

Human Rights and Wrongs: Could Health Impact Assessment Help?

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When western governments talk about civil and political rights, their Asian and other counterparts respond with talk of economic and social rights.¹

While the importance of civil and political rights to health advocates is widely acknowledged, economic and social rights are not yet securely on advocates’ agenda. Health impact assessment is an approach that can promote an appreciation of their importance. This paper introduces health impact assessment, gives examples of how it is being used, links its development to a focus on inequalities in health status, indicates the insufficiency of civil and political rights to protect health, and shows that the use of health impact assessment draws attention to economic and social rights. While civil and political rights are an astonishing social achievement, they are not in themselves sufficient to promote health.

Health impact assessment has been defined as “the estimation of the effects of a specified action on the health of a defined population.”² It is essentially a decision-making tool that draws on a scientific evidence base. It developed out of the now universal acknowledgment of the health impact of public policy,³ coupled with 30 years’ experience assessing environmental (and later social) impact following the U.S. National Environmental Policy Act of 1969.

Health impact assessment is now being employed by international bodies such as the World Health Organization (WHO) and the European Union. In the United Kingdom, the current New Labour government has given considerable encouragement to the development of health impact assessment, and has made a commitment to undertaking assessments of major policies.⁴ In 1997, the government commissioned

the Acheson Report,⁵ an independent review of inequalities in health. The report was commissioned to examine the scientific evidence regarding the causation of inequalities in health status and to recommend key areas for policy development. It adopted a “socioeconomic model of health and inequalities ... in line with the weight of scientific evidence.”⁶ It made thirty-nine recommendations, three of which were given top priority. The first of these proposed that “as part of impact assessment, all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities, and should be formulated in such a way that by favouring the less well off they will, wherever possible, reduce such inequalities.”⁷

This acknowledgment of the need to measure the impact of public policy on inequalities in health was a landmark event in the United Kingdom. Furthermore, the report’s recommendation to track the impact of private health-care provision on inequalities in health extended the scope of health impact assessments beyond public policy to the operation of any agency in the market economy. Health impact assessment can thus be seen as a methodology for exposing the actions needed for, or detrimental to, a sustainable world community — a potentially powerful tool signaling the need for economic and social rights to promote health.

The longest established U.K. health impact assessment program is at Liverpool University, where first the Liverpool Public Health Observatory and then its successor body, IMPACT (the International Health Impact Assessment Consortium), developed and applied systematic methods for health impact assessment.⁸ This has involved a program of case studies prospectively evaluating urban policies and projects.⁹ In brief, the Liverpool approach involves:

- applying a screening procedure to select policies or projects for assessment;

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- defining the scope of the health impact assessment in terms of depth, duration, spatial and temporal boundaries, methods, outputs, and the like;
- policy analysis;
- profiling the areas and communities likely to be affected by the policy;
- collecting qualitative and quantitative data on potential impacts from stakeholders and key informants, using a predefined model of determining health impact;
- evaluating the importance, scale, and likelihood (and, if possible, cost) of potential impacts;
- searching for the evidence to validate data;
- undertaking option appraisal (i.e., developing and choosing from alternative options) and developing recommendations for action; and
- monitoring and evaluating results following implementation.

The model of health employed by practitioners is crucial to both the health impact assessment process and its outcomes. Work in “less developed” countries has tended to employ a medical model, focusing on possible disease outcomes of development projects. Arguably, a social model that incorporates a more holistic concept of health and a broad range of social determinants is more appropriate to policies and to human rights. In Liverpool, a socioenvironmental model derived from the work of Lalonde and Labonté is used. Such concepts of health in turn result in the identification of broader ranges of potential health impacts of projects and policies.

Like science, medicine, and health, health impact assessment is not value-neutral. The values used in carrying out an assessment need to be explicitly stated. Equity is a key value because public policy disproportionately affects the already disadvantaged. This implies a need for the health impact assessment to focus not just on average impact values, but on the distribution of impacts across affected population groups.¹⁰ From the adoption of an equity-focused approach also follows the need for participatory methods and for keeping all stages of the assessment process open to public scrutiny.

