraisal’ model being the most frequently adopted assessment.

4.1.4. When should the assessment be undertaken

The utilisation of HIA as a vehicle for ensuring the long-term well-being of the population should be considered during planning and decision-making (Milner 2004). However, Milner asserts that HIA can be used at any point in the policy-making and planning cycle. All the HIAs reviewed were prospective in nature and a critical theme emerging from the majority of articles reviewed was the need for HIA to influence
decision-making at an early stage in the planning process, before too much time and resources had been invested in developing a policy.

4.1.5. Who should undertake the assessment

Milner (2004) discusses the argument concerning who should undertake an HIA: should decision-makers and planners at local level conduct HIA themselves or should HIA be undertaken by the more ‘objective’ external assessor/s. Milner asserts that while the first approach would more readily fit with a ‘rapid appraisal’ model due to time and resource constraints, it has been criticised as being biased and tokenistic. However, the second approach could become counter-productive as it may be technically difficult and resource intensive.

Milner proposes HIA is about engaging people with broad concepts of health, facilitating a process of health to become a ‘mind set’ within the authority, and about raising health awareness within an organisation. As such, Milner promotes the ‘internal’ approach for the rapid appraisal model with external assessors being used on more comprehensive, in-depth HIAs requiring a range of expertise that in-house staff could not be expected to have. Despite all the HIAs reviewed being rapid appraisals (with one ‘intermediate’ exception) they were usually carried out by external consultants who often worked in conjunction with health professionals, university research teams specialising in health inequalities and regeneration, and officers from the relevant local authority.

4.1.6. Acceptance of HIA

A perceived barrier to HIA is acceptance of the process by local authority staff. One assessor reported that making positive recommendations and displaying a positive and supportive approach to the proposal under examination was helpful in gaining acceptance of HIA as a useful tool. In an endeavour to convince staff of the value of the process, Milner states that ways of evaluating the implementation of HIA and its potential to add value to existing health-gain activities is required. In several case studies, a retrospective analysis of the HIA process was undertaken, and clearly identified overall benefits and positive aspects of the process. Ideally, a retrospective impact evaluation could be applied to a proposal that has been subjected to a prospective HIA and the accuracy of predictions made in maximising positive and minimising negative impacts determined (Douglas et al. 2001; Milner 2004).

4.1.7. HIA is time and resource intensive

The issue of the length of time required to conduct such impact assessments was raised in several reviews. However, the time invested was sometimes seen as time well spent because the HIA framework facilitated efficient discussion and decision-making which often, ultimately, resulted in net gains. Practical difficulties in involving the ‘public’ in the process were acknowledged by Milner (2004), particularly in relation to accessing individual and group stakeholders likely to be affected by the proposal. Milner states that the less time and resources available to the process, the less likely that a broad selection of lay stakeholders will be accessed. The in-house screening within a rapid appraisal process virtually rules out the chance of involving the public at all, undermining a fundamental ‘participatory’ principle of HIA. All case studies reviewed stated a participatory approach was adopted in the HIA. In accordance with Milner’s comment, however, the degree to which consultation was sought in the reviewed HIAs varied depending on time constraints and financial resources. Most impact assessments were based on ‘rapid appraisal’ models which were completed in between one day and four months.
4.1.8. Participatory approach provides unique qualitative data

A common theme emerging from the case studies was the focus on a participatory approach to data collection. This approach afforded assessors the opportunity to obtain all possible perspectives on potential health impacts of proposed policies, particularly when views and opinions were sought from those most affected by the proposed policy. The notion of ‘civic intelligence’ or ‘collective intelligence’ was suggested as a valuable product of this approach which challenged the ‘expert’ view (Elliott & Williams 2003).

The HIAs reviewed utilised both qualitative and quantitative data although quantitative-only assessments were often judged as most appropriate due to the large amount of time and resources required for elaborate qualitative assessments. One assessor raised a concern of the potential for quantitative assessments to ‘miss’ identifying health inequalities due to the ‘bottom line’ summing of statistical analyses which often removed differences between groups. The most common methods of data collection were in-depth key informant interviews (which may have been restricted to professionals with an interest in the policy under review, or extended to comprehensive community consultation with affected local individuals and community groups), open community meetings, small group/focus group discussions (often conducted within the framework of a rapid appraisal workshop held over a few days), and steering committee meetings with core members seconded for their professional and health related expertise. When qualitative data collection included interviews with affected individuals and groups who were able to describe their ‘lived experience’ of an issue or situation, the rich depth of information that was yielded often broadened an understanding of the links between health determinants and the proposed policies/strategies. As very little evidence often exists about how a proposal could cause a change in one or more of the determinants of health, such data is crucial in understanding the potential impact on the health of population groups.

4.1.9. Improved communication, relationships and understanding

Benefits of the HIA process as identified by Milner (2004) include ensuring a more coordinated approach by local authorities to tackling threats to health, the opportunity to promote more effective inter-agency work and the facilitation of the development of effective communication channels between local authority departments and local residents. Milner also mentions the ability of HIA to place health on the non-health policy agenda in local authorities. All of these benefits featured strongly in the majority of the case studies reviewed. In particular, mention was made of improved relationships between councils and local residents, between departments within organisations, and across sectors. Various agencies achieved a greater understanding of impacts and a heightened sense of responsibility.

4.1.10. The importance of context

A critical theme emerging from the HIAs reviewed was the importance of local context. The potential to adjust a policy being considered in order to maximise health gains was often critically dependent upon local factors. In particular, local knowledge and understanding of community power hierarchies and modes of communication, a respect for local ‘collective intelligence’, and an understanding of how local authority organisations operate were mentioned as important variables in the overall outcome of the HIA. The ‘inside’ perspective of local residents was valued by assessors and provided important contextual insights which often would not have emerged from traditional ‘robust’ data collection methods.
4.1.11. A Scandinavian perspective

A review of the literature about the application of HIA at local government level in Sweden, Denmark and Finland revealed two overarching factors influencing the use of HIA in these three countries. These two factors are their membership of the European Union (EU) and their engagement in the World Health Organisation (WHO) project on Healthy Cities.

Through their membership of the EU the three countries are all signatories to the Amsterdam Treaty. According to Hubel (STAKES 2004c p 4), the Amsterdam Treaty states that “a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities”. This provided sufficient justification for applying HIA to the policies of the EU, and highlighted to member states that population health can be affected by policies from all sectors.

Through their membership of the WHO based Healthy Cities Network, cities in all of the three countries have adopted the 2003 Belfast Declaration, which launched Phase IV (2003-2007) of The Healthy Cities project (Belfast Declaration, 2003; World Health Organisation 2004a). The Belfast Declaration states that political leaders must commit themselves to promote “health impact assessment as a means for all sectors to focus their work on health and the quality of life”. Currently the Healthy Cities Network is conducting a two-year project, “Promoting and Supporting Integrated Approaches for Health and Sustainable Development at the Local Level Across Europe” (World Health Organisation 2004b), which will result in the development of case studies of HIA at local level and an HIA toolkit, training module and resource pack. As a consequence of this project, it is envisaged that HIA should be, or should start to be, an integral part of the work undertaken in the cities that are members of the WHO Healthy Cities Network.

A review of the literature about the application of HIA at local government level in Sweden highlighted the need to understand the broader political context within which HIA is applied. Sweden has three levels of government, the national government, county councils, at a regional level and municipal councils, at the local level (Regeringskansliet 2004a). Although responsibility for health care is shared between the three levels of government, most work relating to public health is undertaken by county councils and municipalities (Regeringskansliet 2004b, Regeringskansliet 2004c). The national government is responsible for developing overall health and medical care policies, while the county councils are responsible for the provision of health and medical care, local transport, public roads and regional development. Municipalities are responsible for providing health protection, aged care, social services, housing, schools, employment and protection of the environment (Regeringskansliet 2004b).

Interest in public health issues at a local and regional level increased substantially during the 1990s and led to a commitment from leading politicians in both counties and municipalities to put health on the political agenda (Berrensson, 1998; The Swedish Association of Local Authorities and The Federation of Swedish County Councils 2001). This commitment resulted in the development of a regional public health program and the Swedish HIA tool (Appendix 14), which is now used in both county councils and municipalities. The tool is very well known internationally and includes consideration of social impact, environmental aspects and equality issues. The emphasis of the tool is on the distribution of health impacts across the population at local level (Berensson, 1998).
The current Swedish public health policy states that HIA is an important tool in public health and recommends that the National Institute of Public Health should continue HIA research endeavours (Regeringen 2002). The use of HIA is also an important requirement that is stipulated in the public health policies of several Swedish municipalities and county councils in Sweden (Arboga Kommun, 2003, p. 39; Falkenberg Kommun, 2004; Laholm Kommun, 2003, p. 18).

This review of the Swedish literature revealed that the process of HIA had put health on the agenda of government at the local level (Finer, Haglund and Tillgren, 2002, p.10). Some local authorities have adapted the Swedish HIA Tool to suit their local context while others have used the original tool. HIAs have been applied to a range of proposals, including proposed changes to the physical environment, external purchase of health care services and health care agreements with other county councils and municipalities. The students or civil servants who applied the HIAs reported that the application of an HIA did not intrude too much into their normal work time. An important success factor identified for these HIAs was close collaboration between civil servants and politicians. It was also strongly advised to avoid copying the details of other HIAs which had assessed a similar proposal (Finer, Haglund and Tillgren 2002).

A review of the websites of Swedish municipalities revealed that the Swedish HIA Tool is an integral part of their overall municipal policies or their Agenda 21 programs (Falkenberg Kommun 2004; Laholm Kommun 2003; Orebro Kommun 2001). The municipality of Helsingborg was the only municipality to provide HIA reports on its website. The seven reports that were available were all prospective HIAs which had been applied by public health students from Malmö University. The Swedish HIA tool was used to assess the impacts of a traffic strategy and several proposed physical changes in the city of Söder, on the health of children/young people and adults/elderly. Impact identification and appraisal was undertaken by means of a literature review, and one report noted that it was not always possible to find sufficient scientific information to support the analysis (Jalmgaard et al 2002 p 3). All of the HIAs considered the health impacts on vulnerable or marginalised groups, although community participation was not identified in any of the reports.

Similarly, a review of the literature about the application of HIA at local government level in Finland also required an understanding of that country’s broader political context. Finland also has three levels of government - a national government, several provincial governments and many local municipalities (Savolainen-Mäntyjärvi and Kauppinen 2000, Ministry of Social Affairs and Health 2004a). The Public Health Act of 1879 allocated responsibility for controlling health conditions to municipalities (Haapala et al 2004 p 4). Both primary and specialised health care services, including social welfare, are provided by local authorities. Health care centres are managed by individual municipalities or by a number of neighbouring municipalities in partnership (Konttinen 2004, Ministry of Social Affairs and Health 2004b). The current Finnish Public Health Programme has identified HIA as a “new challenge” for health professionals (Ministry of Social Affairs and Health 2001 p32).

According to Kauppinen (2002), Finland has a long tradition of environmental impact assessment. The 1994 Environmental Impact Assessment Procedure (EIA) Act stipulates that “impacts on human health, living conditions and amenity must be assessed” (Finland’s Environmental Administration 2004; Savolainen-Mäntyjärvi and Kauppinen 2000). However, a study by Välimäki and Kauppinen (2000), found that impacts on people were defined very narrowly, with health impacts being restricted to the impacts due to noise or emissions. One reason for the limited definition as postulated by Savolainen-Mäntyjärvi and Kauppinen (2000), is that perceived health
and perceived health impacts do not have “an established definition or place in the field of environmental impacts”. A study of perceived health impacts in EIAs by Savolainen-Mäntyjärvi and Kauppinen (2000) showed that it was difficult for EIA practitioners to distinguish between perceived health impacts and perceived social impacts. As a result, the term human impact assessment (HuIA) was proposed as a preferred alternative (Appendix 15). Integrating HuIA into local decision-making is now identified not only as a priority for the Network of Finnish Healthy Cities but also as an essential component of any Municipal Welfare Strategy. The National Research and Development Centre for Welfare and Health (STAKES) and the Finnish Network of Healthy Cities (STAKES 2004a; STAKES 2004b) jointly manage the development of suitable methods by which HuIA can be applied at the local level. Additionally, the Finnish Building Act states that “significant social impacts resulting from land use plans must be assessed in conjunction with town and regional planning” and that “alternative solutions and their human effects should be examined” (Kauppinen, 2004).

Descriptions of six HuIA were found on the STAKES website but only three of these (Kajaani, Kerava and Turku) provided sufficient detail to be reviewed for this project (Appendix 16). It was found that all three HuIAs had been used in local decision-making, and each had provided decision-makers with comparisons of the human impacts of three alternative scenarios, accompanied by appropriate recommendations. The HuIA methods were not specified but it was noted that each HuIA was a prospective assessment that utilised both quantitative and qualitative evidence. Although community participation was identified as an important part of the HuIA tool, the participation process was not described in detail in any of the reviewed HuIAs.

4.2 **What did we learn from Key Informants?**

4.2.1 **Health Impact Assessment Experts**

The following themes emerged from the interviews with key informants who have experience in applying HIA at local government level:

- The word ‘health’ has many meanings;
- Champions, allies and leaders are crucial;
- Resistance to HIA is due to confusion or fear;
- Organisational characteristics need careful consideration;
- Building capacity for HIA is crucial;
- Legislating for HIA can bring both gains and losses;
- Positioning HIA requires careful planning;
- The first HIA will determine its ultimate credibility; and
- Applying HIA in local government can bring many benefits.

4.2.1.1 **The word ‘health’ has many meanings**

HIA assumes a very broad definition of health that is underpinned by the social model of health, a model which is not well understood outside the public health sector. The determinants of health is a concept created by public health institutions and may not be the terminology that is understood by those working on similar issues in other sectors, such as social justice and community development. Professionals in traditional health care services do not see the value of HIA to them, as their work is essentially based on a medical model of health.

At a local government level in many countries, the word ‘health’ elicits many different reactions amongst councillors, council staff and the community. With the exception of
councillors who have a particular interest in health matters, most would question
council’s role in addressing any issues related to the social determinants of health.
This attitude is widespread despite the origins of local government itself being
intricately linked with many important public health issues that are associated with
living in urban environments. Councils’ workforce comprises both non-professional
and professional staff, many of whom believe health to be the responsibility of
council’s public health department or external professionals such as doctors, nurses
and allied health practitioners. These staff members often do not understand the
health impacts of their own work and do not routinely work in multi-disciplinary teams.
Most community members perceive local government’s role in health as direct
service provision and are not aware of council’s increasing role in addressing the
determinants of health.

4.2.1.2. Champions, allies and leaders are crucial
The voluntary introduction of HIA into local government will require a powerful
champion, ally or leader, either from within the organisation or from an external
source. Internally, it will be important to seek commitment to HIA from at least one
staff member who occupies a senior position and who can drive this new concept
across the entire organisation. This commitment could come from a councillor in the
form of public statements promoting HIA or from a senior manager who can support
HIA by providing resources, staff time and training opportunities. If no leader
emerges naturally within a council, there may be a need for leadership development
within that council or for an extensive search to find an HIA champion in an
organisation external to council. Such external champions may be political leaders in
other levels of government, leaders in local government or professional associations,
powerful figures in the social justice field or prominent community activists.

4.2.1.3. Resistance to HIA is due to confusion or fear
As HIA is a new concept within the local government sector, there is usually much
confusion about its relevance and fear about the consequences of its application.
Some council staff may be confused about the difference between HIA and risk
assessment, while others may question the type of evidence utilised in the
application of HIA. Some staff members in positions outside the health area may
challenge the need to learn new knowledge about, and develop new skills in, an area
that they may perceive to be outside their professional responsibility.

Some councillors may be afraid that HIA will not offer tangible benefits for them or
their community. Others may be afraid that HIA could be politically unpopular and
may not want to hear the evidence that could potentially be raised by an HIA.

Council’s directors may be afraid that HIA will raise legal barriers for new
developments in the municipality and so will affect the revenue that council generates
by means of new development planning permits.

Council managers may be afraid that HIA will increase staff workloads and impact
negatively on their budgets, whilst interfering with their ability to meet council’s
objectives. There may also be concerns that HIA will affect their department’s
priorities and targets, and will not fit into their current management processes and
structures.

Council’s urban or development planners may be afraid that HIA will get in the way of
their planning practice and will not fit into current planning requirements, particularly
planning cycles and planning processes. They may also be concerned that HIA will
add extra work to their current heavy workload without adding any value beyond that
which other impact assessments currently provide. Finally, there may also be a covert concern that the area of planning which they have traditionally dominated will be colonised by health planners.

4.2.1.4. Organisational characteristics need careful consideration

The successful introduction of a new concept such as HIA into local governments will depend on a range of organisational characteristics, many of which are associated with the council being a bureaucracy which operates by means of numerous systems and employs many people from different professional backgrounds. One council may be more ready than another to introduce HIA due to a confluence of factors that may appear at a particular point in time. A study that is currently being undertaken in the UK, is exploring the concept of “indicators of readiness” for HIA as a means of developing tailored modes of capacity building for HIA in the local government sector (IMPACT, 2004).

All councils comprise numerous departments or divisions or branches that coexist in one organisation as very separate silos. Some councils have begun to create links between their silos by encouraging multi-disciplinary teams and by undertaking integrated planning. Other councils are bound by bureaucratic tradition and maintain the separation of departments and the staff within them. As the application of HIA will require collaboration between council staff from each of the different departments that are responsible for different determinants of health, the more bureaucratic councils will not accommodate HIA easily.

