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An Investigation of the Utilisation of Health Impact Assessments (HIAs) in Irish Public Policy Making

Monica Mary Eileen O'Mullane, B.Sc., M.A.

(100093751)

A major dissertation carried out under the supervision of Dr. Aodh Quinlivan and presented as part of the requirements for the PhD Degree in Government, to Professor Neil Collins, Head of Department of Government, University College Cork

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CHAPTER 1
INTRODUCTION

1.1. Research Aim

It is the aim of this thesis to investigate Health Impact Assessment (HIA) use in public policy formulation in Ireland. The influences affecting the use of HIAs will be examined in this study. Four case studies, where HIA has been conducted, will be used for research analysis. HIA is a policy- and decision-support tool which identifies public policy effects on population health. It "aims to identify how development induces unintended changes in health determinants and resulting changes in health outcomes" (Quigley *et al.* 2006:1). It is an instrument within the current phenomenon of evidence-based policy-making (Whitehead *et al.* 2001; McAuliffe and McKenzie, 2007). Although it has been acknowledged as a worthwhile and necessary tool to inform decision-makers (Wismar *et al*. 2007; Morgan, 2008), the extent to which it is used in policy in Ireland is subject to scrutiny. Are HIA reports being produced and left to gather dust on the shelves of state authorities, glossy evidence-profiles unused in the policy process? What influences the use of HIA evidence?

The answers to these questions lie within this exploratory study investigating the influences on the use of HIA evidence. To date little academic exploration has been conducted in this area and sparse attention has been paid to the use of HIA evidence in policy formulation in Ireland (Kearns and Pursell, 2007). The European Health Observatory on Health Systems and Policies has called for each country to investigate this decision-support tool, as recommended by the pan-European evaluation on HIA effectiveness. Such investigation is required in order to "explore the usefulness of the concept and the feasibility of its implementation in a specific national context" (Wismar *et al*. 2007:28). The United Nations Special Rapporteur on the Right to Health, Paul Hunt, stated at the eighth HIA International Conference that governments, under their obligations in ensuring the right to health (as has been the case since 1948), have a duty to introduce HIAs into all proposals of policies, plans, projects and programmes (Hunt, 2007). Therefore, an examination of the contextual conditions of HIAs and their potential to be used in policies is required.

1.2. Background to Research

The term 'Health Impact Assessment' reveals its core emphasis: to assess the predictive impacts of *all* public policies, projects and programmes upon population health (author's emphasis). The concept stresses intersectoral partnership on an array of public policy issues. The goal is to ensure that population health is promoted, and that health risks, as far as is practicable in the usage of health predictions, are mitigated.

Although various definitions and meanings of Health Impact Assessment exist, most agreement in practitioner and academic circles centre on the definition drawn up by in World Health Organisation (WHO) Gothenberg Consensus Paper in 1999:

> "A combination of procedures, methods and tools by which a policy, a programme, or project may be judged as to its potential effects on the health of a population and the distribution of effects within the population" (cited in Kemm and Parry, 2004:2).

Arising from the conceptual roots of Environmental Impact Assessment (EIA), and public health and health promotion, HIA has become the panacea for a health evidence-based policy-support tool that emphasises the impact of all public policies on population health. In terms of policy-making processes the tool aims to influence the content and implementation of devised policies so as to maximise the health benefits and minimise the identified detrimental effects of the proposed policy. It is hoped that all policies which are appraised using the HIA framework are prospective, so as to maximise the extent of influence, although that is not always the case (Kemm, 2006). HIA is defined as a policy-support tool that will add value to a decision by providing analysis of such positive and negative impacts of a specific policy (Davenport *et al*. 2006). Increasingly the understanding of how to influence policy-making processes appropriately in order to ensure HIA evidence and knowledge use has become one of the most important ingredients for HIA policy adoption.

In Ireland, HIA is best understood by examining the relevant health strategies. The National Health Strategy (2001:61) stated that "HIA will be introduced as part of the public policy development process," and regional authorities were called upon to "consider the impact of their decisions on population health in their area" *(ibid).* A similar message was pronounced in the National Health

Promotion Strategy (2000) and in its review (2004) in the Republic of Ireland. In Northern Ireland, the public health strategy in Northern Ireland (Investing for Health, 2002), which is a cross-departmental document, recognises HIA as a mechanism to reduce health inequalities and as a means of promoting health and wellbeing (Lavin and Metcalfe, 2007). Northern Ireland's regional health strategy (A Healthier Future, 2005) also advocates the use of HIA as a policy-support tool. The implementation of HIA in practice has been at a local government level with the steering support of the all-island Institute of Public Health. For the purpose of this doctoral research, four case studies are examined which vary in their HIA emphases; they vary in their subject focus in each HIA, as indicated in table 1 (page 5).

Each case study was conducted at local government level in Ireland. Although there is divergence in the degree of HIA outcome report and process information available, each are looked at in terms of the following: rationale, background, stakeholders (decision-makers; community representatives; health and social care professionals), methodology, and the policy process and relevant actors envisaged to use the HIA knowledge. The cases were chosen on the basis of their geopolitical locations (two in the Republic of Ireland and two in Northern Ireland) in order to reflect the all-island practice of HIA in this research. The HIA conducted on local traffic and transport in the Ballyfermot community in Dublin was the first case study researched. In this area, traffic problems were cutting through the heart of the community and it was an issue identified by the local community. The HIA was deemed appropriate for examining health impacts. It was then led by the HSE and the URBAN II programme primarily, supported by Dublin City Council. The second case that was investigated was the HIA conducted on the Donegal Traveller Accommodation Programme (TAP). This HIA was carried out and led by the Donegal Traveller Project, in conjunction with the Health Service Executive (HSE) and Donegal County Council. Travellers in the county suffer from poor housing conditions, linked with poor health status, when compared with the general population. This is reflective of the situation nationally.

The third case investigated an HIA carried out on the draft air quality action plan that was drawn up by Belfast City Council. The draft plan required a consideration of health consequences of the policy, as identified by the Environmental Health Manager in the Council as well as the Belfast Healthy

Cities officials. Areas in Belfast were idenitified as having poor air quality and measures were examined as to how such levels could be reduced. The HIA ensured greater community consultation and recognition of the health impacts of physical infrastructure, namely the roads network. The fourth and final case was a social regeneration project in Derry city. This HIA aimed to involve the decanted residents of a social housing estate in the design of their future housing. The HIA was initiated and led by the Northern Ireland Housing Executive (NIHE) in conjunction with the local community health forum, health services (Western Investing for Health), local residents and the housing association.

All four HIAs resulted in greater community mobilisation of social issues and facilitated greater inter-sectoral consultation across the institutional boundaries that normally deal with the abovementioned issues. This research aims to investigate the *extent* of HIA utilisation in policy adoption after the process was completed. The contextual influences were examined which may explain and explore use and non-use, in the aftermath of the HIA process. This research is not solely investigating the use but to what extent HIAs were used.
The Finnish EU Presidency (2006) of the EU advocated the need for HIA usage across Europe. The European leadership highlighted the importance of such a tool by emphasising that HIA is a necessary instrument to ensure 'health (is) in all policies' (Koivusalo, 2006). The central role that HIA plays in the European Healthy Cities Network also illustrates the importance of the tool. Currently Galway and Belfast compose the Irish Healthy Cities. The use of HIA is widespread across Europe, Australia, and parts of the developing world. Apart from the rise of some consultancy firms in the United States, and academic work, HIA has not developed as progressively in the US as in other regions of the world (Dannenberg, 2006). While some countries have institutionalised HIA at a national–policy making level, such as in the Netherlands and Canada, most countries' HIA activity is at local government level.

The area of HIA is still a novel field of inquiry in the spheres of policy analysis and healthy public policy. As a result, it has been deemed appropriate to investigate the phenomenon of HIA influence on the policy process from a normative and relativist standpoint. This proposition is opposed to the more positivist embrace of facts and rejection of abstract conjecture. In addition this investigation is one stimulated by exploratory work, and consequently, is influenced by the heuristic underpinnings of research.

HIA is well-placed within the literature (chapters 2 and 3) and the case study settings (chapter 5 and 6). The rationale for the study is established by a gap in existing research; it has been conducted elsewhere, including the Netherlands (Putters, 2005; Bekker, 2007) Wales (Elliott and Francis, 2005), Slovenia (Lock *et al.* 2003) the United Kingdom (Davenport *et al.* 2006), New Zealand (Morgan, 2008), and across Europe (Wismar *et al.* 2007). It has not yet been conducted solely in an Irish context. The four case studies to be analysed in this research are outlined in table 1. The range of issues at the foci of the cases, and their varying geopolitical locations, adds depth of knowledge to this research. The cases are examined within the multiple case study research design (chapter 4) which provides a protocol for data collection and analysis (Yin, 2003). This research design also ensures that the context-specificity of each HIA is incorporated into the narrative of the every case. The impact of the non-health sector on population health, as is a consideration of the healthy public policy paradigm (Dallaire, 2006; Bekker, 2007; Harney, 2007), is certainly evidenced by the variety of cases to be analysed.

Table 1: Case Studies used in the Research Framework: HIA Subject and Political Jurisdictions

	Republic of Ireland	**Northern Ireland**
Physical Environment	Dublin	Belfast
Housing	Donegal	Derry

A theoretical framework, drawing from institutionalist (structure-orientation), impact assessment (values-orientation) and knowledge utilisation theories, underpin this study. The evaluation of this process will involve an examination of the unit of analysis (the HIA steering groups which were made up of local authority decision makers, statutory health practitioners, and community representatives). The contextual political environment is also looked at within which the HIA is embedded. The overarching structure and underlying values, which are hypothesized as present in each HIA case, are investigated in this research. Section 4.3 of chapter 4 (page 124) provides greater detail of the research framework.

HIAs *should* incorporate available evidence from processes and reports into policy concerns; HIAs *should* influence the policy process. An expectation of the HIA process has established this normative underpinning. This doctoral research is posited to examine whether this is the case or not, and can it be the case in the future. Therefore, a normative understanding underpins the research questions.

The European-wide evaluation of the effectiveness of HIA in policy formulation, funded by the European Union (EU) and the World Health Organisation (WHO), was completed in 2007. This systematic review was long overdue as no previous methodical appraisal of HIA effectiveness within policy processes has been carried out to date (Wismar, 2003; 2004; 2006; 2007). In terms of assessing the implications of HIA as a policy-aiding tool, this aforementioned research project has cited the influence of the institutional and political context upon the effectiveness of HIA as a decision making tool.

This thesis aims to investigate Health Impact Assessment (HIA) use in public policy formulation in Ireland. The influences affecting the use of HIAs will be examined in this study. By incorporating the learning from this European evaluation, in terms of the realms of influence upon HIA usage, this research framework can amalgamate practical learning with academic knowledge.

The following section outlines the structure and content of the thesis.

1.3. Chapter Plan

Chapter 2

This doctoral research is multidisciplinary and is located within numerous fields of inquiry. This is reflected within the literature review, which examines Health Impact Assessment (HIA) in relation to the basic idea of health conceptualisation, dating back to the middle ages. HIA has two identified conceptual roots and dichotomous fields of enquiry: Impact Assessment and Health Promotion. HIA has evolved through empirical investigation and academic and practitioner interest

Chapter 3

Political science, and in particular the policy sciences, have been identified as the key area for explaining the use of HIA knowledge. The key theories in this field are dealt with in chapter 3. Impact assessment provides one conceptual root of HIA, as is evidenced by its rationale and place within the policy sciences. The location of IAs within the policy sciences and the relevance of the IAs to HIA is detailed in this chapter also.

Chapter 4

The study's research methods and techniques are presented in this chapter. A case study design will be used utilising a qualitative methodological approach.

Chapter 5

The health care and local government systems in the Republic of Ireland are described in this chapter in order to outline the case study settings for this research. The two cases conducted in the Republic are provided in this chapter; the HIA on traffic and transport (physical environment) in Ballyfermot, Dublin, and the HIA on the Traveller Accommodation Programme (housing) in Donegal.

Chapter 6

The health care and local government systems in Northern Ireland are described in this chapter in order to outline the case study settings for this research. The two cases conducted in Northern Ireland are provided in this chapter; the HIA on the draft air quality action plan (physical environment), Belfast City, and the HIA on the social regeneration project (housing) in Derry city.

Chapter 7

Practical recommendations and theoretical conclusions are provided in chapter 7. Limitations of research, proposals for further research and overall conclusions are also presented.

As explained in this introductory chapter, this research will investigate Health Impact Assessment (HIA) use in public policy formulation in Ireland. The influences affecting the use of HIAs will be examined. The following chapter commences the literature review with an investigation of the conceptualisation of health, ranging from the biomedical approach to the holistic social model of health. The manner in which health is viewed, understood and portrayed in policy is an important consideration for this research study.

CHAPTER 2
LITERATURE REVIEW I

AIM OF THE LITERATURE REVIEW

The purpose of the literature review is to firstly provide background knowledge on health conceptualisation, public health and health promotion, and Health Impact Assessment (HIA) in terms of its conceptual roots, practical utilisation and theoretical development.

Secondly, this review will chronologically trace the policy sciences and models existent in contemporary political science with a view to finding the most applicable theory for this research.

Thirdly, the literature review will present knowledge pertaining to the impact assessment (IA) technique. The relationship with the Environmental Impact Assessment movement and political science will be examined.

Literature Review Conclusions:

Section 3.3 outlines the main conclusions from the literature review. These are incorporated into the research framework (chapter 4, section 4.3. page 124) which provides the theoretical basis for this thesis.

2.1. CONCEPTUALISATION OF HEALTH

Health is viewed as a "multi-attribute concept" (Tessler-Lindau *et al*. 2003) that relies upon a network of biological, social, economic, cultural and psychological factors (Cutler and Richardson, 1998; Thorsen and Harris, 2002). Different concepts and views of health exist (Seedhouse, 2001), which have considerable influence upon government ideology and policy-making (Downie *et al*. 1996). Understanding the theories of health conceptualisation is integral in understanding the approaches policy-makers adopt in the formulation of public policy, in both the health and non-health sectoral domains. The following demonstrates the varying health conceptualisation approaches that have progressed since the middle ages until the present day.

2.1.1. The Biomedical Model

Since the sixteenth century, the biomedical model has developed in line with Western scientific thinking (Doyal and Doyal, 1984). The history of this model is often associated with Descartes' view of the mind and body as separate systems (Hewa and Hetherington, 1995). Implicit in this medical thinking is the belief that health equates with the absence of illness (Wade and Halligan, 2004). The biomedical model assumes a causal relationship between disease and illness. Indeed, it is undeniable that the success of biomedical approaches is measured by the reduction in communicable diseases over the past two centuries (McLaren, 1998). The "often criticised but nevertheless dominant" biomedical model (Wade and Halligan, 2004:330) was consolidated and advanced by Virchow's research hypothesis that all illness derives from physiological malfunctioning (Porter, 1997). Indeed this conceptualisation and progression of thought pertaining to public health was spearheaded by major figures in the nineteenth century, most notably Villermé in France, Chadwick in England and Virchow in Germany (Chave, 1984; McKevitt, 1990).

The biomedical approach, and medicine as an institution, is still dominant in Western society (Gabe *et al*. 1994; Jones, 1994; Longino and Murphy, 1995; Tormey, 2003). Epidemiological figures of mortality rates (death statistics) and morbidity rates (disease patterns) are currently used as indicators of population health (Tessler-Lindau, 2003), despite the explicit negative connotation inferred by such. Research findings have indicated that the biomedical model is ever-present in societal thinking (Herzlich, 1973; McCluskey, 1989; Blaxter, 1990; Cox *et al*. 1993; Wade and Halligan, 2004). This is also illustrated by the presence of our ill-health systems (Wren, 2003), which place greater emphasis upon the treatment of disease rather than the promotion of health and wellbeing. However, the narrow disease-orientation of the biomedical model is defended by few practitioners and academics nowadays (McKeown and Lowe, 1974; Illich, 1977; Doyal and Doyal, 1984; Nettleton, 1995; Sidell, 2003; McCluskey, 2006a). It is accepted that it lacks the incorporation of other factors that are known to influence health (Wilkinson and Marmot, 2003).

The twentieth century witnessed health conceptualisation theories evolve from such that were characterised by bodily (mal) functioning, towards the more holistic in nature. Maslow's (1954) seminal work identified the limits of this mechanistic medical orientation. His research recognized the need for a more

balanced approach towards health conceptualisation. This is in order to take account of social, emotional, economic and psychological aspects that contribute to overall personal health. This work was duly influenced by the World Health Organisation (1948) definition which recognizes health as being more than solely the non-existence of disease.

The following traces the development of health conceptualisation. The section demonstrates the move away from the narrow medical orientation towards a broader concept of health.

2.1.2. The Biopsychosocial Model

Engel (1977:129) recognised that the biomedical model of disease "leaves no room within its framework for the social, psychological, and behavioural dimensions of illness." The milestone work of Engel (1960; 1977; 1980) challenged the one-dimensional medical thinking supported by the biomedical model. Negative health conceptualisation prevails in the biomedical model (Tessler-Lindau, 2003; Sheridan and Radmacher, 1992). Alternatively, the biopsychosocial model presents a more complex, 'systems theory' approach to health and illness. It provides a conceptual base underlying a broader concept of health (Anderson, 1998). Essentially, this approach propounds the view that social, psychological, and biological factors are interactively related to health and illness (Suls and Rothman, 2004). All of these processes are seen as affecting one another and interacting together in impacting health. Since the seminal work of Engel, research across a substantive range of disciplines confirms how the biological, psychological and social processes combine to affect health outcomes (Cohen, 1998; Baum and Posluszny, 1999). Antonovsky (1996) contributes towards the broader conceptualisation of health with his salutogenic approach. This theory emphasises the protective factors that enable people to be healthy, as opposed to the biomedical approach, which is preoccupied with the risk factors of ill-health.

The biopsychosocial model is widely accepted as the theoretical and practical basis for advancing the concept of health (Suls and Rothman, 2004). It embraces the broader facets that contribute to individual health.

The following section advances from the holistic and broad nature of this model. The social model of health places greater emphasis upon environmental

influences on individual and societal health. Notably, it has been adopted and advocated by the World Health Organisation (WHO).

2.1.3. The World Health Organisation: Forerunner of the Social Model of Health

The biomedical assumption pertains to the view of health as a state without illness. However, the WHO (1948) proposed a definition of health, in terms of positive features rather than the absence of negative ones, as is demonstrated in the following quotation; "Health is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Cited in Ryan *et al*. 2006:ix).

In this definition, the authoritative voice of the WHO sets the agenda for re-orienting curative services to cater for those striving for positive health gain, and not focused solely on those with illness and disease. It is criticised throughout the literature for aspiring to an unattainable level of health (Lewis, 1953; Downie *et al*. 1996; Seedhouse, 1997; Siracci, 1997; Butler, 2002). The definition is misleading, in one sense, as it proposes health as an absolute concept. This is unachievable in reality (Downie *et al*. 1996). However it presents a more positive ideal to strive for, rather than operating from the narrow biomedical focus (Kemm and Parry, 2004). The definition advances a positive concept of health "in which preoccupation with disease is replaced by recognition of the broad social parameters of individual health" (*ibid*:12). Currently, it is acknowledged that it is the social environment, within which one lives, that plays a greater role in individual health, and not solely medical advances and treatments (McKeown and Lowe, 1974; Acheson, 1998; McCluskey, 2006a). This recognition of social environmental influences upon health is demonstrated in the WHO definition. It relates to the social model of health. This emphasises that environmental factors[7] have an impact upon health and illness. There is greater importance placed upon the interaction between the individual and their environment (Williams, 1983; Marmot and Wilkinson, 1999). An influential driver of this approach was Lalonde, Canadian Minister of Health and Welfare, who promulgated the 'health field' concept (Table 2, page 13) in the policy document 'A New Perspective on the Health of Canadians (Lalonde, 1974). The report was critical of the narrow focus of the biomedical approach. It called for

[7] The term 'environment' is used broadly to mean the physical and social conditions within which individuals and communities operate in (Naidoo and Wills, 2000).

improvements within the environment (a structuralist approach) and in behaviour (an individual approach) at societal and individual level (Bunton and MacDonald, 2002). It was proposed that such an approach would lead to a significant increase in life expectancy and decreases in morbidity and mortality rates in population health (Lalonde, 1974).

Table 2: The Health Field

Lifestyle factors	**Biological factors**
Environmental /societal factors	**Healthcare factors**

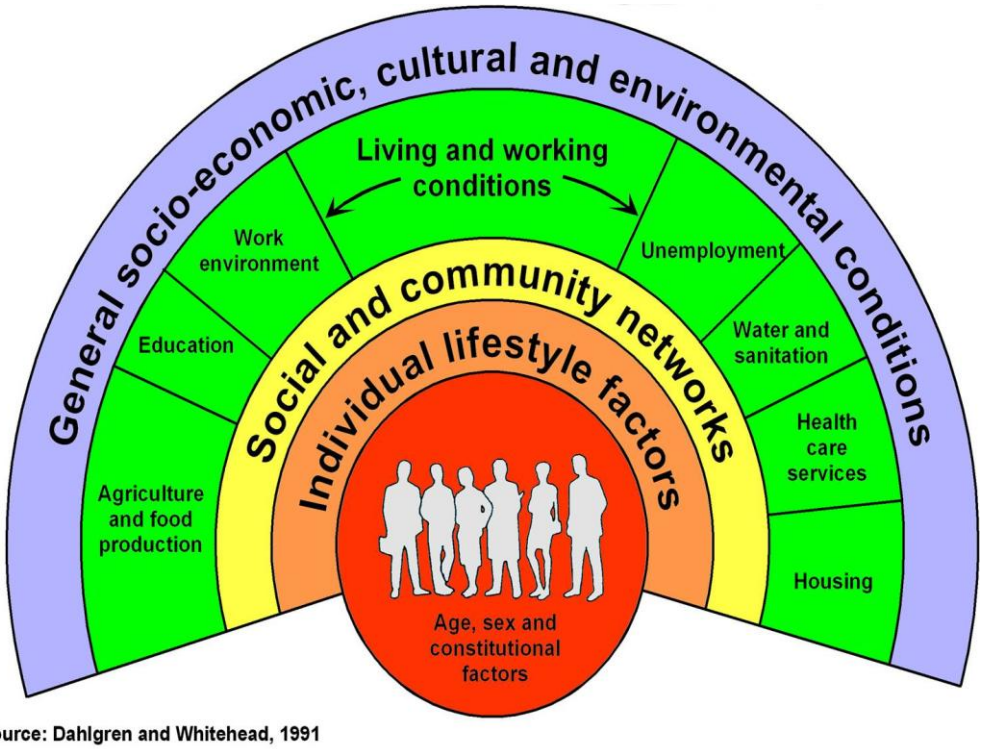
The Lalonde report prompted a series of international charters, conferences and initiatives by the WHO, from 1974 up to the present day. The social model of health acknowledges that, in order to improve individual and societal health, complex social environmental factors facing populations globally need to be addressed (Heller *et al*. 2001). Such a model of health was implicit in the international treaties and statements by the WHO over the next fifteen years or so (Kickbusch, 1997). Indeed, such advocacy of positive health conceptualisation was inferred in the Bangkok Global Conference on Health Promotion (WHO, 2005a).

2.1.4. Determinants of Health

The Lalonde Report (1974) was instrumental in acknowledging the existence of influences or determinants of health. Building on the conceptualisation that health is determined by numerous factors outside the healthcare arena, the WHO Ottawa Charter (1986) emphasised the interdependency and impact of the determinants *of* health, *on* health. The Dahlgren and Whitehead (1991) model illustrates the 'layers of influence' that determine individual health. This social model of health (figure 1, page 14) illustrates the layers of influence, or determinants, upon health. Individuals are indicated at the centre of the model with a set of fixed determinants of health including gender, age, and heredity factors (Naidoo and Wills, 2000; European Commission, 2006). Such biological factors cannot be changed. However, the model indicates the 'layers of influence' that can be modified, ranging from personal lifestyle choices, social and community networks, living and working conditions, to the general

overarching socio-economic, cultural and environmental conditions (Dahlgren and Whitehead, 1991). Those modifiable determinants of health present opportunities for positive health gain (Bunton and MacDonald, 2002) and are increasingly deemed integral to the promotion of health, as advocated at the most recent International Health Promotion Conference (WHO, 2005). Indeed, many of the key health determinants, such as housing, employment, income and transport, are issues which dominate the political arena much of the time (Bambra *et al*., 2005). However, they are not recognised as explicitly political, as will be dealt with in more detail in section 2.2. of the literature review. Suffice to say that it is becoming more widely accepted that many of the major health determinants exists outside the health sector, and thus requires non-health sector policies to deal with them (*ibid*; Milio, 1986; Acheson, 1998; Whitehead, *et al*. 2000; Van Herten, 2001; Kemm and Parry, 2004).

Figure 1: Determinants of Health (Dahlgren and Whitehead, 1991)



Source: Dahlgren and Whitehead, 1991

2.1.4.1. Health Inequalities: The Social Context of Health

Inequalities in health present challenges to society and its leaders, as the gap between rich and poor indicates glaring disparities in health status (Townsend *et al*. 1992; Acheson, 1998; Whitehead, 1999; Perry, 2002; Williams, 2003;

McGrath, 2003; Graham, 2004; Petticrew *et al*. 2004; McCluskey, 2006b). It is widely recognised that the most influential determinants on population health are mainly social, economic and cultural (Whitehead, 1992; Blane *et al*. 1996; Acheson, 1998; Wilkinson and Marmot, 2003). This has been acknowledged in government policies (Department of Health and Children, 2000; Department of Health and Children, 2001) and research investigating inequalities in Ireland (Balanda and Wilde, 2003). Inequalities exist within countries, on the basis of gender and socio-economic class, and also between countries, on the basis of monetary and resource wealth (Wilkinson, 1996; Davey Smith *et al*., 2002; Bambra *et al*. 2005). Approaching health inequalities is an inherently political activity, as only what is politically feasible on the agendas of policy makers, and depending on what the public will accept, will determine the rectifying of blatant inequalities in society (Signal, 1998; McGinnis *et al*. 2002).

Health Inequalities in Ireland: Some are more equal than others

Inequalities in health present challenges to society and its leaders, as the gap between rich and poor indicates glaring disparities in health status (Acheson, 1998; Wilkinson and Marmot, 2003). This has been acknowledged in Irish government policies (Department of Health and Children, 2001; Department of Health, Social Sciences and Public Safety, 2002a) and research investigating health inequalities (Institute of Public Health, 2001; O'Shea and Kelleher, 2001; McCluskey, 2006). Tussing and Wren's (2006) study of the Irish Republic's health care system has highlighted the glaring anomaly of Irish people on lower incomes dying younger and suffering more illnesses than their counter-parts earning higher incomes.[8] It is true to say that unequal societies experience greater levels of alienation and substance abuse than those more egalitarian, socially-cohesive ones (Wilkinson, 1996; Putnam, 2000). Faced with these hard facts, Irish society, and the people elected to public office, has a duty to ensure that medical need is met, despite financial means of the individual in question (McGrath, 2003; Ryan *et al*. 2006).

[8] For instance, unemployed women are more likely to give birth to low weight babies than their higher-income counterparts, while adults and children with low socio-economic status are more likely to smoke and have less healthy nutritional behaviours than those in the higher income brackets (Tussing and Wren, 2006).

2.1.5. Concluding Comments

This section has outlined the significant and most influential theories and approaches of health conceptualisation. The dominance of the biomedical perspective is very much in evidence, but the change in societal thinking towards a more holistic and broader comprehension of health has emerged (McCluskey, 2006a). This is clear in Ireland by the growth of health promotion over the past two decades (Butler, 2002; McCluskey, 2006a; Ryan *et al*. 2006). The biopsychosocial model contributes essential theoretical scaffolding in understanding the interdependency of the wider determinants on health. The social model builds on this while also emphasising the environmental determinants on health.

The next section deals with the rise of the health promotion movement, which adopted and advanced the social model of health, in order to further the progress of positive health and well-being. The health promotion paradigm is an integral conceptual root of the Health Impact Assessment tool as it arises from the healthy public policy action field within the evolution of the discipline. The converging and diverging development public health and health promotion will be discussed.

2.2. HEALTH PROMOTION

This section will present a discussion of the development of health promotion. How it grew from public health will be discussed also. Health promotion aims to improve individual and societal health while endorsing principles of self-empowerment, community action, and healthy public policy-making (Ewles and Simnett, 1999). Previous to the rise of the global health promotion agenda, societies and governments traditionally focused upon the curative services and institutions as providers and enablers of health and wellbeing. However it is now recognised that the most influential health determinants exist outside the healthcare system (Wilkinson and Marmot, 2003). The past two decades has witnessed the remarkable rise of such a radical change in policy direction (Catford, 2004), both in public health policy and practice. From the spirit of Alma Ata (1978) to the Bangkok Charter (2005), this section aims to trace the progress of health promotion with its public health older sibling. Healthy public policy, a health promotion concept that has grown from an embryonic idea towards an accepted approach in advancing health promotion beliefs, will be examined also.

2.2.1. Health, its Determinants and Health Promotion

Labontè (1986) has correctly stated that the broader conceptualisation of health has been adopted by the wider health promotion (Naidoo and Wills, 2000; Kemm and Parry, 2004; Mittelmark *et al*. 2004; Cooke, 2007). The multidisciplinary public health movement recognises the wide-ranging influences on health also (Orme, *et al.* 2007). The environmental determinants on health include social class, poverty, gender, housing, employment, living conditions and access to the health system (Jones, 2000; Dooris, 2006; Barton, 2007). Kemm (2001) frames this health conceptualisation as either being narrow focused, concentrating on the physiological functioning, or being broad in focus which emphasises the physical as well as social, cultural and environmental aspects of health. Social class determinants involve issues of health inequalities. The accepted hypothesis regarding social determinants advocate that wealthier people tend to be healthier and have longer life expectancy rates, as opposed to those less well off (Acheson, 1998; Ewles and Simnett, 1999; Ziglio *et al*. 2000; Graham, 2003; Wilkinson and Marmot, 2003; McDaid and Oliver, 2005; Bambra *et al*. 2005; McCluskey, 2006b). It is through dealing with, and improving, the

determinants of health, those opportunities for health promotion arise (Mittelmark, 2005; Burgoyne *et al*. 2007; Burgoyne *et al*. 2008).

2.2.2. Health Promotion: Public Health Origins and Developments

In 1977 'Health for All by the Year 2000' was launched at the 30th World Health Assembly. This was further endorsed in the WHO's 'Global Strategy for Health for All by the Year 2000' (1981) (Webster and French, 2003). The initiative built on the seminal Lalonde Report (1974) emphasising how changes in individual lifestyles and the wider environment would improve health (Jones and Douglas, 2000). This was the beginning of the 'Health for All' movement, which led to the development of the 'Global Strategy for Health for All by the Year 2000' (WHO, 1981). This Strategy called for governments to ensure health would take higher priority on policy-making agendas; not only in the health sector, but also in non-health sectors (Ewles and Simnett, 1999). 'Health for All' by the year 2000 was clearly an unattainable ideal. The landmark date has come and gone. However, it was the change in policy-makers' mindset which was notable (Naidoo and Wills, 2000; Jones and Douglas, 2000; Bunton and MacDonald, 2002). Governments were urged to desist from focusing solely on the prevention and treatment of ill-health. They were encouraged to aim towards advancing the promotion of positive health and well-being (Gorin and Arnold, 1998). The Alma Ata Declaration (1978) reinforced the message of recognizing the importance of the wider social determinants of health. The Declaration endorsed adopting primary healthcare as a pivotal method for healthcare delivery (Catford, 2004), and inter-sectoral activity as a means to more informed policy-making (Tones, 2001). It contributed to the new health promotion vision by endorsing both structuralist and lifestyle approaches in order to achieve future health gain (Bunton and MacDonald, 2002). Although no single driver may be identified that exclusively propelled the health promotion agenda, the Alma Ata Declaration is viewed as the 'seedbed' for its development for future decades to come (*ibid*). The Declaration introduced the concept of equity with health, and pushed forth an agenda which aimed to reduce the gross inequalities between rich and poor, both within and between countries (Jones and Douglas, 2000; Graham, 2005; McDaid and Oliver, 2005).

Prior to Alma Ata, the public health movement concentrated on modifying individuals' lifestyle choices and behaviours (Tones, 2001). Health was addressed through health education initiatives and disease-prevention and

treatment avenues (Catford, 2003). This restricted focus led to 'victim-blaming'[9] individuals for their unhealthy behaviours. Currently, this concept is understood to be a flawed manner for addressing health-related issues (Pitts, 1996; Ewles and Simnett, 1992; Tones and Tilford, 2001). Post-Alma Ata, health promotion arose as a refreshing paradigmatic break from the narrow disease-orientated methods towards public health (Dooris, 2006). Health Promotion advocated a more informed top-down approach to policy-making, as well as also recognizing the need for a well-anchored bottom-up approach (Butler, 2002; Catford, 2004). In addition, the 1978 Declaration led to the development of a more attainable definition of health. It was such realism that was lacking in the WHO 1948 definition (Tones, 2001; Seedhouse, 1997). Health was no longer viewed as the sole purpose of health promotion, but as a means to an end; namely the achievement "of a more socially and economically productive life" (Tones, 2001:5).

There is ongoing debate and discussion in the literature around the tension, or perceived tension, between the public health and health promotion movements. Orme *et al.* (2007) examine the convergence, divergence or assimilation of health promotion's location with and within public health. The relationship between the two movements can be both harmonious and controversial. Public health has been traditionally concerned with public health medicine, sanitary reforms, local authority hygiene standards and for the prevention of disease outbreak since the 19th century (Ashton and Seymour, 1988; Hall, 2002). The focus away from biomedical concerns and an embrace of the social determinants of health has been recognised. It was notably signalled by the Black Report (1980) and the Acheson Report (1998). Both movements acknowledge the multi-faceted nature of health affects the way it is influenced (Evans, 2005).

The WHO has taken a leading role towards advancing the health promotion agenda. It has been the persistence of this international institution that has ensured the advancement of health promoting ideals and actions. Such were made possible and developed through a series of international conferences,

[9] 'Victim-blaming' is a concept that pertains to individuals being viewed as the only safeguards of their personal health. This explicitly ignores the wider environmental determinants. It is now acknowledged that when individuals are supported within an enabling environment, they are then empowered to make the 'healthier choice', as it is the 'easier choice' (Milio, 1987; Tones and Tilford, 2001).

charters and initiatives. These statements were key landmarks on the plains of the health promotion movement (Ewles and Simnett, 1999; Kickbusch, 2004).

2.2.3. From Ottawa to Bangkok: Continuity or Change?

Globally, a variety of health agencies, governments and state authorities have addressed health promotion (Gorin and Arnold, 1998; Naidoo and Wills, 2000). However, one cannot underestimate the WHO's role in the relentless advancement of the agenda, ever since the endorsement of the 'Health for All' policy initiative in the 1970's. A series of international conferences and charters have nourished the growth of health promotion up to the present day (Kickbusch, 1997; 2004; Naidoo and Wills, 2000; Catford, 2005). These international statements signify a 'strategic checklist' for the progress of health promotion. Such charter agreements recognized the importance that environmental and public policy impacts have on health (Levin and Ziglio, 1996).

In 1984 a discussion document was released which outlined principles and approaches of health promotion. These underlying concepts came to embody the emerging vision (WHO, 1984). This document put forth radical and unprecedented health promoting principles (Catford, 2004). Most notably, it stated that health promotion should focus on the everyday lives of individuals; should work towards the determinants of health; and should enable communities to participate in setting their own health agenda (WHO, 1984; Mahler, 1986). Though such ideas are acceptably conventional nowadays, they represented a caustic break away from the traditional biomedical ethos at the time (Webster and French, 2003).

These principles which endorse empowerment, community action and a broad holistic approach towards health gain formed the basis of the Ottawa Charter (WHO, 1986). This charter arose from the first WHO International Conference on Health Promotion and provided an opportunity for health promotion rhetoric to be translated into a practical Framework for Action (WHO, 1986; Cribb and Dines, 1993; Jones and Douglas, 2000). The Charter advanced a concept of health which combined social and personal resources with physical capabilities. It stated that health promotion should enable people to take control of their own health (Naidoo and Wills, 2000). The charter recognized that health must be addressed simultaneously at individual, community and structural/ policy level (Ewles and Simnett, 1999; Naidoo and Wills, 2000; Webster and French, 2003;

Catford, 2004). A number of strategic action areas were identified in the Charter, through which the WHO's objectives could be successfully attained (Tones, 2001; Tones and Tilford, 2001; Department of Health and Children, 2000).

The socio-ecological approach to health promotion, adopted by the WHO, was demonstrated in the Ottawa Charter's Framework for Action (Table 3).

Table 3: The Ottawa Charter: Framework for Action

OTTAWA CHARTER (1986)	
Framework for Action	***Levels for Operation***
1. Develop Personal Resources	Individual
2. Strengthen Community Action	Community
3. Create Supportive Environments	Structural/ Policy Level
4. Reorient the Health Services	
5. Develop Healthy Public Policy	

Following the original and pioneering vision embedded in the Charter, development of the health promotion agenda has been conducted through a series of international conferences (Ziglio *et al*. 2000; Tones, 2001). Such conferences advanced the various topics that required greater attention[10]. They reflect the evolution of the health promotion movement. Subsequent WHO conferences investigated the five action areas propelled as health promotion strategies in the Ottawa Charter (Jones and Douglas, 2000). Most notably, healthy public policy and the creation of supportive environments have been advanced significantly through the fora of WHO conferences. This reflects the desire to foster politico-economic policy as a way of improving the social and physical environments. In addition, concentration of the WHO on the structural/ policy aspects of health promotion activity indicates the realisation of the overarching importance played by policy and environmental factors on the lives of individuals and societies (Milio, 1987; WHO, 1988; WHO, 1991; Ewles and Simnett, 1999; Naidoo and Wills, 2000; Ziglio *et al*. 2000; Tones and Tilford, 2001; Catford, 2004; 2005; Tang *et al*. 2005a). By focusing on the structural aspects of the health promotion

[10] The Adelaide Conference on Healthy Public Policy (1988); Sundsvall Conference on Supportive Environments (1991); Jakarta Declaration on Health Promotion into the 21st Century (1997); Health 21- Health for All for the WHO European Region (21 targets for the 21st century); Fifth Global Conference on Health Promotion: 'Bridging the Equity Gap' (Mexico, 2000); Sixth Conference on Health Promotion: 'Policy and Partnership for Action- Addressing the Determinants of Health' (Bangkok, 2005)

agenda, the WHO and its members recognise the pivotal role that policy plays in reducing barriers to health-enhancing behaviours, and in increasing cues to health-promoting behaviours (Levin and Ziglio, 2003; Tang *et al*. 2005a).