Good science implies that the methods used should be appropriate to what is being studied, rather than a specific method being used in all situations. Initial indications, however, are that the framework outlined above is sufficiently robust to be applied — with appropriate adaptation — in virtually all situations. For example, an ongoing health impact assessment of a U.K. government vehicle technology strategy (a public-private partnership to predict and plan future vehicle design) is employing techniques from health economics and from transport planning within this overall framework. However, the health impact assessment is at an early stage of development and further refinements will undoubtedly be required.

HEALTH IMPACT ASSESSMENT IN PRACTICE

Within the United Kingdom, health impact assessment is being used in a wide range of projects and policies, especially within government-funded urban development programs. So far, it has been used more in project than in policy development. Because it is a relatively new approach, few examples of completed assessments have been published. Probably the largest project in which health impact assessment has been used was in the development of the second runway at Manchester airport, where a pioneering health impact assessment in the early 1990s identified a wide range of potential health impacts relating both to changes in disease and injury prevalence and to psychosocial changes resulting from the construction and operation of the runway. A wide range of recommendations was made and accepted by the airport developers, resulting not only in modifications to the development proposal, but also in the establishment of a committee consisting of the major stakeholders to monitor implementation of the assessment’s recommendations.

At the other extreme, health impact assessments have been used to enhance the health effects of small local projects, such as housing developments, domestic energy efficiency schemes, community safety (crime reduction) projects, parenting initiatives, and leisure centers. One health impact assessment, related to the proposed development of health promotion, exercise, and sports facilities on a brownfield (former industrial) site, resulted in the project not going forward when the extent of chemical pollution on the site was exposed.

In the policy area, the Greater London Authority is undertaking health impact assessments of its economic and environmental policies. A number of regional transport strategies in the United Kingdom have been subjected to health impact assessments, as has a government burglary reduction strategy.

HEALTH IMPACT ASSESSMENT, HEALTH POLICY, AND POLITICS

Health impact assessment is a decision-making tool of major potential relevance to the exercise of governmental power. Traditionally (and still for many people today), a department or ministry of health is the major government agency whose activities influence the health of the population. The provision of health-care services is the main focus of attention. The size of the budget for hospital and community services and the structure and organization of the health-care services are treated as the key to shaping health. But the starting point for health impact assessment is the recognition that health is not the business of a department of health alone. The policies of other government departments, such as those concerned with transport, housing, sport and culture, taxation, or welfare benefits, also have important effects for health. Taken together, they may have more of an impact on health than health-care services. Furthermore, the other key determinants of health lie outside of government, in the workings of the economic and social system.

Health impact assessment was developed in countries with liberal democratic traditions, where governments get their authority through elections and operate according to the rule of law. Health impact assessment is seen as a mechanism to be used by governments to enhance their capacity for health-promoting policy and to limit their health-damaging policy. It provides a basis for subjecting the exercise of power to public scrutiny and account. And this applies to whatever the source of power. For example, there is substantial evidence pointing to the health impact of macroeconomic actors, such as private sector companies, and public bodies charged with global oversight of economic activity, such as the International Monetary Fund, the World Bank, and the World Trade Organization.

Health impact assessment should be seen as a project still under construction — a potentially progressive and liberating project offering processes and tools for displaying the health-related implications and consequences of diverse policy options. It creates a prominent position in public policy for epidemiology. Health impact assessment has been promoted by social epidemiologists and those in international politics who are concerned about the increasing inequalities in health during the last quarter century, when welfare systems have been under attack in the West and the collective voice of what were formerly called “third world” countries — expressed in the 1978 WHO Alma-Ata Declaration — became muted.

Since then, the voices that have held sway in international policy hail from the Group of Eight nations, the Organization for Economic Cooperation and Development, and the Davos World Economic Forum. These voices rally to the banner of human rights — but to a human rights discourse that begins and ends with the civil and political rights that protect individuals. These are the jewels in the crown of capitalist democracies. Capitalist democracies are less comfortable with signing on to the economic and social rights expressed in the demands for freedom from want and from degraded biodiversity. The insights from feminists and from environmentalist and development-related nongovernmental organizations, however, point to the significance of “upstream” factors for health (e.g., domestic violence) and, therefore, give added weight to the impact of economic and social rights.