The organisational culture of a council will also have a strong influence on the introduction of HIA. A council that supports long-term social planning and has a strong focus on improving health and wellbeing for the whole community will perceive the concept of HIA quite differently to a council with a different focus. A council that encourages continuing professional education for all staff and that ensures that all its decisions are based on evidence will see value in HIA that other councils may not.

The position of the public health planner within council’s organisational structure may indicate the status that is allocated to public health matters within the organisation. The usual proponents of HIA are public health planners who do not occupy positions of power within a council. Their position in the organisational structure in relation to those who make key planning decisions within council, will give some indication of the amount of lobbying that will be required before introducing HIA into the organisation. As strategic or development planners have traditionally had exclusive power over the development plans that are submitted to a council, their position in the organisational structure relative to the health planners’ will also be highly significant.

Whether or not a council has clearly articulated its role in “health” will be of major importance if HIA is to be successfully introduced into that council. Staff who work in areas of council that are not traditionally related to health, such as transport and infrastructure, may already have a clear understanding of the public health implications of their work, if they have received education about the broad definition of health. Staff in these councils will grasp the concept of HIA more easily than staff in councils that are not clear about their role in health or believe that council has no role to play in this area.

Other collaborative decision-making processes that assist in planning a healthy city, may be already occurring between council’s public health staff, local agencies and community members. In one city in the USA, a number of local organisations,
including the city council, have developed a shared vision of what a healthy city would look like, and have attempted to predict how local land use planning initiatives could impact on the dimensions of this healthy city (NACCHO, 2005). As a result, policy changes have been recommended and issues which require ongoing monitoring have been identified. Although not labelled as an HIA, the outcomes of this process bear a strong resemblance to HIA, and it would be inappropriate to introduce HIA into the daily work of such a city council.

All councils will have developed various systems that ensure the smooth operation of the organisation. These systems will need to be examined before HIA is introduced to ensure that HIA can easily be accommodated into a council’s existing structures and processes. The systems of management, resource allocation, internal and external communication, reporting, monitoring and evaluation, are just some of the areas where HIA may need to be incorporated. Council’s strategic planning and policy development systems are of particular relevance to the introduction of HIA, and it will be crucial to understand how planning and policy decisions are informed, how and when evidence is used, if council undertakes its own research, and how and by whom planning and policy decisions are made.

Ultimately, council staff will be responsible for adopting and applying HIA within local governments and their situation must be examined carefully. The initial acceptance of a new concept such as HIA by staff from across the organisation will depend on whether or not they have recently experienced any period of extensive change within their workplace. A period of relative stability within council will be required before staff can comfortably contemplate the introduction of any new concept. As HIA will require staff to work across departments and in teams, councils that have created opportunities for staff from different departments to meet both formally and informally, will be able to introduce HIA more easily than those councils where such opportunities do not exist. Similarly, councils that facilitate the development of strong relationships and networks both within departments and between departments will be better equipped to introduce HIA.

4.2.1.5. Building capacity for HIA is crucial

When contemplating the introduction of HIA into local government, it is crucial to acknowledge the need for capacity building across the entire sector, at both an organisational and an individual level. Very few councils will have any position descriptions that include responsibility for the application of HIA and very few council staff, other than some health planners, will have any understanding of HIA and its use in local government.

Engaging a local government association to fund HIA education and training programs for council staff and commissioning HIA specialists, such as a university HIA research unit, to develop and deliver such education and training, are examples from Wales of successfully working in partnership to build capacity for HIA in the local government sector. The best approach for HIA education and training is “learning by doing” which comprises a combination of workshops, undertaking pilot HIAs and analysing local HIA case studies. Some council staff, who may attend these programs, could discover that their current skills may partially equip them to apply HIA.

It has been suggested that in the future, developers could be persuaded to apply HIA to their proposed developments, and promote this fact as a new and innovative method to gain market advantage. Alternatively, councils could require developers to apply HIA as part of their applications for planning permits. In either scenario, a
program of HIA education and training would be required for both public and private developers. Councils would be the obvious provider of such a program, and would need to allocate resources for its development and delivery. A very practical developers’ HIA toolkit, containing a clear explanation of HIA and a set of simple guidelines about when and how to apply HIA to development proposals, would also need to be produced. Council’s development planners would require specific training to ensure that they could effectively and efficiently assess these new applications.

4.2.1.6. Legislating for HIA can bring both gains and losses
During the past few years, a number of legislative requirements for the application of HIAs have appeared in Europe. In July 2004, a new European Union directive was passed which requires local governments in EU Member States to apply HIA as one component of a broader impact assessment, the Strategic Environment Assessment. In the same year, a White Paper, Choosing Health, was released in the UK and mandated individual HIAs as a component of Regulatory Impact Appraisals. During the past two years, new local government legislation in Wales has mandated the use of HIAs as part of the development of Municipal Health and Wellbeing Strategies. As yet, the ramifications of this legislation are not well understood, but there will undoubtedly be implications for the local government sector. It is envisaged that there will be a need for local government to change their attitude towards HIA, to begin to develop new HIA tools and to commence a capacity building program across all councils. One benefit of such legislation is the fact that both the national and local governments will be obliged to fully or partly fund HIA education and training for council staff. However, with this legal requirement for the application of HIA comes the possibility that HIA could become merely a checklist which is not accompanied by the desired change in thinking about health and the determinants of health across the local government sector.

In the USA, there has been some discussion about including the application of HIA as a “piggyback” clause in the current EIA legislation which controls land use and transportation. However, in following this path, there is a possibility that the application of HIA could be restricted to new development projects in land use and transportation, rather than being applied more widely to programs and policies with potential impacts on other determinants of health.

Some HIA practitioners foresee the development of an all-encompassing “ecological” impact assessment tool that would be mandated and would accommodate a wide range of impact assessments to better inform government decision-making.

4.2.1.7. Positioning HIA requires careful planning
Before building capacity for HIA, it would be advisable to slowly introduce the concept of HIA across the local government sector and into each individual council. Staff in all work areas of a council will need to be engaged by a range of multi-level strategies including:

- Target councillors separately to council’s administration staff, to seek both their commitment and their support.
- Make personal contact with colleagues in council’s planning areas, with the aim of developing new working partnerships.
- Establish accessible and ongoing channels of communication about HIA across the organisation.
- Develop a marketing strategy for HIA that could include:
  - creating excitement about HIA;
  - raising awareness about HIA amongst councillors, council staff and the community;
seeking sponsorship for HIA awareness raising events, such as local government or professional associations;
- ensuring everyone is “on the same page” about the relevance of HIA for that council; and
- providing accessible and appropriate information about the benefits of HIA.

After this preparatory work, there will be a need to develop constituency surrounding the concept of HIA, and to create a small HIA team with sufficient time to dedicate to promoting and supporting HIA. However, sustaining the voluntary application of HIA in that council will ultimately require the creation of a new corporate culture in which “health” is integrated into council’s planning processes. One innovative mechanism that could assist this process is the inclusion of an explicit requirement for the application of HIA, accompanied by appropriate annual targets, in a council’s business plans. Another novel idea that has been tried in one local government in Wales is the development of a position description for a senior manager that includes an explicit requirement to encourage and facilitate the application of HIA within the organisation.

An HIA implementation plan that describes both short term and long term objectives, would allow time to find answers to the following important questions:

- What issues do councillors care about? How could HIA add value to these?
- What are some suitable entry points for HIA within this council? (e.g. other impact assessments or risk assessments)
- What are some proposals to which an HIA could be applied in this council? Can an HIA demonstration model be developed?
- How could a new understanding of council’s role as a “health improvement” agent be introduced in this council?
- How could “health by stealth” be introduced within this council? (i.e. developing a new understanding amongst council staff of how their work can be aligned with council’s municipal public health plan).

4.2.1.8. The first HIA will determine its ultimate credibility

Council’s decision-makers will be convinced of the value or otherwise of HIA by the process and the outcome of the first HIA that is applied in their council. Therefore, the first HIA should be undertaken in partnership with a range of council staff and with HIA experts who can provide training and support for council staff. It is important to avoid an adversarial approach to HIA and to communicate with council’s directors, managers and officers during each step of the HIA to allay any fears as they arise and to engender confidence in the HIA process. Internal discussions about council’s capacity, commitment and strength to deal with any controversial recommendations that may emerge from the HIA, should occur before the HIA is undertaken. Similarly, the issue of funding, both to allow staff the time to apply the HIA and to engage external sources of support, will need early consideration.

The proposal, to which the first HIA will be applied, should be chosen carefully. HIA should not be applied when sufficient evidence exists about all the health impacts of the particular proposal or when a decision has been made and there is little chance of changing it. Nor should it be applied when an initial screening of the proposal reveals no potentially significant health impacts. The proposal should be important enough to both councillors and the community, especially communities whose perspectives are often excluded from public debates. Concurrent HIAs are best avoided at this early stage, as they can be perceived as criticism and could stagnate
in an emotional quagmire. Very politically sensitive proposals are also best avoided unless council is ready and able to face controversy.

The type of HIA that is best suited for application in local government is a rapid, prospective HIA that adequately addresses the issue of health inequalities, and that facilitates community participation whenever possible. Interestingly, preliminary data from the WHO European Commission study which is currently being conducted to map the use of HIA and to evaluate its effectiveness, has shown that HIAs which have been applied to date in 14 EU Member States have addressed health inequalities only superficially and have included community participation only occasionally (Wismar, M., 2004). Although desirable, it appears that these two characteristics of HIAs may not always be possible due to the complexity of the task as well as time and resource constraints.

The HIA tool must be adapted to the specific council and the local context, and should not compromise development severely. It should be easy to use, quick to complete and should show “hard” effects (eg cost-benefit trade-offs). The recommendations that arise from the HIA must be agreed, practical and valuable to the council and its community. The final steps of the HIA, monitoring and evaluation, should not be forgotten, as valuable lessons can be learnt for the future application of HIA within that council. An external agency such as a university can be commissioned to plan and undertake these final steps.

4.2.1.9. Applying HIA in local government can bring many benefits

The application of HIA to programs, projects and policies in local government have brought the following benefits to the council as a whole, to council staff and to the community it serves:

- Provided a systematic method of assessing health impacts;
- Improved on EIAs’ consideration of health impacts;
- Supported intersectoral work;
- Created new knowledge;
- Encouraged sharing of local data and other research findings;
- Was used in arguments by councillors and community members to promote health in a municipality;
- Provided a way of engaging the community;
- Increased open and transparent decision-making within council;
- Was an aid to council’s decision-making;
- Provided a way of developing better public policies;
- Changed policy decision-making within council;
- Created a shift in thinking amongst council’s decision-makers;
- Created new relationships across council;
- Provided a tool by which to build public health capacity in local government; and
- Was promoted as one way that local governments can assist the national government, to curb the rising cost of health care.

4.2.2 Victorian Local Government Experts

Themes one to seven that were discussed in the previous section also emerged from the interviews with local key informants and their comments did not introduce any new information. However, this group of informants identified specific issues that pertain to the Victorian local government sector. Six additional themes emerged from the analysis of these issues:

- Public health planning is not well coordinated in Australia;
• The relationship with State Government is strained;
• There are many demands on Victorian local governments;
• The quality of planning in local government is inconsistent;
• The Victorian local government sector is quite diverse; and
• The issue of ‘health inequalities’ is not on the agenda.

4.2.2.1. Public health planning is not well coordinated in Australia

Public health planning is currently not well coordinated between the three levels of government in Australia. As a result there is much confusion about the respective roles and responsibilities of each level of government in this area of planning. As the meaning of public health has broadened to encompass the social determinants of health, there is even greater confusion surrounding the jurisdictional boundaries that define each government department's area of influence. Any requirement for the application of HIA in one level of government only, will achieve very little in the long term, if a shared vision for HIA is not created by key stakeholders at all levels of government. This vision would need to be accompanied by a plan to synchronise public health planning across government departments at each government level and the joint development of a model for HIA.

The growing awareness of the social determinants of health by council staff in the environmental field is blurring the boundaries between environmental planning and public health planning. Some councils in Victoria have embraced the similarities between planning in these two sectors and have adopted innovative approaches such as Local Agenda 21. Other councils do not perceive public health planning as politically useful for them and have chosen to keep it very separate from council’s other planning responsibilities.

4.2.2.2. The relationship with State Government is strained

Over the past thirty years, the main focus of local government’s role has shifted from providing services related to property to providing services for people. This change has been driven by the increasing number and range of state government programs which require local implementation by councils. Councils’ revenue base is no longer dependent solely on rates from local residents and local businesses, but now also relies on funding from the state government. Although substantial new monitoring and reporting responsibilities have accompanied this program funding, much local data that is collected by council staff, is not readily accessible to the local government sector. A history of minimal dialogue has developed between some sections of these two levels of government and there is considerable scepticism within the local government sector that any new state government initiative will be a means of promoting the state government’s own policy agenda, rather than a way of enhancing local government’s ability to meet the needs of their community.

Considerable tension also exists between councils’ capacity and their obligations to the state government and to their community. The Victorian local government sector as a whole is suffering from "mandate fatigue" as more legislated requirements are being imposed by the state government. This fatigue is augmented by the pressure of "unfunded mandates". All councils would be eager to eliminate cost shifting and many have expressed a desire to collaborate with the relevant state government departments towards an agreed solution.

In matters directly related to land use planning, Victorian councils are uncomfortable with the fact that they do not have complete control of their planning decisions. Under the provisions of the Victorian Planning Provisions (VPP), the State Minister for Planning and/or the Victorian Civil and Administrative Tribunal (VCAT) can override
councils’ planning decisions, if these are challenged by any individual or group, including the State Government itself.

4.2.2.3. There are many demands on Victorian local governments

In addition to the myriad requirements from the State Government, Victorian councils must prioritise often competing demands that arise within their own municipality. The introduction of HIA may not rival the importance of other priority issues that exist in a particular council at a particular point in time.

The geographic location of a particular municipality and its demographic composition will often dictate council’s priorities. The recent “sea/tree change” phenomenon that has been occurring in some regions of Victoria has created huge challenges for some small rural councils that are experiencing strong pressure from rate-payers to maintain current rate levels. Replacing ageing infrastructure that was designed to serve a much smaller population will be a major priority for a council having difficulty meeting the day to day needs of an increasing population. Planners working in these councils will be inundated with applications for planning permits and will not have the time or the energy to devote to learning about a new concept such as HIA. Many small councils in these regions are struggling to find the right balance between responding to the pressure from powerful developers and listening to rate-payers who want to preserve the characteristics of their town and the surrounding natural environment.

A council’s priorities are also influenced by the business focus of the organisation, which is usually determined by its executive team in consultation with the councillors. The professional background and interests of its CEO and senior managers could guide a council to follow an economic development mission or to strive for social justice and community strengthening. Every four years, a range of new interests and new perspectives are added to this mix when each new councillor brings their constituents’ wishes to the council chamber.

In Victorian local governments, health–related issues are rarely part of a councillor’s election platform. On the rare occasion that this may happen, a window of opportunity may open and HIA awareness raising sessions will engender strong support for HIA. However, at the next election this councillor may not be returned, and another HIA champion will need to be found if the interest in HIA is to be sustained. Although some new councillors may be interested in receiving education about HIA, the executive managers may be loathe to spend council’s meagre resources on councillor education programs that will need to be repeated with each new intake of elected members.

4.2.2.4. The quality of planning in local government is inconsistent

The legislation which controls the many and varied planning responsibilities of Victorian local governments, does not articulate the appropriate standard that is to be applied when undertaking strategic, social, community, public health or business planning in local government, or the sanctions if such planning does not occur. Therefore, councils’ planning efforts are not consistent across the sector. If State Government departments now require planning of a higher standard from the local government sector, they will need to fund appropriate initiatives to facilitate this change within Victorian councils.

4.2.2.5. The Victorian local government sector is quite diverse

The seventy-nine councils that comprise the Victorian local government sector have evolved into very different organisations since their formation during the years of the
previous State Government. Some have embraced innovative business models, and have developed understanding, interest and capacity to undertake a range of planning activities at a local level. However, not all Victorian councils have been able to follow this path and many are struggling to meet the State Government’s demands for high quality strategic planning documents. Not all council planners have participated in modern urban planning education and training, as some may have been promoted to senior management from earlier positions as town clerks.

Some more progressive and well-resourced councils have moved from their traditional areas of responsibility in environmental health and public health, to broader models such as Local Agenda 21 and the social model of health. Some councils with large social planning departments are already considering the social and health impacts of their work and have devoted considerable time to embed integrated planning across the organisation and to develop a common language in policy development and planning. However, not all Victorian councils have integrated structures and processes, nor do they facilitate regular and effective communication and collaboration between council staff in different departments. Many rural councils do not have the skill base, staff numbers, financial resources or access to evidence that would be required to undertake any new initiatives such as HIA. The introduction of HIA into such a diverse sector will need to be underpinned by flexibility to allow each council to accommodate HIA as they desire or as they are able.

4.2.2.6. The issue of ‘health inequalities’ is not on the agenda

Although it is acknowledged that the issues of “health inequalities” should always be a component of any HIA, the term “health inequalities” is not commonly heard in the Victorian local government sector. However, council staff working in the fields of community building and community strengthening, have similar goals of access, equity and social justice, and senior managers in councils whose municipalities contain areas of disadvantage are very aware of inequalities in their community.