The Bangkok Charter (2005)[11] identifies the challenges that face health promotion in a globalised world. It presents a commitment to address the determinants of health by engaging the key stakeholders and actors, who are essential in the advancing health promotion movement (Tang *et al*. 2005b). The context for this has changed noticeably since the adoption of the Ottawa Charter (WHO, 2005b). Fundamental demographic, socio-economic, physical environmental and political changes are critical influences on population health, and action addressing them in a globalised world is pivotal for health promotion (Tang *et al*. 2005a; 2005b; WHO, 2005). Government policy and health services research in the twenty years since the Ottawa Charter has reinforced its key messages, and has validated health promotion as a "branch of modern public health aimed at actions tackling the major determinants of health" (WHO, 2005:5; Department of Health and Children, 2000). The principles advocated by the Ottawa Charter, including the broad socio-environmental conceptualisation of health, empowerment, and inter-sectoral approaches to deal with the wider determinants of health, are now recognized as mainstream in the policy-making arena (Department of Health and Children, 2000). Such principles have stood the test of time and are present within the fabric of the Bangkok Charter. This most recent WHO Charter (2005) puts forth the vision of tackling modern-day health challenges by encouraging models and methods for policy development, 'joined-up' government, and inter-sectoral partnership-building for health promotion (Catford, 2005). Such intersectoral activity is a key ingredient in the modern day advancement of health promotion, as health is determined by both health and non-health sectors (Labontè, 1986; Milio, 1987; Townsend and Davidson, 1992;

[11] The Bangkok Charter is structured into four sections: a) the emerging context of health promotion; b) strategies for sustainable integrated health promotion action; c) current and future health challenges; d) challenges and opportunities of globalization.
In order to develop national capacity in health promotion, eight broad domains have been identified which need to be present within a country in order to advance structured and effective health promotion: 1) National policies and plans embracing health promotion priorities; 2)National leadership required for co-ordination and partnerships; 3)Joined-up government is necessary to co-ordinate health promoting principles across all government sectors; 4) Programme delivery required, which requires mechanisms and structures in place; 5)National Partnerships across all sectors are required; 6) Professional development in the arena of health promotion; 7) Performance monitoring is identified as key in order to evaluate and monitor health promotion activities; 8) Sustainable financing is needed in order to fund health promotion priorities (Catford, 2005).

Potter, 1997; Acheson, 1998; Whitehead *et al*. 2000; Lavis *et al*. 2001; WHO, 2005).

The Bangkok Charter represents a continuation of the validated vision endorsed in the Ottawa Charter in the 1980's. It presents a commitment to deal effectively with the concurrent and prospective challenges of globalisation and capacity-building in the policy development arenas. From Ottawa to Bangkok, and through the international statements along the way, public policy development is recognized as a necessary component to push forth a truly health promoting agenda (Milio, 1986; Draper, 1987; Levin and Ziglio, 1996; WHO, 1998; Webster and French, 2003; Catford, 2005; WHO, 2005).

2.2.4. Healthy Public Policy: An Ecological Framework for Policy-Making

Health policy is a category of public policies specifically targeted towards health issues (Walt, 1994a). In contrast, the remit of healthy public policy takes into account the consequences of all government policies, whatever their primary focus (Milio, 2001). It is defined as a policy that "is characterised by an explicit concern for health and equity in all areas of policy and accountability for health impact" (WHO, 1988; Cited in Kemm, 2001:80). Healthy public policy aims to create supportive environments to enable people to lead healthy lives (Milio, 1986). It is essential, in the pursuit of healthy public policy, that all government sectors take health into account when formulating all policies (WHO, 1988). Healthy public policy is a virtuous endeavour, and the following two conditions must be met if it is to be formulated:

- "Health consequences of different policy options have to be correctly predicted.
- The policy process has to be influenced so that health consequences are considered"

(Kemm, 2001: 80).

Healthy public policy is viewed as scaffolding within which the determinants of health may be positively influenced. It enables the consideration of health impacts across a wide sectoral range (*ibid*; Whitehead, 1995; Marmot, 1998; McBride, 2007). Health Impact Assessment (HIA) has emerged as a tool which could satisfy the two abovementioned points, thus facilitating the materialization of healthy public policy.

It is envisaged that economic and health considerations would be dealt with side-by-side in the policy formulation process (Milio, 1986). However politico-economic realities of the policy-making process indicate, the extent to which health is a political issue (Ewles and Simnett, 1999; Bambra *et al*. 2005). It is, more often than not, sidelined for more pressing economic issues in the policy-making process (Munro and Rayner, 1997). Many health promotion researchers have written of the barriers to healthy public policy (Milio, 1987; 2001; de Leeuw and Polman, 1995; Nutbeam, 1997; Goumans and Springett, 1997; de Guia *et al*. 1998; Lavis *et al*. 2001). However, few have examined the full range of potential barriers in a specific field or sector (Lavis *et al*. 2001).

The seminal work of Milio (1986) has promoted the concept of healthy public policy as a means of developing public policies conducive to health, as well as economic considerations. This noteworthy research presents an ecological framework for policy-making, taking into account the socio-economic climate that is present during policy formulation (Leppo and Melkas, 1988). The key players involved in the process, and strategic action required when formulating such policy, all contributes to the policy-making environment (Milio, 1987). This policy-making context, the inevitable 'trade-offs' inherent in the system, and the influence of existing institutional structures (Signal, 1998) means that the realities of policy-making must be taken into account (Draper, 1987; Ziglio *et al*. 2000; Bekker, 2007).

It is important to recognize that the growth of health promotion, since Alma Ata (1977), has coincided with the realisation of governments worldwide that the financing of the expanding healthcare systems does not equate with improved population health (Labontè, 1986; Farrant and Taft, 1988; Crawley, 1987, Milio, 1987; 2001; Potter, 1997; WHO 1998; Quin *et al*. 1999; Catford, 2004). In this regard, demand for healthcare system resources could never meet supply of such, due to the daily increase of public expectation of the services, as well as improved technology (Quin *et al*. 1999). Not only is healthy public policy considered a coordinated and intersectoral framework to achieve 'joined-up' government action, it is also a necessary mechanism for improving population health (WHO, 1998; 2005).

Politics as a Determinant of Health

The determinants of health, particularly those outside the health sector, are most the powerful influences upon population health (Townsend and Davidson, 1992; Acheson, 1998, Wilkinson and Marmot, 2003). However, as succinctly pointed out by Bambra *et al*. (2005: 187), at a time when the importance of public policy as a determinant of health is recognised, there persists "a continuing absence of mainstream debate about the ways in which the politics, power and ideology, which underpin it influence health." Issues pertaining to health, and the promotion of individual and population health, are inherently political and should be recognised as such. Indeed, health determinants and inequalities are two such issues which exemplify the political nature surrounding health (Davey Smith *et al*. 2002; Marmot and Wilkinson, 2003). A third issue regarding the political nature of health is the concept of citizenship. Health has been deemed a fundamental right on the international stage (United Nations, 1948; International Forum for the Defence of the Health of People, 2002) and is accepted as an essential social citizenship right (Bambra *et al*. 2005). Debate around the conceptualisation of health is an example of the tension that persists between capitalism, as an economic system that views health as a commodity, and citizenship, which views health as a right (*ibid*; Marshall, 1963). Health has been progressively considered a commodity, especially since the industrial revolution whereby workers became increasingly reliant upon the market and its behaviours for their survival (Epsing-Anderson, 1990). Although the introduction of the Beveridge welfare system ensured certain health and living standards came to be regarded as rights of citizenship (Cochrane *et al*. 2001), there continues to exist the tension between the innately different values between capitalism and citizenship. Thus, ensuring that health attains a place upon the agenda of policy makers in a constructive and progressive manner is a continuing political pursuit. Health is often viewed as equating with healthcare. The funding, regulation and provision of services are considered that accompany such a concept. This is a gross misrepresentation of health policy and practice. It results in the politics of health being reduced to the politics of healthcare (Freeman, 2000; Bambra *et al*, 2005). This limited view (Carpenter, 1980), in conjunction with health considered both as a commodity in the economic system as being purely the absence of disease results in the persistence of the individualised definition of health (Bambra *et al*. 2005). Within this focus, health inequalities, risk-taking behaviours and lifestyle choices are seen as failings of the individual. The focus is detracted from the overarching politico-economic climate which could ensure

health promoting policies in both health and non-health sectors alike (Frumkin, 2005). Oftentimes health inequalities and determinants of health are confronted within the boundaries of the healthcare system, and the provision, regulation and funding of such (*ibid*). This grossly one-dimensional perspective of health ignores the overarching determinants that require government and policy action. The prevention of ill-health and the promotion of health and wellbeing are intrinsically more cost-effective and sustainable rather than a narrow focus upon curative services combined with the limited political vision that would accompany this policy stance (McCluskey, 2006; Tussing and Wren, 2006). Indeed the Director of the Irish Institute of Public Health, Dr. Jane Wilde stated in 2006 that political leadership and cohesion is required in order to promote the overall wellbeing of the state's health and in doing so, health inequalities must be reduced (Mulcahy, 2006).

Neither has health been a focus of political science, apart from a few exceptions, which looked at the application of political theory to health promotion (Signal, 1998; Navarro, 2002; McGinnis *et al*., 2002). Examination of health in political science is associated with the narrow focus upon the healthcare system. Many proponents and academics in the policy sciences belong to the school of thought that is dominated by the rational choice and institutionalist paradigms. Therefore, much emphasis of academic work relates to the processes, actor-centrism and institutionalism of the healthcare system (Bambra *et al*., 2005; McCluskey and McAuliffe, 2007). This narrow focus on the healthcare system excludes analysis of the wider aspects of health, namely health inequalities, health determinants, citizenship and civil society issues. In order to proceed into the twenty first century with informed, appropriate and improved healthy public policy, analysis of the formulation of the latter concepts would ensure this theoretical and empirical progression. All policy is developed within certain boundaries, which "define what is and what is not, possible or acceptable" (*ibid*: 191). An analysis of how health policy is developed and formulated in government circles would enable improved understanding of how to incorporate health considerations in all policy sectors.

2.2.5. Health Promotion: Not without its Critics

As worthy as health promotion is, it has not escaped denigration. The WHO's role in its development has been criticised from some quarters for contributing to the ambiguity of health definitions (Seedhouse, 1997). Stevenson and Burke

(1991) argue that health promotion overestimates the value of consensus, thus weakening the struggle for social equity and political change. This argument puts forth how there are times when discourse is necessary to achieve a particular health agenda. It is disputed that health promotion dilutes this through an effervescent strive for consensus and partnership (Webster and French, 2003).

Kelly and Charlton (1995) have stated how difficulty arises when advocates in the health promotion movement fail to address the uneasy relationship between social autonomy and the social structure. The movement accepts that action must be taken to alleviate the suffering of oppressed groups, but endorses the idea of free will among the non-oppressed in society. This cannot be avoided to a certain extent. However, it is argued that health promotion is fundamentally a political venture rooted in human choices and prejudices (Seedhouse, 2004). The underlying perceptions and attitudes of the movement should be made explicit at all times; otherwise various interventions and policies could be developed in the name of an elusive 'health promoting agenda' (Seedhouse, 1997; 2004; Sidell *et al*. 2003). In addition, health promotion has been accused of nanny-state tendencies, and of focusing too much attention on individual lifestyle choices, which can lead to 'victim-blaming' (Tones and Tilford, 2001; Butler, 2002; Sidell *et al*. 2003).

The arguments directed at the health promotion movement reflect the continual growth of approaches aiming to advance population health development. Certainly 'the good is the enemy of the best' and despite such criticisms, the movement has proven a workable, albeit flawed, approach to advancing positive health globally (Milio, 1986; Department of Health and Children, 2000; Tones, 2001; Butler, 2002; Levin and Ziglio, 2003; WHO, 2005)

2.2.6. The Future: Public Policy is the Key

The Ottawa Charter called for the building of healthy public policy, which "requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them" (WHO, 1986). Since then, the development of this concept of healthier public policy, which is instrumental for improved population health, has been endorsed (WHO, 1988; 2005; Catford, 2005). Most recently the Bangkok Charter re-emphasised its importance (WHO, 2005). That national public policy has a significant impact on a nation's health is not a new realisation (Moran, 1986; Draper, 1987; Potter, 1997). However, the

impact of public policy is increasingly recognised as both a challenge and opportunity towards greater health gain across all sectors of government activity (Leppo and Melkas, 1988; Farrant and Taft, 1988; Levin and Ziglio, 1996; WHO, 2004). The policy-making process presents an exceptional opportunity to address health inequalities and to improve population health (WHO, 2004; 2005). The role of the state in this regard is unique and cannot be replaced by outside agencies or formidable 'strategic action' models (*ibid*; Tang *et al*. 2005; Ziglio *et al*. 2000; Labontè, 1986; WHO, 1998; Lavis *et al*. 2001).

2.2.7. Thinking about Health, Acting for Health: Concluding Comments

This section has examined the origins of the health promotion movement. It examined the international WHO charters. Such international treaties provide 'snapshot' pictures of the priorities, challenges arising, and opportunities for the future in the health promotion agenda. Public policy, and health promotion's offspring, healthy public policy, have repeatedly emerged as essential opportunities to advance population health. In relation to the barriers towards healthy public policy, little research has been conducted of the obstacles to such coordinated policy making in specific policy domains.

Much research has been conducted of healthcare systems in the academic world. However, there exists a gap in work relating to the analysis of policy processes, actors and institutions in the development of public policy of a particular policy sphere, as opposed to focusing on activities within the boundaries of the healthcare system. Health Impact Assessment (HIA) has emerged as a tool for the development of healthier public policy (Metcalfe, 2007). It is a mechanism for policy to be better informed, and provides a novel opportunity for research as a policy- and decision-aiding tool across the public health and political sciences disciplines. The following section will illustrate further the history, rationale and purpose for HIAs, which is important for the understanding of the tool.

2.3. HEALTH IMPACT ASSESSMENT

"The general proposition that I wish to put to you is that the solution to many of today's medical problems will not be found in research laboratories of our hospitals, but in our Parliaments. For the prospective patient, the answer may not be cure by incision at the operating table, but prevention by decision at the Cabinet table"

Sir George Young,
British Health Minister
(Daube, 1979)
(Cited in Banken, 2004:165).

The above quotation sets the tone for this section of the study. The healthy public policy concept is centered on the idea of influencing health through all government sectors, both health and non-health arenas (Koivusalo and Santalahti, 1999). The policy-aiding tool, Health Impact Assessment (HIA), will be the focus of this segment of the literature review.

HIA is grounded within the social model of health (Kemm, 2001) but it does also consider the biomedical and physical conceptualisation of health (Mindell *et al*. 2003a). This policy-aiding tool is founded from two conceptual 'seedbeds'; healthy public policy (Lehto and Ritsatakis, 1999; Ritsatakis *et al*. 2002) and environmental impact assessment (EIA) (Kemm and Parry, 2004a). Since the establishment of healthy public policy as an action area within the health promotion movement (WHO, 1986; Ritsatakis, 1999; Fehr, 1999a), HIA has evolved as a policy-aiding mechanism. The progression of healthy public policies requires that health consequences be predicted, and for the policy process to be adequately influenced in order to consider possible health effects of policies (Kemm, 2001). HIA satisfies both of these requirements (*ibid*; Putters, 1999; Koivusalo and Santalahti, 1999; Morrison *et al.* 2001; WHO, 2005). Drawing from the philosophy of the health promotion movement, HIA aims to investigate the determinants of health, which are the factors that will be affected by public policies, and to ensure health inequalities are reduced (Douglas and Scott-Samuel, 2001). HIA has a significant role to play in this regard (*ibid*). In addition HIA is the undeniable offspring of EIA albeit at a less developed stage. Environmental assessments emerged in the USA in the late 1960's and their

inability to adequately consider health impacts of projects and policies resulted in the eventual growth of HIA (Joffe and Sutcliffe, 1997; Banken, 1999; Birley, 2003; Bond, 2004).

As well as HIA emerging as a pragmatic tool of the healthy public policy and health promotion movements, and in response to the inadequacies of EIA, it has also been cited as a workable policy-aiding tool (Lock *et al*. 2003; Milner *et al*. 2003). It seeks to influence the policy making process at both the local level (Davenport *et al*. 2006; Glackin, 2006; Doyle, 2006) and at national level (Lock *et al*. 2003; Abrahams, *et al*. 2004; Bekker *et al*. 2004). The HIA tool is viewed as both a means and an end to the policy process (Banken, 2001), as the process of the impact assessment framework is equally as important as the report output (Elliott and Francis, 2005). Theories of the policy process are integral to understanding of the use of HIA evidence in decision making procedures, from the rational synoptic theories to the 'garbage-can' hypotheses (Putters, 2005).

For the purpose of this section, the values and principles of HIA will be defined, drawing from the important literature sources in the field. The overarching legal framework that exists for HIA will also be outlined. Examples of the use of HIA on a practical basis will be illustrated, as will the methodological developments in the field, with particular reference to the issues of evaluation and evidence within HIA. The decision-making function will be demonstrated of the tool. Previous work that has investigated the linkage of HIAs and the decision making processes will be discussed. The conclusion of this section will outline the relevance of previous work and this current HIA research.

2.3.1. Health Impact Assessment: Defined

Although the concept that all public policies affect health is not new (Krieger *et al*. 2003), the systematic appraisal of such policies, as endorsed by HIA, is novel. HIA enables the exploration of policy, programme or project effects in a more systematic and rigorous manner (Kemm, 2001; Barnes and Scott-Samuel, 2006). Definition of the nature and purpose of this mechanism is best understood from the starting point of Scott-Samuel's (1996) seminal paper, entitled 'Health Impact Assessment- An Idea Whose Time has come.' Although discussion of HIA had begun in the 1980's and early 1990's, in its relation to its consideration within the two separate streams of healthy public policy (Milio, 1981) and EIA (Birley, 2003), this paper initiated the debate of the tool as a serious instrument

for better policy-making and prediction of unforeseen effects of policies and projects. Scott-Samuel (1996) called for HIA to sanction features such as of emphasising equitable outcomes, addressing social inequalities, enabling full community participation, and endorsing the use of both qualitative and quantitative evidence.

In the international arena HIA is more recognised and is placed upon a legitimate footing. In the ratification of the Maastricht Treaty (1993) and the Amsterdam Treaty (1999), health protection across all public policies in the EU emerged as a common health policy theme (European Commission, 1995; Joffe and Mindell, 2002; WHO, 2005). Article 129 of the Maastricht Treaty stated that "health protection shall form a constituent part of the Community's other policies (Lock and McKee, 2005), and Article 152 of the Amsterdam Treaty called for a "high level of human health protection (to) be ensured in the definition and implementation of all community policies" (*ibid*; Hubel, 1999). Such recognition from the supranational institution lended much needed credence to the policy-aiding tool. In addition, Strategic Environmental Assessment (SEA) EU Directives, as well as the WHO 'Health for All' policy framework, embrace and acknowledge HIA as a necessary tool to ensure all policies are examined as to their possible health effects (WHO, 2005). Recent Thai legislation has highlighted the potential for the social focus of HIA to be advanced further. The Thai National Health Act B.E. 2550 (2007) states that HIA is designed to be a "social learning process" that involves all stakeholders in society in the examination of policies, projects and plans (New South Wales HIA Project eNews, 2007). There certainly has been international and national pressure upon governing authorities to assess for health impacts (Official Journal of the European Communities, 1999; Morrison *et al*. 2001).

The WHO Gothenburg Consensus Paper (1999) offers the widely accepted definition of HIA, stating that is comprises of:

> "A combination of procedures, methods and tools by which a policy, a programme, or project may be judged as to its potential effects on the health of a population and the distribution of effects within the population"
>
> (Kemm and Parry, 2004a:2).

Evidence-based policy-making has always been an integral consideration in policy development (Nutbeam, 2001; Petticrew, *et al*. 2004; Dobrow, *et al.*

2004). The need for such policy based on prediction-evidence and involving relevant stakeholders, means that HIA is a tool whose time has certainly come, and will certainly be here to stay for the foreseeable future (Kemm, 2005). HIA is a means of evidence-based policy-making that assesses all policies, programmes or projects for effects on population health, which do not necessarily have health as their primary concern (Lock, 2000). Decision-makers are under pressure to produce informed policies, and HIA is an appropriate mechanism to enable intersectoral coordination and teamwork among the relevant stakeholders (Maeland and Hagland, 1999; Mittelmark, 2001). HIA is defined as a decision-support tool that adds value to a policy decision by providing analysis of the possible positive and negative effects of a particular policy, project or programme (Morgan, 1998; Parry and Stevens, 2001; Kemm, 2003; Davenport *et al*. 2006). A successful HIA is one where the findings are considered by decision-makers in the policy process (WHO, 1999; Kemm, 2001; Kemm and Parry, 2004a). It is accepted that health is determined by factors outside the control of the health services and sector (Townsend and Davidson, 1982; Acheson, 1998; Marmot, 1998; Marmot and Wilkinson, 2003; Mindell *et al.* 2004). Health inequality is a determinant of health (Mackenbach, 1994; Petticrew *et al.* 2004; Williams, 2006), as it has long been recognised that those wealthier are healthier, and those poorer live shorter lives (Wilkinson, 1996; Acheson, 1998). This decision-support tool aims to reduce such inequities, by facilitating the setting of health considerations to the attention of policy-makers. HIA provides a necessary framework which enables the use and presentation of best available evidence of possible health impacts (Douglas, 2000; Conway *et al.* 2000). The framework enables the estimation of possible health effects (Ratner *et al.* 1997), and has been deemed by those working with health considerations within the EIA process as the best method for eliciting base-line data for the long-term follow-up of the impact of development on health (Cooper-Weil *et al*. 1990; Lerer, 1999).

The values underpinning HIA are those of democracy, equity, sustainable development and the ethical use of evidence (WHO, 1999; WHO, 2005). Such values set a high standard for HIA to aspire towards, and aim to ensure the mechanism is not only utilised by experts and academics, but as a tool also for community participation in local decision-making procedures (Mittelmark, 2001; Health Impact Assessment Gateway, 2006). The features of HIA indicate it as a multidisciplinary tool which draws on many diverse fields of study, from

epidemiology, statistics and public health to political science and community advocacy (Kemm and Parry, 2004a). It focuses upon the complex determinants of health, involves a wide range of stakeholders, and a short-timescale for the HIA process and report production is the norm (Mindell *et al.* 2004).

HIA seeks to operate as a mediator in the health promotion movement and in shaping the decision-making process, although its influence in this process has yet to be firmly established (Macintyre and Petticrew, 1999; Mahoney and Durham, 2002; Morrison *et al.* 2004; Elliott and Francis, 2005). More research examining the policy process and the decision making procedures, is urgently required (Putters, 1997; 1999; Williams, 2006; Dallaire, 2006).

2.3.2. Alot Done, More To Do

HIA has been promoted in the international and national arenas as an appropriate and necessary mechanism for the consideration of possible health effects of all public policies (Dora, 1999; Department of Health and Children, 2001; Institute of Public Health Ireland, 2003; Lock and McKee, 2005; WHO, 2005). Health economic analyses of possible health outcomes from policies are insufficient in providing a clear and representative picture of policy impacts (Scott-Samuel, 1996; Mindell *et al.* 2001; Mindell and Joffe, 2003). Impact assessment, as a policy-support tool and framework, has already been firmly established (International Association for Impact Assessment, 2006), and HIA draws much of its conceptual and methodological origins from EIA (Joffe and Sutcliffe, 1997). Many examples of completed HIAs exist. This demonstrates the practicability and usefulness of the mechanism. HIA is a necessary tool to further advance the ever-progressing health promotion movement (WHO, 2005).

Despite such a glowing report-card, HIA must meet the challenges it faces ahead in order to continue as a credible and worthy decision-aiding tool. It must be more than just the 'flavour of the moment' (Quigley and Taylor, 2003; Banken, 2001). A number of challenges have been outlined by Kemm (2005) who is one of the authoritative voices in the HIA field. Kemm (2005) states that although HIA is clearly an accepted framework within many countries, practitioners and academic researchers alike must now face the challenge of understanding the decision-making process as it relates to HIA (Mindell and Boltong, 2005). This challenge, of informing the policy process, requires understanding of the various levels of policy-making. Knowledge of the agenda-setting process, decision-

making procedures within Government Departments, 'windows of opportunity,' and timeliness of entering or influencing the process is necessary (Kemm, 2005). HIA has been found to influence the policy process indirectly (Elliott and Francis, 2005), and although no direct links have been made, it may still influence the construction of policy in the future (Dobrow *et al.* 2004). It has been found that effects of policies are oftentimes not realised or experienced by the public for many years after a particular policy action (Scott-Samuel, 2006), which makes further research of the tangible and intangible effects of policies even more pressing (Putters, 2005; Elliott and Francis, 2005). HIA also faces the challenge of being viewed as yet another authorised checklist activity and a bureaucratic burden within administrative structures. In addition, HIA may give the impression that all impacts can be measured, which is oftentimes not the case (Krieger *et al.* 2003). Judging by the success and rise of HIA in the past, such challenges will be overcome, in line with academic research and practitioner experience (Kemm, 2001; 2005).

2.3.3. Health Impact Assessment in Practice: Measurement of Success

The measurement of success of any policy-aiding tool is its use in reality. Theorising, conceptualising and writing reams of scholarly debate are all necessary activities for the development of the field, as long as its use in practice is increasing and continuing. HIA has certainly indicated its usefulness on the ground, as demonstrated by the numerous HIA activities in recent years (Putters, 1999; Mindell *et al*. 2004; Davenport, *et al*. 2006; Health Impact Assessment Gateway, 2006; Department of Public Health and Epidemiology, 2006). Such is the extent of HIA activity, particularly in Europe, that a three-year funded study is currently being conducted on the effectiveness of HIA processes across the region (Wismar, 2004). This study will inform the field of lessons learnt across varying constitutional, institutional and cultural settings, and across both local and national levels of policy-making (*ibid*).

HIA activity is most common in the areas of transport (Dora, 1999; Fleeman and Scott-Samuel, 2000; Douglas *et al.* 2001; London Health Commission, 2001; 2004; Eastern Regional Health Authority Ireland, 2004), urban regeneration (Curtis *et al*. 2001; Winters, 2001; Douglas *et al*. 2004; Mindell *et al.* 2004; Barnes, 2005) and housing (International Institute for the Urban Environment, 1999; Doyle, 2006; Glackin, 2006; Mindell *et al*. 2004). A number of HIAs have been conducted on airport developments in the UK, such as Alconbury Airport

(Close, 2001) and Finningley Airport (Abdel-Aziz *et al*. 2003); in the Netherlands, such as Schiphol Airport (Staatsen *et al.* 1994). HIA activity has spanned into regional and national policies, such as the London Mayoral Strategies (London Health Commission, 2001; 2004; Mindell *et al.* 2003b), the North West Regional Economic Strategy in the UK (Abrahams, 2006), national food and agricultural policies in Slovenia (Lock *et al.* 2003), and the National Alcohol Strategy for England (Kemm, 2004). HIA activity spans across local and national policy levels in many countries and regions across the world (Mittelmark, 2001), including Wales (Breeze, 2004), Scotland (Douglas and Muirie, 2004), Ireland (Mahoney and Durham, 2002; Institute of Public Health, 2003; 2005b; 2005c; Doyle and Metcalfe, 2004) Australia (Mahoney and Morgan, 2001; Mahoney and Durham, 2002; Wright, 2004), Canada (Banken, 2004; Dallaire, 2006), the USA (Dannenberg, 2006), Sweden (Finer *et al*. 2005; Berensson, 2004) and the Netherlands (Putters, 1996; 1999; 2005; Ritsatakis *et al*. 2002; Deelstra *et al*. 2003; Bekker, 2004; Bekker *et al*. 2004).

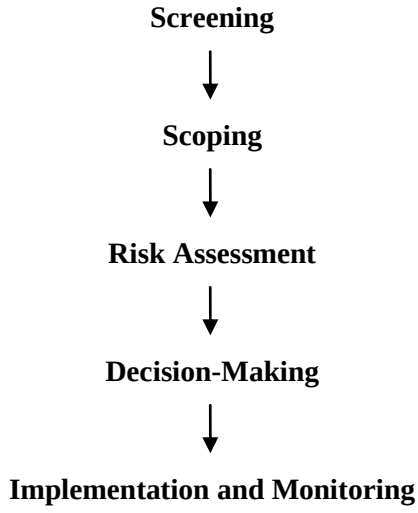
Most of the HIA activity is performed at local level, as national policy-making is more contentious , there exists less political will to take on a new mechanism, and policy-level HIA has less clarity of function than local level due to the specific targets allocated at the local level (Davenport *et al*., 2006). The Welsh Local Government Association (WLGA) produced a policy document entitled 'The Route to Health Improvement: An Organisational Package to Build Capacity for Local Authorities.' This document highlights the need for health improvement across the health and non-health sectors, and suggests health improvement by working across corporate culture, policy development, collaboration, capacity building, and governance and performance management. HIA is a tool that can be incorporated into this type of healthy policy delivery. HIAs that have been conducted are identified as areas for further research and work. There is an identified need for greater evaluation of the HIA framework (Quigley and Taylor, 2003; Atkinson and Cooke, 2005; WHO, 2006b), and the use of evidence within this and the quantification of predicted impacts (Veerman *et al*. 2005; Kemm, 2005). There is a greater requisite for the distribution of impacts throughout the population to be assessed, and the extent to which policy widens the health inequalities (Douglas and Scott-Samuel, 2001; Petticrew *et al*. 2004). Debate persists of the involvement of relevant stakeholders in the HIA process, from key policy-makers to community representatives (Mittelmark, 2001; Kemm, 2005; Cooke, 2006). Indeed, HIA practitioners, academics,

researchers and policy-makers in the field were called upon at the conclusion of the seventh HIA International Conference, to be considerate of communities, and not to allow community participation to become 'tokenistic' and expert-driven (Weeks, 2006). Lessons from HIAs conducted have called for greater understanding of the policy process, with the ultimate aim to influence the process, is immediately required (Kemm, 2001), for both the benefit of HIA practitioners in the field (Elliott and Francis, 2005; Mindell and Boltong, 2005) and academic researchers of the policy process (Kemm, 2001). In particular, such academic political research will supply better understanding of how policies are formulated and the ways in which health impacts will be most helpful for decision-makers (Kemm, 2001; Bekker *et al*. 2004; Putters, 2005).

2.3.4. Health Impact Assessment: Methodology and Current Issues

The methodological origins of HIA are genetically linked to the EIA process and framework (National Health and Medical Research Council, 1994; Arquiaga *et al*. 1994; World Bank, 1997; Morgan, 1998; Lerer, 1999; McCarthy *et al*. 2002; Mindell and Joffe, 2003; Birley, 2003). The stages of the HIA model are similar to those in EIA, as seen from figure 2 (page 37).

Figure 2: Stages of the Health Impact Assessment Model (Kemm and Parry, 2004b:16)



HIA activities have a number of common features, despite the individual contextual circumstances of implementation (Davenport *et al*. 2006). Most HIAs use both qualitative and quantitative evidence, they operate within a particular timescale (retrospective; concurrent; prospective), and they range in scope

(rapid; intermediate; long-term) (Mindell *et al.* 2003a; Kemm and Parry, 2004a). A range of reviews (British Medical Association, 1998; Hansell and Aylin, 2000; Kemm, 1999; McIntyre and Petticrew, 1999; Lehto and Ritsatakis, 1999) of HIA are in existence, as well as various guidelines (Federation of Swedish County Councils, 1998; WHO, 1999; Scott-Samuel *et al.* 2001; Institute of Public Health, 2003; European Commission, 2004) and toolkits (Ministry of Health and Ministry Responsible for Seniors, 1994; Ison, 2000). Despite the range of such materials across country boundaries, the HIAs performed are strikingly similar in methodology (Mindell *et al.* 2004). Practical HIA methodological training is offered in many countries by the governmental public health authorities (Institute of Public Health, Ireland; International Health Impact Consortium, Liverpool; London Health Observatory, London) and the annual international HIA conference allows for mutual learning of methodological advances in the field.

The issue of quantification of health impacts has arisen in recent years (Mindell *et al.* 2001), as HIA has been criticised for lacking in methodological accuracy in the collection and examination of data (Petticrew, 2001; Mahoney and Morgan, 2001; Parry and Stevens, 2001; Mindell *et al.* 2004). The aim of HIA is to use the best available evidence of possible effects of policy on population health (Douglas, 2000; Conway *et al*. 2000; Kemm, 2006). In prospective HIAs, the use of evidence regarding the reversibility of risk factors of health is required, and decision-makers need to have evidence that is reliable and value-free (Mindell *et al.* 2001). In utilising research evidence, decision-makers who took part of a study investigating the use of evidence in the policy process, a significant number of participants called for evidence to be unbiased and objective (Petticrew *et al.* 2004). Although entirely objective HIAs are not one hundred per cent guaranteed, as the assessor's bias could be a confounding factor of bias, it is , however, the task of the HIA report to indicate to decision-makers what the explicit trade-offs for each policy options are within the various alternatives (Mindell *et al.* 2001). An examination of the use of quantitative methods in HIAs has shown that such methods are rarely used, and further research is required in order to quantify socioeconomic and behavioural determinants (Veerman *et al.* 2005). For some commentators, the success and future of HIA will be determined by the use of a rigorous and systematic evidence-base (Popay *et al*. 1998; Egger *et al*. 2001; Mindell *et al.* 2004) and systematic quantitative methods (Mindell *et al*. 2001; Veerman *et al.* 2005). However, it must be noted

that not everything that can be quantified is important, and not everything that is quantified is important (Mindell *et al.* 2001).

Evaluation is also an element that will ensure the credibility, reliability and appropriateness of HIA processes and methods are useful (Atkinson and Cooke, 2005; WHO, 2006b). Quigley and Taylor (2003) indicate how evaluation and 'tracking' of the policy process, in its acceptance of HIA evidence, is necessary to enable better understanding of the framework. HIA requires further monitoring and evaluation, as currently, the direct links between HIA evidence and policy decisions is weak (Mahoney and Durham, 2002; Elliott and Francis, 2005). This need for monitoring and evaluation of effectiveness was reiterated in the Cost Benefits Analysis (CBA) carried out by the York Health Economic Consortium, which concluded that although the benefits of carrying out an HIA outweighed the disbenefits, there was a need to continue evaluating the tool and to encourage mainstreaming of HIA in policy process (Trueman, 2007).

2.3.5. Health Impact Assessment and the Decision Making Process

Although much HIA work has been conducted of local and regional projects and programmes, less experience exists of HIA at national policy making level (Lock *et al*. 2003; Wismar *et al*. 2007). The local level offers greater opportunities for networking, efficiency of evidence utilisation, and transparency of use of HIA evidence (Davenport *et al*. 2006). In their study, which investigated the barriers and enablers associated with successful use of health considerations in decision making, from evidence and influence deriving from the HIA, Davenport *et al.* (2006) concluded that the politico-administrative environment within which HIA must operate, and seek to influence, must be better understood so as to maximise the use of HIA evidence, and to ensure the HIA requirements 'fit' the organisational and political realities (*ibid*). Enabling factors towards health consideration in decision-making included a balance required between HIA credibility, as an objective policy-aiding mechanism on the one hand, and on the other, as a tool which the decision-maker has some degree of ownership. In addition the lack of organisational and statutory commitment to HIA (Elliott and Francis, 2005) and the provision of pragmatic recommendations and conclusions were cited by decision-making participants in the study as enablers to better use of HIA evidence in the policy process. The most striking barrier regarded a lack of knowledge and realistic understanding of the policy process on the part of the HIA assessors and practitioners. Certainly, understanding the decision-making

procedures at policy level is vital if HIA evidence is to be used in the policy process, as each situation is different with a unique set of actors and contextual characteristics. These individual set of circumstances will thus determine how research and HIA evidence will be used (den Broeder *et al.* 2003; Bekker, 2004; 2007). It is essential also, in understanding the usefulness of HIA for the policy process, that less tangible aspects of the process are comprehended, which will indirectly influence the outcomes of the policy process. In addition, the networking opportunities and health awareness-raising features of the process are undeniable albeit difficult to quantify influences on the policy process (Elliott and Francis, 2005; Davenport *et al.* 2006).

Unlike EIA, the HIA process is concerned with the means as well as the ends (Banken, 2001). That is to say, the process of the HIA, which involves the networking of the relevant stakeholders across the varying sectoral domains and the raising of health on the agenda of policy makers, is as important as the outcome HIA report (Mindell *et al*. 2001). The HIA process is first and foremost, where influencing the policy process is concerned, a political activity and a course of action which requires connection within the political structures (Health Development Agency, 2002). From this perspective, HIA is more than the outcome report, as with other impact assessments (Morgan, 1998; Birley, 2003; McCarthy *et al.* 2005). It more than just about providing information, but pertains to achieving change within the policy process so as to better inform policy-makers of trade-offs inherent within the various policy alternatives; to enabling intersectoral networking and communication; and raising awareness of the health agenda across non-health sectors (Putters, 1999; Health Development Agency, 2002). It is a horizontal mechanism which seeks to mobilise partners in the health and non-health sectors (Dallaire, 2006). The time to investigate the policy process is now (Frowen, 2006), so as to better inform practitioners and policy-makers of the process (Morrison *et al*. 2001), as little knowledge of how HIA relates to the policy process is understood (Kemm, 2005). Indeed, if the HIA process and framework offers little to decision-makers but tokenistic gestures, it will be cast aside and attributed little credibility as a policy-aiding tool (Kemm, 2001; Milner *et al*. 2003; Department of Epidemiology and Public Health, 2006). In relation to the usefulness of HIA to the policy process, it offers a necessary framework for evaluation of policy options; is an instrument for intersectoral working; and provides assessment of policy effectiveness (Bekker

et al. 2004; Department of Epidemiology and Public Health, 2006; Abrahams, 2006).

The HIA framework has made significant progress in the last decade (Kemm, 2005), in relation to establishing a standardised methodological approach, usefulness as a community-participative instrument, and in its successful use in various projects, programmes and policies (Winters, 1997; Mindell *et al*. 2003b). Now that the broad definition of HIA has been firmly recognised by the international community (World Bank, 1997; Wismar, 2004; WHO, 2005), and its existence has been justified through various evaluations of the process (Quigley and Taylor, 2003; Atkinson and Cooke, 2005; O'Reilly, 2006), challenges ahead relate to ensuring better use of HIA evidence in policy making processes (Kemm, 2000; 2001; 2005; Banken, 2001; Wismar, 2004; Bekker *et al.* 2004; Putters, 2005; Petticrew *et al*. 2004). Indeed, Putters (1999; 2005) argues that efforts should not be spent on defining HIA, but by investigating the policy context and process that it is expected to influence, manipulate, integrate and advocate. According to Putters (2005), this policy process, and the organisational culture which is unique to each institutional context, requires examination that should supersede all research pertaining to HIA; if the tool is rendered as a misunderstood administrative burden and barrier to policy initiative (Parry and Stevens, 2001; Krieger *et al.* 2003), it will be scrapped by decision-makers. Efforts are required to ensure HIA is viewed as a positive process, seeking to improve positive outcomes and decrease negative outcomes from the policy process (WHO, 2006c). Although the debate regarding understanding of the policy process and its relationship with HIA is still in a fledging state (Milner *et al.* 2003), it is increasingly viewed as an area requiring urgent research. This message was prevalent in every discussion forum by delegates at the most recent International Health Impact Assessment Conference (April 2006). In light of the voluntary status of HIA, in contrast to the statutory recognition of EIA and SEA (O'Reilly, 2006), proactive research into the understanding of the policy process is required.