Human rights and Western liberalism

Human rights discourse is the obvious candidate for applying a value framework to our collective affairs at a global level. While civil and political rights take priority in Western democracies — where they are treated as the core rights at stake when considering links between human rights and health — social and economic rights have been put onto the agenda by “Communist,” “less developed,” and “third world” countries. Such countries assert that access to the means of life is the basic right affecting health. Feminists have argued that we cannot pick and choose among rights, that the full body

of human rights provides a mutually supportive structure essential for health and well-being. Any investigation of the inequalities in health — a major issue for health impact assessments¹¹ — suggests that feminists are correct.

The emphasis on civil and political rights in human rights discourse builds on a wide and complex liberal tradition — one which nourished Kant and Marx as well as Locke and Adam Smith. All of these thinkers believed in the human potential for making sense of the world we live in and that our understanding of the world could help us deal with forces that would otherwise control us. Access to information, the ability to meet and discuss, opportunities to publish what one really thought were fought for within this tradition. So was the development of the rule of law. Civil and political rights are grounded in entitlements that protect us from ignorance and arbitrary coercion, even by duly constituted authorities. The view that civil and political rights are sufficient is fed by the ideological dominance of the United States. This view omits social and economic rights from the rich liberal tradition and gives priority to the right to private property. This, in turn, emphasizes the liberty of individuals as the key value, and due process of law within a given state as the paramount mechanism for protecting rights.

An extensive body of work has shown that the rich liberal tradition is riven with contradictory assumptions, such as those about the conditions for the development of human powers and about the central place accorded the right to unlimited acquisition of private property.¹² The tendency within liberalism that prioritizes property rights derives from John Locke, and took deep root in the United States via the work of Nozick.¹³ On this view, private property rights bear fundamental weight and we have rights *because* we have a property relationship to ourselves. It treats each of us as owners of ourselves. We are deemed to have a natural right to dispose of our capacities and powers as we see fit.¹⁴ This means that we are free to dispose of our labor (or our organs or bodily substances such as blood). This tendency within liberalism is in conflict with the view that we have economic and social rights.

This results in an approach to human rights familiar from Cold War foreign policy and Reaganite domestic policy. It is emerging again in the current Bush administration. These philosophical positions are embedded in institutional arrangements that deflect consideration of how we are systemically connected to one another globally, irrespective of our choices. These arrangements make redistributive social policy unlikely. They include a constitutional arrangement in the United States that prioritizes states’ rights over federal competence; nonharmonized tax and benefit regimes among U.S. states that lead capital to locate in less regulated regions; and a labor market and immigration policy that offer the United States as a magnet for skilled individuals, typically educated in poorer countries to tertiary level. The net effect of these influences is a restricted interpretation of human rights as

applying to individuals presumed to be unencumbered rational economic adult agents (thus excluding obligation-bearing women and their dependent children and/or disabled elders).

The liberal tradition has benefited from at least 300 years of philosophical reflection and institutional embedding. The tendency that gives so much weight to private property rights is nonetheless only one version of the liberal story. Other tendencies emphasize the development of human potential and open the way for economic and social entitlements to be seen as conditions for human flourishing.

Human rights as including social and economic rights

Civil and political rights are progressive “common sense” by contrast with feudal societies, which treated people exclusively as members of communities. Communities that permit unrestricted interference with individuality can be deeply oppressive. Hence, a thirty-something lesbian from Delhi with a Ph.D. in computing might feel herself liberated in Silicon Valley, where close to 30 percent of the companies started in the second half of the 1990s were run by executives born in China or India.¹⁵ She probably benefits from civil and political rights that protect against discrimination on grounds of gender or sexuality. On the other hand, her 14-year-old counterpart working in Delhi in a subsidiary of a U.S. transnational corporation not bound by minimum labor laws is in need of social and economic rights.

Social and economic rights take as their starting point our duties to one another and the location of individuals within structures of interdependence. The International Covenant on Economic, Social and Cultural Rights, the primary embodiment of such rights, makes ambitious demands.¹⁶ It goes beyond “freedom from interference.” It requires action to “create freedom.” The view that commitment to human rights cannot be confined to civil and political rights is increasingly asserted by those whose focus is on health and health care. Considering political and civil rights as well as economic and social rights, the British Medical Association argues “that the full range of human rights is essential and that different categories of rights are interdependent and indivisible.”¹⁷ The Association notes, however, that “industrialized countries frequently emphasize personal liberty and free markets but deny basic socio-economic rights to underprivileged people.”¹⁸

Health impact assessment and human rights

Health impact assessment seeks to locate itself on a broad policy canvas that tracks health impacts across the causal spectrum. It is thus relevant to the concept of human rights advanced by the International Covenant on Economic, Social and Cultural Rights. It does not have to be confined to limits set by civil and political rights.