4.3 What did we learn from Victorian local government staff?

4.3.1 Regional Focus Groups

All of the themes that emerged from the key informant interviews were apparent in the analysis of the focus group discussions. However, participants in these groups provided a number of particular insights related to these themes from their unique perspective as council staff:

- The word ‘health’ has many meanings

Although the major health issue that community members identify is a lack of health services in their municipality, some community members are becoming increasingly aware of the broad determinants of health. Within the local government sector, health is often understood as ‘wellbeing’ or a ‘lack of illness’ and many council staff and councillors don’t understand the health impacts, direct or indirect, of their day to day work.

HIA may be more easily embraced within the Victorian local government sector if the word ‘health’ is replaced with a word that better represents the focus of HIA (eg community, liveability or wellbeing). HIA would then be perceived as everyone’s responsibility rather than solely the responsibility of the health services branch within a council or the doctors and nurses in hospitals.
There is considerable misunderstanding and confusion about the social model of health within the local government sector. Some councils may perceive this broadened definition of health as a potential source of liability. Others may question the extent to which a council can actually influence the determinants of health beyond merely advocacy, as the state and/or federal governments are the major decision-makers in the areas of housing, employment and transport. Before introducing HIA into local government, the DHS should promote a better understanding of the social model of health at both local and state government level, and the ways in which local government could play a role in determining population health.

- **Champions, allies and leaders will be crucial**
  The introduction of HIA would require a champion or driver either within council or from outside the organisation. Each work area of council could include an HIA champion to assist with coordination of HIA initiatives across the organisation.

- **Resistance to HIA will be due to confusion or fear**
  This new style of municipal public health planning that is underpinned by an expanded definition of health, is still new and confusing for many councillors and council staff. Council’s managers are afraid that HIA would increase workloads and impact negatively on their budgets.

- **Organisational characteristics will need careful consideration**
  The conditions that exist within some Victorian councils would favour the introduction of HIA, while conditions in other councils would present a hostile environment to such a new concept. These conditions are the result of many factors which need to be examined before HIA is introduced across the whole local government sector.

Council staff with responsibility for municipal public health planning are not usually in positions within strategic planning teams or corporate management teams. From their lower positions within the organisational structure, many health planners have become frustrated with council’s senior managers who repeatedly dismiss or disregard any attempts at putting health on council’s agenda. Half of the councils represented in the Focus Groups, reported that their councils did not have “health” on council’s agenda nor had they established internal networks and communication channels between health planners and urban planners. Most councils represented did not have integrated planning structures and processes.

Since the introduction of MPHPs into local government in 1988, only a few councils have elevated these plans to the status of major strategic plans which direct the organisation’s strategic directions. A smaller number again, have made reference to health and wellbeing in several other strategic plans which focus on issues such as transport, walkability, services and infrastructure.

The following pre-conditions would need to exist within a council before HIA could be successfully introduced:

- Organisational culture with clear and open articulation of and commitment to council’s role in “health and wellbeing”;
- Commitment of time to develop a common understanding of the word “health” across council;
- Commitment of time to build strong relationships between staff from council’s health and non-health departments;
- Methods for regular formal and informal communication between all council staff, such as cross-functional work teams;
• Well-coordinated planning activities across council; and
• Organisational structure that allows council staff from any department to contact council’s decision makers.

- **Building capacity for HIA will be crucial**
  As there is minimal understanding of HIA and its use within the local government sector in Victoria, there will be a need for programs to raise awareness and build capacity. Before such programs are developed, the issue of funding will need to be discussed with the local government sector. This would include funding for the development and delivery of such programs and funding for replacement staff when other staff members participate in them. Any such programs will need to provide a range of options and opportunities to allow councils to choose those which are most appropriate for their staff and their organisation. To effectively target the many different groups within council, such programs will need to use appropriate language for the community, councillors and council staff respectively. Simple explanations of the social model of health will need to precede any education and training about the application of HIA to local proposals. Some councils may be persuaded to establish a new position within council with responsibility for HIA.

If developers were to be convinced to apply HIAs, each council would need to provide a simple and user friendly developers’ toolkit which reflected its own agenda and the social and environmental conditions in its municipality. Council could also consider rewarding those developers who included an HIA in their development application (e.g. by refunding the developer application fee).

- **Legislating for HIA will bring both gains and losses**
  Past experience indicates that legislating for the application of HIA in local government could be advantageous. Whenever the State Government has introduced a legal requirement for councils to undertake new work, it has provided extra resources to assist the entire local government sector. This method of introducing new work into the local government sector seems to be successful as it provides both “sticks” in the form of legislation, and “carrots” in the form of resources.

On the other hand, if HIA were to be mandated in the new Victorian Health Act, which currently requires councils to develop MPHPs, HIA could suffer from similar problems that have been associated with these plans. Namely, the confusion that surrounds the word “health”, could lead council staff members in non-health areas of council to perceive HIA as the sole responsibility of council’s health planners, rather than a whole-of-council responsibility.

- **Positioning HIA will require careful planning**
  Rather than introducing HIA as a new, stand alone initiative, council managers and staff would understand the relevance of HIA if it were promoted as one of a series of linked initiatives that have recently been launched in the local government sector (e.g. Leading the Way and Environments for Health). If possible, the concept of HIA will need to be associated with the word “corporate” to engage senior council staff and within each council, there will be a need to find levers that could facilitate the entry of HIA (e.g. a research unit, a social planning department or a high level, multi-disciplinary committee with credibility across council). Any correspondence from the DHS that pertains to HIA will need to be printed on paper with the letterheads of a number of State Government departments, to indicate that HIA is of relevance to the whole of council not just to council’s health services’ branch.

The development of an HIA marketing strategy will be crucial, with careful consideration being given to the timing, the delivery and the messenger. As
councillors are very sensitive to any demands from their constituents, specific HIA promotion and education should target community members. HIA Toolkits comprising local case studies will also need to be developed specifically for Victorian councils.

A number of awareness raising events should target key staff within council and should highlight the benefits of HIA, particularly:
- a saving to council;
- what won’t happen if HIA is not introduced to council (similar to risk management concept);
- an improvement in council’s planning and decision-making;
- a contribution to continuous improvement; and
- a better way of doing council’s business.

When preparing to undertake the first HIA at local government level, there will be a need to seek funding to pay for replacement staff when council staff apply the HIA. Funding may also be required to access sources of evidence that will be used in the first HIA. As this evidence will be presented to the community, councillors and non-health council staff, it will need to be very clear and the method of weighting health impacts will need to be transparent. To sustain the application of HIA within the local government sector in the future, HIA will need to be embedded into other local government planning processes (e.g. Council Plan, MPHP or MSS).

- There are many demands on Victorian local governments
The political reality of Victorian local governments is that councils’ priorities change over time and the introduction of HIA will need to compete with the priorities of the moment. Councillors, who may be potential HIA champions and who could strongly support this concept, may not be re-elected at the next four-yearly election. Senior managers, who favour economic arguments above all other evidence, may be able to exert more influence when these HIA champions are no longer in power. Other factors that could influence council’s priorities include:
  - pressure from powerful developers;
  - the “sea change” phenomenon, which increases the workload for council’s planners;
  - pressure from different state government departments to develop more plans and more reports, each with their own planning cycles and reporting requirements; and
  - more projects with short-term state government funding that result in ultimate "cost shifting".

- The Victorian local government sector is quite diverse
The best entry point for HIA and the best staff position to drive HIA will vary between councils because Victoria’s 79 councils have evolved into very different organisations. Some councils have developed a Social Justice Charter and a Bill of Rights and as such will not be receptive if HIA is imposed upon them.

- The issue of ‘health Inequalities’ is not on the agenda
Although some councils are acutely aware of vulnerable groups in their community and have a good understanding of the impacts of social-economic disadvantage, the term ‘health inequalities’ is not commonly used in the Victorian local government sector. This is not surprising as the State Government’s Neighbourhood Renewal programs have been specifically developed to address this issue and there is currently no requirement for local government to take responsibility for this area.
4.3.2 Case Studies

The two case studies highlighted the vast diversity that exists within the Victorian local government sector and provided valuable information about the different roles that HIA could play in two very different councils. Obviously, no generalizations can be made about the other 77 councils across the state, but the contextual features have provided an informed prologue to further discussion about the potential positioning of HIA in local government in Victoria.

Consultations with councillors and council staff in each of the two case study councils reinforced the themes that had been identified by key informants and focus group participants, and introduced particular perspectives on several of these themes.

- **The word ‘health’ has many meanings**

  The understanding of health varies both between and within these two Victorian councils. Although councils’ MPHPs may articulate the broadened definition of health and describe an integrated approach to municipal public health planning, an examination of their MSSs and their CPs respectively, paints a more accurate picture of the understanding of health across the organisation. Evidence of a discussion about the links between land use planning and the public’s health indicates that a council has transformed the rhetoric into action. Some councillors and some council staff, particularly those responsible for social planning, community development, children’s services or support services have a good understanding of the social model of health and of the factors within their community that impact on health. However, other councillors and other staff perceive health to be limited to the medical model of health which has a focus on health services rather than healthy communities. Although senior managers within council, many of whom have engineering qualifications, may believe that they do consider health impacts in their work, it would seem unlikely that they have been exposed to education about the social determinants of health, as this information has not traditionally been a component of professional engineering courses. Planning managers, who state that their planning staff are already aware of the health impacts of their work, do concede that there is a definite gap between what planners know about health issues as they relate to land use planning, and health issues as understood in the social model of health. The word ‘health’ as it appears in HIA, is particularly confusing in the local government sector and the word ‘community’ may be more clearly understood by council staff from the non-health sector.

- **Champions, allies and leaders will be crucial**

  Although there is minimal understanding of HIA within the local government sector, potential champions for HIA could be found amongst some councillors or within council work areas responsible for social planning, resident support services, community planning, community building, business support services or urban design.

- **Resistance to HIA will be due to confusion or fear**

- **The relationship with State Government is strained**

  A major source of resistance to the potential positioning of HIA in Victorian councils is a fear of cost shifting, which is underpinned by long standing suspicion or scepticism about State Government initiatives. HIA may not be welcomed in a poorly-resourced council that is struggling to find a balance between meeting its corporate objectives, encouraging development of the municipality, coping with the “sea change” phenomenon and addressing the issue of deteriorating infrastructure. Equally, it may not be greeted warmly by a well-resourced council that has experienced considerable frustration with State Government departments which
ignore council reports about the growing and changing needs of its municipality.

- **Organisational characteristics will need careful consideration**

While there appears to be an understanding amongst some councillors that local government’s role has changed from providing products to providing services, others, particularly those in rural areas, may hold a strong conviction that their council has more urgent priorities than dealing with what they perceive to be welfare issues. Similarly, although local government’s role in health-related matters has changed and extensive guidance has been provided by the State Government’s *Environments for Health*, this new role may not have been clearly articulated in all Victorian councils. Consequently, many staff from the non-health work areas of council, particularly those who are currently feeling over-worked as a result of the “sea change” phenomenon, are confused about their role in determining the public’s health.

This lack of clarity about a council’s role appears to be intricately linked to its ability to have created a definitive organisational culture during the ten years since the Victorian local government amalgamations. Some councils may have resisted moving into new areas of responsibility and learning from the past, choosing not to use evidence to substantiate arguments or inform decision-making. With no clear direction from senior management or councillors, some council staff may have opted to create their own culture which is often very different to other work areas within the same organisation, thus reinforcing the separation of each bureaucratic silo. Such councils may be unsure how to handle change and may adopt an adversarial approach when confronted with rapid population growth and an upturn in the local housing market. In contrast, other councils may have embedded a strong commitment to managing council’s business very soon after the local government amalgamations, and may have encouraged council staff to undertake extensive education and training (e.g. MBAs). The CEO in each Victorian council appears to play a pivotal role in shaping his or her council’s culture and the values that underpin it; values such as evidence based decision-making, outcome focused business management and learning from past mistakes.

Another legacy of the local government amalgamations is the degree of strategic planning and systematization that has evolved within a council over the past ten years. Some councils appear to have avoided the introduction of integrated strategies, processes, structures and frameworks, choosing to develop only those elements that are legislated requirements, such as the MPHP, the MSS and more recently, the CP. Others have embraced the opportunity to develop a range of mechanisms to control council’s work, with extensive reporting, monitoring and evaluation processes such as business unit plans, continuous improvement plans, TBL reports, risk management plans, council scorecard and key performance indicators. The value that HIA could add to the business of a council which has few systems or strategic plans may be more difficult to describe and the levers for its introduction may be more difficult to find.

Equally related to a council’s culture, is a council’s desire to break down the barriers between its silos and its commitment to do so. Although most Victorian councils would share some common barriers to intersectoral work, such as the physical location of council offices, lack of time to develop a clear understanding of other staff’s work and individual staff members who have difficulty working in multi-disciplinary teams, some councils appear to be more motivated to encourage work across the organisation and have thus progressed further in this area. Facilitating an integrated planning approach to the development of council’s MPHP and planning the co-location of several work teams into one building are examples of the steps that some councils have taken towards promoting a whole of council mindset which would
be required when applying HIA. Others have established lunchtime seminars for staff, internal newsletters and multi-disciplinary committees at either management or officer level, to ensure that staff have opportunities to meet both formally and informally.

It appears that a council which encourages staff to talk and work together, also values community participation, which is a strong underpinning of HIA. Although the BV principles highlight a need for all Victorian councils to regularly communicate with their respective communities and many CPs list ‘community consultation’ as a corporate value, not all Victorian councils may have developed strong and effective working relationships with community members. Since the time of local government amalgamations, some councils have devoted considerable time and effort to the building of a vision for the municipality in close collaboration with a wide representation of their community. Community consultation has become an integral component of their way of ‘doing business’, with the outcomes of this consultation informing every planning process within the council, including the MSS and the CP. There appears to be a strong belief within these councils that it is vital to keep the community informed about council's decision-making processes and to provide a range of programs for the community, such as skills development; volunteer training and leadership. On the other hand, some councils allow their community minimal access to council and have developed very naïve methods of community consultation.

- **Building capacity for HIA will be crucial**

Some councillors and managers can quickly envisage that HIA could bring value to their organisation by improving its decision-making, but they also caution that its acceptance by all council staff could take years, as this would require a change of mindset across the entire organisation. The positioning of HIA would require practical training to reorient councillors' thinking and extensive communication between staff in council departments that have historically been separated. HIA demonstration models would be needed to clearly show the added value that HIA could bring to both the council and the community. A comprehensive and user friendly HIA toolkit for Victorian councils would be essential, particularly for poorly-resourced councils and rural councils. However, the skills required to apply an HIA could be found amongst several council staff who have had experience in the application of either socio-economic impact assessments (e.g. in the context of gambling related issues) or environmental impact statements (e.g. related to extensive developments with potentially large impacts).

Building capacity for HIA amongst developers may offer another means by which councils could ensure adequate consideration of health impacts at a local level. Some developers in some municipalities could be persuaded to apply HIAs if a rating system for ‘minimal health impacts’ for new developments was established in Victoria and if the application of HIA became a marketable feature. Councils that decide to promote the use of HIA amongst developers would need to develop and provide comprehensive HIA training programs and resources specifically targeting this audience. Other developers, who may fear a reduction in their profit margin, may not welcome HIA and would not apply it to their development proposals unless the application of HIA was a compulsory requirement in council’s planning application. These developers could be asked to pay a levy to council for the provision of ‘health promoting’ elements within their proposed developments, thus financially supporting council staff to undertake HIAs as required in the future.
Positioning HIA will require careful planning
Although some council staff may express an interest in facilitating the positioning of HIA into their council, they are also mindful that both time and resources would be required to develop and undertake an HIA education and marketing campaign.

The issue of ‘health inequalities’ is not on the agenda
The understanding of and interest in health inequalities in the Victorian local government sector is centred in councils' work areas responsible for social planning, resident support services, youth services and children's services. Although the term ‘health inequalities’ is not commonly used, these staff members regularly address issues of inequality within their municipality, as much of their work is undertaken at the grassroots level with vulnerable communities and marginalised groups.
5. Discussion

When this research project was first mooted by the DHS in early 2004, the positioning and application of HIA into the Victorian local government sector seemed to be a logical proposition. Although sixteen years had passed since the requirement for MPHPs was written into state law, not all councils had become aware of the health impacts of their policy and planning decisions, and only some had developed a new mindset underpinned by the social model of health. The comprehensive DHS municipal public health planning framework, *Environments for Health*, which was released in 2001, had reinforced the broadened definition of health but had not necessarily persuaded all councils to develop a culture of thinking holistically about health. The associated *Good Practice Program* funding had introduced the concept of best practice in an area of municipal planning that had been inconsistent in its quality, but had not raised the standard of municipal public health planning in all councils. VicHealth’s resource package for councillors, *Leading the Way*, had spread the new and broader interpretation of health to council chambers across the state, but had not necessarily convinced all councillors to prioritise health in their decision-making. It was clear that the goal of putting health considerations on the agenda at the local government level by providing methods for integrating State Government and local area planning, had only been partially realised and that HIA could play a role. It appeared that some alterations of the current methods were required or another method was needed to either increase local government’s understanding of the role of MPHPs or put health on the agenda more clearly.

During this same period in Victoria, there appeared to be a growing interest in HIA as a tool which could both predict potential health impacts of proposed policies, strategies and programs, and assist government decision-making. This interest was particularly strong in the local government sector, as evidenced by the increasing number of council staff who had enrolled in the only HIA education and training course in the state and who had attended other short introductory sessions about HIA which had been facilitated by a range of organisations. Pre-course information from the academic institution which offered this course, revealed that at the time of enrolment, council staff perceived HIA to be a new and innovative mechanism by which health could be prioritised in their council’s decision-making and complement other activities within council.