HIA, as a mechanism of healthy public policy, is currently the focus of a research programme in Quebec, Canada (Dallaire, 2006). This research seeks to investigate how, and why, some people in organisational departments would support the HIA process as part of the overall healthy public policy agenda and 'joined-up governance' structures, and other do not support such activity. By

investigating the policy process, and more specifically by looking at the vertical and horizontal dimensions of decision-making, may greater understanding be sought of the process that will ultimately reject or accept HIA evidence (*ibid*; Frowen, 2006).

On the issue of Healthy Public Policy (HPP), which was the focus of the 8th International HIA Conference in 2007, HIA is deemed an appropriate cornerstone of such a concept. However the success of HIA in evolving as a tool for ensuring healthier public policy is dependent on a number of recurring themes that HIA experts advocated at this event; political leadership is a necessary ingredient (Devlin, 2007); utilising the benefits of local government structures for policy making would enable the utilisation of HIAs (Mahoney, 2007; Ison, 2007b); Managing stakeholder expectations of HIA is important (Mahoney, 2007); the planning process is the gateway for HIA to achieve HPP (Cave, 2007); and the decision makers must be included in the HIA projects from the beginning (Figueras, 2007). Dr. Michael McBride, Chief Medical Officer for the Department of Health, Social Services and Public Safety, Northern Ireland, advocated that HIA is a vital tool to raise the consciousness of decision makers, and increase knowledge of policy makers and policy receivers, of the impacts of development and policy upon population health (McBride, 2007). The overriding consensus of this conference, which brought the international and national HIA community together, was the need for greater understanding of the policy process, and the influences of utilisation of HIAs in such processes.

Commentators, such as Putters (1999), Kemm (2001), Banken (2001), Bekker *et al.* (2004), Bekker (2007), have found difficulty in determining how to appropriately evaluate the HIA tool, in terms of its relationship with the policy process. It is a fundamental yet conceptually difficult one to answer, due to the multidisciplinary nature of the tool, and its various values and principles (Barnes and Scott-Samuel, 2006). However, the European Observatory on Health Systems and Policies (Wismar *et al.* 2007) has pursued a research programme, aimed to answer the abovementioned conundrum (Wismar, 2007). Instead of assessing the effectiveness of HIA in terms of the health gains that result solely from interventions, evaluation will in its place pertain to the influence of HIA on the policy process, particularly on the decision making dimensions of this process. This is the case as such health gains may not become realisable for

decades to come in terms of the burden of disease throughout the defined population (Scott-Samuel, 2006). In this pan-European study, the conceptualisation of the context for HIAs and content of HIAs, was used as suitable labelling posts for the research. The influence of the institutional rules (polity) and the influence of the actor's preferences and value systems, and political context (politics and policy) was used. Bekker *et al.* (2005) also advocated the use of such a diverse and informative framework, due to the novel area of inquiry and need for further exploration of the influences upon the utilisation of HIAs in policy.

Therefore, it is far more practicable and researchable to investigate the influence of HIA upon the decision making process, either in terms of evidence retrospectively used from HIAs conducted (Kemm, 2001), or regarding evaluation of the process in relation to potential use of such evidence (European Observatory on Health Systems and Policies, 2006). Previous research has also highlighted the need to investigate HIAs utilisation within a national and cross-national perspective (Elliott and Francis, 2005; Bekker, 2007; Wismar *et al.* 2007), as "context is everything" (St-Pierre, 2007). The mainstreaming or institutionalising of HIA "will depend on the particular political, administrative and economic context of each country" (Banken, 2003:389).

It is also difficult to directly link the decision making process with the use of HIA, although there are numerous and equally important indirect (intangible; incidental) benefits of the process. Elliott and Francis (2005) deducted from their research, which investigated the linkages between the direct and indirect use of HIAs in policy that the role of decision makers has to be further integrated into the process of HIAs; health service practitioners should not be the sole statutory leaders on the HIA. Decision makers must have ownership over the HIA, and have an input, as they are the destined policy makers. This exploratory research also found that there must be greater understanding of the decision making processes and policy formulation avenues, in order to maximise the use of HIAs, as has been the subject of previous work (Bekker, *et al.* 2004; Banken, 2001; 2003; Dallaire, 2006; Bekker, 2007; Wismar *et al.* 2007). Elliott and Francis (2005) concluded that in order for HIA to gain and sustain credibility, direct linkages between HIAs and their use in policy, and by decision makers, must be made. Suggestions for this include the mainstreaming (institutionalisation; Banken, (2001)) of the tool in decision making processes, managing the

expectations that stakeholders have of HIA from the beginning, and fostering dialogue between statutory and non-statutory groups. The need to mitigate the clash of vested interests and value systems is also referred to as having a negative impact on the use of the HIA in policy, as is the case with other IAs (Bartlett, 1989).

2.3.6. Concluding Comments

Health Impact Assessment is a new field of endeavour that has grown increasingly over the past two decades, both in theoretical development and in practical usage. Now that the field has been established, questions remain as to whether it is a workable policy-aiding tool, which will do exactly that; aid policy to become more informed. This issue is at the centre of this doctoral research, within the Irish context.

Previous work on HIAs and the relationship with the policy making processes will inform the research framework. The influence of the decision making processes are the cause for most inquiry regarding HIA. Increasingly, over the past number of years, it has become important to consider and examine such processes, (Kemm, 2006), in order to establish the role of HIAs in feeding these processes. Without such examination, the abandonment of HIAs to an eternal doom of gathering dust on the shelves of decision making institutions is destined to become a reality. The work of Banken (2001; 2003) and the discourse on institutional embeddedness of HIAs; the work of Wismar *et al.* (2007) upon HIA effectiveness for policy; Bekker (2007) and the place of HIA within the HPP paradigm influences the research framework of this thesis.

In their calls for further research, Elliott and Francis (2005) state that a need exists for research to examine the political and communicative dimension of decision making as an influence upon HIA utilisation; do stakeholders' value-systems and interests (personal and professional) influence the use of HIAs? The direct and indirect linkages to decision making with HIAs must be considered; further research is recommended to examine the decision making processes and HIAs. This point was further discussed at the 7th International HIA conference (Elliott, 2006). This has duly been accommodated within the research framework of this thesis.

In the pan-European study the conceptualisation of the context for HIAs and content of HIAs was used as suitable labelling posts for the research. Bekker *et al.* (2005) also advocates the use of such a diverse and informative framework because of the novelty of the field of inquiry, and the necessity for further exploration of the influences on the use of HIAs in policy. Bekker (2004) and Putters (2005) have established within their research the influence of the vested interests, value-systems and political context upon HIA utilisation.

The research framework and central research questions of this thesis take account of these considerations from previous work done.

Chapter 2 has illustrated the nature of health conceptualisation and the influence such approaches can have on public policy discourse; the importance of the development of the health promotion field for the birth and evolution of HIA within healthy public policy; and the rise and description of HIA has provided a comprehensive picture of the main issues for this research study.

Chapter 3 will provide a chronological account of public policy theories, which will inform the research framework of this study (chapter 4). In addition, the use of impact assessment techniques for policy will be provided in chapter 3 in order to describe the role they play within the policy-making processes.

CHAPTER 3
LITERATURE REVIEW II

3.1. PUBLIC POLICY

The purpose of this section is to trace the depth of theoretical understanding within the policy sciences discipline. This will contribute towards the selection of policy theories which will inform the research framework for the investigation of the Health Impact Assessment (HIA) policy-aiding tool. A chronological account will be provided of the monumental policy theories in the field, with greater attention upon the stagist approach, policy analysis and knowledge utilisation theories, discourse analysis, and institutionalism. This focus upon such theoretical frameworks draws from relevant research in the field of policy-focused HIA (Banken, 2001; 2003; Bekker *et al*. 2004; Putters, 2005; Wismar *et al.* 2007; McAuliffe and McKenzie, 2007).

3.1.1 Policy Science and Public Policy

The discipline that is now known as 'policy science' is a relatively young field of endeavour (Lasswell, 1951; Lindblom, 1959; Lowi, 1972). Indeed as astutely articulated by DeLeon, it has a long history and short past (DeLeon, 1994; Howlett and Ramesh, 2003). That is to say, that although government policies have been studied over the years, methodical analysis of such began over half a century ago. It emerged in North America and Europe in the post-World War II era, in order to examine possible solutions to unprecedented challenges faced by Western governments at that time (Sabatier, 1991; Ham and Hill, 1993). Attention that was focused on public policy was spurred by increasing political and academic interests in policy-related issues, and in the relationship between government and citizens (Howlett and Ramesh, 1995). Certainly, the rise in academic concentration on policies and decision-making procedures is characteristic of the second half of the twentieth century (Robinson, 1999). Scholars of the political process, as observers of government institutions at micro- and macro-levels, found that there existed a glaring gap in research "between prescriptive political theory and the practices of the modern state" (Howlett and Ramesh, 1995:2). In order to resolve political theory with practice, empirical analysis of government policies was pursued (*ibid*). Analysis of government policy required a brand new field of endeavour, separate from the

political science field (Heclo, 1972). Indeed, within political science, empirical observation and detailed analysis of government policies would have been subordinated continually by the study of other approaches to political phenomena (Cairns, 1974). In the changing context of the post-World War II era, a novel approach was sought to enable descriptive, prescriptive and normative analyses of government policies, and of the manner in which they are formulated and executed (Easton, 1953; Dror, 1971; Heclo, 1972; Ham and Hill, 1993; Davies, 2000).

Policy science developed as a branch of political science, albeit as a distinctive and theoretically self-sufficient arm of the discipline. It seeks to establish analytical and theoretical frameworks of state actions.

3.1.2. Understanding Public Policy

Defining Public Policy

"Policy is rather like an elephant- you can recognize it when you see it but cannot easily define it" (Cunningham, 1963).

Policy definition has attracted much speculation but little conformity. At the risk of attempting to define what Wildavsky (1979) considers the indefinable, key explanations of policy conceptualization will be illustrated (Heclo, 1972; 1974; Dror, 1989; Sabatier, 1999).

The essence of 'policy' is that it entails purposive action on the part of the policy-maker (Heclo, 1972; Walt, 1994), in dealing with a problem or issue of concern (Hogwood and Gunn, 1984). Easton (1953) notes how 'policy' is a network of decisions and activities, and the values of the decision-maker underscore the specific policy. Heclo (1972) describes the concept as courses of action rather than the particular decisions themselves; it is the process, not the outcome, which Heclo believes to encompass 'policy.'

Public policy has been described as a 'choice' that governments take in deciding what action to choose, and alternatively, what not to take (Dye, 1972; 1976). This particular conceptualisation of public policy is criticised as unworkable due to its simplicity. However, this has been built upon by William Jenkins, who offers a more exact

definition. Jenkins (1978) views public policy as a process that a group of political actors are engaged in; in order to achieve a set of predetermined goals. The definition proffered by Jenkins is the idea of public policy as a goal-centred behaviour on the part of governments. However, Anderson's definition contributes additional features towards definition of pubic policy (Anderson, 1984). Anderson's observation puts forth how public policy consists of "multiple decisions taken by multiple actors" (Howlett and Ramesh, 1995:6). His definition also underlines the association between government action and an awareness of the existence of a matter of concern requiring action as being important (*ibid*; Anderson, 1984).

Throughout the literature, definitions of public policy range from

> "Declarations of intent, a programme of goals, and general rules covering future behaviour to important government decisions, a selected line or course of action, the consequences of action or inaction, and even *all* government action" (author's own emphasis) (Lynn, 1987:28).

Clearly, policy is outlined succinctly in these definitions, as the actions and non-actions that government takes. It extends, however, beyond the concrete choices made on behalf of the policy-makers and decision-making actors in the process, all inter-related in a web of policy processes and capabilities to act on issues (Howlett and Ramesh, 2003).

Policy: Public versus Private?

The tension that exists between the public and private spheres has persisted since ancient Greek and Roman times (Saxonhouse, 1983). Since the work of Aristotle, and his assertion of the 'polis' being the highest form of human association (Millar, 1944), a search has continued for a negotiation of the tension between the public and private realms of human activity (Dahl, 1970; Parsons, 1995). Political economists contributed to this field of thought by asserting that the market may resolve such friction between conflicting interests (Habermas, 1989). The liberal approach to political theory and practice stemmed from the idea that both public and private interests should be delineated as quite distinct from each other, without undue interference or influence from one domain onto the other. The laissez-faire orientation, which advocates non-intervention of the State's public interests in private

matters of the individual, grew to promote the demarcation between public and private areas of influence (Smith, 1776; Mill, 1968; Hall, 1988; Parsons, 1989). However, such a clear separation between the public (State) and private (market) interests began to dissolve over the course of the early twentieth century (Keynes, 1926; 1936; Dewey, 1927; Beveridge, 1944). The theory of State non-intervention, and of reliance upon market activities in ensuring citizenry welfare, began to crack at the seams of the liberal approach. Critics (*ibid*) argued that the State had a role in the provision and regulation of population welfare policy. This indicates state involvement in matters such as education, transport, health, employment and social welfare policy. Such areas of human activity would previously have been left to the operation of the market's 'invisible hand.' However, it was now asserted that market patterns and movements were inept at solving various problems of social and economic life (Dewey, 1927). Around the time of the emergence of 'New Liberalism' in the 1970's, the domain of public policy science was developing. This new field of endeavour was born at a time when the policy science discipline would grow from the public policy orientation of the State, which pursued a role in managing public affairs, and the problems associated with such management (Lasswell, 1971).

However to say that the 'Old Liberalism,' as pioneered by Smith, had become obsolete is untrue. An emergence of political thinking pertaining to State non-intervention in private individual affairs re-emerged in the 1970's and 1980's, as evidenced in the policies and practices of the British, American and Australian governments. In reconciling the growth of the State in matters of the individual, and the role market forces could play in ensuring greater individual freedom, the bureaucracy, as a rational means of delivering government, emerged (Weber, 1930; 1991). The bureaucratic organisation was promoted as the rational guardian of public interests, and the bureaucrats were thus deemed as rational actors.

However the 1980's was a time period that witnessed the emergence of a branch of liberalism, labelled the 'New Right.' This sought a rolling back of the State from people's lives, and advocated a reduction in public administration. This has been followed by a period, from the 1990's onwards, of endorsement of New Public Management (NPM) principles, which are to be used and institutionalised into public sector activity (Dunleavy, 1991; Hood, 1991; 1994; Farnham and Norton, 1996;

Elcock, 1996). The endorsement of the separation of public and private matters over the past two decades has resulted in the obvious reduction in the role of the State in all areas of an individual's life. A purely laissez-faire approach has not re-emerged as a feature of current political times; the State is still viewed as having a vital role to play in the provision and regulation of services and public policies. However the market is viewed as a framework within which both public and private spheres of influence may be dealt with, while complementing both personal freedom and the well being of society (Parsons, 1995).

Various Approaches to Analysing the Policy Process

Due to the multifaceted and complex nature of the policy making process, various approaches exist in order to understand and make sense of the complicated phenomena.

Some political scientists look to examine the political regime in order to comprehend the policy-making process. This is a narrow way of analysing the process, as this investigation will elicit understanding of how policies vary in accordance with the linkages between society and the political system. This method of enquiry sheds little light on how policies directly are impacted by the regime type itself, and thus is a starting point for more in-depth analysis (Howlett and Ramesh, 1995; Peters *et al.*, 1977; Wolfe, 1989; Hall, 1986; Skocpol, 1985).

Another manner in which scholars of the policy process seek to understand the field of study is by probing for causal variables in the policy process. Such variables are also known as policy determinants (Howlett and Ramesh, 1995). This area of investigation looks to gather evidence which correlates between specific public policies and the features of the micro- and macro-level societal and behavioural factors (Munns, 1975; Rakoff and Schaefer, 1970). Often studies are quantitative in nature and improve understanding of public policy formulation. However, such studies fail to establish the divisional and chronological contexts in which policy is made (*ibid*).

A further strand of literature centres on examination of the policy content. Pioneered by Lowi (1972), this approach focuses on the assumption that it is the nature of the

policy problem, and the solution that is obtained, that decides how the issue will be dealt with within the political system. Lowi's theory states that, depending whether a policy is distributive, redistributive, regulatory or constitutive, determines how it will be dealt with. Looking to the extent of deliberation on the costs and benefits of a particular policy (Wilson, 1974), and examining the policy tools governments have to utilise in implementing policy (Salamon, 1981), may also elicit further understanding of the policy process. Although a worthwhile method of analysis, it is often difficult to establish the nature of the policy problem using this approach, and the scale of the costs and benefits of the various solutions (Howlett and Ramesh, 1995).

The final convention within the policy science literature, in understanding the nature of the policy-making process, relates to policy outcomes and impacts. This theoretical strand looks to correlate the direct and indirect effects of particular policies. In this mainly quantitative examination, the causal factors leading to the development of policy, and the instruments that may have been used in that process, are not considered as influences upon policy development (*ibid*; Weimer and Vining, 1992).

3.1.3. Policy-Oriented Approach

Although many academic scholars have forged the new field of endeavour, Harold D. Lasswell is recognised as the founding father of the policy sciences (Parsons, 1995; Torgerson, 1985; 1986; deLeon, 1999; Robinson, 1999). While for centuries informal advice has been administered to those making political decisions (Howlett and Ramesh, 1995), Lasswell was the first to define, in a logical and consistent manner, this analytical approach of government actions and their outcomes (Lasswell and Kaplan, 1950; Lasswell, 1951). Since then, the policy sciences, and its varying derivatives[12], have developed at a tremendous pace to become an acceptable scientific discipline, with its own set of concepts, methodology and keystone theories (Howlett and Ramesh, 1995; Parsons, 1995).

There has been a development of the rationality of the term 'policy' as being quite distinct from the passion and subjectivity associated with 'politics' (Lasswell, 1951;

[12] Policy science has progressed over time under varying titles and headings, such as policy analysis and public management. However, the essence of the analysis and theory building of the continually growing field comes under the broad umbrella term of 'policy sciences.'

Parsons, 1995; John, 1998). This rational development has laid foundation for the progression of the policy-analytic, or policy-oriented, approach (Ham and Hill, 1993; Howlett and Ramesh, 1995; Parsons, 1995). This approach, of simplifying the complexity of public policy-making into a number of distinctive, originates in the work of Lasswell (1956; 1959). This stages-approach makes policy more amenable for analysis (Easton, 1953; Ham and Hill, 1993) although has not been without criticism (Sabatier, 1991; 1999; Lindblom and Woodhouse, 1993).

Several have contributed to the development of the policy focus in political science, promoting the theoretical foundation of the discipline. The early works of Lasswell, in addition with Easton (1953; 1965a; 1965b), Simon (1957), and Lindblom (1959; 1993), have contributed invaluably to the empirical and normative promotion of the field. Such seminal works will be illustrated further.

The Lasswellian Positivist Approach to Policy-Making

Positivism refers to a philosophical system that is concerned solely with facts and occurrences, and which rejects intangible conjecture (Barnhart and Barnhart, 1994). Although policy researchers have continued to adhere to this quantitative approach, many have recently sought to combine the method of analysis with more qualitative (post-positivist) methods (DeLeon, 1998). Pioneered by Lasswell (1970), the policy sciences consist of three distinct characteristics. Such characteristics, although they have changed according to modern times and challenges (Hansen, 1983; DeLeon, 1986; DeLeon, 1988), are useful dimensions describing the policy sciences (Howlett and Ramesh, 1995). Lasswell, on describing the need to make rational judgements on policy issues, advocates a positivist approach towards policy-making (Lasswell, 1948; 1951). Lasswell first broached the idea of breaking the policy-making process down into a number of discrete stages, as is evidenced in his early work (Lasswell, 1956b; 1971b). Such traits include the multi-disciplinary nature of policy science and the influence of knowledge in that process (Torgerson, 1985; 1986); policy science as being explicitly problem-solving in nature (Lasswell, 1970); and the discipline being explicitly normative and not embedded in a shroud of solipsism (Howlett and Ramesh, 1995). This seminal work emphasised not only how policies were being made, but also how they should be formulated (*ibid*). Lasswell (1970) introduced the idea of knowledge in the policy-making process. His assertion centred on the idea of

policy-making as problem-oriented. This problem-focus meant that, as Lasswell claims, the policy sciences require an amalgam of techniques from various disciplines. This would, in turn, broaden the conceptual map that would define the policy problem as viewed by specialists in the field (Parson, 1995). This policy-orientation, as presented by Lasswell, centres on the policy-making process as a knowledge-based progression, which requires the policy-problem dealt within separate and distinctive stages (Lasswell, 1970).

However Lasswell's analysis concentrates on policy-making within government, and has not much to say on the external influences on the process. Lasswell's confidence in the superiority of knowledge and technical expertise in the policy-making process has been discredited, as governments are often resistant to expert opinion on policy matters (Wildavsky, 1979). In addition, although policy researchers have continued with this quantitative approach in the past, many have recently sought to combine this method of analysis with more qualitative (post-positivist) methods (DeLeon, 1998). Nevertheless, Lasswell's orientation towards the policy-making process as one delineated by distinctive stages, centred on a problem-solving and rational approach, forms the backbone for the policy science discipline. Crucially, Lasswell's academic contribution planted the seed from which future theoretical development in the field grew.

Simon's Bounded Rationality

Simon set about disproving the purely rational focus of policy-making, as pioneered by Lasswell. The conviction of Simon's work was that human rationality in decision-making, within the policy-making process, was constrained and thus 'bounded.' Simon drew from behavioural theory in order to illustrate the 'real world' nature of decision-making, which does not usually follow a sequence of stages, as is proffered by the Lasswellian stagist policy approach (Jann and Wegrich, 2005). However, although rationality was constrained due to a number of factors, improvement of the policy-making process was achievable. Since Simon's milestone work, entitled 'Administrative Behaviour' (1957), a debate has persisted surrounding his suggestion of the rational approach, which takes into account political and organisational realities (Hill 1993). Simon's viewpoint pertained to the examination of alternatives in policy-making, in order to reach a decision that would 'satisfy' interested parties and policy

aims, even if the decision was not perfect or most favourable (Simon, 1957). Suffice to say it was a prescriptive and seminal piece of work that pushed forth the development of policy-making theories.

The Eastonian Model and the Systems Approach to Policy Making

Although not principally a policy scientific model, Easton's (1953; 1965a; 1965b) contribution to the discipline is most noteworthy. This milestone work provided a systems-model of the policy-making process. Essentially, the Eastonian model is based on the assumption that the policy process consists of inputs, demands within the political system, and policy outcomes and outputs (Parsons, 1995). Wildavsky (1979) reminds the academic world of how policy formulation is simultaneously a process and product. This view of the policy-making process from the systems perspective has been promoted and developed further by academics in the field (Sharkansky, 1970; Jones, 1970; Dye, 1972; Frohock, 1979). From the 1960's onwards, the policy-oriented approach developed from a combination of the stagist approach, as pioneered by Lasswell and Simon, and the political system approach as founded by Easton (Ham and Hill, 1993; Jann and Wegrich, 2005).

Others in the field have developed 'systems' models in the conceptualisation of the policy-making sphere. Amongst these include Almond (1966), who puts forth a model of the political system as one consisting of inputs, process functions, and policy functions (Parson, 1995). Karl Deutsch (1963; 1967) perceived the political system as a 'network of communication channels.' He advocates that it is information, and not power, that should be the central focus of political analysis (Parsons, 1995).

Lindblom's Incrementalist Approach

Lindblom is a major contributor in the academic field of the policy-making processes. His name is synonymous with developing research stemming from Simon's rational approach proposition, with his incrementalist theory of decision-making (Lindblom, 1959). The essence of Lindblom's argument was that the stages heuristic approach and the idea of a rational policy making process, as propounded by Simon (1957), Lasswell (1951; 1956) and Easton (1953; 1965), was an ambiguous and inaccurate portrayal of policy making realities (Parsons, 1995). Lindblom refused to accept the rational approach of the stages heuristic and sought to develop a theory of the policy

process that was a truer reflection of practice on the ground. Indeed, policy making, according to Lindblom and Woodhouse (1993:11), is a "complexly inter-active process without beginning or end." Essentially, the argument promulgates that the policy process is more iterative than linear. As maintained by Lindblom, scholarship of the process should take into account all related elements of the political life, such as elections, politicians and interest (lobby) groups. It should also consider the 'deeper forces' of business, inequality and the limited capacities of analysis (Parsons, 1995; Lindblom, 1977; 1979).

3.1.4. Policy Process Models

The world we live in is a complicated place, and the universe of policy making is no less convoluted or multifaceted. It is integral, in the pursuance of explanations in the policy sciences field, to utilise maps, models and theories in order to simplify the complex process.

Fiorina (1975) states that the advantages to using models for investigating phenomena in political science lies in improved accuracy of thought and precision of argument. Models and theories usually indicate whether their particular emphasis is on the micro or macro level. In micro-level models, the individual is the unit of analysis; in macro-level ones, groups, classes and nations, may be the units of analysis. Whether the emphasis is on the individualistic or macro-contextual will depend on which method of investigation best suits the research question.

Models are useful in understanding the multiple factors that mould political and social processes and problems (Parsons, 1995). Such maps and models make up frameworks which enable expression and clarity of thought. All frameworks are unique in that they embody different values, approaches and aims. Explanatory frameworks are used to show "how something happens the way it does," and why it does (Parson, 1995:58). Within this group, one may utilise heuristic models or theories, which aim to proffer a framework which is then used to explore certain phenomena. It facilitates examination of particular problems or processes. An example of this is the policy-making stagist model. On the other hand, one may use a 'causal' model which is far more quantitative in nature. It calls for a hypothesis which is then either proven or disproven.

Alternatively, one may look to use normative frameworks, which set out the circumstances that should exist for certain occurrences to come about. Such frameworks are more concerned with what should be, rather than what is (Parsons, 1995).

Allison's (1971) analysis of the Cuban Missile Crisis (1962) indicates an excellent example of how using different models (rationality; organisational; bureaucratic), all investigating the same phenomenon, can elicit different results and explanations. Although widely criticised from a methodological standpoint (Bendor and Hammond, 1992), Allison's analysis of decision-making during the crisis, by using various models, promotes understanding and an "awareness of the frames which are employed to interpret events" (Parsons, 1995:62).

The following illustrates some of the approaches and frameworks that exist in order to simplify the complex policy-making phenomena.

Stagist Approaches

A dominant paradigm of the policy-making process is the stages heuristic. Paradoxically, it is also the most criticised and is highly contentious (Jann and Wegrich, 2005). Most policy process models draw in some way from the seminal work of Lasswell (1951; 1956; 1959; 1971). Throughout the 1970's and 1980's this stagist application to the policy process was further developed. A number of different versions of the policy typology emerged, as well as research into the individual 'stages' of the policy cycle. Such modifications developed and contributions made were by Jones (1970), Anderson (1984), May and Wildavsky (1978), Jenkins (1978), Brewer and DeLeon (1983), Hogwood and Gunn (1984), Peters (1986) and Bridgman and Davis (2000). Table 3 illustrates some of the various versions of the stagist policy models.

The stagist approach is one which 'breaks' the policy making process into a number of phases or categories, in order to simplify a complex and somewhat confusing cycle of events. Lasswell (1956) first introduced the idea of a prescriptive model of the policy process, which has seven stages (Table 3). The understanding Lasswell had of the policy making process was initially more normative and heuristic than analytical

and empirical (Jann and Wegrich, 2005). However, he recognised the need to look beyond the narrow and linear direction within the policy stages, and to use the framework more as a guideline of the process, as to take account of the social, political, and economic environment (Lasswell, 1960). It has been commended that a new era of post-positivism and analytical thought should be nurtured, albeit keeping the usefulness of the heuristic approach (Parsons, 1995).

The stagist model has been subject to much criticism. Viewed primarily as a rational and linear model of problem-solving within the policy process, the stagist approach is deemed unworkable at worst, and idealistic at best (Stone, 1989; Lindblom and Woodhouse, 1993; Sabatier and Jenkins-Smith, 1993; Sabatier, 1991; Jann and Wegrich, 2005). The assumption that the policy-making process can be divided precisely into stages is one which "overstates the rational nature of policy making and gives a false picture" of the complex and untidy process (Parsons, 1995: 80).

Sabatier and Jenkins-Smith (1993:1-4) put forward five criticisms of the prescriptive stagist approach:

1. The stagist approach does not supply any causal explanation of the policy movement from stage to another.
2. The model cannot be tested on an empirical footing.
3. The model presents a hierarchical framework of how policy is made, without taking account of a more 'bottom-up' approach.
4. The policy cycle does not take account of the multiple layers of policy-makers and multiple levels of governing institutions and groups that contribute to the process.
5. The stages model does allow for integration of policy analysis in the stages cycle; policy analysis does not, and should not, just occur at the end of the model at the evaluation/ termination phase.

Despite such criticisms, this normative model has stood the test of time due to its attractiveness as a rational, orderly model, which is predisposed to evidence-based policy making (Jann and Wegrich, 2005). Although rationality in the policy process is more an ideal than reality, it persists as the aspiration, nonetheless, that policy-makers strive towards. This approach allows for examination of the policy process

over a period of time throughout the stages, supplying evidence of the impact actors, institutions and norms have on the entire process, form beginning to end (*ibid*). Merged with Easton's inputs-outputs model (1953; 1965a; 1965b), the stages approach evolved into a more cyclical model, which emphasizes feedback mechanisms between inputs and outputs. The addition of the cyclical conceptualisation facilitates for more fluidity between evaluation of policy and re-formulation (Jann and Wegrich, 2005). However, regardless of such improvement of the approach, the model is still an ideal-type perspective that is often dismissed by 'real world' practices. The policy process rarely follows the policy cycle stages in such an orderly fashion, and oftentimes stages are mixed up or completely (dis)missed (Parsons, 1995; Howlett and Ramesh, 1995; 2003; Jann and Wegrich, 2005).

Hogwood and Peters (1983) state how policies are created and emerge in a crowded 'policy space.' More often than not, new policies consist of modified versions of old ones. In addition, they put forward the concept of 'policy succession,' which emphasises the way in which most new policies are developed in an already crowded climate of existing policies. This notion, therefore, assumes an important role of earlier policies on the policy making arena. This is a key consideration to comprehend when analysing the policy process. Also, policies in other sectors regularly impact on policy making in all sectoral spheres in the formulation and implementation of specific policy initiatives. It is worthy to note how policies can themselves create side-effects and impacts on later policies, either on cross-sectoral or intra-sectoral policies (Wildavsky, 1979).

While keeping the advantage and limitations of the stagist approach in mind, the following section will detail the intricacies of each policy stage.

Simon, 1957	**Lasswell, 1956**	**Jenkins, 1978**	**Hogwood and Gunn, 1984**	**Anderson, 1984**	**Quade, 1982**	
Intelligence	Intelligence	Initiation	Deciding to decide (agenda-setting)	Problem identification and agenda formation	Problem formulation	
Design	Promotion	Information	Deciding how to decide (issue filtration)	Formulation	Searching for alternatives	
Choice	Prescription	Consideration	Issue definition	Adoption	Forecasting the future environment	
	Invocation	Decision	Forecasting	Implementation	Modelling the impacts of alternatives	
	Application	Implementation	Setting objectives and priorities	Evaluation	Evaluating the alternatives	
	Termination	Evaluation	Options analysis			
	Appraisal	Termination	Policy implementation, monitoring and control			
			Evaluation and review			
			Policy maintenance			

Table 4: Presentation of Variations of the Policy Stages Approach in Chronological Order

Policy Stages

Although varying perspectives and understanding of the stagist approach exist (Parsons, 1995), generally the policy cycle starts at problem definition and establishing the issue on the political and administrative agenda. This is followed by policies being decided upon, formulated, implemented, and finally assessed and evaluated as to their success.

A) Agenda Setting: Problem and Issue Identification

This stage is the starting-line for public policy making, and will have a significant impact on the rest of the process (Cobb and Elder, 1972). The actions taken at this stage of problem and issue recognition determines the policy making pathway (Jones, 1971; Howlett and Ramesh, 1995). Agenda-setting involves placing an issue on the political and administrative agenda (Jann and Wegrich, 2005), which requires recognition and action by public officials (Cobb *et al*. 1976). Research into agenda setting emerged from the pluralist perspective in the United States (US) in the 1960's. This outlook views the setting of agendas as the outcome of competition between actors in the political process (Schattschneider, 1960; Dahl and Lindblom, 1953; Dahl, 1958; 1961). Initially, development of this policy stage materialized from the perspective that socio-economic conditions led to governments responding to issues, and thus agenda-setting (Sharkansky, 1971; Aaron, 1967; Pryor, 1968). However, this viewpoint, and its theoretical 'convergence thesis,' was deemed far too rational by critics (Heidenheimer *et al*. 1975) as it reduced problem and issue recognition down to a simplified, linear process. The evolving concept of agenda-setting began to recognise more political, institutional and ideological influences on the notion of problem definition by governments (King, 1981; Howlett and Ramesh, 1995).

The most important contributions in re-conceptualizing the agenda-setting process commenced with the works of King (1973), Hofferbert (1974) and Simeon (1976). These individuals developed the 'funnel-of-causality' theory, which aimed to depict the inter-weaving relationships that were present between interests, institutions and ideas in agenda-setting. This theory constituted of these variables which operated in much the same political environment, and which were 'nested' in and among one another (Sabatier, 1991). This framework explained relationships using a causal hypothesis (*ibid*). However, it goes little way to clarify the ideas and economic

interests that may be generated by policy actors in agenda-setting (Howlett and Ramesh, 1995). Baumgartner and Jones (1993) put forth the notion of the 'policy monopoly' as being the 'monopoly on political understandings' of specific policy issues. The concept suggests that agenda-setting happens when 'policy monopolies', and the institutional support behind the policy issue, become challenged, thus activating all interested actors in the process (Jann and Wegrich, 2005). In all, the notion that there exists a number of interacting variables, including the actors, interests, ideas, and institutions, illustrates how far removed rationality is from agenda-setting. Downs (1972) contributed to the area with the 'issue-attention cycle' and the cyclical fashion that issues appear on the public agenda, such as the appearance of single issues on the public agenda over time. Cobb and Elder (1972) brought the systemic (public or informal) and institutional (governmental or formal) agenda theories to the research paradigm. This highlighted the levels at which issues are both raised and dealt with. According to this theory, the systemic agenda is one for issue awareness and debate, while the institutional agenda is one for action (Howlett and Ramesh, 1995). Cobb *et al*. (1976) indicated four major phases which exist between systemic and institutional agendas, and much research in this area was conducted using a cross-country comparative analysis, which looked at how agendas are raised in different political regimes. Although this theoretical framework is insightful, it emphasises the regime type as the variable for analysis, not the problem or issue itself. Kingdon's (1984) 'multiple streams model' is a seminal piece of work in the field and is most influential in conceptualising the opportunities and unforeseen events in agenda setting. This theory works from the 'garbage can model' of organisational theory (Cohen *et al*. 1972). It introduces the idea that 'windows of opportunity' become available at particular times for specific policies (Kingdon, 1995; Jann and Wegrich, 2005). Such 'windows of opportunities' open when the usually separate streams- the policy stream (solutions), policies stream (public mood, government changes) and problem stream (problem perception)- interconnect.

Agenda-setting, as the first stage in the stagist approach, influences much of the activities of others in the phases to follow.

B) Policy Formulation

Although some policy analysts believe this stage cannot be investigated as an entity separated from agenda-setting processes (Sabatier, 1988; 1991) or decision-making processes (Jann and Wegrich, 2005), according to the stagist approach this is not necessarily the case (Howlett and Ramesh, 1995).

Since the 1970's, this stage of policy research has been influenced by public choice approaches (Niskanen, 1971; Dunleavy, 1991) and welfare economists' perspectives (Quade, 1976; Carley, 1980; Jenkins-Smith, 1990). Such outlooks assumed far more control and choice on the part of governmental institutions to formulate optimal policies, which is not often the case. There exists a number of constraining factors in this stage, mainly between the various actors in policy development (Sabatier, 1991; Parsons, 1995).

The stage of formulation begins once the government has recognised a problem exists (in agenda-setting). Then the various options available to the policy-makers must be addressed. This process of assessing policy options commences the policy formulation stage (Jones, 1984; Howlett and Ramesh, 1995). Policy formulation 'sets the scene' for the range of policy options decided upon at the decision-making phase. It is during this formulation point that options are excluded or included for decision-making. *How* such options are treated by the actors, interests and institutions in the political and administrative arena is the central concern at this stage in the policy process (Howlett and Ramesh, 1995).

Jones (1984) puts forth a number of defining traits of the policy formulation process:

1. Formulation may involve a number of groups of actors pushing forth proposals in order to have stake in the policy-making process.
2. It is not unusual for formulation to proceed without due consideration given to the definition of the problem or issue, or to have had contact with those affected, or to be affected by the policy.
3. Formulation is often, though not necessarily, the function and remit of administrative agencies and government ministries.
4. It may be the case that formulation and re-formulation occurs, over time, without any consensus upon a specific course of action among the main actors.
5. Throughout the formulation phase there are appeal points for those who lose in the formulation process at any level.
6. The "process itself never has neutral effects" (Howlett and Ramesh, 1995:123). There are winners and losers in the competition of interests in policy formulation.

It is clear from the abovementioned points that this stage is highly nebulous, complex, and is far removed from considering policy options in a rational way. The search for solutions to policy problems is laden with institutional constraints and the power that influential actors have in appraising possible policy options (Majone, 1989). Policy-makers will assess options as to their feasibility. They will judge as to the amount of economic resources and political will that exists for the development of that particular policy preference. However, it is worth mentioning that in this policy process, "perception is as real as reality itself" and oftentimes formulation of policy is constrained, not by the lack of factual evidence or expert advice, but the degree to which it is workable and politically viable (Howlett and Ramesh, 1995:124).

The individual and group actors involved in this process are integral to its operation. Many policy analysts have identified the existence of sub-systems in this level of the stagist process. The interaction of individuals between and within the sub-systems, and the impact of such interaction, elicits much interest from scholars of the entire process. Important theories pertaining to this area of research include the 'iron triangles' of state actors in devising policy (Cater, 1964); Heclo's (1978) 'issue

networks' and Sabatier and Jenkins-Smith's (1993) 'advocacy coalition networks'. These sub-systems will be delved into greater detail in section 2.3.4.2.

An important aspect in policy formulation is the role of policy (expert) advice (Jann and Wegrich, 2005). This issue is increasingly becoming important in policy formulation due to the numerous think-tanks and international organisations that have an input into the knowledge-base for policy development (Stone, 2004; Dolowitz and March, 2000; Albaek *et al*. 2003). Previous models pertaining to policy advice distinguished between 'technocratic' (scientific expertise being deemed superior to political expediency) and 'decisionist' (pre-eminence of politics over scientific knowledge) models in the politics/ science affair (Wittrock, 1991). Empirical studies, however, have shown that policy advice is but one river of knowledge, making its way to the estuary of policy formulation. Politicians and administrative staff may not be swayed much of the time by scientific research or evidence-basis for policy in the short-term, due to the nature of reactive and electoral politics. However, it is more likely to have an impact on the long to medium term perceptions of policy issues and solutions (Weiss, 1977; Lindblom and Cohen, 1979; Jann and Wegrich, 2005).