The WHO Declaration on the Promotion of Patients’ Rights in Europe¹⁹ is an example of a mechanism confined to limits set by civil and political rights. It emphasizes rights to informed consent in relation to health care — especially treatment and participation in research. It entitles patients to know what their diagnosis and prognosis is, options for managing their condition, side-effects of treatments, and so on. It entitles children and young people to be treated as partners in decision-making. These are important gains against a background of paternalistic health-care provision. But it is notable that those drafting the Declaration found it difficult to produce a statement about robust rights to health care in the first instance, limiting themselves instead to rights about how those already with access to health care should be treated. The document is also silent on the entire area of establishing a social and economic environment to promote health.

Arguably, a health impact assessment is implicitly operating in relation to human rights discourse already. Reporting mechanisms set up to support the United Nations Convention on the Rights of the Child involve cooperation at the highest level of government in supplying information for United Nations committee review. On this basis, the United Kingdom has been found negligent regarding avoidable inequalities in health among groups of children.²⁰

Human rights and globalization

Nation-states, in the modern period, have been characterized as those bodies that have a monopoly on the legitimate use of force on their territories. Consequently, human rights discourse has been addressed to nation-states. Human rights can challenge democracies’ complicity in health-damaging world trading regimes. But at present, human rights lacks adequate machinery to address issues thrown up by cross-border movement of peoples and the forces of globalization. Powerful states are typically averse to surrendering sovereignty to supranational tribunals that could hold them to account.

It is notable that some powerful states most keen to extend enforceable global market mechanisms are among the least willing to apply enforceable human rights law to themselves. Hence the United States, loathe to agree to an international court for human rights offences, “initiated legal proceedings against Brazil, through the World Trade Organization’s dispute settlement body, claiming that Brazil’s production of generic drugs breaks international laws on patent protection.”²¹ Meanwhile, weak states cannot or will not protect their citizens “from private power, whether it is paramilitaries committing murder or torture or transnational corporations ... spreading contamination or pollution...”²² In this context, we need a wider canvas for human rights as indicated by the International Commission for Jurists, which debated treating transnational corporations as “para-state entities to be held accountable under the same sort of regime as states.”²³ Unless this is done, human rights discourse will

continue to be defined narrowly, so that it conflicts least with market mechanisms in other aspects of the economy and society. Human rights law runs the risk of falling into this trap if it uses measuring and reporting tools that fail to capture the fundamental causal features in society that social epidemiologists refer to as upstream factors.

CONCLUSION

Health impact assessments can and should aim to provide tools that can capture the most deep-seated, systematic, and global economic and environmental crimes in which humankind is complicit. Human rights discourse offers us a vocabulary for engaging with the collective future of our species. It transcends the boundaries established by treating nation-states as the limits for authority over citizens. It makes claims on behalf of those whose citizenship gives them insufficient protection, such as the asylum seeker. Broadly defined, social and economic human rights discourse makes claims on behalf of anyone, anywhere on the planet, whose well-being is compromised by the “neighborhood effects” of business as usual carried out in the seats of power. A broad approach to human rights highlighting social and economic rights, and a broad approach to health impact assessment grounded in progressive social epidemiology, would enable us to take up the challenge:

[W]e are now a global people ... we are obligated to take responsibility for things that are connected to us, even when far away. Unless we work to understand the links that tie us ... we are puppets, subject to forces we can't or won't control.²⁴

Jonathan Mann popularized the notion that health is a human rights issue. But where did he stand on the question of a narrow or wide interpretation? His view was that the focus should be social rather than individual, directed to threats to the health of whole populations, giving particular attention to inequalities in health status. He was particularly concerned with the “world-wide epidemic of human immuno-deficiency virus and AIDS ... women's health and ... the complex humanitarian emergencies of Somalia, Iraq, Bosnia and Rwanda and ... Zaire.”²⁵ To embark on overcoming inequalities in these areas, he concluded that we have to take the broader view: “protecting human rights is inextricably bound up with promoting and protecting health ... because human rights offers a societal-level framework for identifying and responding to the underlying — societal — determinants of health.”²⁶

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