The research question that directed this project at the time of the application therefore focused on how HIA could be positioned and applied in the Victorian local government sector. It appears that an assumption had been made that HIA should be positioned and applied across the entire sector, as this tool was increasingly being shown to be effective in putting health on local governments’ agenda elsewhere. The data collected in this project from a wide range of sources, provides an objective insight into the potential positioning and application of HIA, but also challenges that assumption. At this point in time, it would appear that HIA can play two crucial and very different roles in the Victorian local government sector: as a complementary method of ‘getting health on the agenda’ or as a particularly effective method to improve councils’ decision making.

It was timely that the current review of the Victorian Health Act also began in 2004. This review proposed legislating for the application of HIA at local government level as part of a flexible legislative framework that would support current and future directions for public health in Victoria. Although such legislation would ensure that HIAs were actually applied at local government level, most key informants in this project cautioned against such action, as the change in mindset which is the ultimate
aim of ‘getting health on the local government agenda’ is not guaranteed by legislation. They cite the example of the experience in Victoria sixteen years after the legislated requirement for all councils to develop an MPHP. There is a strong possibility that positioning a requirement for HIA in a ‘Health’ Act could block the valuable dialogue about a broader definition of health that is only now beginning to occur between the public health sector and some non-health sectors of government, both at the state and the local level. Additionally, as the findings of this project show, strong justification would need to be developed before introducing a new mandate into a sector that is experiencing mandate fatigue and has been encumbered with many unfunded mandates.

The literature reviewed in the course of this project has identified local authorities as key settings for the application of HIA as they are democratically elected and have been legally entrusted to promote or protect the public’s health through strategic planning and systematic action. As noted by Victorian key informants, councils are accountable to their local constituents and will therefore carefully scrutinise any new initiative before it is positioned into their already crowded work agendas. Until there is a legislated mandate to apply HIA, its application will essentially be a voluntary initiative in this sector and each council will examine both its benefits and its associated costs before embracing this new concept.

Seeking to espouse the benefits of HIA to Victorian councils, it must be remembered that the effectiveness of a predictive tool such as HIA in improving either health status or the determinants of health, is yet to be evaluated and is generally agreed to be problematic. When council policies, strategies and programs are altered due to the recommendations of an HIA, it is impossible to compare the altered course of action with the events that have been averted. Until new methodology is developed to evaluate the effectiveness of HIA on health or the determinants of health, the added value that can currently be offered to Victorian councils from the application of HIA are likely to be the improvement of local area planning and the development of better local public policies which for the first time consider potential health impacts and/or weight them equally with other potential impacts. Both the literature and key informants, who have applied HIA at the local government level, agree that its application has delivered a wide range of benefits, well beyond the assessment of potential health impacts. It has put health on the agenda of council’s non-health departments by encouraging key decision-makers in these departments to consider unanticipated health impacts of their decisions, particularly differential impacts across the municipality. Intersectoral collaboration within local government has been facilitated by the application of HIA as it provides a focus for discussion about potential health and equity impacts of council’s proposals and a systematic mechanism for evidence-based planning. Within the local community, the application of HIA encourages ownership of local government decisions by utilising civic intelligence, and identifying and making transparent trade-offs in local government decision-making.

Both Victorian key informants and council staff have identified gaps in councils’ decision-making that could be filled by the application of HIA. As many Victorian councils have not developed a common understanding of the word ‘health’ across the whole organisation, they appear to be unclear about their role in addressing ‘health and wellbeing’ issues. The application of HIA could create an opening for new discussions about the broadened definition of ‘health’ between staff in the health and non-health work areas of council. Although the complexity of policy development and planning for modern urban environments has been acknowledged by the state government, as evidenced by the ‘whole-of-government’ rhetoric and the call for better coordination of services, the local government sector has not responded as
eagerly. The application of HIA could facilitate collaboration that is underpinned by
the social model of health, between key professional staff who each brings valuable
but different perspectives to councils’ decision-making. Recent calls from the state
government for more transparency and accountability in government decision-
making, and more meaningful consultation with the local community, have not been
heard equally across the local government sector. The application of HIA could
introduce a systematic method whereby the local government sector could routinely
consider all available evidence, including civic intelligence, and develop stronger
arguments with which to advocate for their respective communities.

Discussions with council staff in both the focus groups and the case studies also
revealed that although no direct adverse health impacts have been reported due to
their council’s policy development and planning decisions, several indirect adverse
impacts on the determinants of health have been observed. Poor planning decisions
in the early stages of council’s development planning, particularly in the growth
municipalities, has resulted in a lack of infrastructure, such as footpaths and
appropriate pedestrian road crossings. The absence of a common health paradigm at
both local and state government levels has frustrated some council’s ability to secure
the provision of adequate amenities and facilities, particularly for vulnerable groups in
growing municipalities. Other councils have been unable to develop effective local
policies and strategies due to the inflexibility of the reporting requirements of some
state government departments. The positioning of HIA in the Victorian local
government sector could encourage council’s decision-makers to view proposals
through a new lens and take action at the critical early stages of policy development
and planning. However, it could not solve the problems that have been reported by
councils when they advocate for services or infrastructure, or report to the state
government. As several key informants stated, perhaps a strategy to get health on
the agenda at the state government level is also required and would be well received
by local government as a sign of true commitment to getting health on the agenda in
Victoria.

It is important at this point in the discussion to acknowledge that the current political
climate at all levels of government in Australia is very different to that which exists in
other countries where governments are applying HIA. In the UK, it seems apparent
that all levels of government accept the social determinants of health at least in
principle and perceive the application of HIA to major policies as an important
strategy to address the issue of health inequalities. In each of the Scandinavian
countries, the government’s approach to considering health impacts is underpinned
by an ideology that includes a deep concern for human health, with the application of
HuIA in Finland being a logical progression of this thinking. In contrast, it seems clear
from this project that there is minimal understanding of the social model of health
amongst Australian politicians and economic imperatives dominate the political
discourse. The issue of health inequalities is not yet prominent in political debates,
particularly at the local government level. Therefore, it may not be an appropriate
time to offer the application of HIA as a strategy to assist councils to undertake their
core business or to address an issue that has not yet been identified as a problem in
this sector. Rather, HIA could be offered slowly and strategically as a mechanism to
raise awareness amongst councillors and council staff, of the role of local
government policies, strategies and programs in determining the health and
wellbeing of the Victorian people. This approach would require differing levels of
support than would be needed by councils that are already aware of their role and
are taking action to routinely integrate health considerations into their decision
making.
Interestingly, some Victorian key informants and some council staff have questioned the value of introducing a new method to raise council’s awareness of health, in light of other initiatives that aim to achieve the same or similar outcomes. Section 5.1 will discuss these other initiatives and highlight opportunities that may exist for the application of a new method such as HIA to complement or strengthen these. In light of the diversity that currently exists within the Victorian local government sector, a model for applying HIA for different purposes in a range of different councils will be presented in section 5.2. A detailed discussion of the costs and management issues associated with its positioning and application will be discussed in section 5.3.

### 5.1 Positioning of Health Impact Assessment

The positioning of any new concept or work practice into an organisation will undoubtedly create a variety of responses from the staff who often experience a mix of emotions, particularly fear and confusion (Jordan, P., 2005). Many of the barriers to the positioning of HIA into the Victorian local government sector that have been identified in the data, are essentially a response to change in organisations that do not have fond memories of change.

Many council staff acknowledged a sense of fear about the potential time and resource implications of positioning HIA into their organisation, namely educating and training staff, facilitating integrated planning processes, adapting council’s planning structures, collecting and collating evidence, and encouraging extensive community participation. The key informants who have applied HIA at the local government level could not deny that HIA can be time and resource intensive, both in its positioning and application. However, they also highlighted that if the positioning of HIA is carefully planned in consultation with all key stakeholders, and applied in a manner which is appropriate for the particular council, the costs will only be short-term but there will be many long term benefits for both the council and the community. There also appears to be a covert fear in some Victorian councils about the consequences of applying HIAs, which could reveal evidence that councillors do not wish to hear about or could present legal barriers that could stymie development in the municipality. It would appear from the data that those Victorian councils that have not developed the maturity and sophistication to be able to deal with controversy, may not be comfortable applying HIA.

Of equal concern to both Victorian key informants and council staff, was a sense of confusion about the relationship between HIA and other initiatives that direct local government’s core business or assist council staff in their day to day work practices. Rather than suggesting that HIA could replace these initiatives or could be an additional initiative, it is appropriate to suggest based on the findings of this project that HIA could complement or strengthen them by providing a new perspective and new evidence. The legislation that defines the roles and responsibilities of Victorian councils clearly articulates a council’s goals which include “maximising wellbeing” and “improving quality of life” and “providing a pleasant and safe working, living and recreational environment”. The concept of HIA reinforces these goals by firstly assessing potential impacts on “wellbeing, quality of life and the working, living and recreational environment”, and secondly reducing any negative impacts and enhancing any positive impacts. HIA could also complement the intent of this legislation by assessing the potential health impacts of councils’ strategic plans and providing an evidence-based method for prioritising strategies, in a sector where both financial and human resources are scarce (Table 1). Similarly, HIA also reinforces the aims of both current and proposed frameworks that assist council staff in their day-to-day work. It could also complement these frameworks by providing new or adapted checklists or screening tools, facilitating intersectoral planning and action, or
Table 1. Relationship between HIA and legislation related to Local Government

<table>
<thead>
<tr>
<th>Legislation</th>
<th>How HIA could complement the legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Act</td>
<td>• HIA applied to proposed strategies in the Municipal Public Health Plan could assist in prioritisation.</td>
</tr>
<tr>
<td>Local Government Act</td>
<td>• HIA applied to the Council Plan could maximize positive and reduce negative potential health impacts of proposed strategies.</td>
</tr>
<tr>
<td></td>
<td>• HIA applied to proposed strategies in the Council Plan could assist in prioritisation.</td>
</tr>
<tr>
<td>Environment Protection Act</td>
<td>• HIA could provide a process that allows adequate community participation in the assessment of potential health impacts of proposed industrial works or new/amended licenses of certain industrial premises.</td>
</tr>
<tr>
<td>Planning and Environment Act</td>
<td>• An enhanced screening tool could be included in EIAs to more effectively and efficiently trigger the application of HIA, so improving consideration of health impacts in the EIA process.</td>
</tr>
<tr>
<td></td>
<td>• HIA could provide a mechanism to facilitate collaboration between council planners, particularly strategic, statutory and health planners, during the development of the Municipal Strategic Statement.</td>
</tr>
<tr>
<td></td>
<td>• HIA applied to the Municipal Strategic Statement could maximize positive and reduce negative potential health impacts of proposed strategies.</td>
</tr>
<tr>
<td></td>
<td>• HIA applied to strategies in the Municipal Strategic Statement could assist in prioritisation.</td>
</tr>
<tr>
<td></td>
<td>• HIA could form the basis of an education program for members of the Victorian Civil and Administrative Tribunal, to raise awareness of the social model of health and the available data that links land use and development with health outcomes or the determinants of health.</td>
</tr>
</tbody>
</table>

providing examples of how Victorian local government decisions can be informed to positively influence the public’s health (Table 2).

Other perceived barriers to the positioning of HIA related to the day to day operation of local government in Victoria today. The size of councils since amalgamation has resulted in staff being located in different buildings, which creates a physical environment that is not conducive to the development of cross departmental relationships or collaborative work practices. The massive population growth that is evident in certain regions of Victoria, has dominated many council agendas and has demanded rigid forward planning business practices, leaving little room for consideration of new ideas or the inclusion of new work practices. Last but not least, the political reality of council elections causes discontinuity in many work areas across council every four years. As these barriers cannot easily be removed, the positioning of HIA would require careful consideration of the local context to ensure it did not create an additional and unnecessary burden for council staff or councillors.
Table 2. Relationship between HIA and frameworks in Local Government

<table>
<thead>
<tr>
<th>Frameworks</th>
<th>How HIA could complement the framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPHP framework</td>
<td>• HIA applied to specific council policies, strategies or programs could facilitate intersectoral planning and action.</td>
</tr>
</tbody>
</table>
| Primary Care Partnerships                        | • HIA applied to Community Health Plans could maximize positive and reduce negative potential health impacts of proposed strategies and actions.  
  • HIA applied to strategies in the Community Health Plan could assist in prioritisation. |
| Local Policy Planning Framework                  | • HIA could form the basis of a new policy to be included in each council’s Local Policy Planning Framework to ensure consideration of potential health impacts of proposed land use and development. |
| Integrated strategic planning framework (currently proposed) | • HIA applied to the proposed Community Plan could maximize positive and reduce negative potential health impacts of proposed strategies.  
  • HIA applied to strategies in the Community Plan could assist in prioritisation.  
  • HIA could provide a focus for building intersectoral relationships between staff in different work areas of council.  
  • HIA could provide a focus for building intersectoral relationships between staff in local government and those in state government. |

However, despite these barriers, there appears to be an increasing number of champions and allies for the positioning of HIA in Victorian local governments. The PIA has recently initiated discussions to change the Planning and Environment Act by requiring improved consideration of social impacts, and has recommended the development of strategic impact assessments and impact assessment statements for new land use policy, both of which would include considerations of health impacts. Council staff who contributed to this project, many of whom were from the non-health work areas of council, could identify a role for HIA and offered constructive advice about the best method of positioning HIA in their council.

5.2 Application of Health Impact Assessment

There was agreement amongst all data sources that council staff would be the most appropriate people to apply HIA at the local government level, although the most appropriate council staff to apply HIA would vary between councils, depending on the staff member’s individual skills and knowledge, and the position that they occupy in the organisational structure. The fact that students had often been employed to apply HIAs in Sweden, could suggest that HIA practitioners in Sweden may have found that the ability to uncover evidence is advantageous when applying HIA or that exposing students to the concept of HIA early in their professional development would auger well for consideration of potential health impacts at the local government level in the future. Or this may simply be an example of some lateral thinking that was applied when resources were scarce.
Local key informants and council staff suggested that three other groups may be interested in applying HIA at the local level. The first of these groups is the developer, both private and public, who is required to submit applications for new development proposals to a Victorian council. It was speculated that some developers could be interested in applying HIA as they may perceive the application of this new tool to be a potential source of market advantage for their business. Some council staff suggested that developers who chose to apply an HIA to their proposals, could be given an incentive from council, in the form of a refund or reduction of the planning permit application fee. Others suggested that the state government housing regulators could be persuaded to develop a ‘star rating’ system similar to the system which currently rates new homes according to their energy and water consumption. Such a ‘wellbeing rating system’ could rate new neighbourhood developments according to their potential health impacts. The third group that could be interested in applying HIA at the local level is the community itself. Many concerned residents who over the past few decades have become active in the environmental field, may wish to adopt HIA as another valuable advocacy tool to add to their repertoire.

The data indicated that a range of conditions would be required for the successful application of HIA in a Victorian council:

- **A period of relative stability in the organisation;**
- **Champions, allies and leaders for HIA -**
  - a councillor, a CEO or senior manager,
  - a champion in each work area of council;
  - staff in other government agencies;
  - staff in non-government agencies;
- **Levers for HIA within the council -**
  - a research unit or links to a relevant research agency or university;
  - a social planning team;
  - multi-disciplinary committees;
  - policy development processes;
  - well-coordinated integrated planning processes and structures;
  - systematic reporting systems;
  - regular monitoring systems;
  - evaluation methods;
- **Organisational commitment to council’s broad role in health -**
  - commitment of time to develop a common understanding of ‘health’;
  - a public health planning position in the strategic planning team;
  - council’s non-health staff have been educated about the social model of health and understand how their actions impact on health;
  - community members who are aware of the social model of health;
- **Organisational culture underpinned by the following values -**
  - equity and social justice focus;
  - positive attitude to risk and risk management;
  - encouragement and facilitation of professional development for staff;
  - use of evidence in decision-making;
- **Organisational structure that breaks down bureaucratic silos -**
  - staff permitted access to council’s key decision makers;
  - commitment of time to build internal relationships and networks, particularly between council’s health and non-health departments;
  - opportunities for staff from different work areas to meet informally;
  - multi-disciplinary work teams both within and across departments;
  - effective internal communication channels; and
  - collaborative decision-making with local agencies and the community.
Although not all of these conditions exist in all Victorian councils or are required, this does not preclude the application of HIA in this sector, but rather, it requires the development of a range of HIA methods to suit the organisational characteristics and needs of different councils. The development of HIA has been such that it has evolved into a very flexible tool that can be modified to suit the context and the purpose for which it is applied. Some have argued that this flexibility can be perceived as both a strength and a weakness of HIA. It would appear from the findings of this project that a discussion at the state government level about the use of HIA to achieve different aims in different settings in Victoria, particularly its potential links to SIA and possible new integrated impact assessment approaches, would be wise before HIA is positioned in the local government sector. In the pragmatic world of local government in Victoria, engaging in this discussion would not assist councillors or council staff to change their thinking or their work practices. Rather, what council staff in each of the two case study councils requested, was both a clear indication of the value that HIA could bring to council and to the community, and some practical tasks that could be undertaken to improve their council’s ability to consider the health impacts of proposed policies, strategies, programs or projects.