As with all areas of policy research and analysis, this stage of formulation is highly contentious among the different actors and is tenuous at times. The following will demonstrate the decision-making theories that underpin the choices that are made once the actors and other interests have had their input in the formulation process.

C) Decision-Making

Decision-making, like other stages in the policy process, is a complex phenomenon with multiple actors, organisations (and sub-levels), policy issues and constraints (Howlett and Ramesh, 2003). This policy phase has been characterised by being nested in, and dependent on, previous and proceeding policy stages. It is not a self-sufficient policy stage (Howlett and Ramesh, 1995). In addition, it is steeped in political activity and interests, whereby a number of beneficiaries of certain policy decisions will arise, as well as 'losers' of such (Brewer and DeLeon, 1983). Decision-making is one of the most researched areas of policy making (Cahill and Overman, 1990). This is evidenced by the lengthy debate and numerous models pertaining to the area (Simon, 1957; Lindblom, 1959; Bachrach and Baratz, 1962; Dror, 1964; Etzioni,

1967; Allison, 1971; March and Olsen, 1979; Weiss, 1980; Forester, 1984; Teisman, 2000). Wilson (1973) states how the attention on a decision, or set of decisions, provides a perimeter between the normative, on the one hand, and empirical observation on the other. This philosophical tension and academic debate, between the two such opposing concepts, presents the rationale behind the focus upon the decision in the policy-making process. The work of Herbert Simon and others allude to such strain within the administrative, organizational and policy sciences (Simon, 1950; Simon, 1957; Simon and March, 1958).

Key to research in this area of the policy process is in understanding how individual decisions are formulated and operationalised, and to what extent the "investigation of this problem would reveal the negotiable relationship between policy and politics" (Bittner, 1965:254). The administrative/ bureaucratic arm of government is central in the decision-making process as an authoritative actor, in the same way as are elected policy-makers (Aberbach *et al*. 1981). Indeed, as Ireland is a parliamentary democracy, the nub of decision-making responsibilities centres on the legislature and bureaucracy as equal makers of policy (Howlett and Ramesh, 2003). Another important concept to note, when investigating policy decision-making models and empiricism, is the existence of a typology of decision choices (Bachrach and Baratz, 1962). No matter how many actors are involved in decision making, who is involved, or the nature of the problem, only certain two main types of decisions will emerge. 'Positive' decisions, which alter the status quo, and 'negative' or non-decisions (Zelditch and Ford, 1994), which avoid change and maintain the status quo.

Central to the decision-making arena is the place of knowledge in the policy process, and its utilization (Weiss, 1980). How decision makers look at knowledge and deal with it (Teisman, 1992; Kingdon, 1995), define problems and solutions according to personal and professional interests and beliefs (Sabatier, 1988; Schon and Rein, 1994) will be dealt with in more detail in the proceeding section on 'policy analysis and in section 3.2.

As outlined previously, models are necessary to enable to the progression, clarification, explanation and conceptualisation of policy making processes. Howlett and Ramesh (2003) have succinctly surmised that the relevant models in the vast field

of government decision-making styles all have two distinct traits in common; the actors involved in the process, and the limitations upon such, are key features of the processes themselves.

The following demonstrates a critical analysis of the literature pertaining to the major decision-making models in the field. By the 1960's the debate surrounding decision-making styles had centered on rationality and incrementalism, both opposing views of decision-making (Smith and May, 1993; Howlett and Ramesh, 2003). However, from the synoptic approach to the 'garbage-can' hypothesis, numerous decision-making styles and theories have since built upon one another in this policy decision arena.

Rationalism: Linear Activity and Logic in Public Policy Making

An Oxford Dictionary definition of 'rational' deems it as "exercising one's reasoning in a proper manner; having sound judgement; sensible" (Cited in Carley, 1980:10). The essence of such definitions, when related to policy decision-making, alludes to the value-maximising of choice alongside certain limitations (*ibid*). The rational approach, despite criticisms directed at it, provides a good starting point for the analysis of individuals, groups, institutions and actions in policy decision-making (Davies, 2000). Rational choice theory places individual choice as the raison d'être for all political action, and indeed, inaction (John, 1998). It is a prescriptive theoretical framework which is founded in the discipline of economics (Green and Shapiro, 1994; Friedman, 1996). It views human beings as rational actors, motivated by their own self-interest (Stigler, 1975; Hughes, 1998; Hill, 1993), seeking to manipulate institutional rules in order to structure the environment around them (Edwards, 1954). The rational model of decision-making, however, focuses upon analysis of the organisational and institutional environment within which the actor (executive or bureaucracy, or both) operates and reacts to certain situations (John, 1998).

An idealised sequence of rational decision-making is succinctly outlined by Carley (1980:11) in the following:

1. A problem, requiring action, is identified and defined. Values, goals and objectives related to the problem are classified and organised.
2. Alternative strategies are identified for solving the problem.
3. The important consequences which would follow from each alternative course of action are predicted.
4. The consequences of each strategy are then compared with the initial goals and objectives.
5. Finally, a policy is adopted which most matches the goals and objectives, after costs and benefits of each alternative has been assessed.

In accordance with this rational choice decision-making theory, decision-makers are logical 'technicians', selecting the best strategies for a particular course of action after sifting through all possible alternatives. In this sense, rational choice, which is grounded in positivism, is categorised as a 'scientific' approach to decision making (Elster, 1991). It was adopted into organisational behaviour and public administration sciences in the 1930's (Gulick, 1937) and 1940's (Fayol, 1949), in order to establish a school of thought supporting such maximising and rational techniques as applied to the policy processes (Howlett and Ramesh, 2003). Use of rational choice methods and techniques are aimed to provide governments with better planned policies, and to allow for accurate prediction of policy consequences (Hughes, 1998). Although at times rational models and techniques in decision making are deemed aspirational, they provide a good basis for the design and development of policies and policy tools (Carley, 1980; Bregha, 1990; Davies, 2000).

Presented as an idealised, logical and sensible approach to decision-making, rational decision-making has been subject to wide criticisms. The initial and most prominent of such critiques was the work of Simon (1957), which proposed that the limitations of a purely rational approach were impossible to avoid in 'real world' settings. Firstly, Simon noted how rational decision making, in accordance with the model, would only come about if *all* possible alternatives were considered, which rarely happens in reality. Secondly, Simon argued that the rational model assumes that decision-makers

would know all possible consequences of each decision, which is seldom the situation either. Thirdly, Simon noted how each policy option would have to be appraised in accordance with costs and benefits, which is impractical on a daily basis for decision makers. Fourthly, options may be deemed efficient or not so, depending on ongoing time and changing circumstances. Therefore, in a world of constant change and uncertainly, achieving conclusive results utilising the rational model was almost unattainable (Simon, 1955; 1957; Einhorn and Hogarth, 1986). Simon concluded, however, that although in line with the rational model, one could not maximise benefits over costs, but could instead come to satisfy the criteria of main importance in dealing with the policy question (Howlett and Ramesh, 2003). Therefore, Simon's theory put forth the notion of 'bounded rationality,' alluding to the cognitive constraints ingrained in human beings when taking decisions (Fry, 1998). Etzioni (1967) has observed that the rational model represents what should happen, as opposed to what does happen. It is regarded as being too inflexible in considering the spectrum between 'ends' and 'means'; what is considered fact and worthwhile depends very much upon the interests and values of actors involved. The rational model does not take account of such political and life realities (May and Smith, 1993). This notion has been criticised by Lindblom (1959), as throughout the decision-making process 'ends' and 'means' change in line with changing circumstances and political priorities. It is often difficult to establish the consequences of 'means' (policy strategy/plan) and their impact upon 'ends' (policy outcome). Oftentimes, decision makers do not know exactly the consequences a policy may have in the long-run. However, the most fundamental criticism of the rational model is that it is estimated as wholly impractical (Cherns *et al*. 1972; May and Smith, 1993).

Indeed, many researchers in the field (John, 2001:125) find the rational model as

> "An oversimplification of the complexity and limited organisational coherence of decision making. Even if the political system could adopt a rational decision-making strategy, the costs of reaching the standards required would probably paralyse decision-making processes, frustrate the groups involved in the policy process and limit the opportunities for policy-learning."

However this prescriptive and normative model has its strengths, in that it provides an organised framework within which to operate. It must be noted that few people will argue that full rationality is possible in policy making nowadays (Carley, 1980). What

is possible is partial rationality, whereby "only *some* alternatives and *some* consequences are related to *some* objectives" (Author's own emphasis. *ibid*: 15). The guidelines proffered by the rational model are just that- guiding concepts which allow for better informed, planned, designed and predicted policy options. The ultimate aim of such a model is to facilitate better informed judgements from our decision-makers. Various techniques exist which seek to aid the problem solving nature accorded to decision-making from the rational approach. Such policy tools, such as impact assessments and cost/benefit analysis (CBA), will be further dealt with in section 2.4.

Incrementalism: Iterative and Gradual Activity in Public Policy Making

The name Lindblom is synonymous with the incrementalist model of decision making (Gregory, 1993). Emerging in the 1950's, in response to the rational models of decision making, and to Simon's notion of 'bounded rationality,' Lindblom developed a theoretical framework countering the rational model. The paradigm that embodies the work and ideas of incrementalism incorporate a number of key concepts (Dahl and Lindblom, 1953; Lindblom, 1959; Braybrooke and Lindblom, 1963; 1970; Lindblom, 1979; 1980; Lindblom and Woodhouse, 1993):

- ⇨ The level of understanding between relevant variables in policy making is low.
- ⇨ In order to simplify the analysis of possible options, policy makers limit themselves to understanding the variables, values and possible consequences which are of immediate concern to them, and will only alter from the status quo marginally.
- ⇨ Policy actions are founded on a trial and error basis, so that unintended and unforeseen consequences may be more easily coped with.
- ⇨ The policy landscape will not differ drastically from one day to the next. Therefore, political and policy change only occurs marginally. This is the essence of incrementalism; that change comes about slowly and modestly.
- ⇨ That policy making is a process of political and social engagement, negotiation, bargaining, and consensus, between concerned groups who have both similar and contrasting values and priorities. Such is Lindblom's (1965) 'partisan mutual adjustment,' which is a political process contrasting with a centralised, information-focused decision-making environment.

⇨ Political and policy change is not an overriding concern of decision-makers, opting instead for marginal modification than policy revolution.

(Gregory, 1993)

Such underlying concepts help explain the 'disjointed incrementalism,' which is how decision-makers aim to simplify their information-processing tasks, as presented above. Another basis for the incrementalist argument is that change and innovation is often inhibited in the bureaucratic climates in the government institutions. The hallmark of the administrative system does not typically encourage discontinuation from current practices and procedures (Gortner *et al*., 1987; Howlett and Ramesh, 2003), despite recent reform in the public administrative environment (Hughes, 1998; Whelan *et al*. 2004). Whereas the prescriptive rational model is one based on economic assumptions, the incremental model is founded upon political realities of negotiation and bargaining, and is a more descriptive representation. Gregory (1993) differentiates the two between one focused on the policy process (incrementalism) and the other focused on policy outcomes and results (rational model). Lindblom's view was that decision-makers did and should produce policy based upon past actions, building policy upon policy, continually, differing only marginally from the previous action (Lindblom, 1959; 1979). Therefore, the alterations from the status quo are incremental (Howlett and Ramesh, 2003).

As with the rational model, the incremental approach has been subject to criticisms over the years. Primarily, it is the lack of goal-orientation, as demonstrated by the incremental approach, to ensure some level of planning and structure, as opposed to 'trial and error' interventions and policy accretion (Goodin, 1982). Secondly, the model is criticised for being conservative and suspicious of innovation and change (Howlett and Ramesh, 2003). Thirdly, incrementalism is faulted for being undemocratic, as it posits decision-making bargaining among a select few individuals (Gawthrop, 1971). Fourthly, it is deemed a model encouraging a lack of investigation for new policy alternatives, thus promoting a short-term approach to the policy process. This could have unfavourable consequences on society overall (Lustick, 1980). Dror (1964) criticised the model as being far too limited in its approach, as it represents a more stable policy environment, as opposed to crisis or unusual situations requiring immediate policy responses.

Despite counter-arguments from Lindblom (1979), incrementalism is far from an ideal decision-making model which is suited to all political contexts. Several approaches built on the hypotheses advanced by both the rational and incremental models, in the search for more practicable and informed decision making perspectives.

Rationalism + Incrementalism = Third Way Approach?

Writers of the decision-making policy processes sought to extract the best features from both rational and incremental models, in order to construct a more informed explanatory framework. Etzioni (1967) developed the mixed scanning approach by fusing the best qualities of both opposing theoretical models. The rational model, criticised as unworkable, and the incremental model, deemed suitable only for certain policy environments, suggested to Etzioni that a model may emerge by combining the better assets of both models. Building on the work of Simon, Etzioni suggested that the decision-making process was made up of two stages. Firstly, the policy issue would be assessed in the 'pre-decisional' stage, thus employing the incrementalist approach. Secondly, analysis would take place whereby alternative policy options and solutions would be assessed, which takes from the rational perspective (Mintz *et al*. 1997; Voss, 1998). The model presents initial 'scanning' for alternative options and assessing the policy issue, following by a more detailed analysis of such options. Etzioni argued that the model is both a prescriptive and descriptive approach of the policy process, and aims to surmount the constraints of earlier models, while informing the practice of decision-makers on the ground.

Dror (1964) also constructed a 'third' approach to decision making, building on the work of rationalism and incrementalism. Essentially the model seeks to "increase the rationality-content" in decision making, while recognising that "extra-rational processes play a significant role in optimal policy making on complex issues (Dror, 1964: 155). The model has been criticised as reiterating what rational and incremental approaches already put forth (Lindblom, 1964). However, theoretical debate intended to break the undeterred bipolar mould proffered by the rational and incremental models was most welcome. It aided the progression of conceptual understanding of the complexity of policy issues, participating actors in the process and the limitations within which they operated (Smith and May, 1993).

A similar ‘two stage’ model was developed, building conceptually on the work of Etzioni, which is referred to as the ‘poliheuristic model’ (Mintz *et al*., 1997; Howlett and Ramesh, 2003). According to this model, firstly decision-makers use a number of ‘shortcuts’ (heuristics) in order to compensate for the limitations in knowledge that decision-makers are often faced with. Such heuristics include the use of historical comparisons or case studies, use of an incremental style of policy making and a desire to strive for consensus on policy issues (Hood, 2002). In the second stage, the possible solutions are assessed in a more rational analysis. It has been pointed out in the literature how the mixed scanning approach does not differ to any great extent from the rational or incremental approaches. Indeed the assessment of policy alternatives reeks of the rationalist perspective. However the model has been welcomed for presenting a more organised and less overtly political approach than that which is innate in the incremental approach. The mixed scanning contributes to the development of theoretical understanding of decision-making procedures (Howlett and Ramesh, 2003).

Garbage-Can Hypothesis

The ‘mixed scanning’ approach was very much overlooked in the 1970’s in favour of a model which accepted the ambiguity, uncertainty, and oftentimes irrationality of the decision-making processes. This ‘garbage-can model’ of decision making completely denied the policy process of any rationality whatsoever, even more so than that shorn of in the incrementalist approach (March and Olsen, 1979). Building in the assumptions inherent in earlier models that there existed a degree of intentionality and predictability of behaviour and norms among policy actors, March and Olsen (1979) dismissed such hypotheses is favour of conceptualising decision making as wholly unpredictable and ambiguous. According to this theory, decision situations comprised of a “garbage can into which various problems and solutions are dumped by participants” (March and Olsen, 1979:26). The use of the ‘garbage-can’ analogy was used purposely in order to deny an impression of science pertaining to policy decision-making. However, as worthy the theory was in breaking the ‘dead-lock’ that had pervaded the incrementalist versus rationalist debate, one would expect more organisation and deliberation in some instances and in some institutional contexts (Mucciaroni, 1992), if not all, of decision making. This is not considered in the

'garbage-can' model, which is an inherent flaw of the otherwise well conceptually-grounded model (Howlett and Ramesh, 2003).

Recent Approaches: Working with Complexity

By the 1980's, research had grown to recognise the importance of institutions, structures and politico-administrative context in understanding the complexity of decision making. Oftentimes, such policy processes are being conducted across various organisations over various time periods. Weiss (1980) concluded from her work, which investigated the use of knowledge in policy making, how decisions are made in a 'piecemeal' fashion, without an overall goal-driven plan. Such decisions are built upon previous layers of decisions, over a lengthy time period, and with the involvement of numerous decision makers. Unlike incrementalism, which suggest decisions are made incrementally and on the basis of previous decisions, this 'decision accretion' model is not dependent on organisational negotiating and bargaining or groups of participants to explain policy decisions, but instead upon the nature of the policy issue and of the organisation dealing the decision. According to Weiss, decisions are made with each individual actor taking a small step towards the bigger overall decision. Such examination underlines the notion of modern day decision making as occurring in multiple arenas and multiple rounds. Weiss and others (Mintzberg *et al*. 1976; Klijn, 2001) put forth that in reality, decision making occurs in multiple arenas or locations, each environment having its own cultural climate, set of actors and rules of procedures, which are all factors influencing the decision making process (Howlett and Ramesh, 2003). Indeed in taking this concept a step further, Teisman (2000) suggests that in this process of decision making there exists a number of 'rounds' within which decision making takes place. In each 'round' different actors provide solutions to the policy problem. These suggestions are all gathered in a 'round', and are "fed back into other arenas for continued discussion and debate, in a process in which new actors can be activated, new arenas become involved, and new or modified decisions emerge" (Howlett and Ramesh, 2003:178). This portrayal of decision making centres on the interaction and communication between actors, within and between arenas, and on the strategies, procedures and devices used to influence arena outcomes. By focusing on such exchanges, prediction of the types of decisions that arise from such complex and interwoven interactions can be made. In addition, by focusing on such processes and on the roles of different

actors, understanding is elicited of the opportunities in decision making whereby decision outcomes can be better designed and informed (Stokman and Berveling, 1998; Sager, 2001). Currently, much emphasis has centered on decision making tools which aim to ensure policy outcomes are, as far as practicable, informed, and that consequences of decisions are predicted and known (Bregha *et al*. 1990; Kennett, 2000).

The nature of decision making processes are often contingent on the policy issue, the actors involved, the institutional and informational contexts and pre-existing decision making routines and ideas (Howlett and Ramesh, 2003). Such variables are present in some form or another in various decision situations, and the particularity of the circumstance will evoke certain decision making approaches. Forester (1984) has developed the decision making paradigm to an understanding that such styles and types of decisions depend on the policy issue and institutional contexts. His theoretical model (table 5) demonstrates the parameters of decision making, using five key variables. This model demonstrates the extent of complexity of the policy problem, and the variables of 'problem', 'information' and 'time' resources can also be identified in earlier works of Simon and Lindblom (Simon, 1973; Howlett and Ramesh, 2003). The accumulation and use of previous models and the more current ones contributes to greater understanding of the complexity involved in decision making, and also paves the way for much needed empirical studies utilising the frameworks as presented by such models.

Table 5: Basic Parameters of Decision Making (Forester, 1984:26)

VARIABLES	DIMENSIONS
Agent	Single ↔ Multiple
Setting	Single, Closed ↔ Multiple, Open
Problem	Well-defined ↔ Multiple, Vague
Information	Perfect ↔ Contested
Time	Infinite ↔ Manipulated

D) Implementation

Until the 1970's, this stage was not considered as a separate phase in policy making. The recognition of the implementation stage as the 'missing link' in the policy process is regarded as one of the most original conceptual findings in the study of the policy sciences.

Implementation broadly relates to the following:

> "(It is) what happens between the establishment of an apparent intention on the part of the government to do something, or to stop doing something, and the ultimate impact in the world of action" (O'Toole, 2000:266).

In their ground-breaking study of policy implementation, Pressman and Wildavsky (1973) found that it is often not necessarily the problem with implementation but the aspiration of the initial policy objectives, definition and vision that results in policy failure (Davies, 2000). Implementation research varies between hierarchical 'top-down' approaches, which seek to follow policy implementation in a chronological, linear fashion. Co-ordination problems between and within organisations in the policy-making process compose the foremost reason for implementation failure (Jann and Wegrich, 2005). Thus towards the end of the 1970's, a more 'bottom-up' perspective to policy implementation emerged, as the hierarchical assumption did not take account of the actions and decisions of agencies implementing policy on the ground (Hill and Hupe, 2002). This analytical refocusing allowed recognition of the agencies, ministries and individuals who have a role in the shaping of policy outcomes and dealing with contradictory demands regarding implementation (DeLeon and DeLeon, 2002: Hill, 2003). This concept is also known as 'street level bureaucracy' (Lipsky, 1980). The policy implementation stage has progressed into a research paradigm that does not fit neatly into the stagist policy approach (Jann and Wegrich, 2005). Hierarchical governance has been somewhat discarded in favour of embracing a theoretical framework that incorporates a more horizontal conceptualisation of policy-making (Colebatch, 1998). This is necessary as implementation research indicates how all types of actors across administrative and government functions have a part to play in shaping policy outcomes, though these actions do not fit neatly into the linear perspective of the stagist approach (*ibid*; Howlett and Ramesh, 2003).

E) Evaluation

Policy evaluation in the stagist approach, although is located towards the end of the cycle, does not necessarily mean that appraisal takes place at the conclusion of a course of policy action. Evaluation research has developed as a separate subject in the policy sciences, which investigates the extent to which a policy or group of policies meet with the stated aims and objectives (Jann and Wegrich, 2005). It is distinct from impact assessment methods and techniques, which look to appraise the intended and unintended consequences of policies (Scott-Samuel, 1996). Nevertheless, the conceptual roots of policy analysis join these mechanisms for policy-informing together, as established by Kemm and Parry (2004). This stage in the policy process originated as one that was oriented on quantitative measures that systematically apply the idea of experimental testing to policy outcomes and outputs (Hellstern and Wollmann, 1983). While such scientific evaluation is useful in quantifying causal-relationships between inputs and outputs in the evaluation of a policy process, it is too narrowly focused, and thus loses the essence of political process and debate (Howlett and Ramesh, 2003). Evaluations may have feed-back mechanisms that can re-invigorate the process in terms of improving the policy formulation, which ensures ongoing appraisal of policy throughout the various stages. It is certain that, far from focusing on the final analysis of policy, evaluation contributes to the continual policy-making process (Jann and Wegrich, 2005).

As already outlined in an earlier section entitled ‘understanding public policy,’ policy evaluation can refer to the analysis of policy impacts or outcomes, (Weimer and Vining, 1992). Although this school of thought originated as one that solely examined quantitative causal relationships, without due investigation of the accompanying policy processes, it has developed into a more holistic and exploratory branch within the policy sciences.

The following section looks at policy analysis, as a related albeit distinct arm of the policy evaluation stage as it is within the stagist approach.

3.1.5. Policy Analysis: The Art and Craft (Wildavsky, 1979)

Policy analysis is a branch of study that seeks to inform and prescribe solutions and formulae to decision makers, regarding the direction and content of public policies (Weimer and Vining, 1992; 1999). The purpose of policy analysis is to "deepen, broaden and extend the policy-makers' capacity for judgement- not to provide him with answers" (Milliken, 1959:167). Political judgement can be conceptualised as utilising knowledge within a rationalistic model or one of a more pluralistic nature (Steinberger, 1993). Although with different emphases, impact assessment has a place, conceptually and ontologically, within the policy analytical paradigm (Bartlett, 1989; Kemm and Parry, 2004; Kraft and Furlong, 2004). Stone (2002) has produced a body of work that examines the processes of policy making and the underlying values and politics, which have an impact upon the boundary and scope of policy analysis. This work looks at the extent to which policy analysis can inform, objectively or subjectively (depending on which body or individual is providing the information) the public policy pathways.

Policy analysis, for the most part, refers to the analysis of policy options and alternatives (Patton and Sawicki, 1993; Kraft and Furlong, 2004). By this understanding, the type of knowledge that is fed into the policy process, and the epistemological underpinning of it (Guba and Lincoln, 1989; Rossi *et al.* 2004), must be taken into consideration (Weiss, 1977; 1998; Douglas and Wildavsky, 1982; Stone, 2002). In the seminal work 'Speaking Truth to Power,' Douglas and Wildavsky (1982) conceptualise that knowledge and policy are two distinct spheres, and the relationship between the two are linked by a bridge of 'information flow' which may or may not 'fit' suitably to all policy processes. For the most part, information does not find its way into policy. Weiss (1977) questioned this rationality of the linkage attributed to this information stream between policy and knowledge, stating that values of the policy actors and researchers, and the reality of 'compromise-making' in policy processes, needs to be acknowledged. Values throughout the policy process are an important consideration, whether implicit or explicit. Weiss (1980) and Weiss and Bucuvalas (1980) put forward the hypothesis which is more posited on the side of incrementalism; that policy develop as a result of 'knowledge creep' and is formulated through a process of incremental decision making and gradual policy evolution (Bekker, 2007). Indeed the rationalistic approach defies and denies the

political dimension of knowledge utilisation for policy. Knowledge is not often used in a non-partisan, apolitical and technocratic manner. Oftentimes, there exists a politics of use and non-use of knowledge within the policy process; the evidence of certain knowledge put forth may be factually correct but politically inexpedient (Patton, 1997). This must be taken into account in order to form an accurate picture of knowledge utilisation within the public policy making process (Chelimsky, 1995).

Weiss (1991) conceptualises this newfound land of knowledge utilisation for policy as adopting a more incrementalist stance towards the domain; a long-term utilisation of knowledge is incorporated into her new hypothesis.

Weiss (1991) categorises models for knowledge utilisation into three groups, as cited in the work of Bekker (2007:54/55) regarding the investigation of HIA as a tool for Healthy Public Policy:

1. Knowledge as a provider of facts to fill a knowledge gap
2. Knowledge as provider of ideas for conceptual policy development
3. Knowledge as provider of arguments as ammunition in the policy arena

This categorisation builds on the work of Janowitz (1970) who recognised the potential for conceptual utilisation of knowledge over time, labelled as 'enlightenment.' The consideration of politics underlying the use of knowledge and the evaluation of policy rejects the rationalistic approach to evaluation, and recognises the degree of policy learning that can occur in the policy processes; direct use of knowledge is no longer the only form of utilisation that is recognised, given the political nature of using knowledge in policy (Patton, 1997; Sanderson, 2002).

Rossi *et al.* (2004:411) have moved this school of thought onwards with their conceptualisation also, with the following categorisation of utilisation of knowledge in policy:

1. Instrumental utilisation: The documented and specific use of knowledge.
2. Conceptual utilisation: The use of knowledge "to influence thinking about issues in a general way."
3. Persuasive utilisation: The use of knowledge "to either support or refute political positions- in other words, to defend or attack the status quo."

A similar typology was also used in the European-wide evaluation of HIA effectiveness in policy making (Wismar *et al.* 2007: 19/20). Degrees of effectiveness (of use in policy) varied across the cases:

1. Direct effectiveness: The HIA has contributed to and modified the policy decision.
2. General effectiveness: The HIA was taken into consideration but the results did not modify the decision or policy.
3. Opportunistic effectiveness: Appears to have an effect, but in fact the HIA was only commenced because it was expected to endorse a particular policy stance
4. No effectiveness: The HIA had no impact on the policy process whatsoever. No cases were categorised in this grouping.

The epistemological and ontological viewpoint of the concept 'knowledge' is a contentious point underlying the policy research of knowledge utilisation; what is meant by knowledge? (Weiss, 1980; Guba and Lincoln, 1989; Cooper, 1999; Rossi *et al*. 2004; Nutley *et al*. 2007). The meaning of knowledge is a socially constructed concept and term. The latent, and not so latent, meanings and interpretations underlying the 'knowledge' concept must be clarified at the beginning of policy processes. This point has been highlighted in the work of Bekker (2007), who investigated the policy processes and the manner in which HIAs can be redesigned so as to inform policy and aid decisions in the maximum way possible.

The paradigm of policy analysis, as one approach to policy study, is indeed an art and a craft, and demands the intuitive creativity and insightful foresight of both researchers and policy makers to 'make best use' of available knowledge for pending decisions.

3.1.6. Policy Discourse Approaches

This approach seeks to examine the policy process in relation to language, communication, and systems of beliefs, values and ideologies (Parsons, 1995). As demonstrated in the seminal works of Bachrach and Baratz (1970) and Lukes (1974), policy problems and solutions should be analysed in a way that is at a 'deeper' level than the stagist or decisional approaches provide in policy process examination. Thus the emergence of 'deep' theories brought forth dimensions and frameworks that enable analysis of policy problems and agendas. Whilst not always empirically apparent, policy problems and agendas may be theoretically investigated through structures of values, beliefs and ideologies (Parsons, 1995; Bekker *et al*. 2004). This approach provides an alternative analytical lens to the dominant normative and prescriptive stagist model.

'Deep' level approaches have been advanced by the main philosophers, sociologists and psychologists in the field, who have analysed the subtleties of underlying systems of ideologies, views and beliefs as having influence throughout the policy-making process. The earliest research originates from the time of Gramsci and his seminal work pertaining to the hegemonic status of the ruling classes (Westergaard and Resler, 1976). It was his hypothesis that first propositioned how power is not a transparent construct, but a suppressed process whereby the ruling classes monopolised the psychological hold over the ruled. The hypothesis set forth by Gramsci, metaphorically speaking, laughs in the face of a free, democratic society where problem definition in the political process is open and transparent. This proposition was further developed in the works of Bachrach and Baratz (1970) and Lukes (1974). Clegg and Dunkerly (1980) applied this psychological-monopoly control to organisations, demonstrating how the entities are not just functionaries but are also replicating the philosophies of the bourgeoisie (Parsons, 1995). Clegg and Dunkerly (1980) also posit the assumption of capitalism as being ingrained in individuals, further demonstrating the subtleties of the underlying views, beliefs and ideologies as

affecting society, and thus the political community, at a deeper level. Marcuse (1972) and Habermas (1989) bring sociological and Marxist dimensions to the policy process approach, stating that the agenda-setting of problems in the policy process must be facilitated by mechanisms which would not sustain and promote the power and ideologies of the ruling classes. Foucault's (1965; 1977; 1980) theory of the use of knowledge as power on the part of the State further contributes to the maintaining of an uninformed class, and thus disempowered one (Parsons, 1995).

Two major schools of 'deep' theorists exist in this paradigm, which contribute to the examination of policy problems, agendas and solutions (Edelman, 1988; Fischer and Forester, 1993). Both groups will be looked at in the following.

'Linking Levels of Analysis' (Ham and Hill, 1984)

This examination of the policy process sets forth a theoretical framework, which, as according to the insight of Ham and Hill (1984), provides a 'middle-range' level of analysis. This links policy formation, micro-level decision-making and the macro-level political system in a tangible triadic association. Writers of the middle-range approach (Burrell and Morgan, 1979; Clegg and Dunkerly, 1980; Salaman, 1981; Benson, 1982) although are founded in context of either the Marxist or Weberian perspective, agree on the proposition that understanding of the essence and structure of the political system requires deeper analysis as opposed to solely focusing on the organisational and political structures. Parsons (1995) correctly places their analysis of the policy process as deriving from the power within society. These theorists seek to indicate the extent to which power is employed in a capitalist system as being at a much deeper level than at organisational and political institutions.

Benson's (1982) model is most influential as it frames how some issues are kept away from the policy-making process while others are filtered through it. An examination of the 'deeper' structures, underlying the surface organisational and political institutions, allows for analysis of the underlying values, assumptions and ideologies in the policy unit. In this model, the unit for analysis is a particular policy sector. Each sector is composed of networks of inter-dependent agencies and organisations that are reliant on each other for resources and information.

A policy sector may be investigated at three levels (Parsons, 1995:149):

1. Administrative structure
2. Interest structure
3. Rules of structure formation

Benson's model of a policy sector emphasises how the third level (rules of structure formation) is at a deeper level in the sector and has more strength to shape the administrative and interest structures. Such 'deep' rules work to ensure some agendas reach the policy-makers attention, while others are excluded, thus constraining the choice and power of decision-makers. The model does not indicate to what extent the administrative and interest structures will have a degree of autonomy from the lower embedded rules, although Benson believes the two upper levels may have some independence over time (Ham and Hill, 1984).

The Argumentative Approach

The theorists considering this approach look to explain power and policy processes by highlighting the important role language plays in shaping society (Parsons, 1995). The key concern of this approach is the examination of how language helps shape society's world view. The analysis of the political discourse and dialogue is important in order to understand the way messages and arguments are constructed (Majone, 1989; Fischer and Forester, 1993). The 'argumentative' approach centres on the 'articulative dimensions of public policy' and the way in which political argument and dialogue is formed (Parsons, 1995:151). Some commentators view such dialogue and communication as an input in public policy (Almond and Powell, 1966), while others place greater importance on policy discourse. Edelman (1988) and Hoppe (1993) posit political discourse as the centre stage of politics and policies; it is the theatre within which politics is acted out.

The following illustrates this:

> "Policy-making becomes the capacity to define the nature of shared meanings; it is a never ending series of communications and strategic moves by which various policy actors in loosely coupled forums of public deliberation construct inter-subjective meanings. These meanings are continually translated into collective projects, plans, actions, and artefacts, which become the issues in the next cycle of political judgement and meaning constructions and so on" (Hoppe, 1993:77).

In relation to the policy process and agenda-setting, this approach looks at how language frames, shapes, and structures a policy issue or problem (Majone, 1989). The beginning of the policy cycle is the most important part where this discourse analysis is concerned, as the initial shaping of a problem or issue may determine how it is dealt with throughout the process. Quantitative textual analysis is one research method that can be used to establish the message or argument within the political communiqués (Edelman, 1988; Fischer and Forester, 1993; Dryzek, 1993).

3.1.7. Institutionalism

Over the past decades, policy commentators in the field have examined political institutions, focusing on how institutional rules impact upon individual behaviour in policy-making (Kiser and Ostrom, 1982; March and Olsen, 1984; 1986; Moe, 1984; Sabatier, 1999). Along with the development of the policy sciences as a discipline, the study of institutions, as the context framing political behaviour and action, began to take momentum. Prior to the 1960's, institutionalism was an abandoned area of study in political science (Parson, 1995). However, it is recognised as having an integral role in explaining policy definition and policy-related behaviour (Howlett and Ramesh, 2003).Rhodes (1996) marks the key difference in the traditional 'old' institutionalism and the 'new' institutionalism, as being the emphasis on description and understanding of the former approach, and the more explanatory, methodological and analytical manner of the latter. The acknowledgement of institutional influences on policy making in particular was not present; this structural influence was considered in a more heuristic light; it "was a matter of common sense" (Rhodes, 1996:42).

Finer (1932; 1954) was a major figurehead in the old institutionalist school, advocating this approach. He conducted work investigating the institutions by way of observation of formal structures across various countries.

New Institutionalism: The Normative and The Empirical

A new approach, however, which was grounded in a more scientific and methodical school of thought arose after the 1950s (Millar, 2003). New institutionalism iterates that policy making is determined by the institutions in which it is formulated. The emphasis of this approach is upon the institutional determinants of policies and their outcomes, and on the directions and behaviour of individual actors operating in the institutional frameworks. In relation to policy making, the seminal paper of March and Olsen (1984) exemplified the new wave of thinking. This piece of research stated that the theories and methods of institutionalism until that time were insufficient in explaining the structural and normative influences upon individual behaviour, and that the time had come to develop new analytical tools. The time had come to investigate the impact institutions had on political and social outcomes, and upon individual behaviour (March and Olsen, 1986; Hall and Taylor, 1996; Rothstein, 1998).

The work of March and Olsen (1984; 1986; 1989; 1995; 1996) made major contributions to the new wave of institutionalism, setting forth the normative dimensions in particular (normative institutionalism, Peters, 1999), upon which other branches of the theory were developed (economic; sociological; political). By way of definition, March and Olsen (1989: 21/22) state that institutions are

> "Collections of interrelated rules and routines that define appropriate actions in terms of relations between roles and situations. The process involves determining what the situation is, what role is being fulfilled, and what obligation of that role in that situation is."

According this definition, institutions are made up of rules, norms, and routines (Peters, 1999). Although from the rational-choice institutional paradigm, Ostrom's (1999:36) definition also helps with understanding the normative nature of institutions, referring to "many different types of entities, including both organisations and the rules used to structure patterns of interaction within and across organisations." The normative institutionalist school is characterised by placing values and norms as

primary factors to explain individual behaviour within institutions; such actors are embedded rather than separate individuals within the institutional structures and routines (Peters, 1999). Institutional structures are viewed as being more normative in influence, than coercive. Such structures shape behaviour (March and Olsen, 1996). The 'logic of appropriateness,' a feature of the integrative political process, regarding individual's relationship with the organisational structure; whereby "participation in integrative institutions is undertaken on the basis of commitment to the goals of the organisation" (*ibid*: 27). Related to the normative institutional school, is the branch known as empirical institutionalism, which investigates what works and what does not work to produce policy decisions or maintain the status quo. The main source of institutional application is empirical (March and Olsen, 1989). This type advocates the basic premise of March and Olsen; institutions shape and mould individual behaviour. This branch examines the impacts that institutional arrangements can have on individual behaviour.

In critiquing this approach, there is some 'looseness' of the conceptual assertions (Signal, 1998). The normative school has been criticised for being too vague and therefore, without any explanatory value. However, it is a useful tool for the exploratory analysis of institutional influences upon the use of knowledge in policy making (McAuliffe and McKenzie, 2007).

New institutionalists argue that these settings frame reality in policy making (March and Olsen, 1984). The focus is upon the institutional arrangements and procedures that shape policies, ideas, values, and the actions of individuals or groups (actors) operating within the institutional boundaries. Such institutional factors impact upon actors' interests, values and approaches to policy-making and process outcomes. Some commentators would go so far as to say that certain institutional procedures exist that are favourable to effective decision-making and implementation (May, 1993; March and Olsen, 1997; Siedschlag, 2000; Howlett and Ramesh, 2003).

Hall and Taylor (1996) put forth the assertion that all actors within the relevant institutions of interest understand and acknowledge the institutional norms, procedures and values. Indeed, the institutional approach to study within the policy

and political sciences is at the very heart to understanding the impact of externalities upon individuals within an institutional context (Koebe, 1995).

Three types of institutionalism exist in this policy-making approach, namely economic, sociological and political (Parsons, 1995). Economic institutionalist theories grew expansively from the rational choice paradigm, which generally employs the standards of neo-classical economics upon political conduct and activities (*ibid*; March and Olsen, 1984; 1995; Ostrom *et al*., 1994; Ostrom, 1999). These economic perspectives of institutions, known also in its variant forms as public or rational choice, are deductive approaches to the policy-making phenomena as viewed from an institutionalist angle. Examples of the theories, which collect under the umbrella of economic institutionalism, include actor-centred institutionalism (Scharpf, 1997), transaction-cost analyses (Williamson, 1985; North, 1990) and 'principal-agent' theories (Alchian and Demsetz, 1972).