In light of this request and the diverse sector into which HIA would potentially be positioned, a Continuum Model (Table 3) has been developed to assist council staff to select from a range of different HIA methods that could be used to address the different needs of different councils. According to this model, consideration of health impacts can be classified as routine (Level One), strategic (Level Two) or occasional (Level Three). A council that does not have health on its agenda would be advised to initially choose HIA methods in Level One, until it developed a better understanding of and a greater commitment to the health role of local government. The reason for this selection is that staff may have difficulty convincing executive managers and councillors to undertake either rapid or comprehensive HIAs. They would achieve greater gains by choosing from a range of HIA methods that do not require a strong commitment to health and can be applied routinely, such as:

- HIA checklist included in Council Reports to alert councillors to the potential impacts on health of some types of proposals;
- Adaptation of statutory planning checklists to include more comprehensive consideration of potential health impacts;
- HIA screening tool to assess the potential health impacts of proposed physical infrastructure, such as footpaths and lighting;
- HIA checklist for use in an annual audit of the potential health impacts of council’s past decisions;
- HIA screening tool to assess the potential health impacts of the work of each of council’s departments;
- HIA checklist to assist staff in identifying potential health impacts of new projects which could add value to future funding submissions; and
- Adaptation of the social component of TBL reports to more effectively consider potential health impacts.

A council that has placed health on its agenda, but has not moved to effective integrated planning with its community, would be advised to choose HIA methods in Level Two, as there may not be sufficient commitment to undertake Level Three tasks. Over time, as health is more firmly placed on council’s agenda, HIA methods from Level Three could be selected. Such councils could apply a rapid HIA to:

- corporate strategic plans;
- large urban design frameworks;
- plans for future facilities in new growth areas;
- service provision options;
Table 3. Continuum Model - Consideration of Potential Health Impacts

<table>
<thead>
<tr>
<th>HIA Method</th>
<th>Reason for applying an HIA method</th>
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<tbody>
<tr>
<td><strong>LEVEL ONE</strong></td>
<td></td>
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<tr>
<td>Checklists or screening tools routinely applied by trained council staff</td>
<td>To improve councillors’ decision-making. To improve planners’ decision-making. To convince council’s engineers and other staff in assets or infrastructure departments of the need to consider the health impacts of their work. To track the impact of councils’ decisions over time by collecting and collating the consequences of these decisions. To increase knowledge of the social determinants of health across council. To strengthen council’s applications for funding. To improve TBL reports.</td>
</tr>
<tr>
<td><strong>LEVEL TWO</strong></td>
<td></td>
</tr>
<tr>
<td>Rapid, prospective HIA, applied strategically by trained council staff early enough to influence decisions</td>
<td>To add another type of evidence from the research literature to support council’s arguments. To facilitate intersectoral work in preparation for the development of council’s MPHP. To legitimize council’s social planning work. To get youth impacts on council’s agenda. To get family impacts on council’s agenda.</td>
</tr>
<tr>
<td><strong>LEVEL THREE</strong></td>
<td></td>
</tr>
<tr>
<td>Comprehensive HIA which includes extensive community participation, applied occasionally by HIA consultants to proposals of enough importance to councillors and the community, but not too politically sensitive (unless council is ready and able to face controversy).</td>
<td>To assess the potential health impacts of large proposals (policies, programs or projects) where there is a high probability of an impact of large magnitude on many people in the municipality. To increase attention to the determinants of health in existing Environmental Impact Assessments, which currently consider environmental, social and health implications of development projects.</td>
</tr>
</tbody>
</table>

- new capital works proposals;
- new community consultation strategies;
- local government determination of rates program; or
- the location of aged care facilities in the municipality.

In contrast, a council that has clearly defined a healthy municipality and is undertaking effective integrated planning across council and in partnership with its community may discover that it is already undertaking tasks that are very similar, if not identical to, the HIA methods in Level Two and Level One. Therefore, it would be advised to select a Level Three HIA method. This approach could be applied to
proposals for extensive plans or developments or policies which have the potential to impact on large sections of the population or to produce multiple impacts. Examples of such proposals are the erection of wind turbines in the municipality or a drought social recovery policy or the integration of a new residential suburb into an established municipality.

When a council chooses to apply a rapid or a comprehensive HIA, they could select from a number of tools that have been applied in local government, such as the Swedish HIA tool or the Luton Borough Council HIA Guide, as no HIA tools have yet been developed specifically for use in Victorian councils. All HIAs should consider impacts on the health of vulnerable groups and should endeavour to include community participation within resource and time constraints. The form in which the HIA report is presented to council’s key stakeholders and the language used throughout the HIA process must be appropriate for a non-health audience that is accustomed to the print media’s short, sharp messages. HIA experts have warned against merely copying a completed HIA that has been applied to a similar proposal elsewhere. This shortcut will not reveal all potential health impacts that could occur in the local area where the proposal will exert its influence. Of equal importance is the fact that neither council staff nor community members would have ownership of this ‘shortcut’ HIA approach and may therefore have little commitment to implementing its recommendations.

5.3 Management issues associated with HIA positioning and application

As HIA is a new concept in Victoria, much of the confusion that is reported in this project, arises from a lack of accessible and appropriate information that is relevant to the Victorian local government sector. Key informants who have applied HIA at local government level reported that any capacity building for HIA is best preceded by a period of slowly introducing the concept of HIA. The development of a two-pronged, long-term HIA positioning plan, which was suggested by focus group participants and council staff, appears to be a logical step that could allow adequate time for due consideration to be given to the concerns which have been highlighted in this project. As advised by a number of key informants, such a plan would need to engage a wide range of key stakeholders both within and outside the local government sector at the most appropriate time for all concerned, to slowly build constituency for HIA across Victoria.

The data has suggested that the two-pronged approach should include both a marketing strategy and a capacity building strategy. A major component of an HIA marketing strategy, as suggested by key informants, could be a series of separate HIA awareness raising programs targeting councillors, council staff, developers and the community respectively. Each of these programs could highlight the findings of this project and other relevant HIA research projects that are currently being undertaken in Victoria, in a manner that is appropriate to the needs of the audience. Special attention could be given to harnessing the high level of enthusiasm about HIA that appears to have been generated by this project, and utilising the regional offices of state government departments to establish a network of emerging HIA champions and allies from councils across the state. Any HIA capacity building strategy would need to focus on both individual and organisational capacity for HIA. As council staff and every other group who may be interested in applying HIA at the local level, would require education and training before they can confidently and effectively apply any HIA methods, the services of an HIA specialist unit would be required. A similar capacity building strategy has been adopted in Wales, where the assistance of the HIA unit in a nearby university was sought to develop and present
education and training programs for officers in the local authorities. A range of educational and training options would be required to meet the needs of busy professionals in the local government sector and of any interested private developers. They could also provide assistance in the development of HIA toolkits and relevant databases which are specifically designed for the Victorian local government context. A crucial component of this strategy which was repeatedly mentioned by council staff would be the development of HIA demonstration models that could provide tangible examples of the application of HIA to local proposals, rather than theoretical case studies or HIAs that have been applied in other countries.

If HIA is to be positioned in the Victorian local government sector, continuing support will be required to ensure its application in this sector is sustainable and effective. Continued access to current evidence regarding health impacts of a range of proposals will be essential, as many councils do not have research capabilities or the resources to employ researchers. An appropriate quality control mechanism will need to be developed to ensure that HIAs applied in the Victorian local government sector are of a high quality, and can add to the HIA body of knowledge that continues to grow worldwide.
6. Conclusion

This project has provided an opportunity to pause and reflect before positioning and applying a new method of putting health considerations on the agenda of seventy-nine councils, many of which appear to be unsure of their role in health.

At this point in time, no other jurisdiction in Australia is exploring the positioning or application of HIA at local government level by the methods adopted in this project. No HIA has ever been applied in any Victorian council other than in an environmental health context.

The concept of HIA appears to have strong support from senior managers in the DHS, from some non-government organisations in Victoria and from some staff in some Victorian councils. HIA appears to reinforce the intent of the legislation which determines the roles and responsibilities of Victorian councils, and also complements several frameworks that guide their day to day operation. It is particularly noteworthy that there appears to be a strong synergy between the concept of HIA and the integrated approach to government thinking which is currently being discussed at state government level.

However, without a legislative requirement mandating the application of HIA in the Victorian local government sector, its use will essentially be voluntary. Therefore, the positioning of HIA in the Victorian local government sector would more appropriately be focused on those councils that are both willing and able to apply HIA methods as described in the continuum model which has been proposed in this report. Careful planning in collaboration with many key stakeholders will be required to ensure that the barriers that have been identified in this project are overcome, or at least acknowledged, and the associated costs are reduced or shared. Champions for HIA will need to be nurtured and HIA allies will need to be found in non-health sectors of government. In the short-term, councillors and council staff will require HIA education and training, while the community and private and public developers may require such education and training in the long-term.

Both the DHS and the Victorian local government sector have a unique opportunity to develop their own approach to HIA, if they so desire. Those councils that are willing and able to apply HIA can realise many benefits beyond the assessment of potential health impacts of proposed policies, strategies and plans. By working together and sharing the lessons learnt about the process and the outcome, these two levels of government in Victoria can contribute to the creation of better public policies, and ultimately to an improvement in the public’s health.
7. Recommendations

- **That a plain language brochure about HIA and the project findings be published**

Much of the fear and confusion surrounding the positioning and application of HIA could be diffused by publishing the findings of this project in a plain language brochure. Such a brochure should explain the potential role that HIA could play in getting health considerations on the agenda in the Victorian local government sector in a format that would meet the needs of multiple audiences.

- **That opportunities to raise awareness of HIA amongst professional planners in local government be sought**

As this project has generated widespread interest amongst planning professionals in the Victorian local government sector, a range of opportunities should be sought to raise awareness of HIA and disseminate information about the project findings, such as the state wide Good Practice Program Conference. Existing partnerships between DHS regional staff and staff in regional councils should be utilised to explore the potential role that HIA could play in these regions.

- **That an intersectoral committee be established with key stakeholders at state government level**

Given the synergies between HIA and the intent of the legislation that defines the roles and responsibilities of Victorian local governments, discussions should be brokered between senior staff from:

  o state government departments, namely the DHS, the DSE and the DVC;
  o local government associations, namely the MAV and the VLGA;
  o the planning association in Victoria, namely the Planning Institute of Australia (Victoria); and
  o the peak health promotion body in Victoria, namely VicHealth.

This intersectoral committee should urgently address the following issues:

1. **The need to seek and nurture HIA champions and allies**

   The three HIA research projects that have recently been undertaken in Victoria have resulted in the formation of a loose network of champions and allies for HIA. This network should be formalised to become an action based group that provides a forum for ongoing discussion and debate about the use of HIA as one method of getting health on the agenda of local government in Victoria.

2. **The need to include a ‘health’ overlay or equivalent instrument in the Victorian Planning Provisions.**

   Although some Victorian councils have expressed interest in developing HIA policies for inclusion in their respective Local Policy Planning Frameworks, the most effective and efficient strategy to ensure consideration of health impacts in land use planning in Victoria would be to include a ‘health’ overlay or similar instrument in the State Policy Planning Framework of the Victorian Planning Provisions.
• **That capacity for HIA be built in interested councils**

A strategy, which utilises the Continuum Model for consideration of health impacts as described in this report, should be developed to assist the Victorian councils that have shown interest in positioning and applying HIA in their organisations.

• **That resources be allocated to undertake HIA demonstration models**

An effective method of demonstrating the role that HIA could play at the local government level and the efficacy of such a tool in this sector would be to undertake local demonstration models. Interested Victorian councils should be the lead agencies in at least two HIA demonstration models. Ideally, one demonstration model should link to a proposed strategic plan and the other would be the application of HIA to a proposed program or project that is in some way associated with one or more determinants of health.
8. References


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### Appendix 1 - HIA Case Studies (United Kingdom): Summary A

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<th>Case Study</th>
<th>Who</th>
<th>What</th>
<th>Why</th>
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<tbody>
<tr>
<td>Aylesbury Plus New Deal for Communities (NDC) Delivery Plan</td>
<td>Commissioned by: <strong>Health First</strong> (health promotion unit for Lambeth, Southwark and Lewisham Health Authority and Southwark Housing (London Borough of Southwark). Applied by: independent public health specialist.</td>
<td>HIA of Aylesbury Plus New Deal for Communities (NDC) Delivery Plan – evaluation of <strong>regeneration programme</strong>.</td>
<td>Four primary aims: (1) produce thumbnail sketch of likely health impacts of program; (2) identify gaps in the Plan with aim of <strong>strengthening Plan at early stage</strong>; (3) commence process of making explicit links between proposed plan and health status; (4) commence identification of possible benefits of more in-depth HIA at later stage.</td>
</tr>
<tr>
<td>Bro Taf Health Authority</td>
<td>Commissioned by: <strong>Bro Taf Health Authority</strong>. Applied by: <strong>Bro Taf Health Authority</strong></td>
<td>HIIA of <strong>determinants of child health</strong> in Bro Taf – region encompassing four local authorities.</td>
<td>A health inequalities impact assessment model was developed based around a planning question of 'how can we best reduce health inequalities in families with children by equitable access to high quality health care?'</td>
</tr>
<tr>
<td>Cambridgeshire County Council &amp; Peterborough Unitary Authority</td>
<td>Commissioned jointly by: <strong>Cambridgeshire County Council &amp; Peterborough Unitary Authority</strong>. Applied by: external consultants</td>
<td>HIA of <strong>Structure Plan (land-use planning) document</strong></td>
<td>Commitment to addressing health inequalities. Desire for health objectives to be considered and to be influential in relation to planning and development of strategic policy. Also to develop toolkit for future use when examining health impacts related to plan/policy development.</td>
</tr>
<tr>
<td>City of Edinburgh Council</td>
<td>Commissioned by: <strong>Scottish Executive Health Dept.</strong>. Applied by: <strong>Scottish Needs Assessment Programme – external public health</strong></td>
<td>HIA examined (i) impact of 3 separate transport policy scenarios on 3 different population groupings and (ii) health impacts of housing investment in</td>
<td>Recognition of links between transport and health and housing &amp; health - conducted to identify possible inequities in policies.</td>
</tr>
<tr>
<td>Location</td>
<td>Commissioned by</td>
<td>Applied by</td>
<td>Purpose for HIA conducted and HIA viewed as</td>
</tr>
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</table>
|-------------------------------|---------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------
| Greater London Authority      | Greater London Authority (GLA). Applied by: Steering Committee comprising representatives of GLA, London Health Commission, London NHS, public health specialist, external consultant, London Health Observatory's HIA Facilitation Mgr | HIA of overarching spatial planning strategy (encompassing transport, economic development, air quality and bio-diversity strategies) | HIA viewed as a way in which to embed health into the work of the GLA and a tool to assist in delivering on priorities within the London Health Strategy (viz. transport, black & ethnic minority health, health inequalities & regeneration). |
| Luton Borough Council         | Directorate Management Team within Environment and Regeneration at Luton Borough Council. Applied by: Environmental Health Facilitators | HIA of Local Plan (land use), with particular emphasis on reduction of perceived negative health impacts arising from selected policies relating to housing. | Purpose for HIA was to influence decision-making-through policy and to tackle health inequalities. Two primary aims: (1) to ensure health impacts of proposals can be considered by selected council policies, programmes and projects and (2) to develop a workable tool for use in future HIAs. |
| Merseyside Integrated Transport System | Liverpool Health Authority. Applied by: Liverpool Public Health Observatory | HIA of 4 broad policies and related flow-on policy actions of MerITS – integrated regional transport strategy in Merseyside (5 local authorities) | HIA conducted to predict likely health impacts arising from implementation of MerITS & to pilot a method for HIA for application to policies and strategies. |
| Salford Royal Hospital        | Capital Development Directorate of Salford Royal Hospital NHS Trust (Salford Trust). Applied by: School of Environment & Life Sciences, University of Salford. | HIA of joint major project for redevelopment and changes in methods of service delivery at Salford Royal Hospitals Trust (SHIFT) and provision of 4 integrated primary health & social centres (LIFT) | HIA viewed as opportunity to influence joint proposals at planning stage to make positive contributions to Salford communities. |
| Welsh Assembly Government     | Welsh Assembly Government. Applied by: Research Team, School of Social Sciences, Cardiff University. | HIA of proposed housing development. | HIA conducted as means of tackling health inequalities and improving well-being. Council sought evidence-based resource to inform decisions. |
### Appendix 2 - HIA Case Studies (United Kingdom): Summary B

<table>
<thead>
<tr>
<th>Case Study</th>
<th>Approach/Tools</th>
<th>Lessons Learnt – Benefits/Enablers</th>
<th>Lessons Learnt – Difficulties/Barriers</th>
</tr>
</thead>
</table>
| Aylesbury Plus New Deal for Communities (NDC) Delivery Plan | • Prospective  
• Merseyside Guidelines  
• Qualitative  
• Evidence based on analysis of the Plan plus expert public health knowledge.  
• Rapid appraisal  
• Matrices prepared categorising potential positive and negative impacts (based=upon 6 major categories of health determinants). Matrices included assessments of measurability of the impact and risk level of the impact.  
• Findings incorporated into final draft Plan for submission to Dept of Environment, Transport & the Regions. | • Matrix framework facilitated identification of gaps in coverage of health issues within the Plan.  
• The HIA revealed the potential of the Plan for positively impacting the health of Aylesbury residents.  
• HIA revealed potential cost savings in terms of treatment and care costs to the NHS and social services, plus contribute towards lowering incidence of degenerative diseases amongst disadvantaged groups.  
• Mental health and well-being predicted to be positively affected, both long and short term. | • Assessors expressed concerns re an inherent danger of increasing health inequalities should only partial implementation of HIA recommendations be implemented. |
| Bro Taf Health Authority | • Prospective  
• Multidisciplinary appraisal team  
• Inequality emphasis  
• Merseyside guidelines, 5 basic steps  
• Qualitative  
• Participatory  
• Rapid appraisal – 3-4 days including meetings & research.  
• Evidence based  
• Step 1: brainstorming session - Steering Committee discusses effects and impact of health determinants on specified planning area. | • Integration of HIA into planning process provided framework that enhanced discussion and decision-making.  
• Multidisciplinary, evidence-based approach makes explicit problems and solutions and draws attention to deficiencies in planning = formalisation of process closes important information gaps in decision-making process.  
• HIIA assisted in reducing health inequalities by providing indicators of prioritisation of appropriate interventions.  
• HIIA resulted in staged introduction of structured health visiting. | • Time consuming process – however integration of HIA framework resulted in net gain of time due to enhanced discussion and decision-making.  
• Beware of introducing bias into research phase by selectively using literature rather than conducting systematic review encompassing... |
Step 2: Discuss **how acknowledged determinants operate locally**
- Step 3: Evidence based research undertaken by steering committee members.
- Step 4: **Identify opportunities for action** resulting from examination of evidence.
- Step 5: **Rate** opportunities for action in terms of – strength of evidence, magnitude of possible impact, probability of achieving change locally, and time scale for change implementation.

Healthcare Trust became **enthusiastic collaborator** – since introduced HIA into own servicing planning.
- Process **highlighted resource allocation inequities** resulting in 3 additional health visitors being employed.

**Cambridgeshire County Council & Peterborough Unitary Authority**

- **Staged approach**
  - Stage 1 – a **description of principal health characteristics** of Structure Plan area.
  - Stage 2 – analysis of key health issues arising - setting out main health priorities and objectives.
  - Stage 3 – preparation of **HIR framework** against which Structure plan policies were assessed.
  - Stage 4 – **detailed analysis of predicted health impacts** of Structure Plan policies using HIR framework.
  - Stage 5 – Conclusions & Recommendations.
  - **Matrix developed** – formed part of HIA framework.

- **HIA provided opportunity to address health inequalities** through policies supporting regeneration in deprived wards
- HIA resulted in **better relationship with land-use planners** the led to authors of Structure Plan referring to health promoting initiatives throughout the document
- HIR used as a tool to **review strategic policy with positive results**.
- Gained understanding of relevance of land-use planning to healthcare & public health planning.
- Learnt importance of **time spent early** in process to understand terminology, objectives and priorities between partner organisations.
- Found to be **useful tool in enabling close working relationships** – provided platform for discussion of health impacts.

- **Detailed matrices**, although useful, revealed **difficulty of measurement and quantification of health impacts**. Recommended further research and development of matrices to further refine this tool within the process.
- **Length and expense** of process acknowledged.
- **Time invested** by members of health authority was considerable – even with using external consultants – recommended future HIAs consider human and financial resource required.

- Healthcare Trust became **enthusiastic collaborator** – since introduced HIA into own servicing planning.
- Process **highlighted resource allocation inequities** resulting in 3 additional health visitors being employed.

- Take especial **care with inequality assessments** to confirm that areas believed to be most deprived, are the most deprived.
| City of Edinburgh Council – 2 appraisals (transport strategy and housing policy) | • Prospective  
• Qualitative only  
• Merseyside Guidelines (housing policy)  
• Adapted HIA guidance from Scottish Office (transport strategy)  
• Participatory  
• Rapid appraisal  
• Steering Committee established – comprising professionals, council transport planners, community representatives from two local groups.  
• Collated background information through policy analysis and literature review.  
• Scoping undertaken by steering committee – determined boundaries of HIA. Identified relevant secondary data sources.  
• Rapid appraisal workshops – identified impacts and determined priorities - focus groups, in-depth interviews, matrices prepared showing how each impact would affect different population groups.  
• Recommendations formulated and circulated for comment prior to policy implementation.  
| To address health inequalities recommend constructing population profile as part of the preparatory methods in the HIA = a focus on the different health needs of population subgroups within target population would be achieved.  
• Time and resource constraints addressed by parsimonious data collection – 'fit for purpose', not 'all information possible'.  
• Health impact of transportation policy ingrained into policy development – offers real opportunity for making a difference to health & wellbeing.  
• Closer relations between health and local authority partners facilitated by process.  
• Understanding of need to have local policy that seeks to reduce inequalities achieved.  
• Rapid assessment viewed as efficient and prompt – created model for ongoing dialogue.  
• Both HIAs revealed more positive than negative impacts. HIA can be positive way to work across sectors to promote healthy public policy.  
| Difficulties encountered by assessors in obtaining adequate public participation and community representation, plus resource and time constraints.  
• Reliance on key informants with local health and transport knowledge only meant assessment of policy compromised – did not gain perspective of all people impacted.  
• How to scope impacts – what are parameters?  
• Ethical concerns re which populations and subgroups might be considered. Different impacts on different groups must be made explicit.  
• Measurement difficulties in defining the policy and impact of local context to be considered.  
• Ensure recommendations are possible, practical, and closely connected to the health impacts identified. |
Greater London Authority

- Prospective
- Multidisciplinary
- Multi-sectoral teams.
  - Phase 1 - **Steering Committee** established to develop the process & organise HIAs.
  - Phase 2 - **Scoping** undertaken by steering committee – discussion topic areas with greatest opportunity to increase health gain and address inequalities identified and developed for small group discussion.
  - Phase 3 - **Rapid appraisal workshop** – half day – small group discussion examined specific area of strategy.
  - Phase 4 - **Evidence based review** of research. Then discussion from workshop small groups, together with summary of evidence based review, documented and written up.
  - Phase 5 - **Recommendations formulated** and draft report sent to all participants for comment & feedback. Responses incorporated into revised draft report which was sent to LHC for debate and additional comments.
  - Phase 6 - **Final report** submitted to mayor, Assembly and strategy development team. Where possible recommendations incorporated into draft strategy prior to public consultation.
  - Phase 7 - **Qualitative evaluation of HIAs** conducted by external consultants.

- **To alleviate anticipated resistance and to gain acceptance of the process of HIA** the first HIA made a series of positive recommendations & was supportive of majority of proposals in the document being assessed.
  - **HIA adopted as a tool at the point where a draft strategy was completed** and had been submitted to the Assembly and functional bodies responsible for scrutiny.
  - HIAs on draft transport strategy and draft economic strategy **ensured health more integral to both strategies**
  - Incorporation of HIA into scrutiny process resulted in **health being considered at much earlier stage in strategy development process**
  - **Engaging stakeholders** successful in achieving several corporate goals (placing health on the agenda, raising awareness of health and & its determinants with officers of GLA.
  - Recommendations not incorporated were examined as to ‘why not’ – such accountability ensured sustainability of health on the agenda through continued dialogue.

- **Concerns were expressed re possible recommendations and implications of such recommendations arising from the HIA in relation to specific aspects of the strategy** (refer Lessons Learnt/Enablers for how this concern was addressed).
  - **Difficulties encountered in identification of topic areas with greatest opportunity to increase health gains and address inequalities in some strategies.** In these situations core team decided most important topic area to concentrate on.
  - **Difficulties for facilitators of small groups: desirous of joining discussion rather than just facilitating. Potential power dynamic implications may affect participants’ ability to ‘voice’ their views.**
  - **Participants of small groups felt less time should be spent on**
| Luton Borough Council | • Prospective  
• Adapted from Parry & Stevens guidelines (2001, cited in Egbutah & Churchill 2002).  
• Pilot Study - Qualitative only  
• Participatory  
• Intermediate appraisal  
• Steering Committee established - acted as overall management group, agreed boundaries, supported assessors. Comprised LBC officers with specialist knowledge and those able to disseminate information, plus professionals and public health officers.  
• Screening & Scoping tools developed and utilised. Scoring system to scale degree of potential impact (screening tool) and to develop list of target groups and potential health impacts for further examination and research (scoping tool).  

| Screen tool (despite having a subjective scoring system) successfully identified ‘large’ impacts to further examine.  
• Systematic procedure of scoping tool resulted in assessment being completed to a consistent standard.  
• Scoping needs to be quick and easy.  
• All assessments consistent (one sitting)  
• Focus group discussion – maximum 12, attendees asked to discuss their views on policies being assessed from perspective of potential impact on their health. Also discuss both direct effects and knock-on effects and links (if any).  
• Important to recruit as broad range of people to participate in focus groups as possible = balanced discussion.  
• Provide focus group participants with a | • Presentations at workshops & more time discussing topic areas of interest. Also participants less knowledgeable of strategy found discussion questions too broad.  
• Need to review how evidence is collated and used in light of potential legal challenges to issues associated with strategies.  

| Steering Committee – pay attention to administrative matters (e.g. notification of meetings, ensure apologies covered by substitute, take time to educate re HIA and policy at initial meeting).  
• Ensure manageable number of policies are screened and consider timescale of policy to ensure recommendations adopted at planning stage.  
• Do not hold too many |
| Community consultation with local reps from Luton – focus groups.  | brief outlining HIA & have someone directly related to policy present.  |
| Literature review – provided evidence base relating to identified health impacts. | Focus groups – facilitator & observer /reporter required - tape record meetings.  |
| Diagrammatic display of impacts identified – connections interpreted by assessors. | ‘Large’ impacts need focus group discussion with facilitator. ‘Low’ impacts can be examined as an 'officer appraisal' (desktop).  |
| Recommendations formulated from consultations and literature review. | Other ways to gain relevant information – workshops, case studies, use of scenarios.  |
| | HIA found to be [useful tool for highlighting health](#) and raising its importance on Council agenda and amongst planners.  |
| | HIA viewed as [important element in developmental work on Integrated Impact Assessment](#). Allowed its use with other elements within an IIA, eg equality impact & economic impact assessments.  |
| | [Recommendation well received](#) – able to be incorporated within review of policy planning process. Assisted in supporting other work being undertaken by LBC.  |
| | focus group meetings – time consuming.  |
| Time consuming – assessors noted not all policies or projects need full assessment – rapid or desktop appraisals adequate for some.  |
| Confusion related to terminology and definitions – assessors noted HIA is organisation specific. Ratification of definitions recommended.  |
| Monitor administrative issues such as efficient conducting of meetings and focus groups.  |

Merseyside Integrated Transport System

- Prospective
- Qualitative only
- Participatory
- **Steering Committee** established – comprised commissioners, assessors, project/policy proponent and other stakeholders, reps of affected communities.
- **Scoping** undertaken by steering committee.
- **Matrices** developed (4x6 framework) - categories of health influences to 4 policy elements of MerITS.

- **Matrix system** found to [streamline and focus discussion](#) on broad health categories affected by each policy measure.
- **Matrix particularly useful in identifying recurring themes** and priority impact areas.
- **Recommend that an initial brainstorming session** for all key informants be held using the matrix method to [identify priority impact areas](#). This may enhance the data.
| Salford Royal Hospital | Data Collection: semi structure interviews with key informant groups involved or affected by MerITS.  
| Data Collection: semi structure interviews with key informant groups involved or affected by MerITS.  
| Literature review – identified evidence related to known health-related impacts of transport. Priority impact areas identified.  
| Recommendations formulated from impacts identified in lit review and key informant data.  
| • Merseyside Guidelines  
| • Prospective & Participatory  
| • Qualitative & quantitative  
| • Rapid appraisal – over 4 mth period  
| • Steering Committee established – recruit ext assessor.  
| • Scoping undertaken by steering committee.  
| • Rapid appraisal workshop – half day – 50 delegates including carers, health managers and community leaders. Small group discussion of impacts under 6 core themes. Key informant interviews (25) – community reps, professionals and health agencies. 5 focus group meetings – local community groups. Matrices of prioritised impacts for each main category of health determinant.  
| • Evidence based research review.  
| • Recommendations formulated, draft report sent to all participants. Responses incorporated into revised draft report sent to LHC for debate & additional comments.  
| • Final report submitted to mayor, Assembly and strategy development team. Where possible recommendations incorporated into draft strategy prior to public consultation.  
| • Qualitative evaluation of HIAs conducted by external consultants.  
| | Participatory approach seeking view of local citizens and professionals identified both positive and negative impacts of joint project being more broadly linked to health and wellbeing of community than more clinical and medical focus pervious held with NHS and Salford Trust. Thus ‘expert’ view of impacts challenged and assessor recommended local view should be trusted and ‘bottoms up’ approach encouraged in HIA.  
| | Whole system’s HIA averted NHS agencies to their impact on quality of life in the city (other than through health care delivery).  
| | HIA made explicit need for Salford Trust to consider its impacts on community – e.g. identification of employment opportunities linked to joint project.  
| | HIA introduced SHIFT project to community resulting in increased level of community involvement.  
| | Findings presented in format that mirrored community plan – facilitated integration of HIA into decision-making process  
| • Need for operational definitions of health to be extended from traditional clinical service provisions and delivery perceptions to include consideration of social inclusion and activities associated with improving wellbeing for all communities. |
| Welsh Assembly Government                                                                 | • Prospective         | • Using local reps to steer process resulted in both ethical and practical benefits to the process and the community as follows:  
- ensured degree of control by local people.  
- broke down mistrust towards outsiders.  
• Local involvement was enhanced by conducting meetings in familiar environment, limiting professional jargon, approaching local reps via community organisation rather than statutory body.  
• Improved communication between officials and locals on housing decisions.  
• Tenants & Residents Assn formed.  
• Foundation laid for further community-based regeneration partnerships.  
• HIA created context that facilitated skill development of people involved.  
• Qual & participatory approach revealed strong community links, contrasting to image of decline and deficit suggested in quantitative analyses of area.  
• Understanding of residents’ concerns re change emerged from data collection.  
• Important contextual insights obtained from local people’s views.  
• Local knowledge revealed meaning of health determinants and impact on daily routine and lives – would not have emerged from traditional ‘robust’ data collection methods.  
• Difficulties arose re context – methods of communication re decision confusing – formal (council written correspondence) versus informal (local ‘grapevine’). Also need to understand role of hierarchical power positions within specific communities. |
| • Qualitative                                           | • In-depth interviews with key informants who worked and/or lived in the village. 15 individual interviews, four group interviews.  
| • Participatory – community consultation                | • Local community meeting – 50 attendees.  
| • Evidence based – literature, scenarios, & local residents | • Draft report distributed – then challenged or confirmed at community meeting.  
| • Steering Committee established – comprising key representatives and two local residents.  
| • In-depth interviews with key informants who worked and/or lived in the village. 15 individual interviews, four group interviews.  
| • Local community meeting – 50 attendees.  
| • Draft report distributed – then challenged or confirmed at community meeting.  
| • Small group discussion at community meeting – explored links between housing, health & well-being policy. |
Appendix 3

Reference Group (Terms of reference, members, meetings)

Purpose

To provide advice and guidance in the conduct of the project, The Positioning of Health Impact Assessment (HIA) in Local Government in Victoria, that aims to explore the application of HIA within the planning role of local government.

Membership

The Reference Group will include:

- Mary Mahoney, Coordinator of HIA Research Unit, Deakin University
- Grace Blau, Research Fellow, HIA Research Unit, Deakin University
- Iain Butterworth, Senior Lecturer, School of Health and Social Development, Deakin University
- Holly Piontek-Walker, Team Leader Local Government Partnerships, Public Health Group, Department of Human Services
- Monica Kelly, Manager Partnership Development, Public Health Group, Department of Human Services
- Rachel Cowling, Policy Analyst, Department for Victorian Communities
- Nicola Foxworthy, Social Planner, Department of Sustainability and Environment
- Clare Hargreaves, Senior Policy Adviser, Municipal Association of Victoria
- John Biviano, Director Research Workforce & Tobacco Control, Victorian Health Promotion Foundation
- Stephanie Knox, Planning for Health and Wellbeing Project, Planning Institute Australia (Victoria)
- Kerry Stubbings, Manager Social Policy and Health Support, Moreland City Council
- Kerryn Lewis, Health Promotion Officer, Whittlesea City Council.

Key Responsibilities

- Participate in Reference Group meetings either in person or by teleconference
- Assist in identifying and engaging appropriate key informants who will inform the research
- Provide specialist information on relevant literature or case studies
- Review progress reports and offer specialist advice or guidance on the direction of the research
- Assist in formulating recommendations for the positioning of HIA in local government
- Facilitate the dissemination of findings.
Meeting Frequency and Duration

It is proposed that the Reference Group meet four times during the course of the project for approximately one hour. However, the venue is booked for one and a half hours should the need arise for a longer meeting. An additional meeting will be held to review the final report if required.

As the project is scheduled for completion in early October 2005, the Reference Group will cease to function after this time.

All meetings will be held at VicHealth, Ground Floor, 15-31 Pelham Street, Carlton South.

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<thead>
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<th>Meeting Dates</th>
<th>Key Tasks</th>
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<tr>
<td>Monday 6 December 2004 (9-10am)</td>
<td>• Project briefing</td>
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<td>• Presentation of proposed approach</td>
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<tr>
<td>Monday 4 April 2005 (9-10am)</td>
<td>• Presentation of preliminary findings</td>
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<td></td>
<td>• Determine need for further investigation</td>
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<tr>
<td>Monday 4 July 2005 (9-10am)</td>
<td>• Progress report</td>
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<tr>
<td>Monday 12 September 2005 (9-10am)</td>
<td>• Formulate draft recommendations</td>
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<td></td>
<td>• Agreement on dissemination strategy</td>
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Appendix 4

Working Group (Terms of reference, members, meetings)

Purpose

To provide regular guidance and local information to assist in the conduct of the project, The Positioning of Health Impact Assessment (HIA) in Local Government, that aims to explore the application of HIA within the planning role of local government.