Alternatively, political institutionalism seeks to elicit understanding of the role such organizations or institutional units play in forming public policy. This is conducted by investigating the relationship between state and society. This primarily inductive approach puts forth the notion that policy-making is a result of the internalised value systems and agendas within institutions, as opposed to the environmental pressures and forces (Skocpol, 1985; March and Olsen, 1984; 1995; Parsons, 1995). A branch of this political institutionalism is known also as socio-historical institutionalism (statism) (Howlett and Ramesh, 2003). This political institutionalism is characterised as viewing the state as the primary political-process agent and leading institution in society (*ibid*). This arm of institutionalist theory has been succinctly summed up by Stephen Krasner (1988)

> "An institutionalist perspective regards enduring institutional structures as the building blocks of social and political life. The preferences, capabilities, and basic self-identities of individuals are conditioned by these institutional structures. [ ] The range of options available to policy-makers at any given time is a function of institutional capabilities that were put in place at some earlier period, possibly in response to very different environmental pressures" (Cited in Howlett and Ramesh, 2003:44).

The third approach, sociological institutionalism, has been advanced by the work of commentators in the field, such as March and Olsen (1984), Perrow (1986) and DiMaggio and Powell (1991) and Scott (2001). This branch is related to the normative institutionalism as is found within the political and policy sciences, as it is present within sociological and organisational schools of thought (Peters, 1999). This perspective endorses the institutionalist approach, emphasising how political action and thought are constrained by institutions. Agenda-setting, problem definition, policy formulation and outcomes are all variables and activities shaped by the institutional setting (Parsons, 1995). The focus of this sociological outlook is on the organisational nature of institutions, and the environment within which such exist in, for instance, the political and social environment. Some organisations have more control over their environment than others. In addition, there may be dominant individuals (elites) within the organisation who display more control than others over resources, information and agenda-setting of policy issues (Perrow, 1986; Parsons, 1995).

Some of the dominant institutionalist approaches will be examined in greater detail in the following two sections. An example of both deductive (hypothesising) and inductive (exploratory) frameworks will be demonstrated.

Actor-Centered Institutionalism

This deductive (axiomatic) approach has emerged from the rational choice paradigm (John, 2001). It grew from a questioning of the influence economic and social institutions had on the policy-making process, from the initial stage of issue recognition or problem definition towards the final policy outcome (March and Olsen, 1984; Howlett and Ramesh, 2003). Scharpf (1997) initially coined the term 'actor-centered institutionalism,' which refers to understanding and thus explaining social processes in the context of institutions, be they physical entities or invisible networks of alliances and inter-agency relationships (Schepsle, 1989).

Stemming from the rational or public choice theories, actor-centered institutionalism primarily views individuals as the actors in policy-making, as opposed to such being composed of groups or classes. Such individuals are the focus of this theorising, as are their priorities, interests and available resources (Sabatier, 1991; 1999). These actors are the unit of analysis in this approach, and the extent to which institutional rules,

procedures and values affect behaviour is the nub of this approach. However, actor-centered institutionalism differs in part from its genetic link in the rational choice framework, as it takes into consideration how the values, rules and customs affect behaviour within the institutional setting. It also is concerned with how the organisation, structure and hierarchies within government impacts upon how the State is operated. Howlett and Ramesh (2003) indicate also how this branch of institutionalism takes into account how historical development can limit concurrent and future behaviours, expectations and policy patterns (Keohane, 1989). Institutions include those entities which affect behaviour of actors operating within them, such as bureaucracies, organisational structures and marketplace systems. The term also includes the values, rule, codes of practice which, in some way, affect the operational pathway of individuals and groups (Ostrom, 1999; Howlett and Ramesh, 2003). Overall, the critical arguments of this approach are that it views human beings as rational actors; perceives their behaviour as strongly influenced by institutional rules; and that individuals look to manipulate institutional rules to change others' behaviour (Sabatier, 1999).

One theoretical framework from this general approach is the Institutional Rational Choice, as propounded by the work of Ostrom and others (Kiser and Ostrom, 1982; Ostrom *et al.*, 1994; Ostrom, 1999). The underlying purpose of this theory, and its deriving institutional analysis and development (IAD) framework, is to promote decision-making which ultimately results in better policy-outcomes (Gibson, 2005). Institutional Rational Choice interprets actions as a result of the values and resources available to the individual actor, as well as of the decision situation (Kiser and Ostrom, 1982). By amalgamating institutional theory with rational choice, analysis of becomes better adapted to real-world policy making (John, 2001). Importantly, the assumption exists that, under different circumstances and differing rules, the individual actor would operate and behave differently, thus indicating the unavoidable institutional influence (Sabatier, 1999). This approach to institutional examination provides three tiers of decision-making (Ostrom, 1999), upon which policy may be impacted by institutional factors.

The levels vary from the highest level (constitutional) down to the lower level (operational):

1. Constitutional: The constitution and related structures that govern the legislature. It is at this level that decisions are made pertaining to who enters the policy-making process, and what rules will underpin the course of action.
1. Policy/ Collective-Choice: The statute that governs the institutional setting, for instance, agency.
2. Operational: The actions and decisions made by the 'street level bureaucrats' in the institutional setting.

(Sabatier, 1991; Ostrom, 1999)

These three tiers offer opportunities for analysis of policy outcomes, be they decisions made at a level that are determined by rules set from the higher level (Ostrom, 1999). Therefore, the 'street-level bureaucrats' operate within the rules as set from the higher levels, whereas the procedures, rules and laws set in the highest level fulfil a theorising role until they are acted upon at the lower stages. This is an excellent framework for assessing the effects that individuals and institutions have on government policy decisions (Sabatier, 1991). However, the focus on individual behaviour within the institutional structure is cumbersome and almost unworkable, due to the plethora of institutions that exist across the policy community (*ibid*).

The IAD provides an empirically-tested framework (Ostrom, 1986; Schlager, 1992; Oakerson, 1992; Ostrom *et al*., 1994) which aims to allow analysis and measurement of how institutions affect the rules presented to individuals, the motivations behind subsequent action, and what emerges as their resulting behaviour (Ostrom, 1999). Essentially the framework offers a multi-tier conceptual map; a problem at any of the three levels can be analysed. An action arena must be identified, which pertains to the "social space where individuals interact, exchange goods and services, solve problems, dominate one another, or fight" (Ostrom, 1999:42). This arena is made up of an action situation[7] and the actor[8] within it. The action arena is made up of one set

[7] The action situation may be characterised by seven variables: 1) participants; 2) positions; 3) outcomes; 4) action-outcome linkages; 5) the control that participants exercise; 6) information; 7) costs and benefits attributed to outcomes (Ostrom, 1999).

[8] An actor, which may constitute an individual or private-sector actor, is assigned with four defining variables: 1) the resources the actor brings to the situation; 2) the value that the actor assigns to action;

of variables composed of the action situation, and another set of variables attributed to an actor. Both elements are required if appropriate explanation and prediction of results is to be acquired. The action situation seeks to explain regularities in actions and resultants outcomes, with a view to changing and reform them. The actor in a given situation is deemed a rational being, and so is perceived as acting in his own self-interest. The analyst seeks to investigate the actor's values, resources, information, and beliefs, as well as what the internalised tools used to decide upon strategic action (Ostrom *et al*., 1994; Ostrom, 1999). This framework has been deemed as close to a "covering theory" as is in existence in the social and political sciences (Sabatier, 1999:264), Acclaimed as an impressive theory and body of work, it has been applied to a significant amount of empirical tests in field settings.

Socio-Historical Neo-Institutionalism/ Statism

Like its deductive cousin above (actor-centered institutionalism), this institutionalist approach seeks to explain and analyse the influence institutions hold over the policy-making process (Steinmo *et al*. 1992). However, here the familial similarity ends, as this statist approach differs from its counterpart in a number of fundamental ways (Peters, 1999). Firstly, this approach does not attempt to focus primarily upon individuals or their behaviours. Secondly, the existence of institutions is taken for granted, without questioning their origins. Finally, the statist approach is not inclined to downgrade institutions into variables such as norms, rules, or customs (Powell and DiMaggio, 1991; Howlett and Ramesh, 2003), whereas the normative version is more amenable to variable-centered research. This perspective views the state as having a leading role in society and as an integral actor in the political process; the 'rules of the game' have been established within which the political actors must operate (Immergut, 1992; Rothstein, 1998). Sociological theorists have propounded the approach as one in which the state's hegemonic role allows it to structure and form societal relations and organisations (Nettl, 1968; Hintze, 1975; Weber, 1978; Scott, 2001; Howlett and Ramesh, 2003). This approach recognizes that the policy process is best understood within the concept of the state being unavoidably 'nested' in society's affairs (Therborn, 1986). Since the state is the central and most powerful entity in this theoretical equation, the extent to which it is 'strong' and is able to dominate in areas

3) the way which actors use and acquire knowledge and information; 4) the processes actors use for basis of action (*ibid*).

of culture, economy, society and , indeed, policy-making, is a key focus in this approach (March and Olsen, 1989; Skocpol, 1985). However, it is difficult to digest this distilled 'state-centric' approach, which views the state as strong and coercive, for two reasons. Firstly, no matter how autonomous a state's powers are, its will may not always be enforced (Howlett and Ramesh, 2003). Indeed, in democratic nations, the electoral system guarantees a curbing of statist powers. Secondly, no matter how similar 'strong' or 'weak' state tend to be, there will always be factors which differentiate the way in which similar problems are dealt with another way. Thus, other societal and cultural factors must be taken in account (Przeworski, 1990). This approach has been criticised for being unable to explain institutional change (Hall and Taylor, 1996). However, this approach is generally used in its more diluted form, whereby the state's role in society is assessed, and the impact such has on institutional actions (Cortell and Peterson, 2001).

3.1.8. Concluding Comments

This section of the literature review provides a chronological overview of the main policy scientific models, throughout the seminal works of Lasswell (1951; 1970), Simon (1957), Easton (1953; 1965) and Lindblom (1959). The stagist approach was provided in this section, as it is the most dominant and sustained approach to policy study (Howlett and Ramesh, 2003). However, it has not escaped criticism (Sabatier and Jenkins-Smith, 1993), as the rationality of the stages heuristic and the inability of the model to incorporate policy analysis and knowledge utilisation are deemed as hindrances to application of the model to real-world policy study. Theories of the stagist approach seek to explain than seek to indicate way of changing in a pragmatic way (Rossi *et al.* 2004).

Institutional theory (March and Olsen, 1989; 1996; 2005) provides a framework for investigation of the influences upon the utilisation of knowledge for policy (Weiss, 1980; Rossi *et al*. 2004; Wismar *et al*. 2007). In an Irish context, McAuliffe and McKenzie (2007) have acknowledged the importance of institutional theory in explaining the trends of policy making in healthcare specifically, by taking account of implicit (such as a changing emphasis of healthcare upon a strategic policy vision) and explicit (such as political and organisational leadership) institutional factors. March and Olsen (2005) argue that certain factors can constrain or enable actors to

operate within the institutional frameworks, and a comprehension of these factors will facilitate more informed research into the use of knowledge within policy making, particularly in the use of HIAs for healthier public policy. Former research has recommended that novel research frameworks must be formulated based upon a theoretical framework that will allow for the examination of HIAs from a policy scientific stance. This research has recommended the use of institutional theories (Bekker *et al.* 2004; Putters, 2005) and theories of policy analysis (Bekker, 2007) for future study into the use of HIAs for policy.

The following section provides a description of the impact assessment technique and its use for policy making processes. The section provides background information on the IA concept, which is necessary knowledge for the understanding of the context of HIA in this research study.

3.2. IMPACT ASSESSMENT

This section will provide an overview of impact assessment (IA) as a policy instrument, as well as analysis of how it relates and interacts with policy making models. In particular, the decision-making stage will illustrate this relationship. This section will continue with an examination of the various theories and conceptual frameworks that have been employed to investigate the use of IAs in policy making. In conclusion to this section, the literature that will inform the research framework for this study will be provided.

3.2.1. Understanding Impact Assessment

There is a wide consensus as to what impact assessment (IA) is and its general purpose. The European Commission (EC), which conducts impact assessments of its own proposed regulatory and legislative policies, cites the rationale of IA from the Goteborg European Council (June 2001) and in the Laeken European Council (December 2001). Both fora introduced two important considerations, which are relevant in the realm of impact assessment:

1. To consider the effects of policy proposals in their economic, social and environmental dimensions.
2. To simplify and improve the regulatory environment.

(European Commission, 2006)

The adoption by the supranational institution of this policy-aiding instrument lends partly to its credence in the policy making world. The establishment and legalisation of Environmental Impact Assessments (EIA) in the United States for more than three decades provides much scope for understanding the basic tenets of the policy tool overall (O'Riordan and Hey, 1976; Canter, 1996; Morris and Therivel, 2001; Bond, 2004).

Unlike other policy-aiding instruments, such as economic appraisal techniques, impact assessment aims to facilitate a more participative decision making process (Parsons, 1995). It has been envisioned, within the context of Environmental Impact Assessment, that it would "become a valuable instrument for improving the political process," would engage relevant community stakeholders on an equal footing with elected policy makers and administration staff, and would enhance democratic wellbeing (O'Riordan, 1976: 215). Indeed, in many instances, it is striking how the courts, who must deal with challenges by environmental groups or individuals, "have embraced the importance of EIA not simply as a technocratic aid to better decisions, but as a participative and democratic means of involving the public in decisions on projects" (Tromans and Fuller, 2003: preface).

It must be noted, however, that the participatory nature of impact assessment, as learnt from EIA and Social Impact Assessment (SIA) processes in the United States, is quite complex and difficult to guarantee (Burge, 1998; Gregory *et al*. 2001; Ritsatakis, 2004).

Defining Impact Assessment

Overall, the core aims and purpose of the tool are universally accepted. It is viewed as a policy-aiding tool, which enables the analysis of possible positive and negative impacts that a policy decision may have (Parsons, 1995). Rossi and Freeman (1993) define IA's as frameworks of investigation, within which estimation of intended and unintended effects of policy can be measured. They also acknowledge that definitive measurement of such policy consequences cannot be made with absolute certainty. However, it is not the aim of an impact assessment to provide such guarantee. Its central purpose is to evaluate the possible consequences of policy decisions, in order to better inform decision makers of options (*ibid*; EC, 2002; International Association for Impact Assessment (IAIA), 2006; Deelstra *et al*. 2003). An important point to note is that IA's are not envisioned as substitutes for the decision making process, but to provide support for those formulating policy (EC, 2006). The universal goal of all impact assessments, whether their primary focus be environmental, health, social, poverty or regulatory, is to bring about a more ecologically and economically sustainable environment and equitable society (IAIA, 2003).

Understanding Impact Assessment: A Bridge between Science and Policy-Making

Carley (1980) provides two underlying assumptions for the impact assessment rationale. The first assumption states that the future can be predicted with a certain degree of reliability, albeit not complete certainty. This can alter the direction of particular policy initiatives and strategies. Secondly, that the policy-makers will take on board the information and findings as presented by the specific IA. This is demonstrated by amending the decisions that may have otherwise been made (Peterson and Gemmell, 1977; Kraft and Furlong, 2004). Although various problems of causation and social complexity may oppose such underlying assumptions, they compose the basic foundation for policy analysis, evaluation and learning, and methods facilitating such (Carley, 1980; Parsons, 1995; Howlett and Ramesh, 2003).

Impact assessment is a recognised policy-making tool, acknowledged and utilised by international institutions, such as the World Health Organisation (2004) and European Commission (2006). It is also a tool that is increasingly integrated and used in Ireland in its various forms, as illustrated in appendix 1. The WHO-United Nations Environment Programme Health and Environmental Linkages Initiative (HELI) has surmised that impact assessment is an integral 'link' in the policy-making chain, complementing scientific evidence

with the politicised processes in which decision makers operate (WHO-UNEP, 2004). It is deemed a practical tool, which can ensure that both qualitative and quantitative evidence are considered in the decision making process. This guarantees that more informed policies are developed, as well as strengthening the decision making process (*ibid*; Corvalan *et al*., 2000).

3.2.2. Impact Assessment in the Policy Making Process

Impact Assessments are viewed as policy-aiding tools, which are generally categorised under the umbrella of 'rational decision making' or 'rational techniques' (O'Riordan and Hey, 1976; Carley, 1980; Parsons, 1995; Putters, 1996; Hertwich and Hammitt, 2000; Kraft and Furlong, 2004). However, these policy-aiding mechanisms can be utilised successfully, albeit differently, within other decision making policy models (Bekker *et al*, 2004; Morgan, 2008).

Although a text that was produced almost three decades ago, Michael Carley's (1980) work provides insight into some pertinent issues surrounding the use of impact assessment frameworks in current day policy making (Davenport *et al*. 2006; IAIA, 2006). While Carley locates impact assessment as being grounded in rational decision making and he acknowledges the undeniable pluralistic nature of the policy making process. No matter how rational or logical policy makers intend to operate, their institutional setting and context will influence the policy outcome (Department of Taoiseach, 1996). Instead of bowing to this pluralistic deference, impact assessment techniques must adapt and become institutionalised appropriately into the policy making arena, whilst accounting for pluralistic decision making processes.

A major criticism of impact assessments is that they "obstruct new development, are overly pessimistic, and generally slow down progress" (Carley, 1980:138). However, it has been noted by those involved in impact assessment processes (EPA, 2002; 2003b; Scott, 2006; Byrne, 2006) that it is a useful tool in bringing scientific evidence to the policy makers' attention, and in ensuring the local community being affected by development projects, are heard. Certainly, Carley's (1980: 139) assertion that "one man's pessimism is another's healthy scepticism, and the optimal rate of progress depends, of course, entirely on one's definition of progress," illustrates the differential and pluralistic attitude towards impact assessments.

Oftentimes, in policy making the process is far from apolitical, and the information and knowledge as presented in impact assessment reports must adhere to the political nature of the policy making processes (Deelstra *et al*. 2003; WHO-UNEP, 2004).

Value Judgements

A value is a standard that guides action, attitudes, philosophy, judgement, rationalizations, comparisons, and attempts to influence others (Rokeach, 1973). Recognition of the role which value judgements play in decision making is essential in comprehending the rationale and formulation of policy decisions (Hertwich and Hammitt, 2000; Bekker *et al*. 2004; Bekker, 2007). Value judgements relate to the perception of one group of policy making actors of what a 'good' decision is, which may be the exact opposite perception of another party (European Commission, 1998). Acknowledgement of such value judgements is necessary, as no matter how scientific or rational policy process may appear to be, it is oftentimes ingrained subconsciously with sets of values, assumptions, beliefs and ideologies of policy analysts and policy makers (Carley, 1980).

The trade-offs and value implications that policy options contain must be communicated appropriately and unambiguously to the policy maker (WHO-UNEP, 2004), in order to ensure the decision maker is fully informed, both in terms of scientific knowledge, and of the politico-administrative policy context.

Decision Making Models: Framing Impact Assessment Techniques

The implementation of impact assessment processes and frameworks has been found to be reliant upon the overall political-administrative context of the decision making procedures (Gazzola, 2006; Morgan, 2008). This has been found to be the case in an examination of Strategic Environmental Assessment (SEA) practices throughout the EU (Glasson and Gosling, 2001). Indeed, as much as impact assessment is deemed an appropriate, informative and methodologically-systematic decision-supporting tool (der Vorst *et al*. 1999), the importance of such tools to inform policy making remains marginalised to a large extent (Weston, 2002). Most work pertaining to impact assessment is based upon the assumption that by providing decision makers with predictive and systematic information, the policy making process overall will be improved (EPA, 2002; Grist, 2003; Van der Vorst *et al*. 1999; Scott, 2006; Harris, 2006). However, this rational approach, although is the logical process all policy makers strive for (Davies, 2000; John, 1998), is not always possible due to a number of constraints. Such limitations which are the characteristics of real-world decision making (incrementalism), include cognitive constraints, behavioural biases, variability of preferences and norms. The distribution of decision making over actors and time and the concept that the process is one composing of bargaining and negotiation between multiple actors and institutional layers are limitations characteristics of real world decision making (Krnv and Thissen, 2000).

One study (Bekker *et al*. 2004) has examined the use of information from Health Impact Assessment (HIA) in the decision making process and how such knowledge utilization differentiates depending on the decision-making approach. Tables 6 and 7 illustrate this matter. In the rational decision making model, policy makers optimize knowledge utilization and produce policy decisions based upon complete and independent information (Putters, 1996). Alternatively, the incremental decision making model explains policy making by conceptualising the process as one where decisions are made gradually, one marginally different decision upon another, and over time and human resources, a decision emerges. The mixed scanning model is presented in this research as being a 'compromise' approach between the rational and incremental schools of thought. In this approach, decision making is viewed as utilizing limited available knowledge and choice, although the sequence of policy making actions depends upon the overall formulation strategy. Bekker *et al*. (2004) conclude that each decision making event is policy, time and place specific, and this in turn reflects the decision making model of the policy in question. By examining the values, beliefs and ideologies of decision makers, one may elucidate understanding of the reasoning behind non-use of scientific evidence (Weiss, 1977; 1986; Walt, 1994b; Cross *et al*., 2000; Plouffe, 2000; Lomas, 2000). In addition, the authors conclude that institutionalism and discourse analysis

are other theoretical insights that will further aid understanding of the actor's perspective, and perception, of utilising information in decision making.

Table 6: Contrasting policy models and underlying assumptions (Bekker *et al*, 2004: 142)

	Rational Model	Incremental Model	Mixed Scanning Model
What and How	Sequential order of policy stages. Full knowledge. Free choice of goals and means. Clear objectives as a starting point.	Disorderly sequence. Poor knowledge. Limited choice. Mutual adjustment objectives.	Sequence depends on strategy. Limited knowledge. Limited choice. Conflicting policy objectives of fundamental and incremental decisions.
Who and Context	Central actor with decisional power. Stakeholders absent or full support. Stable environment.	Multiple actors with decisional power. Powerful stakeholders, little support. Unstable environment.	Similar to incremental

Table 7: Policy Models and Research Utilization (Bekker *et al*. 2004: 143)

	Rational Model	Incremental Model	Mixed Scanning Model
How research is viewed	Research is essential key in policy cycle to fill the knowledge gap	Research is merely one means to address uncertainty surrounding policy process	Both lack of knowledge and certainty; Research offers knowledge on interaction between elements of policy cycle.
Type of research	Specialized techniques; quantification; causality or risk assessment. Research offers evidence-base; immediate useable knowledge.	Consultation; qualitative data; patterns of risk perceptions. Research offers insight. Usable in the long-run.	Combination of both rational and incremental types of research Useful when policy process is properly understood and methods fit policy problem and dynamics.

3.2.3. Concluding Comments

> "Let us not be judged ten years or so from now as a pack of enthusiasts who, like King Canute, had to embark on an extravagant experiment in order to prove the impossible" (Lord Zuckerman, 1976: 225/226).

Integral to the success and acceptance of impact assessment, both as a policy-aiding approach and as a methodology, depends on it not becoming too cumbersome (Zuckerman, 1976). If it is not useful for policy makers in presenting alternative policy directions, and allowing for analysis of possible consequences of decisions, then the tool will be despised, and written off as an administrative burden. This is the opposite effect such a policy-aiding tool should elicit. Lessons learned from established impact assessment tools, and application of such in an appropriate manner, should maximise the benefits of impact assessment. The abovementioned quotation by Lord Zuckerman illustrates the warning from three decades ago, of the possible costs of impact assessment tools, although with a specific emphasis upon EIA. As will be demonstrated in the next section, this warning is a cautionary forewarning for HIA enthusiasts.

Impact assessment as a policy-aiding tool, was analysed for its degree of influencing government decision-making through institutional analysis by Bartlett (1989, cited in Banken, 2001:389), who concluded that

"Impact assessment does not influence policy through some magic inherent in its techniques or procedures. More than methodology or substantive focus, what determines the success of impact assessment is the appropriateness and effectiveness in particular circumstances of its implicit policy strategy."

Indeed, impact assessment tools must be policy-relevant and policy-helpful, otherwise they will lie as dormant instruments within the policy making environment. With particular reference to HIA, Bekker, et al (2003; 2004) found that the utilisation of evidence from the HIA process for policy is time-, place-, and event- specific (context-dependent). By investigating the values and beliefs of decision makers one may elucidate understanding of the reasoning behind the use and non-use of evidence (Weiss, 1977; 1986; Cross *et al*., 2000; Plouffe, 2000; Lomas, 2000).

This section of the literature review has indicated the place of IAs within decision making models and policy making climate. The work of Bekker *et al.* (2004) highlights the need for further research into the utilisation of evidence from such policy-aiding tools, specifically in that research, the HIA tool. The institutionalist approach, as derived from the policy sciences, is recommended for further research into the examination of the relationship between HIAs and the policy process. In addition, value judgements that policy actors bring to the policy processes is an important variable to consider as an influence upon the eventual use of the IA (Rokeach, 1973; Patton, 1997; Hertwich and Hammitt, 2000; Rossi *et al.* 2004; Bekker *et al*. 2004; Bekker, 2007).Values of such actors, and the value judgements regarding the use of IA evidence for policy, will be incorporated into the research framework of this study.

The following section summarises the important points from the literature review. These main points are used for the research framework (chapter 4).

3.3. Making Sense of it all: Conclusions from the Literature Review

The purpose of the literature review was to provide present knowledge and research on health conceptualisation, health promotion, and Health Impact Assessment (HIA) in terms of its conceptual roots, practical utilisation and theoretical development (chapter 2). Chapter 3 provides a chronological review of the policy scientific theories and models, as well as presenting knowledge of the impact assessment (IA) technique.

The aim of this section is to draw the main conclusions from the literature review, which inform the research framework (chapter 4, page 124) and provide the theoretical basis for this doctoral study.

CHAPTER 2
Health conceptualisation

The biomedical and social models of health have influenced the way in which health is conceptualised in the public arena (McCluskey, 2006a). This is evidenced in Ireland by the growth of health promotion over the past two decades (Butler, 2002; McCluskey, 2006a; Ryan *et al.* 2006). The social model of health (Dahlgren and Whitehead, 1991), which takes account of individual, community, environmental and policy determinants of health, is the conceptualisation health that is central to the HIA mechanism (Kemm and Parry 2004). The wider determinants of health have been taken into account in this research, as is evidenced by the case study selection and the research design.

Health Promotion

World Health Organisation treaties and agreements have set the scene for the health promotion agenda globally for the last number of decades. It has provided the framework for the rationale for HIA, as evidence in the Gothenburg Consensus Paper (1999). Public policy, and its health

promotion offspring, healthy public policy (Metcalfe, 2007), have repeatedly emerged as essential opportunities to advance population health. It is clear that much academic research conducted relates to healthcare systems and their impacts upon population health, in terms of the work developed within the political sciences. HIA provides a novel opportunity for research to bridge the health determinants and public health spectrum, and the public policy spheres.

Health Impact Assessment

Health Impact Assessment is a new field of endeavour that has grown increasingly over the past two decades, in theory and practice (Kemm and Parry, 2004; Wismar *et al. 2007*). The HIA field has been firmly established (Harney, 2007), but questions persist as to whether it is a workable policy-aiding tool, which can allow for knowledge to be used in policy, so as to better inform those producing policies of intended and unintended consequences of such plans.

Previous work on HIAs and the relationship with the policy making processes will inform the research framework. The influence of the decision making processes are the cause for most inquiry regarding HIA. Increasingly, over the past number of years, it has become important to consider and examine such processes, (Kemm, 2006), in order to establish the role of HIAs in feeding these processes. Without such examination, the abandonment of HIAs to an eternal doom of gathering dust on the shelves of decision making institutions is destined to become a reality. The work of Banken (2001; 2003) and the discourse on institutional embeddedness of HIAs; the work of Wismar *et al.* (2007) upon HIA effectiveness for policy; Bekker (2007) and the place of HIA within the healthy public policy paradigm influences the research framework of this thesis.

In their calls for further research, Elliott and Francis (2005) state that a need exists for research to examine the political and communicative

dimension of decision making as an influence upon HIA utilisation; do stakeholders' value-systems and interests (personal and professional) influence the use of HIAs? The direct and indirect linkages to decision making with HIAs must be considered; further research is recommended to examine the decision making processes and HIAs. This point was further discussed at the 7th International HIA conference (Elliott, 2006). This has been accorded within the research framework of this thesis.

In the pan-European study (Wismar *et al.* 2007), the conceptualisation of the context for HIAs and content of HIAs was used as suitable labelling posts for the research (polity, politics and policy). Bekker *et al.* (2005) also advocates the use of such a diverse and informative framework because of the novelty of the field of inquiry, and the necessity for further exploration of the influences upon the utilisation of HIAs in policy. Bekker (2004) and Putters (2005) have established within their research the influence of the vested interests, value-systems and political context upon HIA utilisation.

The research framework and central research questions of this thesis take account of these considerations from previous work done.

CHAPTER 3
Public Policy

This section of the literature review provides a chronological overview of the main policy scientific models, throughout the seminal works of Lasswell (1951; 1970), Simon (1957), Easton (1953; 1965) and Lindblom (1959). Theories of the stagist approach seek to explain than seek to indicate way of changing in a pragmatic way (Rossi *et al.* 2004), and are not comprehensive in their ability to explain policy making realities (Sabatier and Jenkins-Smith, 1993).

Institutional theory (March and Olsen, 1989; 1996; 2005) provides a framework for investigation of the influences upon the utilisation of

knowledge for policy (Weiss, 1980; Rossi *et al*. 2004; Wismar *et al*. 2007). In an Irish context, McAuliffe and McKenzie (2007) have acknowledged the importance of institutional theory in explaining the trends of policy making in healthcare specifically, by taking account of implicit and explicit institutional factors. March and Olsen (2005) argue that certain factors can constrain or enable actors to operate within the institutional frameworks, and a comprehension of these factors will facilitate more informed research into the use of knowledge within policy making, particularly in the use of HIAs for healthier public policy. Former research has recommended that novel research frameworks must be formulated based upon a theoretical framework that will allow for the examination of HIAs from a policy scientific stance. This research has recommended the use of institutional theories (Bekker *et al.* 2004; Putters, 2005) and theories of policy analysis (Bekker, 2007) for future study into the use of HIAs for policy.

Impact Assessment (IA)

The most important consideration for impact assessment tools is that they must be policy-relevant and policy-helpful, otherwise they will lie as dormant instruments within the policy making environment, 'left to gather dust on shelves.' With particular reference to HIA, the utilisation of evidence from the IA process for policy is time-, place-, and event-specific (Bekker, *et al.* 2004), and an investigation of the values and beliefs of decision makers, one may elucidate understanding of the reasoning behind the use and non-use of evidence (Weiss, 1977; 1986; Cross *et al*., 2000; Plouffe, 2000; Lomas, 2000).

This section of the literature review has indicated the place of IAs within decision making models and policy making climate. The work of Bekker *et al.* (2004) highlights the need for further research into the utilisation of evidence from such policy-aiding tools, specifically in that research, the HIA tool. The institutionalist and value-judgement approaches, as derived from the policy sciences, are recommended for further research into the examination of the relationship between HIAs and the policy process.

CHAPTER 4
METHODOLOGY

Chapter Outline

The purpose of this chapter is to present the technical aspects of the research methodology. An overview of the main tenets of the case study research design is provided with an accompanying rationale for each methodological selection. Qualitative methods used for data collection and analysis are described. The research framework and strategy is outlined which draws from the literature and models of good practice in political science research.

4.1 Research Methods in Political Science

There is much debate in political science circles pertaining to the need for rigour in research methods (Dorein, 2006; Bennett and Elman, 2006). It is essential that political scientists adhere to standardised methods and techniques that have stood the test of peer-reviewed studies and empirical investigation over time (Rihoux, 2006; Hofmann-Lange *et al*. 2006).

Over the past twenty five years a number of scholars and researchers have contributed to the realm of qualitative and exploratory research, and have thus developed the context for case study research designs. Eckstein's (1975) seminal work on case study typologies initiated the development of systematic and rigorous research methods, focusing in this instance on the case study approach. Since 1975 numerous works have contributed to the landscape of political and social science research methodologies and strategies. Most notably George (1979), Lijphart (1971), Przeworski and Teune (1970), George and McKeown (1985), Yin (1994; 2003), Gomm (2004), George and Bennett (2004) and Bennett and Elman (2006), each contributing to the growing school of methodological and epistemological thought. The case study approach in particular, whilst having a number of limitations, specifically referring to case study selection biases, validity and authenticity, and theoretical generalisations (Gomm *et al*. 2000), is widely used in political science research (Eckstein, 2000; Burnham *et al*. 2004).

4.2. Case Study Research Design

Case studies come in single-case or multiple-case forms, depending on the research question and hypotheses of each study. For this research, a multiple-case study is employed which will investigate the influences of the contextual environment upon the phenomenon of policy processes at local government level. This type of design is suited to one that requires an intense examination of the contextual environment of research (Yin, 2003) which is the situation for this HIA research. A multiple case was chosen to elicit patterns across a number of cases; a comparison of patterns in the use and conceptualisation of the HIA approach in policy was best sought through the analysis of a number of cases. Since HIA is such a novel approach in Ireland, two from Northern Ireland and two from the Republic of Ireland were chosen.

The definition of a 'case' is taken as "an instance of a class of events" (George and Bennett, 2004:17). It refers to a phenomenon of interest. The aim of the study is to develop "theory regarding the causes of similarities or differences among cases of that class of events" (*ibid*: 18). The research questions and theoretical framework then decides the case selection for the research. Case studies are most suitable for study that requires an in-depth focus on certain phenomena within a temporal setting, which an investigation of HIAs requires. This research strategy enables the testing of hypotheses and facilitates data collection and analysis within the overall design (Yin, 2003; Burnham *et al*. 2004). Importantly, it must be noted that case studies are viewed as both a research method and technique on the one hand, and a research design and strategy on the other (Gomm *et al.* 2000: Grix, 2001; George and Bennett, 2004). How ever it is used, depends on the research question.

In the instance of this doctoral research, framing methodology within the structure of the case study research strategy is deemed appropriate, in order to ensure standardisation of data collection and analysis across the cases and to guarantee each case was approached in the same manner.

The methodology used in this thesis will adhere to the case study research design framework and theoretical underpinning.

Although case studies are not designed to use qualitative methods and techniques exclusively, as a mix of evidence from inductive and deductive approaches is feasible (Fenno, 1978), qualitative research methods were used in this study. This was deemed suitable in order to provide an in-depth and concentrated study of each HIA phenomena. There is a triangulation of data sources, namely documentary evidence, expert interviews and observation. This ensures validity in the research, as well as an ability to subjectively reconstruct the social reality that was in existence in each of the HIA cases (Schwartz and Jacobs, 1979; de Laine, 2000; Ritchie and Lewis, 2003). Indeed, the ontological standpoint of the case study approach is somewhat divided between the positivist school on the one side, and the interpretivist on the other (Gomm *et al*. 2000). Instead of being aligned with one approach over another, case studies allow the exploration and elaboration of key events and social phenomena presented in an analytical narrative format.

4.2.1. Case Study versus Comparative Research Design

The essence of the case study design is that it attempts to establish why and how a set of decisions under scrutiny were taken and implemented (Yin, 1994; 2003). It is the aim of comparative research to identify differences and similarities, whilst using a system of classification for direct comparison, across systems, states and institutions (Landman, 2000:4-10). A starting point for any comparative study is to establish working hypotheses for quantitative prediction (Grix, 2001; Hopkin, 2002). The starkest difference between the case study and comparative research design is that the former allows for greater depth of investigation, and although comparison is inevitable in research, it allows for exploratory research. The case study design is appropriate for investigation into novel areas that have been unexplored, either in a particular country, institution, or social network (Yin, 2003). The case study design can involve a single case, or multiple cases, depending on the research context and question. However, the comparative design must involve multiple cases (Landman, 2000; George and Bennett, 2004; Bennett and Elman, 2006). Appropriate to this research question, the case study approach "tries to illuminate a decision or set of decisions: why they were taken, how they were implemented, and with what result" (Schramm, 1971, cited in Yin, 2003:12). By examining the decisions pertaining to the use of HIA knowledge, the case study approach is clearly suitable for this research.

This doctoral research will use the 'explanatory case study' design as it seeks to establish the contextual environment of the set of decisions within a contemporary environment (Grix, 2001; Yin, 2003). It is vital to note that although the HIAs of the case studies in this project have already been conducted, the use of evidence is still on-going. Evaluation reports of the HIA are on-going. The completion of the HIA outcome report is not the conclusion of the decision-making process; in policy-making circles, this is usually the beginning.

In all, there are three types of case study, as outlined by Yin (1994:1):

1. Descriptive
2. Exploratory
3. Explanatory

Descriptive case studies relate to a historical subject matter. It is the aim of this type of study to give an account of a particular issue, but not necessarily to provide an explanation. Exploratory case studies, conversely, are conducted to ascertain the relevance of working hypotheses and causal variables in research (Grix, 2001). The most commonly used case study type is the explanatory category which allows researchers to conclude generalisations by extracting the one case study's findings to other cases, either within the same research or with external cases in the literature. Indeed, 'how' and 'why' questions are explanatory in nature and such questions "deal with operational links needing to be dealt with over time, rather than mere frequencies or incidence" (Yin, 2003:6).

The 'how' question is one of a descriptive nature; it aims to depict an account of the study. The 'why' question adds another dimension; it seeks greater depth and explanation from the research. These questions are likely to be appropriate for the use of case studies, experiments or histories, as indicated in table 8 (page 110). This type of case study is amenable to the use of the process-tracing technique (Bennett and Elman, 2006).

In the instance of the HIAs in this research, the case study design is appropriate in answering the research questions:[9]

How do institutional structures influence Health Impact Assessment usage in policy?

How do value judgements influence Health Impact Assessment usage in policy?

Why is the degree of use, both direct and indirect, varied in different contexts?

What are the barriers and enablers to the use of HIAs?

Table 8: Relevant Situations for Different Research Strategies (Yin, 2003: 5).

Strategy	**Form of Research Question**	**Requires Control of Behavioural Events?**	**Focuses on Contemporary Events?**
Experiment	How, why?	Yes	Yes
Survey	Who, what, where, how many, how much?	No	Yes
Archival analysis	Who, what, where, how many, how much?	No	Yes/ No
History	How, why?	No	No
Case study	How, why?	No	Yes

Other typological classifications of case studies include the intrinsic, instrumental and collective case studies (Stake, 1995). Since this study investigates four HIA cases across various geopolitical locations, it can be classified here as a collective study. According to Stake (1995) in this instance, the cases examined together enable the in-depth investigation of an issue or phenomenon. The selection of cases is thus related to this type of case study approach, as the cases should represent the issue or phenomenon, with a view to deriving findings that are representative of the cases

[9] Please refer to section 4.3. for more detail of the research framework and research questions (page 124).

chosen. However it is important to note that "case study research is not sampling research" (Stake, 1995: 4). One does not study a case in order to discover more about another, albeit the derivation of contingent factors associated with findings. One uses the case study approach in order to elicit the contextual and environmental factors that explain the working research hypotheses. Case studies allow for the testing of a theoretical framework, with a view to contributing to the empirical and theoretical propositions initially set out.

Hague and Harrop (2001: 81) provide a classification of cases; the representative case (typical of the category); prototypical case (expected to become typical); deviant case (the exception to the rule) and the archetypal case (creates its own category).

When selecting the cases of this doctoral research, these typologies and classifications were acknowledged during the construction of the research design.

4.2.2. Defining the Case Study as a Research Strategy

The questions of this research complement the use of the case study design. The investigation into the contextual influences upon the use of HIA knowledge in policy-making is also focused upon contemporary events, which is another prerequisite for the use of this design. All of the HIAs were conducted in recent years but the policy-making process is still in the course of using some, if not all, of the knowledge derived from the HIA. In addition, not only will the HIA outcome report impact upon the policy-making process but the cross-sectoral collaboration, and the intrinsic values in this process is another factor to take into account when evaluating each case.

The following definition encompasses the main elements of the case study approach and is the one used for this research:

> "(It is an) empirical inquiry and evaluation method which investigates a contemporary phenomenon within its real-life context, addresses a situation in which the boundaries between phenomenon and context are not clearly evident, and uses multiple sources of evidence" (Yin, 1994:59).

As Yin (2003), the authoritative voice on case study research states, this design calls for answers to 'how' and 'why' research questions. Therefore, it is essential that the methods employed to answer the set questions fulfil their purpose.

4.2.3. Advantages and Disadvantages of the Case Study Research Strategy

The case study approach to research has as many strengths and weaknesses as the comparative method. It is important, however, to take account of the issues associated with the case study research strategy. Consideration must be made of these when designing the overall research plan and conducting the data collection and analysis.

George and Bennett (2004), two respected voices in case study methodology and approaches, have outlined important advantages and disadvantages of the strategy that this researcher, as all must, take cognizance of during the conduct of research.

Strengths:

Conceptual validity is strongly enabled for the researcher in order to formulate testable indicators for the empirical data. A case study approach allows for such validity. The approach is used by researchers to conduct "contextualised comparison" across a small number (*n*) of cases (George and Bennett, 2004:19). Such in-depth research may lead to discovery of equifinality, meaning that the phenomena being examined exhibits several explanations for the same outcomes and the paths of the phenomena may or may not have the same variables in common.

A strong factor of case study research is the flexibility for deriving new hypotheses. Often throughout the data collection phase, or during the pilot case study, the researcher may establish that the independent variables initially conceptualised during the desk top phase of literature review, are insufficient, not grounded in reality, or require greater dimensional attention; they may be not be as one-dimensional as previously thought. This aspect of case studies is most suitable for exploratory research designs.

This research design allows the investigation of causal mechanisms, both in single case analysis and across cases. The potential growth of intervening variables for each

case is enabled with this awareness of causality. The definition of causal mechanism is such "that operate only under certain conditions" (*ibid*: 21). Case studies are a strong approach and methods for such examination.

Limitations:

Case selection bias is the most pertinent limitation of case study designs and required due attention by the researcher (Bennett and Elman, 2006). The danger is that the cases are self-selected without consideration of linkages to the theory or methodology rationale. However, unlike researchers who abhor the selection of cases along the dependent variable (King *et al.* 1994), case study researchers do this deliberately (Dion, 1998). Such cases selected with similar outcomes can allow for exploration of variables which are not necessary conditions for the dependent variable (George and Bennett, 2004).

It must be duly noted that case studies allow for examining "whether and how a variable mattered to an outcome" as opposed to the quantitative approach of how much it mattered (*ibid*:25). The extent to which variables go far enough to indicate necessity or sufficiency in explaining the dependent variable is tied up in the identifying of scope conditions. Each researcher who employs the case study research design must be aware, and make allowances for the degree of certainty over variable and the cope of their explanatory power, especially in the instance of equifinality.

Case studies also are in danger of lacking generalisation (Lincoln and Guba, 2000; Bennett and Elman, 2006). However case studies do not claim to make generalisations across instances and populations, except in contingent ways (George and Bennett, 2004). This research design contains an implicit trade-off between the degree of data richness and representativeness. Case studies do allow for the exploration of causal pathways of variables and conditions and will produce findings based upon contingent factors.

Case studies have been criticised for lack of independence across cases; that there exists a relationship and osmosis-effect of cross-learning in the environment within which the cases inhabit. The lack of independence reduces the degree of freedom on the one hand, but using the method of process-tracing in each case, an inductive

examination of the relationship between cases can result in greater learning and understanding of the phenomena being studied.

4.2.4. Knitting the Methodological Strands Together: The Research Design

The research design for this study is the plan that has guided this researcher in the "process of collecting, analysing and interpreting observations" (Nachimas and Nachimas, 1992: 77). It is the "logical mode of proof" that enables the explanation and testing of causal variables and hypotheses (*ibid*).

As established in the preceding sections, case studies are "an all encompassing method" (Yin, 2003:14). It is derived from the historical methodological perspective but in contrast to adopting a purely historical approach, case studies include both direct observation of events or processes and interviews with people involved in the events or processes. An advantage to the case study is its ability and flexibility to incorporate various strands of data sources, which has been the situation in this doctoral study (*ibid*).

In accordance with Stake's (1995) typology, this research design is a collective case study, as a number of cases were chosen for study to allow for examination of the process and outcome of HIA in each instance. A single case study design was deemed unsuitable for this research as a comparison of patterns and trends in the degree of use of HIAs would provide greater insight to the influence upon HIA utilisation in policy, and the extent of that utilisation.

The HIAs used in this research fit into Hague and Harrop's (2001) classification of cases (representative). They were chosen on the dependent variable. This selection is subject to criticism as it reduces variation in the cases. However, the literature suggests that the selection of cases along the dependent variable (hypothesised outcome) is feasible, as long as there is some variance in the independent variables and geopolitical context of the cases (Dion, 1998; Yin, 2003; George and Bennett, 2004). Therefore, each HIA selected for this research was viewed as a representative case prior to data collection (ie. typical of the category); each one was completed to the end (outcome reports were concluded in each instance) and all employed

internationally endorsed HIA methodology and approaches. The variation in the cases exists in their distinctive geopolitical location, HIA subject matter, stakeholders (actors) and policy environment. From the outset, all were deemed to be similar and representative cases. The extent, to which it is the reality of the situation, was elucidated in the data collection phase and thawed out in the analysis phase. Table 9 outlines the case studies that will be used in this research.[10] It is the extent that is being studied and investigated.

Table 9: Research Case Studies

Title of HIA	**Public-Policy Issue**	**Policy-making setting**
HIA of Traffic and Transport in Ballyfermot (2004) Evaluation of the HIA is on-going	Transport	Health Services Executive (HSE); Dublin City Council; (Eastern Regional Health Authority) HSE
An HIA of Northern Ireland Housing Executive Proposal to Redevelop Dove Gardens Estate (2005)	Housing	Northern Ireland Housing Executive; Belfast City Council
HIA of Travellers' Accommodation Programme in Donegal, Ireland (2005-2008)		HSE, Ireland; Donegal County Council
HIA of the Draft Air Quality Action Plan for Belfast (2006)	Physical Environment	Belfast City Council,

A) Designing the Case Study Research (George and Bennett, 2004)

1) Specification of the problems and research question

The research framework (section 4.3) and literature review (chapters 2 and 3) both illustrate the existing research in HIA in terms of policy-making (Banken, 2001; Kemm, 2003; Bekker *et al*. 2004; Putters, 2005; Davenport *et al.* 2006; Bekker, 2007), the gaps in the theories and models used in this foregoing literature to explain

[10] Please refer to chapters 5 and 6 for more detail on the case studies in this research.

HIA and its use in policy, and the alternative theories that were deemed inappropriate for this study.

Therefore the research questions have been derived from the gap in the literature and the need for more adequate theories and empirical indicators to explain the use, and non-use of HIAs for the course of action that they were formulated for, the policy process.

In accordance with George and Bennett's (2004:76) typological classification of theory-building research, this study employs the 'building block' research approach, in that patterns in the phenomenon being studied are elucidated for study. In this type of research, it common that the cases are selected on the dependent variable, as in this instance the study provides explanations for causal pathways and for equifinality if it is present.

Below presents the central research questions. Further detail and hypotheses for this study are outlined in greater depth in section 4.3.

> How do institutional structures influence Health Impact Assessment utilisation in policy?
>
> How do value judgements influence Health Impact Assessment utilisation in policy?
>
> Why is the degree of utilisation, both direct and indirect, varied in different contexts?
>
> What are the barriers and enablers to the use of HIAs?

2) <u>Developing the research strategy: Specification of the variables</u>

The research strategy was formulated in alignment with the study questions after the construction of the theoretical framework. The strategy outlines the operationalisation of this framework with the identification of variables. This research looks at the degree of importance of the independent variables (institutional and value influences)

on the dependent variable (use of HIAs) in order to assess the degree of variance of the latter variables. Process-tracing is the appropriate case study research technique that is used in each case study chapter and allows for the presentation of facts in an analytical narrative. This technique will reveal the relationships between the variables and the different causal pathways that may result in the outcome.

3) Case selection

Case selection is an important aspect to the research framework and methodological direction of this study. It is linked to the type of study it is; in this instance it is a theory-testing one and so a greater number of cases is permitted so as to enable such analysis. Theory-generating research would require fewer cases and greater in-depth analysis of cases.

As in other studies, case selection is as much opportunistic as methodologically grounded (*ibid*; Collier and Mahoney, 1996). The practical realities of research overtake abstract theoretical hopes in the case selection phase, as Wismar (2007) reflected upon at the conclusion of the pan-European evaluation of HIA effectiveness.

In this doctoral study, screening of possible cases was informed by exploratory interviews with experts within the field at the 7th Health Impact Assessment International Conference (5th-6th April, 2006). Meetings with the Public Health Development officers in the Irish Institute of Public Health (Dublin Office, September 26th, 2006) also informed the selection. The case selection for this study reflects the range of HIAs conducted in Ireland to date. As was considered in other HIA case study research (Elliott and Francis, 2005), they have been conducted at local level[11], within local authority areas, are investigating a range of policies, proposals and projects, and are a mix between retrospective and prospective HIAs.

The vast array of experience and knowledge of HIA development throughout Ireland of such individuals was integral to the development of this study and the selection of cases. The Irish Institute of Public Health (IPH) is the leader for the development and training of HIA to statutory, voluntary and community bodies. It is an all-island

[11] With the exception of the HIA of employment policies.

statutory body which provides expertise and advice to the central government Departments of Health in Northern Ireland and the Republic of Ireland. Due to the legitimacy accorded to such a body, completed HIAs that were recorded on the database of the IPH at the time of case selection (December 2006) were chosen for this study. An all-island perspective was deemed suitable, since HIA is being developed on an all-island basis. The manner in which the approach is being progressed across the two jurisdictions would further inform the research in answering the central question of how and why institutional and value-judgement influences impact the use of HIAs for policy. Cases with varying subject matters were chosen to add depth of knowledge to the research. Two cases (Belfast and Dublin) that were chosen as Irish HIA cases in the European study of HIA effectiveness were used in this study, so as to allow for comparison of results (Wismar *et al*. 2007).

There was variation in case selection based on the jurisdiction divide. Two cases are based in Northern Ireland (Derry and Belfast) and the remaining two are in the Republic of Ireland (Dublin and Donegal). This selection ensured a fair analysis of HIA use across the country and the variability of the range of HIAs and their locations adds depth to the research.

Therefore each HIA selected for this research was viewed as a representative case prior to data collection (ie. typical of the category); each one was completed to the end (outcome reports were concluded in each instance) and all employed internationally endorsed HIA methodology and approaches. The variation in the cases exists in their distinctive geopolitical location, HIA subject matter, stakeholders (actors) and policy environment. From the outset, all were deemed to be similar and representative cases. The extent to which it is the reality of the situation was elucidated in the data collection phase and thawed out in the analysis phase.

4) Describing the variance in the variables

According to George and Bennett (2004:84) it is difficult to describe variance before "the researcher becomes familiar with how they vary in the cases examined." Therefore this aspect of the case study design was dealt with after case study analyses were conducted.

Description of variance can be applied to independent and dependent variables equally, depending on what research aims are being achieved. In this research, the dependent variable consisted of varying degrees of use. It was realised by this researcher that degrees of differentiation were required for this variable, so as to ensure the necessary depth and for a comprehensive picture to emerge. That is to say, it would have been less fruitful to describe the dependent variable variance as use of HIA or non-use of the HIA; indirect and direct use has added the necessary dimension and contributes greater learning to the theoretical framework and literature in the area.

In relation to variation in case study selection, four cases have been chosen on the basis of the dependent variable; therefore the rationale of the thesis is to trace the processes and discover differences and similarities.

There was variation in case selection based on the jurisdiction divide. Two cases are based in Northern Ireland (Derry and Belfast), while the others are in the Republic of Ireland (Dublin and Donegal). This selection ensured a fair analysis of HIA use across the country and the variability of the range of HIAs and their locations adds depth to the research.

5) Formulation of data requirements and general questions

The requirements of data collection are established in the theoretical framework and research strategy (Yin, 2003; George and Bennett, 2004). Each case study was conducted with a topic guide and central research questions at the fore of this researcher's logistical approach at all times during data collection. This ensured inhabitancies within the research mindset during the field trips and guaranteed standardisation across the cases. The methods employed in this research are mainly qualitative in nature; all attempts necessary to maintain rigour yet allow flexibility was sustained by this researcher as far as practicable. The general questions used for this study were included in the topic guide (appendix 2) and there is a clear relationship between the theoretical framework and variance of the variables (independent and dependent).

B) Conducting the Case Study Research

There is widespread agreement among commentators in the field that qualitative research requires clear description (Lincoln and Guba, 1985; Miles and Huberman, 1994; Holstein and Gubrium, 1997; Silverman, 2000; Patton, 2002) in terms of the research methods used and of the findings. This is to ensure open transparency throughout the research and to assist in checks on validity by outside individuals (Ritchie and Lewis, 2003). This section outlines the quality assurance checks on how this research was conducted and the techniques that were employed to integrate quality assurance into the methodology.

→ Case Study Protocol

Qualitative methodology faces the perennial question regarding reliability of research processes and the subsequent derivation of findings (Silverman, 2000; Ritchie and Lewis, 2003). The techniques that are used within the methodological framework of qualitative research must be open to viewing by outside onlookers so as to demonstrate transparency. This is the situation when using the case study research design and methods (Yin, 2003; Bennett and Elman, 2006). Using a case study protocol during the research process is one way of ensuring the manner in which data is collected during field trips is carried out in a rigorous and standardised way. This protocol is advantageous when conducting single and multiple case studies, but essential for the latter. It ensures that forethought has gone in to the planning of the research, that problems could be anticipated prior to the field trip. The protocol maintains the focus of the researcher on the central research questions and reflects the line of inquiry to an outside audience (Yin, 2003). Appendix 2 provides the protocol used during the field trips for this study. It acted as an aide the researcher, ensuring all the aspects were covered on the field trip and all questions asked. Appendix 2 also provides the topic guide used for the interviews, including the research questions and prompts (which are directed at the researcher, not for the interviewee) which remained at the forefront of the investigation at all times.

→ Validity and Reliability (Replicability) Measures

Yin (2003) outlines the four conditions that should be met in order to ensure case study research contains the necessary reliability and validity checks. This is to ensure that data collection and analysis is as ‘water-tight’ as is possible in qualitative

research (Lincoln and Guba, 1985; Holstein and Gubrium, 1997). The following provides four conditions and how they are satisfied in this research.

Internal validity: Test #1

This category of validity ensures that the inferences made by the researcher is correct and answers the research and theoretical questions adequately, based on the available and convergent evidence. An inference occurs in case study research "every time an event cannot be directly observed," which is the instance in this study (Yin, 2003:36). The types of inferences made in research and the awareness of rival explanations is necessary during the design and conceptualisation of the research strategy, in order to forearm the researcher of such queries as much as possible.

External validity: Test #2

This test of validity relates to the generalizability of the research findings to studies beyond the case study in question. Although generalisation in case study research is a difficulty, given the small number of cases (Lincoln and Guba, 2000) linkages between the immediate study and theories and other studies in the literature can be elicited. This is illustrated in the case study chapters (5 and 6) and in the conclusion chapter (7).

Construct validity: Test #3

This validity test requires the operationalisation of variables, as derived from theories and concepts, throughout and across the case study research. Multiple sources of evidence that indicate convergent paths of inquiry (Yin, 2003) enable the operationalisation and validity-check of the research variables.

Reliability: Test #4

The aim of reliability is to reduce errors and biases in the study. It is to ensure that if another researcher were to conduct the study over again, they would arrive at the same, or closely similar, results. In order to ensure this happens, this doctoral study documented the data collection procedures in the form of the case study protocol which can be viewed in appendix 2.

The test of inter-rater reliability was used in this study to guarantee internal reliability and replicability of research (Lewis and Ritchie, 2003). This technique ensures quality assurance in the research. It demonstrates that the research is as robust as is possible by conducting quality checks on the data and its interpretation (*ibid*). Appendix 3 outlines the procedures for the inter-rater exercise, which includes the notes regarding the coding of other researchers.

C) Description and Analysis

There are two types of case study analysis; controlled comparison and process tracing and congruence testing. The former seeks to ensure all variables in the cases are constant except for one, thus furthering scientific explanation of the theories. The latter technique of process tracing allows a researcher not to replicate the reasoning of such explanation, but to "increase confidence in a theory" (George and Bennett, 2004: 153). Process tracing enables the relationship between the variables to be examined and the congruence method establishes how congruent (or not) a theory is with the findings of the cases.

Within-Case Method of Causal Inference: Process Tracing and Congruence Methods (George and Bennett, 2004; Bennett and Elman, 2006).

Process tracing is an integral technique for a case study strategy that requires theoretical narratives and within- and cross-case analysis. The technique allows the tracing of certain processes by using an explicitly described analytical comb (research framework) in order to establish theoretical and empirical inferences. Process tracing is grounded in the constructivist approach, whereby it allows description of causal pathways in a historical setting (case study research). It is widely used and increasingly advocated in political science. Hall (2000) notes its importance in theory-oriented research.

There are two main types of process tracing; detailed narrative (historical) and analytic explanation (theoretical). The use of the hypotheses and generalisations in the latter are introduced as part of a narrative in order to ground the case study story in the theoretical bedrock (George and Bennett, 2004). This latter type of process tracing is used in this research study, so as to enable the correlation and inference-building

between theory and empirical observations. However the more general explanatory type of process tracing is used in this study; causal pathways are not minutely explicated. Instead, hypotheses are linked from the data to wider generalisations. This is in line with the research questions which aim to trace patterns across cases (more intricate tracing is more suitable for single case analysis). In addition, this cognisance of wider generalisations is a familiar concept in political science, in the move up the ladder of abstraction.

There are also various forms of causal processes, which range from linear causality; complex causality in the convergence of several factors towards an outcome; and a more complex causality which involves interacting causal variables that are not independent of each other. The latter form of causality is most representative of this research as the independent variables are interlinked to some extent; the value judgements can be inextricably linked to the cultural dimension of the institutional influences in the cases. Path dependency is a method which would add explanatory value to the process-tracing in this research. However, the length of time in each HIA case study does not provide an adequate longitudinal process for an assessment of causal pathways, critical junctures and crisis points to be made (Pierson, 2004). Nevertheless, the influence of historical institutionalism in this research has been explored and adapted to this study (chapter 3).

The two main limitations of process tracing relate to its inadequacy to confidently provide a strong argument for causal processes that do not have uninterrupted casual pathways. In addition there is also the possibility of many hypothesised causal mechanisms in any piece of process tracing material (George and Bennett, 2004). In order to reduce these limitations of process tracing, this research study has sought to explicitly identify all variables and hypotheses through the analysis and identified factual errors and gaps in evidence (*ibid*).

4.3. Research Framework: Questions and Hypotheses

It is the aim of this thesis to investigate Health Impact Assessment (HIA) use in public policy formulation in Ireland. The influences affecting the use of HIAs will be examined in this study.

The rationale underpinning this research is to assess whether institutionalist structures and value-judgements influenced the process of HIA usage in policy-making, and *how* this was the case. The dependent variable has been drawn from knowledge utilisation and policy analysis literature, in order to ascertain direct or indirect use of HIAs in policy, and the extent of such usage.

The use of case study methodology with institutionally-generated theoretical propositions is the suggested way to proceed in political science research. This has been advocated by commentators in the field who encourage this marriage between theories and methods (Peters, 1999; Lowndes, 2002) in conceiving an appropriate research model.

There was variation in case selection based on the jurisdiction divide. Two cases are based in Northern Ireland (Derry and Belfast), while the others are in the Republic of Ireland (Dublin and Donegal). This selection ensured a fair analysis of HIA use across the country, and the variability of the range of HIAs and their locations adds depth to the research.

The aim of the thesis is to investigate HIA use in policy formulation in Ireland. In order to investigate the use of HIAs and the knowledge they generate for policy making, influences on the use of HIAs will be examined. Previous work investigating the relationship between the policy processes and HIA use has recommended an examination of the institutional structures and underlying values as influences upon HIA use in policy (Kemm, 2001; Kemm and Parry, 2004; Bekker *et al*. 2004; Putters, 2005; Dallaire, 2006; Wismar *et al.* 2007; Bekker, 2007; Morgan, 2008).

Therefore following on from this rationale, the central research question is viewed below. The emphasis on the ‘how’ and ‘why’ aspects of the question are directly

linked to case study research design. This ensures linkage between theory, methods and research model/framework (Littig, 2006).

Central Research Question:

How and why do structures and values influence the use of HIAs in policy?

It is the aim of this thesis to investigate Health Impact Assessment (HIA) use in public policy formulation in Ireland. The influences affecting the use of HIAs will be examined in this thesis.

Arising from this central research question (CRQ), more are posed for this study. The CRQ asks both a descriptive (how) and analytical (why) question in relation to the factors of influence (structural and value-judgements). Therefore, sub-research questions are related to the assertion that institutional and value-judgements are influences on the use HIAs for policy. These questions have been formulated within the methodological and epistemological approach of case study research design.

The following research questions are posed as 'how' and 'why' questions, which is necessary for case study research, in order to facilitate descriptive and analytical exploration (Yin, 2003; George and Bennett, 2004).

> How do institutional structures influence Health Impact Assessment utilisation in policy?
>
> How do value judgements influence Health Impact Assessment utilisation in policy?
>
> Why is the degree of utilisation, both direct and indirect, varied in different contexts?
>
> What are the barriers and enablers to the use of HIAs?

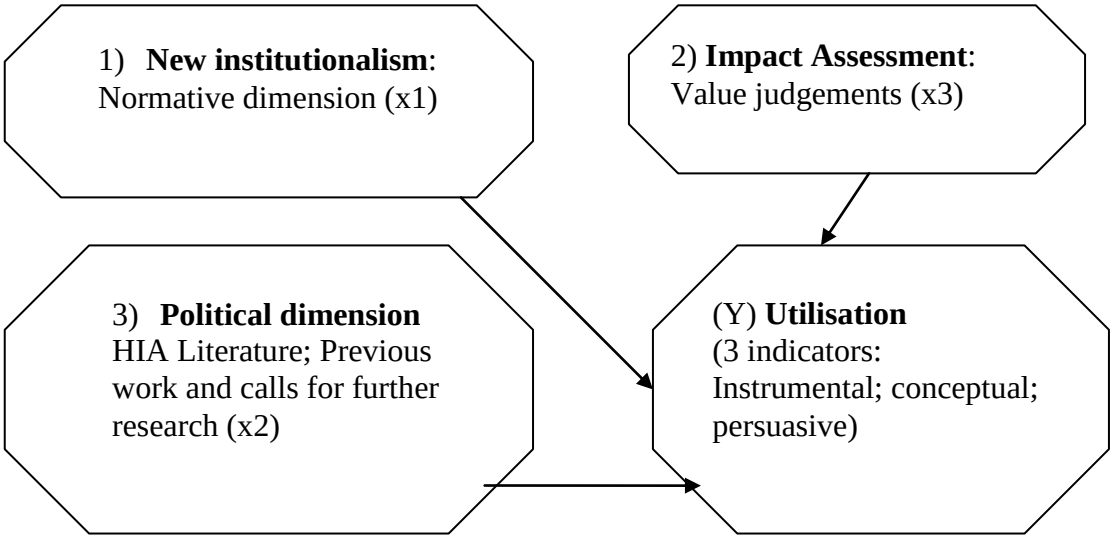
Figure 3 (page 127) illustrates the theoretical framework for this study, which draws from three schools of literature (chapters 2 and 3). Each case study will utilise the

method of process-tracing in order to describe the hypothesised influences on HIA use (independent variables) and the degree of use in policy (dependent variable).

The influences (independent variables) upon HIA use (dependent variable) are the changeable effects that will be investigated in this research. The hypothesised outcome, which in this case is the extent to which HIAs are used in policy processes, will be assessed in terms of the degree of knowledge utilisation, as indicated in table 10 (page 135). Policy analysis and knowledge utilisation theories informed the construction of this variable and the direct and indirect utilisation indicators (chapter 3). For the purpose of this research, the relationship of the influences to the dependent variable (extent of HIA use) is explored in a holistic sense; the influences together are examined and the extent of HIA use is examined, as illustrated in the case studies (chapters 5 and 6) and in the thesis conclusions (chapter 7).

Greater detail of the variable relationships will be presented in the next section.

Figure 3: Theoretical Framework



Hypotheses

When one set of actor's attributes are used to predict another actor's endeavour, the research displays features of 'variable-centred research' (Dorein, 2006). This is the intention of the proposed research framework; to establish the circumstances and influences upon HIA usage.

The aim of this research is to establish and analyse the context of institutional and value judgement influences. This is proposed within the Irish setting and case studies. The influence of the independent variables, and the factors that are deemed as enabling or hindering the utilisation of HIA evidence in policy-making, will be evaluated.

The hypotheses (propositions) for this research are drawn from the central research questions and provide greater detail of what is being assessed in this study. They are dually informative of the direction and boundary scope of the research.

Hypothesis #1

HIA utilisation is possible with institutionalisation

Sub-hypothesis (variable indicators)

- Normative dimension (norms→standards→processes)
- Political dimension

HIA is a policy support tool that aims to inform policy decisions by making explicit the health impacts of each policy document or proposal. It strives to maximise the benefits and minimise the negative aspects of policies, and policy proposals (Scott-Samuel, 1998; Barnes and Scott-Samuel, 2002). The concept of institutionalisation (the degree of embeddedness of the HIA tool within institutional structures) with regard to HIA in this research, refers to the "systematic integration of HIA into the decision making process" (Wismar *et al*. 2007). HIA institutionalisation involves the tool, its evidence and knowledge, becoming part of the rules and processes of decision making across the relevant institutions (decision making bodies and statutory agencies), thus making use of one the strengths of HIA as a policy-aiding tool; it being an intersectoral mechanism for all stakeholders to participate (Banken, 2001; 2003). Kearns and Pursell (2007) concluded in their evaluation of the Ballyfermot Traffic and Transport HIA that the role of the health services and local government in institutionalising HIA into its policy process rules and procedures is a vital step in embedding the tool in public policy formulation. Without this vital step, the future development of HIA is tenable and uncertain, as has been the experience across European countries with HIA institutionalisation (Wismar *et al.* 2007).

The influences of the institutional norms (polity) are hypothesised as shaping the use, nor non-use, of HIAs. The extent to which institutional structures support the utilisation of HIAs in Ireland will be established in this research. A number of theoretical indicators will be employed in order to ascertain the degree of this proposition. Normative and political institutional influences will be examined, in order to establish what should be happening in the institutional frameworks, and what influence the political dimension has upon the use of HIAs. The shaping of actor's preferences and the political context (political dimension) (Elliott and Francis, 2005; Bekker *et al*., 2005) is also an important indicator of institutional influence. This

choice of normative and political institutional influences has been conducted in the European evaluation of the tool's use and effectiveness across the continent (Wismar *et al.* 2007), thus ensuring this study is comparable within the wider context of research design and findings.

Institutional Influences

Normative dimension

How institutions impact upon policy-making and individual behaviour in such processes has occupied the analysis of policy academics over previous decades (Finer, 1954; Kiser and Ostrom, 1982; Immergut, 1992; Peters, 1999; March and Olsen, 1984; 1995; 2005). Political institutionalism propounds the view that policy formulation is the result of internal value and belief systems (norms), as opposed to the sole influence of external forces (Skocpol, 1985; March and Olsen, 1989; 1995). A branch of this institutionalism is known as socio-historical institutionalism, or statism, which views the state as the leading political-process agent and dominant societal establishment. However, in practice, the hegemonic role played by the state in all public affairs is improbable (Przeworski, 1990). In reality, the approach is used as an analytical tool to enable an assessment of the state's role upon institutional actions. In addition, the emphasis of institutional influences and the placement of ideas, norms and discourses underlying such impacts is an important aspect of this theoretical branch (Hall and Taylor, 1996). Empirical investigation in political science, utilising historical institutionalism as an analytical lens, has become an increasingly useful mechanism in demonstrating the influences upon the policy-making processes (Powell and DiMaggio, 1991; Peters, 1999), with a particular focus upon inertia within the policy-making process. Steinmo *et al.* (1992) published a seminal piece of work pertaining to this branch of 'new' institutionalism.[12] This research puts forth socio historical institutionalism as a very tangible theory in explaining influences within institutions, and in explaining institutional actions. More in particular, however, this theory seeks to explain the inaction and inertia within institutions (*ibid*; Rose and Davies, 1994; Rothstein, 1998; Millar, 2003). Indeed Genschel's (1997) study

[12] March and Olsen (1984) coined this phrase, so as to delineate the difference between the recognition of institutionalist forces as being very distinctive, tangible and measurable variables in explaining institutional actions and policy process within them, from the old institutionalist traditions of viewing nothing spectacular in such an analytical theory (Lowndes, 2002).

highlights this aspect. This approach is appropriate for this doctoral study, as inaction, institutional inertia and lack of utilisation of HIA knowledge is one of the defining features of the relationship between the policy process and HIAs in Ireland, as learnt from exploratory interviews (O'Mullane, 2007a; 2007b).

However, because the length of time of the HIA processes being examined, and their subsequent journey into the public policy processes is relatively short (on average less than five years for each contemporary HIA case study) an undiluted historical institutionalist approach will not be used. A mix of theoretical concepts will be employed, as is suitable for the research questions (Knill, 2001; Grix, 2004). Institutionalist theory, which has been advocated as more of an 'organising perspective' than a prudent causal theory in the behavioural sense (Gamble, 1990; Rhodes, 1995; Lowndes, 2002), is used in this thesis to enable an examination of policy making structures, which HIAs aim to inform. This will be looked at by adopting a normative and empirical institutionalist approach (March and Olsen, 1984; 1989; 1995; Peters, 1999). In line with the proposition of using institutionalist theory in a multi-theoretic research framework (Rhodes, 1995), this study will draw upon impact assessment theories, with an emphasis on the role of value judgements.

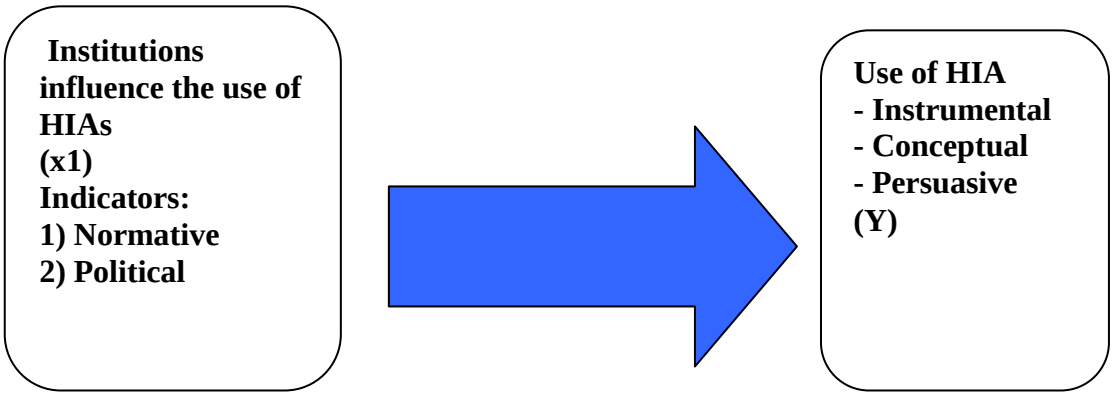
This study will establish the theoretical framing from these elements of a system-centred approach to analysing influences on evidence use in policy-making.

Political dimension

Previous academic research, investigating the use of HIAs in policy-making, has established the influence of the political context upon HIA evidence utilisation (Bekker, 2004). The direct and indirect influence of the political environment, and actor's preferences in policy-making, are important considerations when investigating influences upon HIA utilisation (Elliott and Francis, 2005; Bekker *et al.*, 2005; Putters, 2005).

In this doctoral research, the influence of actor preferences in the usage of HIA evidence, as well as the influence of the political context and knowledge-streams of policy formulation, within which HIA is trying to infiltrate, will be analysed.

Figure 4: Conceptual framework: Institutions influence the use of HIAs



Hypothesis #2

HIA utilisation depends on the value judgements of the policy actors

Impact Assessment (IA) is a tool defined by Robert Bartlett (1989:1) as constituting "a general strategy of policy making and administration- a strategy of influencing decisions and actions by a priori analysis of predictable impacts. A simple, even simplistic, notion when stated briefly, making policy through impact assessment is in fact an approach of great power, complexity and subtlety."

A definition of the concept 'value' to be used in this research is as follows:

"A value is a standard that guides action, attitudes, philosophy, judgement, rationalizations, comparisons and attempts to influence others (Rokeach, 1973).

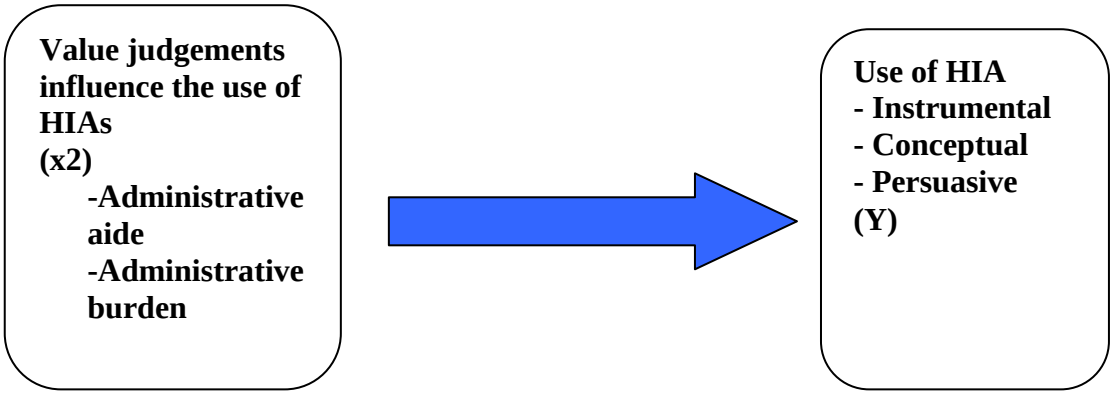
It is vital to understand and take account of the role that value judgements play in policy making. Such judgements relate to the perception of what a 'good' decision is over another groups', and the two may have diverging points of view. In order to avoid rationalising the policy process to any idealistic extreme, the role that values play in the consideration of HIAs in policy is an integral aspect of this research.

The WHO Gothenberg Consensus paper (1999), the most cited document in HIA literature, highlights the pertinence of values underlying the processes, institutions and actors that HIAs are attempting to influence. The paper states that "values evolve and change in time. It is suggested that they can also be changed by the processes of impact assessment themselves" (cited in Bekker, 2007: 32). The WHO paper emphasises the need to consider the influence of values upon decision making processes and the need to take them into account when establishing the influence that HIAs can have upon such processes (ECPH, 1999)..

Sub-hypothesis (variable indicators)

- Value judgements view HIA as an administrative technocratic burden
- Value judgements view HIA as a useful informative aide.

Figure 5: Conceptual framework: Value Judgements influence the use of HIAs



Enablers and Barriers to Utilisation: A Check-List

Lock and McKee (2005), Davenport *et al*. (2006), Wismar *et al.* (2007) and Burns and Bond (2008) have conducted research into the incorporation and consideration of HIA, and the broader concept of health, in policy. The WHO Gothenberg Consensus paper, the seminal public endorsement of HIA from an international perspective, also encouraged the investigation of the barriers and enablers for HIA use (European Centre for Health Policy, 1999).

The employment of this check-list in this research is to establish the contextual conditions inhibiting or enabling the utilisation of HIAs in policy. This section of the research, which is not explicitly part of the theoretical framework, is aimed to add an informative dimension to the research and allow for a validity of findings between the application of the framework and the construction of this check-list, which has been built in a snow-balling and sequential fashion from one case to another.

Two categories of enablers and barriers were collated and reflected upon by the chairperson of the Ballyfermot HIA, Dr. Catherine Hayes after the conclusion of that project in 2006. One category related to the conduct of the HIA, and the other related to the decision makers, policy process and policy environment. The latter category is of relevance to this research. It was presented by Dr. Hayes to the Department of Public Health (HSE, Eastern Region, 13th January, 2006) and also to the comprehensive training as provided for by the Institute of Public Health Ireland (26th September, 2006).

Enablers and Barriers of the Place of HIA in the Policy Process (Hayes, 2006a)

<u>Enablers</u>

- Involved in planning and conduct of HIA
- Input from outside decision-making process
- Clear organisational commitment
- Subject non-controversial
- Realistic recommendations

<u>Barriers</u>

- Lack of awareness of health by other sectors
- Lack of knowledge of policy-making environment

The Ballyfermot case study was the first conducted in this research, in order to use this check-list and apply it during the course of data collection, specifically for the expert interviews. Each interviewee was asked if they agreed or disagreed with the reflection of Dr. Hayes, and was asked also to contribute additional enablers and barriers specific to their HIA experience. This check-list was use din the subsequent cases sequentially (Donegal→ Belfast→ Derry). The findings of this aspect of the research contribute significantly to the practical recommendations of the thesis, for the future development of HIA in both Ireland and on the international landscape.

Unit of Analysis

The unit of analysis in this research is the HIA group in each case study. This was made up of a number of individuals from statutory, voluntary and community sectors. The unit of data analysis was different, consisting of the individual interviews and documentary evidence.

The analysis includes micro (individual actors and their value judgements) and macro (institutional structures and the associated normative and political dimensions) levels of analysis. This is line with the overarching research question; how and why do the overarching structures and underlying values influence the use of HIAs in policy?

Drawing from the work of middle-range level scholars of policy analysis, Ham and Hill (1984) conceptualised the important linkage between the understanding of institutional and political structures, and the politics of discourse under the surface of such institutional structures. Broadly speaking, if the use of knowledge is about power (Foucault, 1980), then the examination of such within political and institutional structures requires a deeper level of analysis in order to analyse norms, values and assumptions. Therefore, for the purpose of this doctoral study, the levels of analysis will be two-fold; institutional and political structures on the one hand, and the underlying values on the other.

Linking the Data to the Hypotheses: The Dependent Variable (Y)

The influences (independent variables) upon HIA knowledge utilisation (dependent variable) are the changeable atoms of effects that will be investigated in this research. The hypothesised outcome, which in this case is the extent to which HIAs are used in policy processes, will be assessed in terms of the degree of knowledge utilisation, as indicated in table 10 (page 135). Policy analysis and knowledge utilisation theories informed the construction of this variable and the direct and indirect utilisation indicators (chapter 3).