Membership

The Working Group will include:

- Mary Mahoney, Coordinator of HIA Research Unit, Deakin University
- Grace Blau, Research Fellow, HIA Research Unit, Deakin University
- Necia Burford, Regional Support & Development, Partnership Development, Public Health Group, Department of Human Services
- Holly Piontek-Walker, Team Leader, Local Government Partnerships, Public Health Group, Department of Human Services
- Ron Frew, Local Government Partnerships, Public Health Group, Department of Human Services
- Shauna Jones, Regional Health Promotion, North & West Metropolitan Region, Department of Human Services
- Brian Kirkby, Environmental Health Unit, Department of Human Services
- Tim Owen, Manager Public Health, Gippsland Region, Department of Human Services
- Malcolm Foard, Social Planner, Boroondara City Council
- Jacqui Croxon, Health Project Officer, Wyndham City Council
- Representative from East Gippsland Shire Council

Key Responsibilities

- Participate in Working Group meetings
- Provide information on local issues relevant to the project aims
- Assist in identifying and engaging key local informants

Meeting Frequency and Duration

It is proposed that the Working Group meet at approximately six weekly intervals, on seven occasions during the course of the project from 10.30am to 12.30pm. Meetings will be held at DHS, 120 Spencer Street, Melbourne where facilities for voicepoint are available. As the project is scheduled for completion in early October 2005, this Working Group will cease to function after this time.
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<td>Friday, 26 July 2005</td>
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</tr>
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Appendix 5 - Selection Criteria for Key Informants

1. HIA experts
Background information will be collected from people experienced in the application of HIA at local government level. Whilst not directly relevant to the policy and planning processes in Victorian local government, these interviews will provide valuable information to underpin judgements about the positioning and application of HIA, and management issues surrounding both the positioning and the application.

Appropriate people will be selected from a list comprising:
• contacts known to the researchers;
• people recommended by the members of the project Reference Group and Working Group;
• people recommended by prominent HIA practitioners and researchers;
• authors of reports of HIA-related work undertaken at local government level, that have been published in relevant national and international newsletters (eg newsletter of the USA National Association of County & City Health Officials and the UK Public Health News);
• authors of recent reports found on the Health Development Agency’s HIA website - www.hiagateway.org.uk;
• authors of reports presented at the most recent HIA Conference in Birmingham, UK; and
• respondents to a general request for assistance posted on the following international email lists –
  o Social determinants of health
  o Social policy
  o European social policy
  o Health equity
  o Public health.

Approximately six to eight people will be interviewed to learn the following lessons:
• Why HIA was used in the local government context?
• What were the perceived benefits?
• What was the area of application?
• What approach was used and why?
• Who completed the work?
• What are the key lessons that can be shared in terms of positioning, application and management of the HIA process at local government level?
• How were inequalities incorporated into the HIA?
• What suggestions and advice can the key informant provide to us?

Selection Criteria
1. Is a staff member in local government who has applied HIA at local government level within the last four years.
OR
2. Is a staff member of a government authority or local government association or a consultant, who, within the last four years, has worked closely with staff in local government who have applied HIA at local government level.
AND
3. Has NOT been recently interviewed by other staff in the HIA Research Unit at Deakin University
4. Has NOT been cited in the literature review for this study.
5. Is available to participate in an interview during February 2005.
2. Victorian Local Government experts

As the research question underpinning this study is specifically focused on decision-making by Victorian local governments, information about their planning processes and structures and their development of policies, programs and projects are essential components of the data.

Whilst these informants will not necessarily have extensive knowledge or experience in the application of HIA, they will provide valuable information about the Victorian local government sector particularly the experience of “putting health on the agenda” in local government decision-making.

Appropriate people will be selected from a list of names comprising:
- contacts known to the researchers;
- people recommended by the members of the project Reference Group and Working Group; and
- people recommended by prominent staff members in local or state government in Victoria.

Approximately six to eight people will be interviewed to learn the following lessons:
- What purpose/s could HIA serve at local government level in Victoria?
- What decision-making processes and structures currently utilised by Victorian local governments in their various planning roles and in the development of policies, programs and projects, could accommodate HIA?
- What barriers might preclude the application of HIA by Victorian local governments?
- What issues specific to local government in Victoria would require future consideration before HIA could be rolled out?
- If HIA were to be applied at local government level in Victoria:
  - What parameters would need to be set on the application of HIA?
  - Who could be responsible for the application of HIA?
  - What levels of support could be provided to people undertaking HIA in local government?
- What suggestions and advice can the key informant provide to us?

Selection Criteria

1. Has extensive knowledge of and/or experience in current planning processes and structures associated with the development of Victorian local government’s policies, programs and projects.
   OR
2. Has extensive knowledge of and/or recent experience in “putting health on the agenda” of Victorian local government decision-making.
   AND
3. Is NOT a member of the project Reference Group or Working Group.
4. Is NOT a member of the DHS regional health planners’ professional networks in the North & West or Gippsland Regions
5. Is NOT contributing to other HIA projects that are currently being undertaken by Deakin University’s HIA Research Unit.
Appendix 6 - Key Informant Interview Questionnaire

HIA experts

- What is your current knowledge of the use of HIA in local government?
- Have you or any of your colleagues applied HIA within local government policy and planning processes?
- Who introduced and implemented HIA at local government level?
- How often has it been applied?
- To what was the HIA applied?
- Was the issue of health inequalities incorporated into the HIA?
- Why HIA was used in the local government context?
- What important lessons have you learnt about the application of HIA in local government?
- What should the triggers be?
- When should HIA not be undertaken?
- Should it be applied routinely, occasionally or strategically?
- What barriers did you find?
- What enablers did you find?
- What important lessons have you learnt about the tools needed to apply HIA in local government?
- What level of capacity building has been required?
- What was the level of institutional support for HIA within the local authority / government?
- Was there any resistance to the application of HIA?
- If so, what was the nature of the resistance and how was it overcome?
- What impact (positive or negative) did the application of HIA have on local government decision-makers?
- What impact (positive or negative) did the application of HIA have on members of the community?
- What other suggestions or advice can you provide to us?

Local government experts

- What is your current knowledge of the use of HIA in local government?
- What is your current knowledge of policy development and planning in local government in Victoria?
- In your opinion, what is the level of readiness of local government in Victoria, to consider “health” in policy development and planning?
- In your opinion, what is the level of interest in “health inequalities” in local government in Victoria?
- In your opinion, what are the barriers to considering “health” and “health inequalities” as part of the core business of local government?
- In your opinion, what is the level of awareness in Victoria of the potential role and value of HIA in “putting health on the agenda” of local government?
- In your opinion, what management issues would need to be considered before positioning and applying HIA in local government in Victoria?
- What other suggestions or advice can you provide to us?
Appendix 7 - List of Key Informants

HIA Experts

Debbie Fox
Researcher assessing local government readiness to apply HIA, England

Louise Nilunger
Project Manager, Healthy Cities & Urban Governance, Copenhagen, Denmark

Rob Faulkner
Environmental Health Manager, Liverpool City Council, England

Rajiv Bhatia
Director, Occupational & Environmental Health, San Francisco Department of Public Health, California, USA

Lynne Lawrie
Executive Director, Toronto District Health Council, Ontario, Canada

Ashley Gould
Policy Officer, Local Government Association, Cardiff, Wales

Matthias Wismar (26 May)
Health Policy Analyst, Project Coordinator, WHO Belgium
Report of 3 year EU HIA study

Victorian Local Government Experts

Robert Hall
Director Public Health & Chief Health Officer, DHS

Jan Ryan
Crime Prevention Victoria, DoJ

Peter Lyon
Manager Sustainable Futures, DSE

Geoff Underwood
Development Facilitator, DSE

Sally Semmens
Integrated Transport Strategies, DoI

Joe Cauchi
Director, Sustainable Communities, Mornington Peninsula Shire Council

Leigh Snelling
Manager, VLGA

Mark Marsden
Planning Advisor, MAV

Bill Russell
Consultant to DVC project to examine rationalisation of local government planning

Jim Smith
Past President, Australian Institute of Environmental Health, Victoria

Jan Barrett
Municipal Early Years Plans program, Victoria

Noel Gately (referred by Heidi Dixon)
VicUrban, State Government developer
Other Key Informants – To be sent a short questionnaire (if required)

Liz Trayhorn
Healthy Kingston Coordinator, Kingston PCT, Surbiton, England

Mike Simpson
Public Health Strategy Officer, Leeds City Council, England

Rachel Flowers
Public Health Specialist, NHS Milton Keynes, PCT, England.

Tony Neul
Neighbourhood Improvement Manager, North East Lincolnshire Council, England

Alison Colby
Researcher supporting development of HIA at local government level, Wales

Colin Cox
Assistant Director, Joint Health Unit, Manchester City Council, England

Geoff Green
Academic consultant to Regional Public Health Service, Yorkshire & Humber Regions, England

Chimeme Egbutah
Luton Borough Council & Luton Health Action Zone, England

Sue Milner
North Liverpool PCT, England

Mark Kieselbach
Planning Director, Meridian Township, Michigan, USA
### Gippsland Region

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Jeanette Draper</td>
<td>Social Planner</td>
<td>Bass Coast Shire Council</td>
</tr>
<tr>
<td>Linda Kee</td>
<td>Environmental Health Officer</td>
<td>Bass Coast Shire Council</td>
</tr>
<tr>
<td>Rachel Bell</td>
<td>Community Planner</td>
<td>East Gippsland Shire Council</td>
</tr>
<tr>
<td>Heather Farley</td>
<td>Social Planner</td>
<td>Latrobe City Council</td>
</tr>
<tr>
<td>Stacey Sherriff</td>
<td>Senior Manager Community Services</td>
<td>South Gippsland Shire Council</td>
</tr>
<tr>
<td>Robyn Duffy</td>
<td>Senior Environmental Health Officer</td>
<td>Baw Baw Shire Council</td>
</tr>
<tr>
<td>Frances Ford</td>
<td>Rural Access Project Worker</td>
<td>Wellington Shire Council</td>
</tr>
<tr>
<td>Geoff Hill</td>
<td>Environmental Health Officer</td>
<td>South Gippsland Shire Council</td>
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### North & West Metropolitan Region

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Marc Florio</td>
<td>Planner, Youth and Family Services</td>
<td>Brimbank City Council</td>
</tr>
<tr>
<td>Lainie Hansen</td>
<td>Health Projects Coordinator</td>
<td>Melbourne City Council</td>
</tr>
<tr>
<td>Lynley Dumble</td>
<td>Health Planning Officer</td>
<td>Maribyrnong City Council</td>
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<tr>
<td>Lisa Wilkins</td>
<td>Social Planner</td>
<td>Melton Shire Council</td>
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<tr>
<td>Jacqui Croxon</td>
<td>Health Development Officer</td>
<td>Wyndham City Council</td>
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<tr>
<td>Angela Vindigni</td>
<td>Health Promotion Officer</td>
<td>Moonee Valley City Council</td>
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<tr>
<td>Loretta Asquini</td>
<td>Health Planning Officer</td>
<td>Hobsons Bay City Council</td>
</tr>
<tr>
<td>Lynne Galanti</td>
<td>Acting Health Promotion Officer</td>
<td>Hume City Council</td>
</tr>
</tbody>
</table>
Appendix 9 – Focus Group Questions

A. Is “health” and “health inequalities” on the agenda?

1. In your opinion, is either “health” or “health inequalities” on the agenda of any local governments in this Region?
   a. If yes, what is understood by the word “health” and how did it get on the agenda?
   b. If no, do you think it should be on the agenda?

2. In this Region, what factors do you believe hinder local government’s consideration of “health” and “health inequalities” as part of its core business?

3. From what you now know about HIA, could HIA put “health” and “health inequalities” on the agenda of local governments in this Region?
   a. What other role/s could HIA play within local governments in this Region?

4. What did you know about HIA before attending the presentation this morning?
   a. If you knew about HIA before this morning, where did you hear about it?
   b. Do you think HIA would be useful in local government?

5. Has anyone here or any of your council colleagues, applied HIA to local government policies, programs or projects? If so:
   a. On what was it applied?
   b. How was it applied?
   c. How often was it applied?
   d. What lessons did you learn about applying HIA and the tools needed to apply it?
   e. What effect did HIA have on council’s decision-making?
   f. What effect did the application of HIA have on your community members?

B. Key information

Positioning of HIA

1. What conditions do you believe would be necessary for HIA to be applied in local government in this Region?
   a. Conditions in the state
   b. Conditions in the Region
   c. Conditions in your council
   d. Other conditions

2. What factors do you believe could create barriers to the introduction or application of HIA in local government in this Region?
   a. Factors in the state
   b. Factors in the Region
   c. Factors in your council
   d. Other factors
Frameworks for application of HIA

1. What parameters do you think should be set on the application of HIA in local government in this Region?
   a. Triggers or screening criteria
   b. HIA approaches – checklist, rapid or comprehensive
   c. Level of consultation and community engagement
   d. Other

Management issues surrounding the positioning & application of HIA

1. Who do you think should be responsible for the application of HIA in local government in this Region?
   a. Council staff (eg those who are responsible for policy development and planning)
   b. HIA consultants
   c. Others

2. What levels of support do you think would be required for people undertaking HIA in local government in this Region?
   a. Training
   b. Resources
   c. Other

3. How could the current relationship between local government, local and regional service providers, and DHS in this Region, influence the application of HIA in local government in this Region?

4. What areas require further consideration before HIA can be rolled out in local government in this Region?

C. Summing up

1. Is there anything else you would like to add to the discussion today?
Appendix 10

Consultation List Case Study One (East Gippsland Shire Council)

Jane Rowe
Mayor
Linette Treasure
Councillor
Management Team meeting
  Group Managers (4) and CEO
Kate Nelson
  Group Manager, Community Department
Aaron Hollow
  Senior Statutory Planner
Planning team meeting
  Development Department (statutory planners, land planners, strategic
  planners, recreation planner, natural resource planner, building surveyors)
John Roche and Rod Poynton
  Environmental Health Unit
Melissa Bentzen
  Economic Development and Tourism Admin Officer
Sandra Bailey
  Business Support Officer
Anna Cook
  Community Building and Citizen Services unit
Community Building team meeting
  Community planner, various project officers (rural access, community
  development, community building)
Rachel Bell
  Community Planner
Rhonda James
  Transport Connection Project Officer
Appendix 11

Consultation List Case Study Two (Wyndham City Council)

Cr Henry Barlow
  Councillor – Cowie Ward
Bernie Cronin
  Director – Wyndham Services
Bryan Berry
  Manager – Social Development
Rebecca Roebuck
  Social Development Coordinator
Rob McVernon
  Community Development Coordinator
Priscilla Mayne
  Resident Support Services Coordinator
Jacqui Croxon
  Health Development Officer
Tina Parras
  Manager – Organisational Development
Sandra Mitchell
  Children's Services Planner
Peter Van Til
  Manager – Town Planning
Karen Hose
  Town Planning Policy & Projects Coordinator
John Moore
  Strategic Planning Coordinator
David Rasmussen
  Executive Assistant / Corporate Planner
Lois Binnie
  Manager – City Presentation
Robert Jenkins
  Environmental Health Services Coordinator
Cory Becker
  Youth Planning Officer
**Appendix 12 - Site Visit Questionnaire**

**Exploratory Questions**

**POLITICAL ARM (people)**

1. What makes local politicians care?
   - What was their platform?
   - How can HIA add value to what they care about?
   - What are the major community issues or needs?
     - What is their understanding of “health”?
     - What is their understanding of council’s role in “health”?

2. Is there any understanding of HIA and its role in local government?
3. Is there a champion for HIA?
4. Is there political commitment for HIA?
5. Is there political support for HIA – additional resources (human, time, material) and opportunities for staff training?
6. Has “Leading the Way” been presented?

**ADMINISTRATIVE ARM (people)**

1. What is the organisational focus / organisational objectives?
2. Are there sufficient resources to undertake core business?
3. Is there any understanding of HIA and its role in local government?
4. Is there a champion for HIA?
5. Is the CEO or/and other leaders committed to HIA?
6. What are managers’ concerns about HIA – increasing workloads, financial costs, meeting organisational objectives?
7. What are officers’ concerns about HIA – how to do it, tools?

**ORGANISATION (a system)**

1. What are the specific politics and power differentials within council?
   - What is the nature of the relationship between major “silos”?
     i. Between those responsible for MPHP and others?
     ii. Between all departments that are involved in any planning?
   - What is the relationship between directors / managers and officers?
   - What is the relationship between directors / managers and councillors?
   - What is the relationship between officers and councillors?

2. What are the specific politics and power differentials between council and external partners?
   - State & federal government?
   - DHS?
   - The community?
   - The media?

3. How does the organisation handle change?
   - Has there recently been a period of significant change?
   - When did it occur, about what and why did it occur?
   - How are new ideas or work practices introduced?
     - Information, persuasion, education, implementation?
     - Skills, staff, time, costs?
     - Has “learning by doing” being applied before?
• Any recent example of success factors?
• Are staff usually retained for more than 7 years?

4. What is the organisational culture – obedience, learning, innovation, best practice, integrated approach to working across divisions?

5. Is there an overarching philosophy or epistemology that underpins all council’s decision-making?

6. Are staff encouraged to participate in local and regional networks and partnerships?
   • LGPro networks
   • VLGA networks
   • DHS networks
   • Health-related networks.