Table 10: The Degree of Utilisation of HIAs in Policy Making

Independent variable: Degree of utilisation	***Instrumental (direct)***	***Conceptual (indirect)***	***Persuasive (indirect)***
Ballyfermot			
Donegal			
Belfast			
Derry			

This section has outlined the research framework and questions for this study. The following outlines the methods that are employed to investigate the use of HIAs.

4.4. Case Study Methods

The case study design cites the use of multiple sources of evidence as essential in maximising the potential of this design type.

The following describes the two methods employed for this research, providing a rationale for their use and the manner in which they were implemented in this study.

1) The Expert Interviewing Method

35 semi-structured interviews were conducted with informants. The HIA chairpersons were interviewed in each case, as well as those who were part of the HIA steering groups in each case (unit of analysis). Informants who were not involved in the groups but played a pivotal role in the context of each HIA case were also interviewed. Appendix 4 gives an account of those interviewed for each case, the dates of interviews and the organisational affiliation of each individual. 14 exploratory interviews were conducted at the beginning of the research when formulating the study questions and when selecting the HIA cases. During each field trip this researcher conducted exploratory interviews that were opportunistic in nature and provided greater detail of the institutional context which the HIAs are attempting to fertilise. Appendix 5 also outlines the exploratory interviews in each case.

In total, 49 interviews were conducted for the purpose of this research.

Expert interviewing is gaining considerable support within the social and political sciences as a distinct and informative qualitative research method (Kezar, 2003; Burnham *et al.* 2004; Dexter, 2006). This specialised interviewing technique has been used in this research. The interview is the most common mode of conceptualising individual experience (Gubrium and Holstein, 2001). The individuals interviewed in this study were primarily chosen because of their membership in the HIA steering groups, and as importantly, due to their specialised knowledge. It was such knowledge, and the meaning the individuals attached to their views, that provided the basis of data. The interviews were not planned as being transformational as some expert interviews are in political science; it was not the aim of this research to change the ontological view of the interviewee's world (Padfield and Proctor, 1996; Kezar, 2003). The interviewees were accessed in their own institutional context as far as was possible (Odendahl and Shaw, 2001), as accessing such individuals in their natural setting is deemed the better option for this type of context-oriented research. As part of this empirical inquiry of a relatively unexplored research area, the expert interview is a technique that will allow great in-depth investigation of the HIA and policy-making processes (Dexter, 2006).

In order to ensure standardisation, a topic guide was used for the basis of each interview, which will draw from, and be based upon, the research framework (section 4.3., page 124)

The purpose of the topic guide is as follows:

- As a statement and reminder of key objectives
- A checklist of important issues
- An aide which is to be learned rather than read (Dexter, 2006)
- To enable comparison across interview for the interviewer
- An accountable document that provides for research transparency
- The starting point of analysis

(Littig, 2006b)

Wengraf's (2001) formula for enabling the process of ensuring the theory and research questions are embedded in a logical and transparent manner in the interview

material is used for this study. This process was employed for this research. The central research questions (CRQ) formed the basis of this guide; from these overarching questions the theory questions (hypotheses) (TQ) that this research is to investigate (ie. the institutional and value-judgement influences on HIA usage in policy) are born. The next stage in this linear process is the formulation of the interview questions (IQ), which are presented in appendix 2, along with the topic guide used for each interview.

CRQ→ TQ→ IQs

Interviews were held with three stakeholder groups in each HIA case study; key decision-makers, community representatives, and health and social care professionals. As far as is practicable, the same number of interviews will be held for each group, within each case, to ensure standardisation in the process. Tape recording was used in interviews with explicit and stated permission of interviewees, except for phone interviews.

Selection of Interviewees

Key stakeholders and actors were interviewed in this study. Appendix 4 and 5 gives an account of those interviewed, the dates of interviews and the organizational affiliation of each individual. Selection of interviewees was based primarily on the HIA steering committees in each case, as this grouping formed the unit of analysis in the study. This was the scope of selection criteria for this research, although individuals were also interviewed who may not have had a direct role on the HIA steering committee but played a vital part in the context of the process. Exploratory interviews played an important role in constructing the contextual scope of the HIAs being studied and the policy environment within which they operated and aimed to influence. As many individuals who were available at the time of data collection were accessed for interviews as part of this research. However staff turnover was a major consideration during the data collection phase of research; many individuals who worked on the HIAs had moved jobs and were inaccessible despite efforts made to trace such individuals. The snowballing technique was also employed concurrently during this research in the selection of interviewees. This technique involves asking

those being interviewed if they can recommend anyone else to be interviewed who also fit the selection criteria (Ritchie and Lewis, 2003).

Doing the Interviews

A topic guide was prepared which derived directly from the research framework and hypotheses at the time of data collection. Although the central research question was never altered throughout this study, the flexibility of the case study research design allowed some amending of the independent variables, in order to ensure the design and questions were appropriate and workable for this thesis. This flexibility was evidenced in Fenno's (1978) case study work[13], as the research framework was altered during the process of data collection. However, in order to sustain rigor and logic, the research questions of this study were never altered.

The topic guide is provided in appendix 2 and the clear linkage between the research questions and interview questions is indicated. This ensured the theory questions were persistently in the mind of this researcher during data collection. Each interviewee was asked the same questions, although the guide was based on a semi-structured framework and also allowed for interviewees to deviate into other areas of discussion.

Analysing the Interviews

The data collected from interviews can be presented "as a coherent life history" or coded "in terms of ideas, themes and hypotheses" (Bouma and Atkinson, 1987: 216). Wengraf (2001) devised a strategy for delving into the data, becoming immersed in it and then arriving out with findings and classifications of themes. Wengraf's conceptualisation was adhered to during the construction of the interview topic guide and theory questions, from which the interview questions arose, as seen below:

[13] *Inductive/ deductive paradox (Fenno, 1978)*
The flexibility of the case study research design allows the reiteration of the research framework, between the commencement of research, pre-data collection, post-data collection and analysis of material. However the central research questions remained constant and the topic guide and case study protocol helped ensure this at all times.

Coming up with topic guide:

Central Research Question→ Theory Questions→ Interview Questions

Coming out of the interview material:

Interview material → Answers to Theory Questions → Answers to Central Research Questions

This strategy for ensuring a linkage between theory, interviews and analysis is necessary for the robustness of findings and analysis of this research. However in order to trace the process of establishing descriptive and explanatory analysis from the interview data, Ritchie and Lewis' (2003) framework approach was utilised. This approach was chosen instead of the other leading approach to qualitative interview analysis; known colloquially as the German school of thought (Bogner *et al*. 2004): the exploratory approach to analysis. This approach is more appropriate when a maximum of ten interviews is being analysed as it enables a very in-depth immersion in the data. However, this approach is not suitable for this research, which analysing 35 expert interviews with exploratory interviews informing the descriptive narrative of the case studies.

Ritchie and Lewis (2003) have established three essential steps in analysing interview data, as indicated below:

1) data management
    - familiarisation
    - constructing index (give examples of indices in the thesis to illustrate the matrix and way of doing it)
    - applying the index
    - setting up thematic charts
    - charting groups

2) descriptive analysis
    - Detection
    - Categorisation
    - Classification

3) explanatory analysis

During the conduct and write-up of each case study, the manner in which this framework for analysis was employed, will be presented in chapters 5 and 6.

Appendices 10, 12, 14 and 16 detail the manner in which the Ritchie and Lewis framework for analysis was used.

2) Participant Observation: The Known Observer (Schwartz and Jacobs, 1979)

In conducting expert interviews with both members of the HIA steering groups, and individuals within the contextual confines of the HIA environment, it was deemed appropriate to carry out participant observation in each case study. Indeed, interviewing alone does not suffice nor has the ability in demonstrating the social reality of each HIA phenomena; a combination of interviewing and participant observation is a more holistic manner in carrying out qualitative research. It is a method to observe whether people "mean what they say and say what they mean" (Schwartz and Jacobs, 1979). Taking a symbolic-interaction perspective, as conceptualised by George Herbert Mead and Herbert Blumer, and developed constructively by Barney Glaser and Anselm Strauss within the grounded theory approach, it is important for this researcher to have some involvement with the environmental context in order to understand the phenomena being described in the interviews.

For the purpose of this study, the researcher adopted the role of the 'known observer' in the social world when meeting with the interviewees in their natural social setting. In this role as known observer the researcher can objectively appraise the situation by limited involvement in the social setting. The advantage of this method is that those interviewed and conversed with during the field trips acknowledge the researcher as a known incompetent, and therefore hope to transfer information and knowledge to this researcher. This explains why travelling to the geographical settings where each HIA was conducted, within the various organisational institutions and agencies, was important. If a sense of where those involved in the HIAs was not important to the research, or the setting of the community's health profile that was integral for understanding, then a trip to the towns and cities where the HIAs took place would not have been necessary. Conversely, a disadvantage of being a 'known observer' is that the researcher does not gain experience in engaging in the activities of others within the social setting, and does not integrate fully into the setting, as would be the case if adopting the 'unknown observer' role. However, for the purpose of this

research, it was deemed appropriate to maintain some objective distance within each meeting and setting during the data collection phase (Jorgensen, 1989; Janesick, 1998), in order to maintain some research distance whilst acknowledging the inextricable meshing of the human (individual) in the social world (collective).

Interviews and survey questionnaires could have been conducted from the ease and comfort of the office telephone and computer.

Although due to the timetables of some interviewees, and the inability for this researcher to conduct all interviews in person due to temporal and financial constraints, some interviews were carried out on the telephone. However, most were conducted face-to-face and within the natural setting of each individual (de Laine, 2000).

During the field trips to Dublin, Donegal, Belfast and Derry, this researcher spent time in each of the organisations and agencies where the individuals being interviewed, worked (with due permission accorded by the relevant gatekeepers). Appendix 6 provides subjective field accounts of the experiences had with those interviewed and met with and the overall experience as a researcher on the field trip. These accounts which portray the conscious experiences, had whilst on the field trips away, form one stream of knowledge, to produce the overall picture of each individual case study.

3) Documentary Evidence

For the purpose of this study, documents were used in conjunction with observation and interviewing techniques. The use of documents in case study research is advocated by Yin (2003) as another source of evidence in the in-depth investigation of each case. There are two main types of document analysis (Sarantakos, 2004). The first type involves a document study which places an emphasis on the description of documents and the summation of factual information. The second type is content analysis which involves the examination of trends and patterns within the text of the document (Krippendorff, 1980; Silverman, 2000). It is the first type that this research study has used. Appendix 8 presents a detailed summation of the key documents

examined for each of the HIA cases. These include the HIA reports and policy documents which are relevant to the HIA.

4.5. Concluding Comments

This doctoral study is based upon a research design that is suitable for investigating a novel area of HIA research that has not been investigated previously in an Irish setting.

An explanatory case study design strategy provides the research skeletal-structure in this study. In accordance with Yin's (2003) classification of appropriate research that is suitable for case study design, this research is deemed appropriate; it does not take account of behavioural events and has a focus upon contemporary events; lacks a clear distinction between the phenomenon and the context; and answers 'how' and 'why questions.

The following chapter outlines the health system and local government system in the Republic of Ireland. This institutional context will provide necessary background information for the presentation of the two case studies conducted in the Republic; the HIA of Traffic and Transport in Ballyfermot, Dublin (2004) and the HIA of the Travellers Accommodation Programme in Donegal, (2005- 2008).

CHAPTER 5
CASE STUDIES IN THE REPUBLIC OF IRELAND

Chapter Outline

The aim of this chapter is to detail the case studies in this research from the Republic of Ireland. An overview of the health system is presented as well as an overview of the structure and history of this tier of government, in order to provide the contextual background for this study.

A descriptive presentation of the two case studies that were investigated in the Republic of Ireland will be provided in this chapter. Such cases will be presented in terms of their rationale, background, and objectives, methodology, stakeholder involvement and HIA outcomes. A description of the policy process, which the HIA knowledge is to be assimilated into, will be provided. An analysis of the expert interviews will be carried out in sections 5.3. and 5.4., as well as the application of the research framework to the empirical data.

5.1 Health System in the Republic of Ireland

5.1.1. Historical Overview

As in all countries, a mixture of cultural, ideological, economic and political influences combine to structure the contemporary health care system (Tussing, 1985; Quin, 1999). Certainly, the Irish state is no different in this regard. The influence of its colonial past, post-independence political evolution, power balances between the various actors in the health system, and modern-day knowledge of health and disease have amalgamated to weave the system we have today (Lyons, 1973; Barrington, 1987; Dooney and O'Toole, 1992; Murray, 2006).

Although prior to the nineteenth century, when health care provision depended much on traditional health and self-diagnosis, the post-nineteenth century period witnessed the rise in the control of religious orders over health care provision (O'Donovan, 2005). Although the delivery of health and social services by the religious orders supplied much needed relief to the starving and disenfranchised populace (McLaughlin, 2001), the orders' dominance within the health care system allowed them to yield great control over issues of personal health (Fuller, 2002). State

intervention in health matters of the day was minimal, due to the laissez-faire philosophy of the governing British administration. However, the enactment of the Irish Poor Law (1851), and the commencement of the [14]Dispensary Services (1850's), indicates recognition of the state that delivery and organisation of medical care and relief was necessary (Malcolm and Jones, 1999). The period between the years 1900 and 1970 witnessed a dramatic rise in state intervention in the health system. However, although the system we have today is closely aligned with the Beveridge model of welfare (Beveridge Report, 1942), the Irish independent state decided against universal access to care in the 1940's (Wiley, 2005a). Indeed, the Irish parliamentarians' rejection of the Health Insurance Bill (1911)[15], which laid foundation to the modern British welfare state (Cochrane *et al.* 2001), resulted in Ireland sailing in a different welfare direction from its colonial ancestors. This was due to vehement opposition from the medical profession and the Church against the legislation (Lyons, 1978), and fear on the part of Irish politicians in financing the legislative provisions.[16] The dominant Catholic Church believed the expansion of state-intervention into matters of the individual and family would be a gross interference into personal and intimate affairs (Whyte, 1980; Inglis, 1998; Fuller, 2002). Also in opposition, the medical profession felt such universality would result in a 'socialisation' of health care, which they believed would be an injustice to the middle and upper classes (Lyons, 1978; McLaughlin, 2001; Murray, 2005).

By inhibiting universality of access to health services, these two vocal interest groups ultimately prevented equality of provision (Wren, 2003). The outcome of this was the

[14] Unlike the Poor Law that was enacted in the English system (1848), there existed a clause in the Irish Poor Law that local General Practitioners (GPs) would operate outside the walls of the workhouses. This provision introduced the Dispensary Doctor Scheme, which divided the country into 700 dispensary districts, each being allotted a salaried medical doctor who would diagnose low-income individuals. These individuals obtained 'tickets' in order to visit the doctor, without having to pay for the service. This system was in place until 1970, which was then essentially replaced by the General Medical Service (GMS) structure (Barrington, 1987; Murray, 2006).

[15] This Bill proposed a compulsory and voluntary insurance scheme, medical benefit which would cover free GP care, and it offered protection from dependence on the Poor Law arrangements (Barrington, 1987).

[16] At this time, it seemed quite likely that Ireland would gain control over its domestic affairs, within a set of arrangements called Home Rule. Therefore, Irish parliamentarians in Westminster feared that they would have to finance the costly provisions of the 1911 Health Insurance Bill in the future. This explains their insistence of Irish provisions that would exclude the more costly clauses from applying to the country. However, due to many factors, most important being the commencement of the First World War in 1914, Home Rule, and thus any negotiations for Irish political independence, was ruled out by the British administration.

formulation of the 'two-tier system,' which is an "extraordinary symbiosis of public and private medicine" (Barrington, 1987: 285). As the health system evolved throughout the twentieth century, the inequity of health care access, which is implicit in such division between financial means and medical need, is both what is uniquely characteristic of the Irish health system, and what is iniquitous of its underlying ethos (Tussing and Wren, 2006).

In 1947 the first attempt at strategic planning in health care was provided within that year's Health Act. [17] It aimed to reform the system by enabling greater access of low-income population groups to medical care. It also contained maternity and childhood public health measures, in order to tackle the rising mortality and morbidity rates of newborn babies and young mothers (Lyons, 1978; Barrington, 1987).

The following Health Act (1953) contained the public health provisions, although in a diluted form so as to appease the powerful interest groups.[18] This piece of legislation also defined in law the categories of service users that were entitled to free medical care. Such categories depended upon an individual's level of income (lower, middle and upper) (Murray, 2006). The Voluntary Health Insurance Act (1957) also went further to embed the dual mix of public and private health care funding, delivery and provision (Wren, 2003).

The Health Act (1970) introduced a re-structuring of the Irish system. Not since the introduction of the Poor Law system in the 1850's had the country experienced such dramatic organisational change.

The country was divided into eight regional boards, in a bid to decentralise health care administration and delivery, although after 1977, funding of the system was through national taxation, as local rates had been abolished (Leahy and Wiley, 1998). The decentralisation move was an attempt to take 'health out of politics' (Barrington, 1987). This was certainly an ambitious endeavour (Walt, 1994). The arena of health

[17]Although the State implemented measures to upgrade the hospital institutions and protect workers against medical costs (National Health Insurance Acts, 1929 and 1933), it was not until the Health Act (1947) that a long-term strategy was put in place.

[18] The Health Act (1953) introduced free hospital care for the majority of the population in addition to provision regarding pre- and post-natal care.

politics in Ireland, as in other countries (Hill, 1996), evokes riot-like reactions to both health system inertia and changes (Tussing and Wren, 2006). The rationale behind the regionalising of the system was to allow local administrative units cater for their local needs, thus taking the health system out of national politics and away from the frenzied media attention and national political machine (Barrington, 1987; Malcolm and Jones, 1999). It was envisioned that the regional units, being led by an administrative ethos of impartiality, would result in better informed health policy (McKevitt, 1990). Local elected representatives now held places on the governing committees of the regional boards, along with ministerial appointments and medical representatives. However, this measure of decentralisation resulted in increased parochialism of health within the regional boundaries, and not within the impartial hands of the administration regional boards (*ibid*).

5.1.2. Health Policy and Reform

The evolution of the health care system occurred in a rather piecemeal manner (Barrington, 1987). The Church, medical profession and the State had a role to play in the development of today's system. The 1980s was a time of economic recession, with unemployment and public sector inefficiencies haemorrhaging the country's economic potential (Clinch *et al.* 2002). During this decade, health care policy was one characterised by under spending and organisational neglect. Pressure increased from the early 1990's for increased funding and reform of the system (Quin, 1999). Between the years 1996 to 2002, health spending increased by 162 per cent compared to the expenditure over the previous decade (Wiley, 2005). The manner in which health policy was planned and delivered was also undergoing change (*ibid*; Tormey, B., 2003; Wren, 2003). Reasons for reform relate to the inequity of access to care and the debate over the public/ private health care provision, the increasing health expenditure that yielded few benefits by way of increased effectiveness and efficiency in the system; an imbalance in the services provided, where acute care outweighed resources in the community and in primary care; and the increased demands of the populace (Quin, 1999).

The National Health Strategy entitled 'Quality and Fairness: A Health System for You' was launched in 2001, during the first term of the Fianna Fail and Progressive Democrat coalition. This health strategy was unique in that it consulted the public,

medical profession and other stakeholders during its formulation. Key aims of the reform programme, has highlighted in the 2001 strategy, were to improve patient care, provide better value for money (VFM) and improve health care management (Department of Health and Children, 2001). This document was a serious attempt at health care planning, and contained a number of strategic goals and frameworks for change.[19] It initiated the commencement of a plethora of studies that examined the health system. The most comprehensive investigation of the system took place via numerous task forces.[20] These bodies investigated all aspects of the system with a view to formulating key recommendations for change, from organisational change ('Prospectus Report'), to improved financial management ('Brennan Report') changes in the employment of staff ('Hanly Report').

Numerous recommendations emerged from these studies, many of which were reiterated across the various investigations. One such recurrent theme was that of organisational centralisation and rationalisation of the health service agencies. The aim of this was to reduce fragmentation of service delivery throughout the country, and to strengthen governance and accountability. The resultant measure was the establishment of the Health Services Executive (HSE), a single entity which would have sole responsibility over the heath system. A reorganised role of the Department of Health and Children in having more focus upon policy formulation and less emphasis upon service delivery, and the establishment of the Health Information and Quality Authority were to ensure standardised quality of care across all agencies. The Health Act 2004 legislated for these changes, and as of 1st January 2005 the HSE took over responsibility for the health services from the eight regional boards, thus introducing the most dramatic change in the system since the legislation of 1970.

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[19] National Goals of Strategy: Better health for everyone; Fair access; Responsive and Appropriate care; High performance. Frameworks for Change: Reforming acute hospital system; Funding the health system; Strengthening primary care; Developing H.R.; Organisational reform; Developing Information System

[20] Audit of the Structures and Functions in the Health System ("Prospectus Report") (2003); Commission on Financial Management and Control Systems in the Health Service ("Brennan Report") (2003); Health Service Reform Programme (2003); Report of the National Task Force on Medical Staffing ("Hanly Report") (2003); Health Reform Programme Communications Strategy (2004); Composite Report on Health Service Reform Programme (2004); The National Health Information Strategy (2004) ; Report of National Consultative Forum Proceedings (2005)

5.1.3. Health Impact Assessment in the Republic of Ireland: Grounded in Policy Statement

One of the key objectives within the Health Strategy (2001:61) was the importance of locating population health within the remit of public policy development. The strategy identifies Health Impact Assessment as an integral policy-proofing tool, as defined in the following:

> "(It is) a means for all sectors to determine the effects of their policies and actions on health and it has the potential to bring greater transparency to the decision-making process by clarifying the nature of trade-offs in policy" (*ibid*).

The Department of Health and Children is identified as having main responsibility in ensuring HIAs are implemented and supported throughout the system. Regional- and local-level structures, such as local authorities and county development boards (CDBs), are to be encouraged in assimilating HIAs within the policy process. The importance of ensuring HIAs are conducted at local level is emphasised throughout the Health Strategy. The Health Information and Quality Authority (HIQA) also have a designated role to play in the mainstreaming of HIA within the health structures. The Strategy states that "health impact assessment will be introduced as part of the public policy development process" (*ibid:*157), at all tiers of governance. This is a prophetic and bold call for this policy proofing instrument to be institutionalised within Irish policy making circles.

5.1.4. How healthy are the Irish? - Health Status and Demographic Profile

Over the past four years the country's population has increased by 8 per cent, and with 4.2 million people residing in Ireland, the Republic is witnessing the biggest population increase since 1851 (HSE, 2006). Although Ireland has a relatively young populace compared to our European partners, with just 11 per cent of the population over 65 years, this is set to change. By 2036, 20 per cent of the population will be over 65 years of age (*ibid*). The changing demographic profile means that the government and policy-makers must ensure appropriate measures are in place to ensure informed and effective health promoting policy is formulated.

Morbidity Rates: Disease Patterns

Circulatory disease and cancer account for almost 65 per cent of all deaths in Ireland (Department of Health and Children, 2001). This is followed by respiratory diseases, injuries and poisonings. Cancer is a leading cause of both mortality and morbidity in the country (Campo *et al.* 2004), and it is estimated that one in three people will develop cancer (National Health Strategy, Department of Health and Children, 2001). Cardiovascular disease is a leading cause of morbidity and it results in premature mortality, which is one of the highest rates in the EU (Tussing and Wren, 2006). In addition, suicide is the most common cause of death as registered under 'injuries and poisonings' (*ibid*). The National Strategy for Action on Suicide: 'Reach Out' (2005) is a concerted effort on the part of policy-makers to address this critical albeit muffled 'cry for help' which results in the deaths of many Irish people annually (Clinch *et al*. 2005; Keohane and Kuhling, 2004). Associated with suicide is suicidal behaviour, such as deliberate self harm (DSH). Rates for DHS are increasing amongst teenagers and appropriate government-led strategies are required if such behaviours are to be reduced and mitigated (Morey *et al.* 2008). The rate of youth suicide in Ireland is fifth highest in the EU, at 15.7 per 100,000 for 15 to 24 year olds, with a greater proportion of deaths among males (Tussing and Wren, 2006). This figure contrasts with suicide patterns in other countries, where the rates are higher among older men (Health Service Executive (HSE), National Strategy for Action on Suicide, 2005).

Mortality Rates: Life Expectancy Patterns

As illustrated in table 11 (page 150), Irish men and women die prematurely compared to the average Western European (OECD Health Data, 2005). Although Irish life expectancy has increased over the past 50 years in tandem with economic growth and quality of life (Quin, 1999), it has not increased in line with our EU partners (Institute of Public Health, 2001).

Table 11: Irish and EU Average Life Expectancy

2002	At Birth		At Age 65	
Area	Males	Females	Males	Females
Republic of Ireland	75.1	80.3	15.4	18.7
EU 15	75.8	81.6	16.3	19.9
EU25	74.8	81.1	16	19.6

Source: Central Statistics Office, Irish Life Tables No. 14, June 2004[21]

5.2. Local Government System in the Republic of Ireland

This section will provide an account of the system of local government in the Republic of Ireland. An historical account of local government is provided in appendix 7. It is important, within the context of this research, to have sufficient understanding of the policy-making structures and processes in place at local level.

The Current System of Local Government

The following section will illustrate the fundamental structure of local government today, in terms of form (composition), functions, financial arrangement, and the reform and modernisation agenda.

Form

The current structure of local government in the south is made up of three tiers. The 8 regional tiers were introduced to monitor the activities of projects at local level throughout the country. The county level authorities include the 29 county councils and 5 city councils (34 in total), and are deemed the primary units of local government (Collins and Quinlivan, 2005). At sub-county level, there are 75 town councils and 5 borough councils, which carry out functions for urban areas in particular. The Local Government (Dublin) Act (1993) legislated for the creation of the only county councils to be instituted since the foundation of the state; Dún Laoghaire-Rathdown, Fingal and South Dublin (O'Sullivan, 2003) (see figure 6, page 151)

[21] Cited in Tussing and Wren, 2006:41

Figure 6: Map of Dublin County and City Council Boundaries

Function

As designated by the Public Bodies (Amendment) Order (1975), there are 8 function groups which local government has responsibility:

1) Housing and building;
2) Road transportation and safety;
3) Water supply and sewerage;
4) Development initiatives and control;
5) Environmental protection;
6) Recreation and amenity;
7) Agriculture, education, health and welfare;
8) Miscellaneous

As has been illustrated in the previous section, functions of local government have been continuously eroded over the past number of decades. In 2004, in terms of current expenditure, the following illustrates the expenditure on the range of functions carried out at local government level:

Road transportation and safety (27.6 per cent)
Environmental protection (19.2 per cent)
Housing and building (14.9 per cent)
Water supply and sewerage (12.5 per cent)

(Indecon Report, 2005:ii)

With regard to local government functions, Ireland rates quite poorly in comparison with international countries. Daeman and Schaap (2000) have concluded that the powers and functions of local government in Ireland are narrow compared to other jurisdictions, most particularly in the areas of health, education and welfare. Reasons for the limited functions at local level can be understood in the context of central government's tendency to withdraw functions as opposed to supporting local authorities to retain their responsibilities.

Finance

Local government expenditure, as a percentage of Gross National Product (GNP), increased from 2.1 per cent in 2000, to 3.1 per cent in 2004. There has been an increase in expenditure overall since 1996. Reasons attributed to this include the growing population, the demands of the growing economy and consequences of contributing the national development infrastructure programme (Indecon Report, 2005).

Local government in the Republic is funded through a number of routes, including commercial rates, charges for goods and services, and transfers from central government via the Local Government Fund. Based on 2004 annual figures, charges for goods and services were the most significant source of funding (31%), while funding from central government (23%), general purposes grant (21%) come next in line of significance. Commercial rates remain an important source of revenue for local

authorities, providing a quarter of funding (Indecon Report, 2005; Department of the Environment, Heritage and Local Government, 2007).

Politicisation of local government

In the Republic of Ireland, the 1920s was clearly a time when the system was highly fraught with political tension and military activities, as the country was in the midst of a bloody civil war (Quinlivan, 2006). Nowadays, however, electoral politics have ensured that the country conducts debate and discussion on local issues within the council chamber. In the local tier of governance, there are 883 seats at city and county council level, while another 744 at town and borough level (Kenny, 2004).

Collins and Quinlivan (2005:388) note how local elections have been used by the electorate "to give the government of the day a mid-term shock." The local elections in 1999 seemed to have gone against this convention, in providing Fianna Fáil with a good outcome (Kenny, 1999). However, the convention seemed to hold true again for the 2004 elections, with the largest government party witnessing a significant drop in its support.

Kenny (2004), in analysing the results of the most recent local elections notes quite a number of changes. Overall, voter turnout increased by almost 10 per cent on the 1999 turnout figures. This is a much-needed boost in support for local authorities, which have historically been treated with indifference by the public. Fianna Fáil lost 80 seats (9 per cent of the total) while Fine Gael's performance, although steady, did not reap the spoils of their rival's losses. While the Progressive Democrats (PDs) lost six seats on their 1999 election, while other parties increased their seat-share on the 1999 figures, including Labour (18 seats), Green Party (10 seats) and Sinn Féin (17 seats). Indeed, Sinn Féin, as the only all-island party, gained 50 per cent more seats in 2004 on their 1999 performance. Non-party candidates, also known as Independents, increased from 85 to 89 seats, between the 1999 and 2004 elections. The next local election is due to take place in 2009, two years into the term of the current Fianna Fáil/ Green Party/ PD national coalition government.

Reform

Contemporary debate on local government in Ireland centres on reform and the extent of it in reality. Comparatively the Republic of Ireland has fewer local government functions than many European partners, and this anomaly is being somewhat addressed through measures of reform (Quinn, 2003). Reform and modernisation has been slow over the years, and radical change has been avoided as much as possible. Until the decimation of the local functions from the 1970s onwards, the system was adjusting well to the management system, with a few amendments to it in favour of councillors.[22] Following the starvation of local authority finances during the 1980s, a decade already in the midst of national economic recession, the 1990s was one characterised by a reform agenda.

A need for greater recognition of local government in constitutional law, more fiscal independence, support structures for councillors, greater consultation with the community (Quinn, 2007), and an easing of the frustrating central/ local government relationship are among some of the key areas requiring reform. Numerous reports during the 1990s recommended curative measures to the ills of local government. 'Better Local Government (BLG) - A Programme for Change' (1996) is seen as a seminal policy document, recommending key areas of reform. [23] BLG is grounded in the rise of New Public Management (NPM) and the drive for efficiency and value for money in the public sector (Keogan, 2003). BLG should be viewed as the resultant document of the various reports of the 1990s. It set the scene for the reform elements of the Local Government Act (2001). Amongst some of the central aims of the legislation, the most pertinent related to a modernisation of local government law, to enhance the role of the elected members, to support local interest in policy-making and to support the programme of renewal (*ibid*). The key outcomes of the act were the annual representational payment for elected members and the abolishment of the dual mandate.[24] Constitutional recognition of local government in Bunreacht na hÉireann (Irish Constitution), which resulted in an amendment to the legal document in 1999 (article 28A), was an important step to ensure that tier of government was

[22] City and County (Amendment) Management Act, (1955)

[23] 1) Enhancing local democracy; 2) Serving the Customer Better; 3) Developing Efficiency; 4)Providing Proper Resources for Local Authorities

[24] Due to pressure from backbench TDs in the Dail, dual mandate was shelved until it finally was in enacted via the Local Government (No. 2) Act 2003.

acknowledged in law. However much political will, ministerial foresight and societal enthusiasm for local government are necessary if the required changes are implemented.

The following sections (5.3. and 5.4.) will detail the two case studies that were investigated for this study in the Republic of Ireland; HIAs conducted in Dublin and Donegal.

5.3. HIA of Traffic and Transport in Ballyfermot (2004)

Part I: Descriptive

A comprehensive retrospective HIA was carried out in 2003 and 2004 pertaining to the transport initiatives ongoing in Ballyfermot, Dublin. Ballyfermot is situated within the boundary of Dublin City Council, currently in the south central area. The HIA involved a number of stakeholders and an expert advisor from the UK. A mixed method design was used for this impact assessment utilising both qualitative and quantitative techniques. This is the first HIA carried out in Ireland relating to traffic and transport of in an inner city community.

Rationale and Background

The fundamental purpose of this HIA was to assess the air pollution levels in Ballyfermot and to investigate its impact upon the local populace. Transport initiatives ongoing in the area would be looked at within the context of the process, in terms of their success in reducing traffic in the area. The health impacts of transport and traffic on human health and wellbeing is well-documented, in both Dublin (Kelly and Clancy, 1984; Clancy *et al*., 2002), across the island (Institute of Public Health, 2005), and internationally (Acheson, 1998; Marmot and Wilkinson, 1999; Douglas *et al.* 2007). The choice of Ballyfermot for this HIA was deemed an appropriate choice by the advocates of the project as the area is a recognised socio-economically disadvantaged community with a poor physical environment (Hayes, 2003). Measures that would be put in place to reduce the levels of traffic would benefit the community at large. These initiatives were also believed to improve the social capital in the area and would empower the resident stakeholders to take control of an issue directly affecting the community at large (Eastern Regional Health Authority (ERHA), 2004).

One of the members of the URBAN II Ballyfermot team reiterates this rationale for funding the HIA project in the following:

> "(The HIA came) under the environmental enhancement measure (of URBAN II) and we decided to look at effects of traffic from a noise pollution perspective. People in the community were concerned about Liffey Valley development nearby also, and the HIA fed into that. There's also a history in Ballyfermot of pollution research, Dr. Hadd conducted research on respiratory diseases, and looked at the Ballyfermot area. It was the first area to be introduced with smokeless fuel also, as Dublin City Council chose Ballyfermot as the area to get it for the first time because of the research done in there" (Interview, 4th October 2007).

Objectives of the HIA

The proposed aim of the process was to carry out a HIA on transport initiatives in the Ballyfermot area, and to then use the findings to achieve the following objectives:

- Influence the delivery of future transport policies and safety initiatives in the community.
- Inform the second review of the Dublin City Council Road Safety Plan
- Provide a health focus to the Air Quality and Noise Assessment Project being conducted concurrently by Dublin City Council and funded by Urban II
- Influence the resource allocation for future health service delivery in Ballyfermot.

(ERHA, 2004:4)

The HIA was also expected to improve cross-sectoral collaboration on matters of health and physical exercise; to promote understanding across the various sectors of the link between transport and health status; to engage the community in active decision-making and to enable various sectors (statutory, voluntary and community) to work in partnership; and to enhance learning in the area of HIA (Hayes, 2003).

Terms of Reference

More specifically, the terms of reference of the HIA were

> "to assess the health impacts of traffic elements of the Ballyfermot Village Plan, and the health impacts of the transport infrastructure support under the National Development Plan (NDP)" (Hayes, 2006). [25]

Table 12 outlines the health impacts of traffic and transport, which the HIA sought to address and investigate.

Table 12: Health Impacts of Traffic and Transport

Health Promoting Impacts	**Health Damaging Impacts**
Enables access to: o Employment o Education o Shops o Recreation o Social support networks o Health services o Countryside Opportunities for Exercise	Accidents Pollution: o Carbon monoxide o Nitrogen oxides o Hydrocarbons o Ozone o Carbon dioxide o Lead o Benzene Noise and vibration Stress and anxiety Danger Loss of land and planning blight Severance of communities by roads

URBAN (2002:6)

Within the terms of reference it was specified that the Merseyside Guidelines would be used as a standardised methodological framework for conducting the HIA.

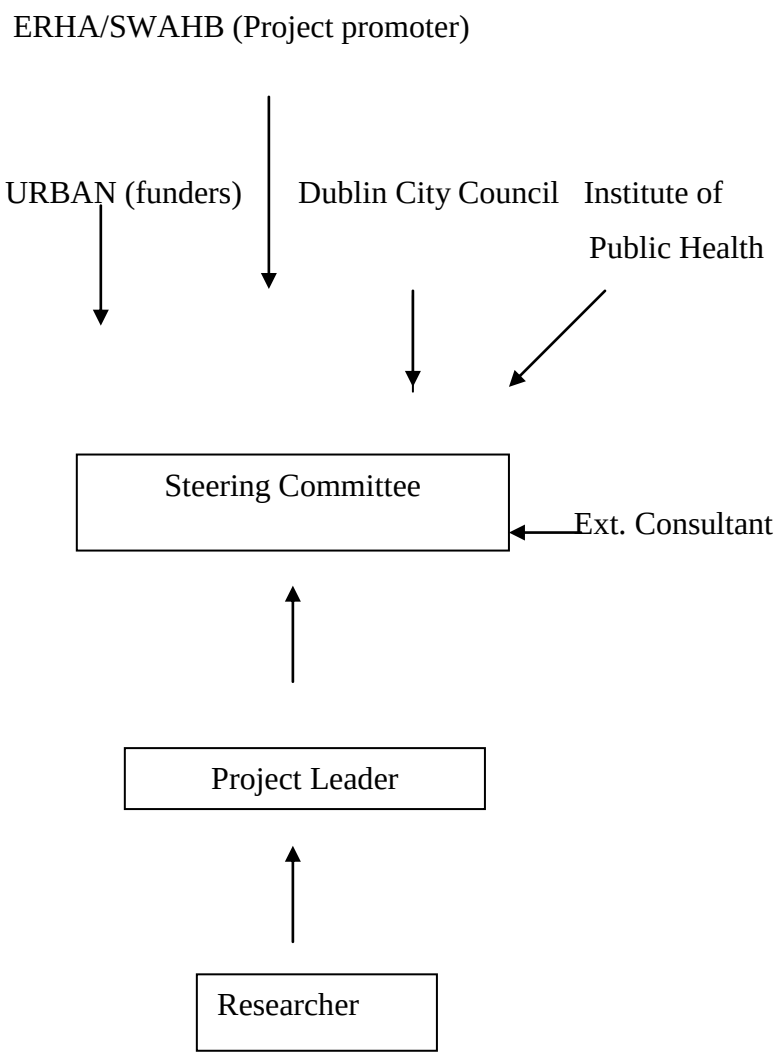
Stakeholder Involvement

The Department of Public Health in the ERHA was successful in the tender for a HIA on traffic and transport in Ballyfermot in 2003, to the project funders, URBAN II. A Steering Committee was established to manage and lead the HIA and ensure all stages, from literature review through data collection, were kept on schedule and in

[25] Ballyfermot Transport Initiatives, Dublin City Council (Ballyfermot Village Plan): 1)Traffic calming measures- ramps and speed cushions; 2) Traffic islands and pedestrian refuge areas; 3) Road signage and traffic light installations; 4) Construction of designated bus and cycle lanes

accordance with the outlined objectives. This committee consisted of representatives from the ERHA, the South Western Area Health Board (SWAHB), URBAN II, residents from the local community who would be affected by initiatives in the area, the Institute of Public Health, Dublin City Council (including planning and traffic officials and engineers), and an external consultant. There were no local council elected members on the committee.[26] The wide variety of stakeholders indicates the nature of the multi-sectoral dimension of a HIA in transport and traffic. Figure 7 illustrates the management structure that was drawn up for the HIA.

Figure 7: Structure of Management of the HIA (URBAN, 2002:4)



[26]This is the situation in all the HIAs of this study. No variation in this instance of case study selection.