7. Does the workforce include professionals with capacities relevant to the application of HIA?
   • Research skills
   • Long-term planning skills (eg strategic planning, social planning, health planning)
   • Policy development skills
   • Comfortable working in an integrated manner
   • In which division / unit are the staff with these skills located?

8. Where does the MPHP fit in the hierarchy of plans and strategies?
   • Who has responsibility for its development and its implementation? In which division / unit are they located?
   • Is there a public health unit or public health planner or health promotion officer? What is their role?

9. What is the understanding of or interest in “health” across the organisation?
   • Within non-health divisions / units?
   • Amongst directors / managers?
   • Amongst councillors?

10. Is there any understanding of or interest in “health inequalities” across the organisation?
   • Within non-health divisions / units?
   • Amongst directors / managers?
   • Amongst councillors?
   • What work is being undertaken in this area?

11. Is there a Best Value unit or Best Value officer?

12. Is there a TBL unit or TBL officer?

13. Is there a social planning unit or social planner?

14. Is there a research unit or research information officer?
   • Is any local research undertaken?
   • Is local data collected and used in planning?
   • Is the data from the Burden of Disease study used in planning?

ORGANISATION (processes and structures)

1. Is there a specific process for policy development?
   • Where does it occur?
   • Who is involved?
   • When does it occur?
   • How are conflicting perspectives managed?

2. What different types of “planning related” activity occur? (eg Council Plans, corporate planning, business planning, strategic planning, development
planning, social planning, services planning, statutory planning, health planning etc)
- Are planning activities well coordinated across the organisation?
- What structures and processes are associated with these types of planning?
- Are they effective?
- What is their purpose?
- Who participates?
- Do any of these activities generate revenue for council?
3. Do those staff members involved in any “planning related” activities ever meet or collaborate?
   - Formally or informally?
   - Why do they meet?
   - Regularly or occasionally?
   - When and where do they meet?
   - Who meets?
4. What risk assessment or risk management programs exist?
   - What structures and processes are associated with these programs?
   - Who participates?
5. Is any type of impact assessment undertaken?
   - What types?
   - When is it applied?
   - Who applies it?
      - Within council
      - Outside council eg developers
   - How are the recommendations enacted?
6. Would the developers who operate in your municipality, be interested in applying HIA as part of their development proposals / planning permit applications? Why or why not?
7. How are resources allocated to different divisions / units?
   - Who makes proposals?
   - Who makes the final decision?
8. What communication channels exist?
   - Between managers and officers?
   - Between officers and officers?
   - Between managers and councillors?
   - Between officers and councillors?
   - Between officers and community?
   - Between council (as a whole) and community?
9. What reporting mechanisms exist?
   - What is their purpose?
   - Are they effective?
   - Who contributes?
   - How do they contribute?
CAPACITY TO ACTION HIA RECOMMENDATIONS
1. How will HIA recommendations be prioritised?
   - By whom? When?
2. How will HIA recommendations be implemented?
   - By whom? When?
3. How will HIA recommendations be evaluated?
   - By whom? When?
Appendix 13 - Pre-site visit summary sheet

Summary of Literature Review

A review of the literature on Health Impact Assessment (HIA) at local government level in the United Kingdom, Sweden, Denmark and Finland revealed a varying degree of acceptance and use of HIA at this level of government, and very few HIA tools that have been developed specifically for local governments.

- In the UK there is an acceptance at national and regional levels of the broader model of the determinants of health and the fundamental principles of HIA. The present UK government’s commitment to addressing health inequalities and the wider determinants of health has led to a recommendation that HIA be undertaken at all government levels on all major policies that may have a direct or indirect effect on health. Various HIA tools, such as the Merseyside Guidelines for Health Impact Assessment, have been developed.

- Although Sweden, Denmark and Finland are all signatories to the Treaty of Amsterdam (which requires HIA to be applied to policies of the European Union) and each have municipalities involved in the WHO Healthy Cities Network (which requires political leaders to commit themselves to promote “health impact assessment as a means for all sectors to focus their work on health and the quality of life”), the application and positioning of HIA is different in each of these countries. Sweden has developed a specific HIA tool and Finland has developed a Human Impact Assessment (HuIA) tool, which encompasses components of HIA and Social Impact Assessment (SIA). Both countries have neither a national policy nor legislation that prescribes the use of HIA. Similarly, Denmark has no national policy or legislation in place but is only beginning to conduct research on how HIA could be used at local government level.

Local governments have been identified as key settings for the application of HIA because they:

- are democratically accountable;
- participate in a consultative relationship with local constituents;
- are key players in multi-, single-focus, and cross-cutting strategic partnerships;
- have community planning responsibilities;
- have a legal power of ‘well-being’;
- are often legally empowered to promote or protect public health through systematic action;
- have scrutiny functions;
- have responsibility for governance of social care; and
- are well placed to monitor and evaluate interventions aimed to improve health.

A number of key issues associated with the introduction of HIA into local government and its application within local government were identified.

- **Defining health**

Difficulties were acknowledged in defining and understanding health and health-related terminology. This resulted in confusion around identification of health impacts and their links to particular policies and in measurement and quantification of impacts.
• **What Should Be Assessed**
  There is agreement that it is not practical for all policies and programmes to be subjected to an in-depth HIA and that initial screening of policies and strategies is necessary to prioritise proposals for assessment. Such screening tools alleviate the pressure of time and resource constraints resulting in a ‘rapid appraisal’ model being the most frequently adopted assessment in local government.

• **When Should HIA be Undertaken**
  Although HIA can be used at any point in the policy-making and planning cycle, if the aim is to influence decision-making, HIA should be applied at an *early* stage in the planning process before too much time and too many resources have been invested in developing a policy or plan.

• **Who Should Undertake the Assessment**
  There is some debate about whether HIA should be conducted by decision-makers and planners at local government level or by more ‘objective’ external HIA consultants. If HIA is intended to introduce people to the broad concepts of health and to facilitate a change in ‘mind set’ within the organisation, local government staff should be the HIA practitioners. It has been suggested that the ‘internal’ approach should be reserved for the rapid appraisal model with external assessors being used on more comprehensive, in-depth HIAs which require a range of expertise that in-house staff could not be expected to have. All the HIAs reviewed were rapid appraisals which were usually carried out by external consultants who often worked in conjunction with health professionals, university research teams specialising in health inequalities and regeneration, and officers from the relevant local government.

• **Acceptance of HIA**
  A perceived barrier to the introduction of HIA is acceptance of the process by local government staff. Council staff need to be convinced of the value of HIA and its potential to add value to council’s existing activities.

• **HIA - Time and Resource Intensive**
  Most HIAs were based on ‘rapid appraisal’ models which were completed in a period of one day to four months. Civil servants who conducted these HIAs did not find that the application of HIA to their work made the preparation of cases longer.

• **A Participatory, Qualitative Approach**
  A participatory approach was adopted in all the HIAs that were reviewed, although the degree to which consultation was sought varied depending on time constraints and financial resources. This approach afforded assessors the opportunity to obtain all possible perspectives on potential health impacts of proposed policies, from the ‘expert’ view to the community view that is based on ‘civic intelligence’. The most common methods of data collection were in-depth key informant interviews, small group/focus group discussions and steering committee meetings with core members seconded for their professional and health related expertise.

• **Improved Communication, Relationships and Understanding**
  It was found that the application of HIA put health issues on councils’ the agenda and improved relationships between councils and local residents, between departments within the organisations and across sectors. There was a greater understanding of health impacts and a heightened sense of responsibility.

• **The Importance of Context**
  One of the major lessons from the literature was that the HIA tool must be developed and adjusted according to the direction and needs of the local community and in collaboration with councillors and civil servants. Local knowledge and an understanding of the community power hierarchies and modes of communication, and an understanding of how the local government operates were mentioned as important variables in the overall outcome of the HIA.
• **Critical success factors**

Important factors for the success of HIA in local government were found to be close collaboration and agreement between civil servants and councillors, and avoiding the risk of copying already formulated HIAs instead of developing a new HIA for each proposed policy or plan or project.

**Summary of Interviews with Key International Informants**

**Introduction of HIA**

- A “learning by doing” approach to the introduction of HIA works well in local governments.
- Organisational characteristics of a Council can influence the introduction of HIA into that Council.
- Need to target the political arm and the administrative arm of local government separately.
- Ensure that HIA is given both political commitment in the form of public statements and political support in the form of additional resources (human, time, material) and opportunities for staff training.
- Need commitment from the leaders of the organisation (eg CEO)
- HIAs should be applied strategically, after they meet specific screening criteria.
- HIA should be applied to policies or projects that are important enough to both the politicians and the community, particularly communities whose perspectives are excluded from public institutions.
- Introduce HIA in partnership with council staff who have good knowledge of the local area and have strong local networks, and with external agencies that have expert skills in the application of HIA and can provide training and support to council officers.
- The first HIA that is applied in an organisation will be the most important, as it will need to convince decision-makers that HIA can add value to the decision-making process and that the data is sound.
- HIA is a waste of time if no process has been developed by which the organisation can prioritise the recommendations in an HIA report, and has the capacity and commitment to implement them.

**Implementation and the HIA Tool**

- Rapid HIA is the best form of HIA to be applied at local government level.
- Health inequalities should always be an integral component of any HIA.
- Involve directors, managers and officers in all steps of the HIA implementation process to allay any fears associated with the introduction of a new work practice and to demonstrate that staff can work together to successfully apply an HIA.
- All staff should be able to see “what’s in it for me”.
- The HIA tool should be adapted to a specific organisation in a specific context.
- The HIA tool should be easy to use, quick to complete and practical, should show “hard” effects (eg cost-benefit trade offs) and shouldn’t compromise development too severely.
- When applied to some larger or more important policies or plans, HIA should be more collaborative and engage the participation of a range of key stakeholders to capture “civic intelligence”.
- Consider engaging an external body to evaluate the process that was followed in applying the first HIA.
Appendix 14 – The Swedish HIA Tool

The Swedish HIA tool consists of three components:

- Health Question
- A Health Matrix
- A Health Impact Analysis

The Health Question is seen as a simple option that can be adopted prior to consideration of a policy proposal or a collective decision at a meeting. The Health Question consists of three questions related to consequences for human health supplemented with comments on the motivation for the proposal (project or program), a suggestion for alternatives and an overall assessment. The first question looks at whether the proposal promotes the development of health in vulnerable groups through the social environment such as ability to work. The second question looks at whether the proposal promotes the development of health in vulnerable groups in relation to determinants of health such as physical environment. The third question looks at whether the proposal is in line with the overall policy for the municipality or county council.

The Health Matrix is a simple matrix supplemented with question three (above) and the three areas of comment on motivation for the proposal (above). The Matrix looks at long-term and short-term impacts for prioritised group(s) and the entire population within eight health related areas. The eight areas are:

- Democracy/opportunity to exert influence/equality
- Financial security
- Employment/meaningful pursuits/education
- Social network
- Access to health care and welfare services
- Belief in the future/life goals and meaning
- Physical environment
- Living habits

The Health Impact Analysis is guided by both general and more specific questions relating to public health, policy and the proposal (program or project).
Appendix 15 – Human Impact Assessment

In 1999 a handbook on the assessment of social and health impacts was published by the Finnish Ministry of Social Affairs and Health (Kauppinen 2002). This handbook uses the term Human Impact Assessment (HuIA), which brings together HIA and SIA. HuIA is also used in work on impact assessments by the National Research and Development Centre for Welfare and Health (Stakes).

Kauppinen (2002) describes the development of HuIA as being divided into three phases. The first phase is where HIA and SIA are separate and each contains the other. That is, the two types of impact assessment are competing for being the umbrella concept. The second phase entails HIA and SIA approaching each other to create a common area. This area is a grey no-man's-land that, according to Kauppinen (2002), can consist of perceived health or mental health. This phase is where HIA was in Finland after the publication of the impact assessment handbook by the Ministry of Social Affairs and Health. The third phase is described as a utopia. This phase is where HIA and SIA are merged together as opposite ends of a continuum. In this phase all impacts on humans have a health and a social dimension. The idea that either HIA or SIA is the umbrella concept will lose its meaning as a common new umbrella concept of HuIA will be created.

Stakes (2000) describes the Finnish HuIA procedure as being made up by six stages where participation of residents and experts is seen as vital for success. The six stages do, to some extent, resemble the procedures identified in the Merseyside Guidelines for Health Impact Assessment (Scott-Samuel et al 2001 p 5-7). However, the identification of impacts is done by using a check-list (Stakes 2001 p 2), which is different from the tool used in the Merseyside Guidelines. The six stages of HuIA are:

- Determining the need for assessment
- Acquisition of basic information
- Identification and delineation of impacts and alternatives
- Assessment of alternatives and impacts
- Decision
- Monitoring

The first stage is deciding whether there is a need for an assessment. A working group consisting of residents and other stakeholders is set up to plan and carry out a HuIA if a decision is seen to have possible extensive impacts on people’s welfare, housing conditions, movement or services. According to Stakes (2001), impacts can also be assessed in a setting of objectives. This means that a HuIA can be conducted if decision makers want to assess how objectives can be achieved.

Second stage entails gathering information on the present state of the affected area. This should ensure that the working group develops a common understanding of the decision or objective under assessment. The information will provide the basis for alternative approaches, the assessment and monitoring.

The third stage includes identifying impacts and possible alternatives. This is done by looking at different population groups, different areas, or different times. Alternatives should include new ways of solving issues as well as including a zero alternative, which includes what will happen if no change is implemented.

Stage four includes recording different opinions on possible impacts of the different alternatives from various stakeholders. This is done in an assessment table, which,
according to Stakes (2000), “compares how various objectives are realized in different alternative solutions”.

In stage five a decision is made and a report that describes “the objectives, the alternative solutions, and the comparison, including the impacts” is written. This should enable decision-makers to understand the effects of the different alternatives.

Stage six includes monitoring, which starts after an appropriate amount of time has passed since the commencement of the activity. In this stage information on anticipated impacts and unexpected impacts is gathered. This stage aims to enhance the quality of future assessments.
1. Kajaani

In 2003 a HuIA was conducted on the execution of the well-being strategy in Kajaani. The background for the HuIA was thoughts on how to continue the work on the well-being strategy and a felt need to be involved in the realization of a regional administration experiment (authors note: this is not explained further). The working group included a ward sister, a basic security director, a planner from the technical sector, a labor protection delegate and representatives from the Education and cultural Services, the Sports Council, the Council for the Elderly, the Advisory Council for Children and Youth Affairs, The Kajaani Polytechnic and the Research and Development Centre of Kajaani. The HuIA was conducted through an initiating workshop, discussions in the group member’s organisations and discussions in workgroup meetings. No participation by the community was identified.

Three models were created:
- Model 0 - a sectored legislation –based model
- Model 1 – a sector based combination model
- Model 2 – a client-based model

The goal of the HuIA was “to analyse the models and their impacts to:
- Supplement the well-being strategy
- Come into operation in the project for the elderly and in the update report of the well-being of children and the youth, and in the well-being model (author note: this is their words. It is not explained further)
- Support the planning of the management model of Kainuu region”

The results of the HuIA are, however, not shown at the website as a table for one of the other municipalities is shown.

2. Kerava

In Kerava municipality a HuIA was conducted in 2003 on the effects of the Kerava employment unit operations. The motivation for conducting the HuIA was threefold.

- Ensure constant attention to employment by policy-makers
- Improve the effectiveness of the activities and generate new ideas
- Give their experience with HuIA to other municipalities

The working group that conducted the HuIA consisted of the Director of the Employment unit, the employment coordinator, the secretary of the preventive work committee and a contact person of the Finnish Healthy Cities Network. Participation by the community or the clients of the employment unit was not identified.

The HuIA were undertaken on two different areas of the employment unit’s operations. One on the basis of resources and one on the basis of the methods of getting clients employed.
From a standpoint of resources (funds, staff and other resources) three possible models were identified:

- No action model – keeping staff and financial contributions as they were
- Reduction model – reduced staff and financial contributions
- Addition model – addition to staff and financial contributions

Through the HuIA it was found that impacts from the three models could be expected on the clients, the society, the environment, the image of Kerava, and on the employment unit. For the society, analysis was made on attitudes and values as well as social and health care costs.

On the basis of the methods of employment three models were identified:

- No action model – working with the client in mind with methods varying
- Flexible model – focus more on the clients personal needs and requests
- Employment model – actions solely focus on employment

These models were analysed in relation to the impacts on the employment unit clients in regards to issues such as their life situation, motivation, impacts on the family, relationship, income, health and self-esteem.

The HuIA was given to decision-makers, used when applying for employment funds, and used to organise and clarify working methods within the Employment Unit in what was seen as a continuous process.

3. Turku

In 2003 students at the Turku polytechnic conducted a HuIA on the plans for construction of a new cabin in a recreational area in Turku. The background for the HuIA was the demolition of an old cabin located in the area and the subsequent plans for the construction of a new cabin.

Stakeholders identified three models:

- No action model – no new cabin. Proposed by residents of the area
- New cabin at same site – proposed by young people who were the main users of the old cabin
- New cabin at a new site – proposed by a working committee

The three models were analysed in regards to the object of impact, such as other people, children and health sector, and the impact, such as public image, littering and accidents.

The HuIA was conducted through the use of assignment cards. The cards had instructions on the phases of information search, analysis and assessment and more specific instructions on different standpoints (authors note: This is their word) of impact such as environment, young children and disabled. Both quantitative and qualitative methods were identified as methods of information gathering.

The HuIA was used to initiate discussion on whether the cabin should be build and if so where. The outcome of the discussion was not reported.