Health Services (former Eastern Regional Health Authority and South Western Area Health Board)

The Health Services were to play an integral role in the HIA, both in terms of its planning, conduct, management and dissemination of findings. On the Steering Group there were four members; one of whom is still currently in her position and was available for interviewing as part of this research. This individual was also the chairperson of the group, who is based in the HSE and is currently working to promote the work of the Health Intelligence and Quality Authority in Steven's Hospital, Dublin. This is the statutory body assigned the task of institutionalising HIA within the HSE. This individual worked within the former ERHA and was the chairperson of the Steering Group, and viewed her role as a strategic and leading one (24th July, 2007).

Dublin City Council

Dublin City Council (DCC) is the local government authority governing the area of Ballyfermot. It was vital that officials from the Council were present on the HIA as many of the recommendations would require action and decision making at the local authority level. Both the health services and the Council were identified as the key decision makers in the HIA report (ERHA, 2004). Four members from the Council were present on the HIA Steering Group. One member of the Dublin Transportation Office was also present. Due to turnover of staff, those currently still working in their positions of employment were interviewed for this research, which included the Ballyfermot Area Managers (former and current) and the senior engineer in the Office of the Director of Traffic. The DCC has decentralised its offices from Wood Quay in the city centre to various areas in the Dublin suburbs. The Council officials working in the area are based in the Ballyfermot Civic Centre. Members of the Council that were interviewed for this research viewed their roles on the HIA as providing technical expertise and to "explain existing transport policy" (12th October 2007); as an "overseeing role and (in) bringing together local knowledge and the DCC perspective" (8th November 2007); and to proof-read the final document (28th November 2007).

URBAN II

URBAN II is the Community Initiative of the European Regional Development Fund (ERDF) for sustainable development in disadvantaged urban areas in the EU, for the time period 2000 to 2006. URBAN II seeks to promote the implementation of innovative models of development for the economic and social redevelopment and regeneration of urban communities. The project advocates cross-country learning of experiences through the European network of cities and partners (Dublin City Council, 2001a). In 2000 Ballyfermot's priorities for action were identified through community consultation, and the Traffic and Transport HIA (2004) fits into these areas of action (URBAN, 2002).[27] Since 2001 Ballyfermot URBAN staff and the local community have worked together to bring about sustainable projects, in order to initiate positive change. Dublin City Council is the local authority with responsibility to oversee the work of the programme in Ballyfermot. An important contextual factor of the URBAN II programme in Ireland is the nature of local government reform.

Such reforms in Ireland aim to "maximise local democratic influence on the local decision making process (which included) the establishing of Strategic Policy Committees and Area Committees" (*Ibid*: 6). URBAN II involves the collaboration of local stakeholders and actors within the new framework of working in local government. Members of the Area Committee (elected representatives) have a key role in the democratic accountability of the work of the programme. Quinn (2007) reiterates this message of enhancing public consultation for local government. One of the members of the URBAN Ballyfermot team interviewed for this research stated how the programme has benefited the working of local government, and has changed the attitude of the Council towards community involvement in decision making. This changed attitude of the local authority benefited the HIA programme also:

> "Alot of good has come from the programme (URBAN II) and one of the advantages has been the experience for Dublin City Council, they've realised that working with the community for the community is a good way of working and it's paved the way for the future hopefully, paved a new vision, which can only be good" (25th April, 2008).

[27] Priorities: 1- community participation; 2- civic services integration; 3- infrastructure development; 4- youth and family; 5- technical assistance (Dublin City Council, 2001a).

URBAN II has run over its time scale and is envisioned to complete its work by September 2008.

For the purpose of this research, two members of the URBAN Ballyfermot team were interviewed. Both described their involvement in the process of HIA in an overseeing capacity (Interviews 4th October 2007 and 25th April, 2008).

RAPID, Ballyfermot Area Office

The RAPID (Revitalising Areas through Planning Investment and Development) programme is a central government strategy, introduced in 2001 and delivered to 46 areas throughout the country. In 2006 an evaluation of the RAPID programme was published for the then Department of Community, Rural and Gaeltacht Affairs, which emphasises the importance of community participation in local partnership processes, and identified the "lack of success in empowering the community to influence the decision-making process" (cited in Community Workers Cooperative News, 2006). The HIA in Ballyfermot was hoped to engage the community to ensure they attain a role in the local area decision-making processes. The Ballyfermot RAPID programme attained full status in 2007 and is integral to the collective activity of the community.

Based upon community consultation, the RAPID programme, which runs over 5 years, will incorporate the following areas of work:

- Crime and safety
- Education
- Family support
- Youth support
- Health
- Physical environment
- Employment and training

(Ballyfermot RAPID Programme, 2007)

The RAPID coordinator, who was interviewed for this research, has been integral to the continuation of the HIA working group (known locally as the Impact Group), in order to maintain sustainability of the community action that was initiated within the

HIA in 2004. He stated that community involvement is vital to continue the work started in the HIA, "otherwise statutory agencies come into an area, work, and then go away again. The community must be involved and to measure effectiveness, (there) must be community involvement" (25th April, 2008). This involvement is being maintained through various other initiatives, regarding community health gain and transport concerns of residents.

Community Representatives

Local community representatives were a distinct and important actor on the HIA Steering Group. The HIA methodology advocates the importance of the involvement of members of the community who will be affected by the policy decisions which the impact assessment process is aiming to influence. As was derived from data collection and interviews with the Steering Group members, they played a vital role in maintaining the HIA Group at local level among residents. They were also involved in a field trip to Italy, as part of dissemination of the HIA findings to other European partners. One of the four representatives was interviewed for this research; this person described her role on the HIA as "making sure what the community wanted would be acted upon" (22nd November 2007).

External Consultant/ HIA Expert

An external consultant from the University of Birmingham was hired to provide practical skills and research expertise to the HIA process. This person has been involved in the field of HIA, both in terms of academic and practical experience of the approach and technique, and described her role "very much advisory" on the Steering Group (11th October 2007). The external expert was interviewed for this research.

Institute of Public Health (IPH)

The Institute of Public Health is an all-island agency, which is based in Dublin and Belfast. It aims to address the island's public health needs by conducting research and informing governing departments of health requirements of the population. One of the key areas of work of the IPH is to promote awareness of HIA, to provide training of the technique and to conduct research into the health impacts of non-health sector domains (for instance, health impacts of the built environment, IPH, 2006). The Steering Group had three members from the agency, but only one was currently

working in the IPH at the time of this research; associate director of the IPH. This person was interviewed for this research, and described his role on the HIA as "advisory, supportive... in supporting the chairperson," as well as instrumental in undertaking parts of the HIA process (9th October 2007).

Methodology

A comprehensive retrospective HIA was conducted in Ballyfermot, Dublin. A concurrent or prospective impact assessment was not viable, as the measures proposed by Dublin City Council relating to traffic and transport in the area were already decided upon by the time to HIA commenced.

The Merseyside Guidelines for carrying out a HIA were adhered to, overseen and led by the Steering Committee (Scott-Samuel *et al*., 1998).

Data was collected for the impact assessment by using both qualitative and quantitative research methods, as indicated in table 13.

Table 13: Methodologies used in the Ballyfermot HIA (ERHA, 2004:4)

Qualitative methods	**Quantitative Methods**
Focus groups with residents	Review of data related to the health status of Ballyfermot residents, and a review of data of levels of traffic in the area
Interviews with informants, for instance, teachers, Gardai and health workers	Literature review of evidence relating to health and traffic, including a review of transport/ traffic HIAs already conducted.

The findings from the data collection were collated and triangulated with evidence from the literature and other information relevant to the HIA. In this instance, findings from the Ballyfermot Air Quality and Noise Assessment were used during this stage (Dublin City Council, 2004). An 'appraisal day' was held to identify a number of recommendations for future traffic-related policy decisions for the Ballyfermot area. The stage following this appraisal involved the steering committee communicating the

provisional findings from the HIA to the Ballyfermot community. The individuals involved in the interviews, focus groups and key representatives of the community were involved in this feedback stage.

HIA Outcomes (ERHA, 2004)

An evaluation report of this HIA was published in 2007 (Kearns and Pursell, 2007), three years after the completion of the project. This appraisal provides evidence as to the achievement of the proposed aims and objectives of the impact assessment process.

It was hoped that although the HIA had been completed too late to be considered in the Dublin City Council Road Safety Plan, the HIA would be utilised in the upcoming Road Safety Plan by Dublin City Council (DCC)

After correlation of quantitative data collected in the HIA with the air quality assessment carried out by the DCC as the same time, it was concluded that air pollution levels were within international standards. Lifestyle behaviours of residents in the community, particularly smoking, were identified as risk factors more likely to damage the health of residents than environmental air pollution. However, the HIA outcome report did specify that monitoring of air pollution levels needed to be maintained in order to sustain the healthy situation in Ballyfermot and surrounding areas.

The HIA process uncovered numerous health issues, in particular the extent of health inequalities within to the community. Ballyfermot, and all disadvantaged communities, are prioritised in terms of resources provision and health services. The assessment of need and health status, derived as part of the impact assessment process, is aimed to be used by the local area health board at the time (SWAHB).

An intangible and yet vital outcome of the HIA process was the degree of inter-sectoral cooperation and partnership on matters relating to health and transport. In addition, the involvement of URBAN II was hoped to give the findings of the HIA a wider European audience. URBAN II is a European wide project and dissemination of findings from individual country's projects is one of the features of the initiative.

It was identified by the Steering Committee that the involvement of the Institute of Public Health was integral to the success of the project, in terms of dissemination of the project's findings, and as an integral network of statutory, voluntary and community groups on the island of Ireland.

It is standard international practice that specific recommendations would be proposed at the conclusion of a HIA process, which was the case in this instance.

Policy Process for the Ballyfermot HIA

The Ballyfermot HIA was a retrospective impact assessment process which aimed to assess the health impacts of transport initiatives in the community. The chairperson of the Steering Committee, Dr. Catherine Hayes, has identified a number of hindering and enabling factors that influenced the HIA process (table 14, in terms of the decision-makers and the policy making environment.

For the purpose of this research, this list of enablers and barriers (table 14) has been tested in terms of relevance to other HIA cases that have formed the basis of analysis.

This is in line with the identified necessity to investigate such enablers and barriers, both from an international (WHO Gothenberg Consensus, 1997) and academic (Davenport *et al*. 2006; Bekker, 2007) perspective.

Table 14: Enablers and Barriers of the Decision-makers and Policy Process in the Ballyfermot HIA (Hayes, 2007).

Enablers	**Barriers**
Involved in planning and conduct of HIA	Lack of awareness of health by other sectors
Input from outside decision-making process	Lack of knowledge of policy-making environment
Clear organisation commitment to HIA	
Subject matter did not arise controversies	
Realistic recommendations were presented to the decision-makers	

It was the aim of the HIA Steering Committee that findings of the process would to be used by Dublin City Council (DCC) in its Road Safety Plan and City Development

Plan, by the SWAHB and the HSE in the formulation of tailored health services for the community, and more broadly by the Department of Transport as part of the NDP. The extent to which this has been the case is the emphasis of this doctoral research.

Appendix 8 provides background information as derived from the key documents in the discourse of the area of traffic and transport in Ballyfermot, Dublin.

Part II: Analysis

As outlined in chapter 4, the framework approach to analysing interview data will be used for this study (Ritchie and Lewis, 2003). In this Ballyfermot case study, 8 people were included for semi-structured expert interviews, and 3 for exploratory interviews, as can be seen in appendices 4 and 5. Appendix 10 presents the process of data analysis, which traces the degree of abstraction and data refinement, beginning with the raw data through to the establishment of indices, categories and finally, classifications. The latter group is linked to a greater degree with theoretical concepts, and particularly with this study's variables.

Two exploratory interviews were also carried out for this research; the Ballyfermot RAPID coordinator (24th April, 2008), and a local elected representative on Dublin City Council (24th April, 2008). These interviews informed this case study by providing necessary background information, and by contributing certain perspectives of Dublin City Council.

INSTITUTIONAL THEORY (x1 and x2)

Hypothesis: HIA utilisation is possible with institutionalisation

HIA is a policy-support tool that aims to inform policy decisions by making explicit the health impacts of each policy document or proposal, and strives to maximise the benefits and minimise the negative aspects of HIA (Scott- Samuel, 1998; Barnes and Scott-Samuel, 2002). It aims to inform the decision makers of such potential impacts of a policy, project or programme.

Sub-hypothesis (variable indicators)

The normative dimension alludes to the norms within institutions that can go some way to explain the behaviour of actors in the institutions and organisations. It is from this normative institutionalism that the 'major comeback' of the new institutionalist approach made its way (Peters, 1999). March and Olsen's seminal work (1984; 1989; 1995) puts forward the proposition that the behaviour of individuals must be explained and explored within normative principles; individual action being constrained or enabled by the institutional setting and it's norms, standards and processes that come from that environment. The influence of the institution, and its norms, has been cited in previous HIA policy research, as a further explanatory theory to explicate of the influence upon the use of HIAs in policy (Banken, 2001; 2003; Bekker *et al*. 2005; Kemm, 2005; Bekker, 2007; Morgan, 2008).

A number of questions were asked during the interview phase of data collection, in order to establish the degree of influence the norms of institutions had in the use of the HIA report, and the knowledge that came from that and it's preceding process. The topic guide, containing the standard interview questions, is in appendix 2.

Are Institutions Ready? The Timing of HIA as a Policy Support Tool

The timing of HIA as a policy support tool was asked in order to establish the perspective of those in the HIA Steering Group which included both decision makers of statutory bodies and the community perspective (URBAN II and Ballyfermot resident).

Five of those interviewed stated that yes, the time was right in our policy making world for HIA to influence and thus inform policy. These individuals came from the Institute of Public Health, URBAN II, community and Dublin City Council. Two respondents were more sceptical of the process, stating 'maybe'; they believed there were a number of possible constraining factors that might inhibit the incorporation and use of HIAs in policy.

One individual from Dublin City Council stated that no, the time had not come for HIAs to be used in the policy process, as is further illustrated in the following:

> "It's (HIA) a useful exercise in gathering statistics but not sure what changes have come from the study apart from a number of recommendations. This HIA has not paved the way, I don't think so" (8th November, 2007).

Despite this negative perspective of the HIA process and the impact it can have on the policy process, the overall sentiment of the Steering Group was that the time had come for knowledge and evidence from HIAs to be used to influence policy making.

The answers to this question were analysed, firstly by indexing the answers, and then by categorising these indices. A number of positive factors were identified by the interviewees, illustrating their belief in how the time had come (in the sentiment of Alex Scott-Samuel, 1996) for HIAs to influence policy and how there are certain factors that enable this, or could enable it to influence policy.

Firstly, the fact that the HIA process involves consultation with people was deemed a positive step for the future use of HIAs, as indicated by the current Local Area Manager of Ballyfermot (28th November, 2007). This would increase the longevity and sustainability of HIA as was the sentiment also of the RAPID coordinator (24th April, 2008). Also the HIA tool was deemed as a useful one and would be viewed increasingly as useful if it was systematically conducted in the policy making process, as stated by the individual from the IPH; "it's a useful tool but needs to become more systematic, systematic appraisal of policy, and HIA is the tool for that" (9th October, 2007).

Some negative factors were identified, ones that illustrated the difficulty for HIA to influence policy. These included partnership difficulties, as identified by the chairperson of the group, who is based within the HSE. The process was deemed a useful exercise by one member of DCC but he was not of the opinion that any changes had come from the HIA in policy making. Other negative factors include how the HIA may complicate policy formulation even further, and may be a hindrance than a help, which was stated by the external consultant. The current Local Area

Manager put forward the view that HIA was not the cure for all ills of informed policy making; "not the panacea to all ills" (28th November, 2007).

However despite some negative attributes assigned to the timing of HIA in policy making circles, the interviewees identified some 'do-ables'; some actions that need to be taken to ensure HIA is used and is appropriate for the policy agenda.

HIA awareness is needed so that different members of different organisations understand the purpose and process of the tool. Political will was identified as a crucial factor that was required if HIA was to progress as a meaningful tool that could make real change to policy and inform the policy process, as was stated by the senior engineer in DCC; "you need political will from the top, political and managerial, need local authorities involved, and need political buy-in" (12th October, 2007). This follows onto the next necessary factor which is the crucial ingredient of local authorities to be involved in the HIA process from the beginning, a top-down approach being advocated by the individual from the HSE. Recognition of what the tool can and cannot offer should be stated at the beginning of each HIA process as recommended by the external expert on the Steering Group. The HIA is a "provider of evidence" and is in existence to inform policy but ensuring expectations are not raised too high of HIA is important, as we may "assume (there is) a logical decision making path but the truth, as I'm sure you're aware of, is not like that at all. We need to get smarter about the policy making process. There are complexities in the process and in some ways HIA makes it more complex, brings more problems than solutions" (11th October, 2007).

Normative Dimension: Do Institutions Shape Behaviour?

The use of institutional theory in this study is to explore the extent of the influence that certain institutions have in the use of HIAs and the knowledge that came from them which was intended to inform policy, both in the short and medium term.

Those interviewed in this case were stakeholders in the HIA process and were on the Steering Committee as representatives of their relevant institutional bodies, be it from a local authority (DCC), health service (HSE) or community perspective (URBAN II,

community representative/ local Ballyfermot resident). The responses to this section were grouped into categories after an indexing process took place. Firstly, the interest of the institutions in the use of HIAs, and the knowledge they bring to policy, is looked at within the context of 'what works and what does not work' for institutions in the use of HIAs. Secondly, the level of analysis looks at the processes; both the HIA and policy processes are examined separately. The degree of opportunities and challenges within both these processes is looked at, with particular attention given to how the HIA process can inform the policy process, within the context of the institutional settings.

Institutions: Macro-Level of Analysis

The HIA was promoted and led by members of the HSE and indeed the process was chaired by such a member. This decision making body is then both an owner and user of the HIA knowledge. Research conducted by Davenport *et al.* (2006) has termed this owner/ user dynamic in their research on decision makers and HIAs in the UK. It was stated by the chairperson of the HIA that a "key objective for the HSE is for HIA to be institutionalised; for it to be transformed and used in the HSE" (24th July, 2007). This is supported by the policy of HIQA (Health Intelligence and Quality Authority) which also advocates this message. This individual admitted that although the progress of HIAs is still at an early stage of learning and development, the policy of the HSE is to promote and advocate its growth and use. This individual is also a key member of the HIQA, working on the HIA agenda in conjunction with the IPH. This assertion of the momentum and drive to embed HIA in the institutional structures of the HSE, in its bureaucratic armoury, from such a high-level individual, is testament to the rearing of the tool in the Irish health services. Kearns and Pursell (2007) also concluded that the tool being embedded in the health services was a necessary requirement if HIAs were to be mainstreamed and used on a systematic basis to inform policy, both within and outside, the health services.

The importance of local authorities in having a central role, both on HIA steering groups, and in the use of HIA evidence, was highlighted by the Ballyfermot HIA chairperson, who stated that "the local authority need to come on board, what's needed is a top-down approach from them" (*ibid*). It is necessary to have the main decision making bodies involved in the HIA process, and at least awareness of the

processes ongoing, as they are the institutions to directly use the health impacts knowledge in policy.

Institutional structures of the different bodies, however, can be a barrier to the development of HIA, as is indicated in the following by the senior engineer in DCC:

> "Different organisations would have control over budgets, might not be doing same thing on Steering Committee, not all doing the same aim, difficult to pull all together, HSE budgets and local authority separately implement with coordinating committees. That can be a problem" (12th October, 2007).

The different agendas and interests of the varying institutions which are brought to the table by the members can inhibit the progress of the HIA, although this can be negated by a clarification of such issues at the beginning of the process, as suggested by the member of the IPH.

Another DCC member also stated that an "institution has to be persuaded of the benefits of HIA, so that it's not a philosophical exercise" (Interview, 8th November, 2007). When asked to clarify this statement, the interviewee stated "I mean that it's too academic focused, not outcome focused." This indicates the view that the HIA must ensure it fits the expectations, requirements and norms of the institutions that are represented on it, and will use it, in the short and long term. This 'institutionalisation' of HIAs, by becoming embedded in processes and procedures by aligning itself with such norms, is an important step towards such institutionalisation as has been the case elsewhere (Banken, 2001; 2003; Putters, 2005; Bekker, 2007; Morgan, 2008). Consideration must be made by the promoters and stakeholders in the HIA processes of the institutions ultimately to use the HIA, and without threatening the integrity of the process, must be taken into account.

In terms of institutional working and the processes at play, partnership is difficult and can be painstaking at times, as was the case with the Ballyfermot HIA. The HSE chairperson stated it "can be time consuming and difficult" (24th July, 2007).

The community representative stated that there were clearly institutional constraints inhibiting the behaviour of certain individuals involved in the HIA process. However, these constraints, with regard to the DCC, were overcome once the relevant

individuals were amenable to the HIA and the work being done, "and they (DCC) listened and acted" (22nd November, 2007).

HIA Process: Micro-Level of Analysis

The process of HIA was deemed as restrictive and thus inhibiting the innovation of policy, as was noted by the URBAN II member. This is a criticism of HIAs and indeed of the impact assessment tool in general. The process itself must not become a threat to policy creation and innovation in the future. A member of the DCC pointed out that the HIA was also too theoretical, that is was not outcome focused and this was a constraining factor on its feasibility and workability into the future.

> "My impression was the process and study not on outcomes and maybe that's understandable, but danger of being too theoretical and academic; enough doctors around!" (8th November, 2007).

The process is also misunderstood as was stated by the member of the IPH. Capacity building and training in HIA is one way that Ireland, along with other European countries, has sought to increase awareness, understanding and the use of HIAs in policy and practice. The chairperson of the HIA stated that at the time the Ballyfermot HIA was being conducted there was very little awareness of the tool, but that if it were to be done again, she believes that momentarily more people have come across it, there is greater awareness and therefore greater amenability to the idea of HIA and the role it can play in informing policy and influencing the policy process (Interview, 24th July, 2007).

Policy Process: Micro-Level of Analysis

Regarding the point of the HIA tool being viewed as an inhibiter to policy innovation, some expressed the view that it is seen as a "burden to policy makers" and it is also competing with other impact assessments (Interview, IPH member, 9th October, 2007). These concerns have been raised in the other cases, as well as in the HIA and IA literature. The normative institutional structures clearly are not aligned with the HIA process, and so without this matching of processes and ideas, the future of the HIA tool is tenable. The fear that it would end up gathering "dust on shelves", as expressed by members of URBAN II (4th October, 2007) and DCC (28th November,

2007) , may well become a reality, if it is viewed as not working in parallel with the institutional structures of decision making.

The planning, funding and timing of the HIA were deemed as vitally important activities and procedures that required institutional involvement, on the part of individuals ('gatekeepers'). Without such involvement, the HIA would prove a very difficult process to commence, as was the case with the Ballyfermot HIA in the beginning (HSE representative and HIA chairperson, 24th July, 2007).

A number of recommendations were unrealistic and unattainable, as concluded in the evaluation of the HIA (Kearns and Pursell, 2007) and as elicited from the interviews in this research (DCC member, Local Area Manager, 28th November 2007 and 24th April 2008). The current Local Area Manager stated the following:

> "The DCC talked about places for bike users to have showers in the report?! That can never be implemented and not going to happen, not realistic and why they put that in is beyond me, always need an element of realism for sure. Otherwise these documents will just gather dust on shelves and never be used, and then HIA will get bad press because it isn't used. You need implementable recommendations."

This point once again reiterates the importance of working the HIA process in conjunction with the policy process, and with an appropriate level of knowledge of the policy process, otherwise it can be to the detriment of the tool.

The member of the IPH stated that the institutionalisation landscape for HIA lies in it having a mandatory basis within the health strategies of Northern Ireland and the Republic of Ireland. The following illustrates this point:

> "The health lens that HIA brings should be more enshrined in regulatory control and enforcement. Same as in EIA, and more so in SEA….And then there's Integrated Impact Assessment (IIA), there's a place for health in that, an emphasis for health. Other than that, the mandatory basis for HIA would be in Quality and Fairness in the South, and Investing for Health in the North (health strategies)" (9th October, 2007)

The solution to these problems, which makes the journey with and through the policy process difficult for HIA, may be down the IIA route (Integrated Impact Assessment),

as was suggested by the IPH member. IIA is being piloted and developed in Northern Ireland, in the Office of First Minister and Deputy First Minister, and devotes a certain space for health impacts and considerations (Interview with a senior official in the OFMDFM, Belfast, 21st February, 2008). This matter is being considered on an on-going basis by the IPH; an amalgamation of the impact assessments in Ireland (EIA, SEA, HIA, and PIA) may be the future path of the development of such frameworks.

Political Dimension: Does Politics Matter?

Elliott and Francis (2005) found in their research on the Welsh HIA experience that the influence of the political environment and agenda, and the different interests around the HIA 'table' was considered an important dimension to note when looking at the influences upon HIA usage in policy. This was also found in other HIA research (Davenport *et al.* 2006; Bekker, 2007, Wismar *et al*. 2007). The new institutionalist strand of political science theory also contends that the political dimension is an important one to take into consideration, when investigating the influences upon individual and collective behaviour and action (Immergut, 1992; Peters, 1999). Thelen and Steinmo (1992) point out that politics can have as much influence over institutional behaviour (in this case, the use and assimilation of HIAs into policy making processes within decision making institutions) as institutions can in shaping individual behaviour. The extent to which this dynamic interaction was lived out in this Ballyfermot case is illustrated below.

This study investigated the influence of such a political dimension, by asking the interviewees to what extent were politics at play between the varying interests in the conduct of the HIA.

The responses to this question have been categorised into four groups. The political dimension at a micro-level (individuals) and macro-level (institutions) was identified, as well as the meaning of evidence and how that arose some tensions, and the nature and meaning of 'politics' during the HIA process.

Individuals: The Gatekeepers to the Institutions

It was pointed by the individual working in the HSE that all individuals came to the HIA with their own agendas and interests, as is illustrated in the following. "Each person has their own agenda, it's real life! DCC reluctant at beginning, but then were most enthusiastic, maybe they feared health at the table" (24th July, 2007). This individual made particular reference to the local authority and the members representing that body as being sceptical at the beginning of the HIA. This point of view was reiterated by the community representative also, but the statements were qualified by pointing out how such individuals became more enthusiastic and less fearful and unsure of the HIA as time went onward.

There were varying degrees of involvement identified by the member from the Institute of Public Health, as he believed that some individuals came to the table with different levels of commitment. "No conflicting interests but varying degrees of involvement. Some time was spent around roles to be fulfilled by members, the role of URBAN, role of Public Health departments et cetera. People came to the table with different degrees of willingness" (9th October, 2007). These degrees of willingness on the part of individuals in the process impacted on the HIA and increased the work-load for some around the table, thus causing tensions and the potential for conflict.

Institutions: The Gate and the Building

A member from URBAN II stated how she believed there was more tension with members from the health services, as illustrated in the following:

> "We at URBAN strongly pushed for the HIA, and we pushed the community participation element. The (former) Health Board weren't as used to the community being involved as the URBAN staff was" (4th October, 2007).

This statement illuminates the problem that can arise with intersectoral working in policy issues. The chairperson of the group stated quite vehemently during the interview (24th July, 2007) how partnership between the different sectors and institutions was very difficult. The member from the Institute of Public Health also reiterated this when discussing value systems of individuals coming to the process, stating that it would be of help if all individuals in the process clarified the values of

the institution that they were representing at the table, in order to prevent conflict or tension further on in the HIA process.

It was also highlighted in the interviews how the attitude of some individuals towards the HIA process, coming from certain statutory institutions, would be to "leave it gather dust on the shelf" (URBAN II, 4th October, 2007). Indeed, a member of one of these institutions (DCC) qualified this fear, by stating that if HIAs were deemed unworkable with unrealistic recommendations attached to them, then there was the danger that such "documents will gather dust on shelves and never be used" (28th November, 2007).

However, on a more positive note, the Senior Engineer of DCC stated that whilst there "probably was tension, it (the HIA) was a good opportunity to explain policies to those with a health background, and the process was useful" (12th October, 2007). The interviewee noted how much cross-sectoral and cross-institutional learning can come from such intersectoral tools of working in policy areas.

Whose Evidence is it anyway?

A clash of opinions on what counted as evidence and what value was put on certain evidence arose on the Steering Committee, as noted by the external consultant and expert in the HIA field, as stated in the following:

> "(It was) certainly apparent that different people have different views. An example of such was an issue about air pollution. The environmental health people had data on air pollution but wouldn't release it. There were clashes between the community, health boards, Council, on the evidence about air pollution, ie. the community believed there was alot but the evidence said it wasn't particularly high. Certainly territories clash; there are battles between who has the right evidence" (11th October, 2007).

The perceptions around evidence highlighted certain conflicting situations during the process of the HIA. Such instances are reflective of the power-dynamic between those in echelons of power and scientific knowledge and lay people living on the ground but without such expertise of knowledge. This issue screams of the power dynamic in Foucault's (1980) and Lukes' (2005) writings. This tension arising from a difference of opinion and standpoint impacted on the HIA process, and influence people's views

of the HIA itself, of the process, and of the findings finally coming from the impact assessment.

Politics? Not here!

The mention of the term 'politics' during the interviews in this case study raised a few eyebrows amongst some interviewees. Although such individuals, as all did, admitted to the presence of conflicting views and tensions during the HIA, it was a "politics with a small p" and of no great issue (HSE chairperson, 24th July, 2007). An individual from DCC stated "I wouldn't call it politics, just different focuses; the HSE focused on methodology and process, and the DCC on outcomes" (8th November, 2007).

However, no great conflict of opinions hindered the HIA process to any great degree and any issues that arose during the process were dealt with openly within the framework of the HIA. They were facilitated within the HIA, which has been devised to allow for such traits of inter-sectoral working.

VALUE JUDGEMENTS (IMPACT ASSESSMENT THEORY) (x3)

Hypothesis: HIA utilisation depends on the value judgements of the policy actors

The complexity of the policy process was pointed out by the HIA expert, viewing the process as "a logical decision making path….(which) is not like that at all" (11th October, 2007). There are many complexities in the pathways of policy that need to be considered, especially when assessing the use of HIA for policy.

Another important and related issue is the question of the role that values, beliefs and assumptions play in the policy process. The role of these values has been the topic of research in impact assessment literature, and is being used as an explanatory variable in this study; to assess the influence of value judgement in the use of HIAs. As no matter how rational the policy process may appear to be, it is ingrained with value systems and beliefs (Carley, 1980; Krnv and Thissen, 2000; Weston, 2002; Bekker *et al.* 2004).

The following categories were elucidated from the interview data. For the purpose of this research, 7 categories were devised from the data that group together the varying ideas and opinions of the interviewees in the role that values play, and the influence they may have in the policy process.

Community

Many responses to this question pertained to the value placed on the opinion of the Ballyfermot community. Although the value placed on the community's perspective may be of little concern to policy makers when they are formulating policy in years gone by, the new wave of consultative and bottom-up approaches to policy making in local government and within the centralised HSE is given more attention and greater activity. This sentiment was emphasised in interviews, specifically with the RAPID coordinator (24th April, 2008), a member of URBAN II (24th April, 2008) and a DCC member (28th November, 2007). Great value was placed on the views of the community during the HIA process, and this point was positively affirmed during the interview with the community representative on the Steering Group (22nd November, 2007). The Steering Committee informed the community of its recommendations and feedback from the community was incorporated into the final HIA document. One issue that was amended was greater attention to be given to the elderly and disabled in the public transport system, (HSE chairperson, 24th July 2007), which were implemented on the ground (DCC Local Area Manager, 28th November, 2007).

The Local Action Group (LAG) was set up to implement the HIA recommendations specifically for the community to deliver. This group had difficulty sustaining itself once the HIA finished and once URBAN II input was reduced. However, the Ballyfermot RAPID project will reactivate the group and will continue to implement the recommendations of the HIA, as well as new community concerns, from September 2008 onwards (RAPID Coordinator, 24th April, 2008). The primary purpose of the LAG was to ensure the community would have a role in implementing policy at a ground level. The hope of URBAN II was that this "active citizenship group……..will carry on and influence policy" (4th October, 2007).

Values

The responses of those interviewed regarding the role of values and beliefs in the policy process, and thus in the role of the value placed on HIAs which may go on to influence policy, were a proposition widely accepted. No interviewee rejected the question as defunct or irrelevant in this case study. The member of the IPH developed the point further and stated that it would be helpful if all stakeholders would clarify their value systems early on in the process, so as to establish the beliefs and attitudes people had of HIAs, informed policy making and consultative policy aiding tools such as IA frameworks (9th October, 2007). A member of the URBAN II team stated vehemently how "values and attitudes of people involved were definitely there" and their role throughout the process of the HIA, and in the aftermath, was an important factor to consider when evaluating the use, or non-use, of the HIA knowledge and evidence (4th October, 2007).

Institutional complexity

One member of the HIA Steering Group stated "it is my belief is that it's (HIA) good, but practicability and so many institutions involved is a problem" (DCC, senior engineer, 12th October, 2007). The interviewee discussed the role that many value systems played in the process, and how this complexity can complicate the development of the HIA tool in practice, and can inhibit its success and therefore usability, in the future.

Negative attitudes to HIA

There were some negative opinions and attitudes expressed of the HIA process. This may have had a role in the development of the process during the conduct of the assessment. It also may inhibit its use by the members, and their affiliated institutions, into the future, as the HIA report is being used on an on-going basis, according to many of those interviewed. A member of DCC stated "I believe you need research for informed decisions but I found this a wooly exercise" (8th November, 2007). This individual went to say that the HIA was not geared towards achievable outcomes or deliverables, but instead was more concerned with the process being rigorous and methodical. Variants of this opinion were given in the interviews with the other members of DCC (28th November, 2007 and 12th October, 2007). He went to say "the

process than product was more important here." This negative perception and experience may be explained as a clash of institutional values. However, whatever the reasoning, these opinions of the HIA process may impact on these city council officials becoming involved HIAs in the future.

Must be implementable

Following on from the above point, an associated issue related to the HIAs being realistic and providing achievable recommendations. If unachievable suggestions are made in the HIA, a bad impression is then formed of the process, which will impact negatively on it into the future. This may shape prejudices against the tool and inform attitudes, assumptions, values and beliefs that act as constraints in the area of HIA work further down the line.

The current Local Area Manager (28th November 2007) stated that it is the lacking deliverability of HIAs that can be a constraining factor, "especially if someone had something completely off the wall. Going back to the point of what's realistic. It would be a disservice to HIA if not feasible recommendations are put into the report."

A member of URBAN II reiterated this point of realism in recommendations in response to this interview question. She went to say that the involvement of the Green Party in national politics, and their consideration of informed policy making as part of their party manifestos and principles, and in areas of environmental health and wellbeing, "will influence what's incorporated into policy planning, so their influence might seep downwards" (4th October, 2007). The interviewee allots a degree of influence to national politics, and in particular to a political party and their value systems, in impacting on the development and use of HIAs in local policy making circles.

Need for legislation

The senior engineer of DCC stated, in response to this question, that the fact that HIAs are not enshrined in legislation makes it difficult to become incorporated into mainstream policy making. Therefore it is difficult to break the mould of the values and attitudes that are associated with other IAs (12th October, 2007). For instance, he stated that HIA was, at times, perceived as "piggy-backing on EIA," which he viewed

as a negative phenomenon as it was associated with making EIA more cumbersome and difficult for officials. Such an attitude can thus impact negatively on the value placed upon HIAs as policy aiding tools.

Persuading Institutions and People

Majone (1989) argued that the policy process can be manipulated and persuaded as to what is, and is not, feasible. According to this work, Majone proposes that policy arguments are founded on value judgements, and not always based on rational and logical thinking processes of policy makers. This assertion is true in the case of the Ballyfermot HIA, as far as the interviewees are concerned. The current Local Area Manager stated that "people are open to persuasion, to be persuaded by the valid argument, and there were many views around the table" (28th November, 2007). He went on to say that if the HIA process fails to produce concrete and achievable deliverables, a disservice will be done to the tool. However, if solid and realistic recommendations are suggested, then those around the table, and outside the HIA process, can be persuaded of its benefit and its usefulness for policy making.

Another member of DCC also made the point that "people have to sell the value of HIA and what it is," the benefits of the tool and the solidity of its outcomes (8th November, 2007). A further point associated with this was developed by the chair of the Steering Group, who stated "how communication is packaged" to those outside and inside the HIA group is important, so as to get as many supporters of the process on board as possible. The more in support of the HIA, the greater chances that it will be accepted and used by policy makers (24th July, 2007). A certain amount of 'politicising of HIA' is involved, in order to spread the word and broadcast its practicability. At the end of the Ballyfermot HIA a big launch event was organised. The Lord Mayor at the time was Councillor Michael Conaghan, who is also a current and very vocal local elected representative of the area, launched the report in Dublin City Council headquarters. Newstalk interviews were given at the event and Muiris Houston wrote about the HIA in the Irish Times Health Supplement. The project also won the Irish Healthcare Awards 2005 for best innovation practice. Such activities further highlight the work of the HIA, disseminate its findings, and portray to a wider audience the feasibility and usefulness of HIAs for policy making.

ENABLERS AND BARRIERS: A CHECK-LIST

The respondents in this study were asked about enabling and hindering factors towards to the use of HIA knowledge in the decision making process. The Ballyfermot case study was the first one investigated in the data collection of this study. The check list (below) was formulated by Dr. Catherine Hayes, specifically in relation to her Ballyfermot experience. It was presented at the three-day comprehensive Health Impact Assessment Training, which this researcher attended. It was organised by the Irish Institute of Public Health (September 2006, Grand Canal Court Hotel, Malahide, Co. Dublin)

For the purpose of this research, it was deemed appropriate to use this check-list, formulated in Ireland, for the case study research. This is so as to establish the level of agreement on the contextual conditions for use in the HIAs studied in policy and to construct any additional suggestions that may come from the interviewees. Interviewees were asked whether or not they believed the enablers and barriers were present in the HIA that they participated in, from their experience.

Another comparable study of such enablers and barriers was conducted in the UK (Davenport *et al.* 2006) and provides an interesting instance for comparison in the results section. One of the authors of this aforementioned study was involved in the Ballyfermot HIA and pointed this out during data collection.

Enablers to the policy process in having decision makers involved (Ballyfermot) (September 2006)

1. Involved in planning and conduct of HIA
2. Input from outside decision-making process
3. Clear organisational commitment
4. Subject non-controversial
5. Realistic recommendations

Bad points of decision makers and policy process

1. Lack of awareness of health by other sectors
2. Lack of knowledge of policy-making environment

During data collection, all eight interviewees were asked as to their level of agreement with the abovementioned enablers and barriers. As can be viewed in appendix 9, all were in agreement with the check list.

Additional enablers were also suggested. The respondent from URBAN II stated the importance of the leader in an institution for the use of HIAs, as "otherwise it can go by the wayside" (4th October, 2007). Leaders as advocates for HIAs in an organisation could have the power and momentum to push the tool ahead, and equally could inhibit the progress, as the "top person (can be) for or against the idea of HIAs."

The community representative suggested that the HIA was a good tool for establishing other areas of health-related matters that required attention. For instance, the HIA in this case related to traffic and transport. However the HIA process established that other health-related issues would benefit from initiatives and interventions in the area. Therefore "healthy eating and walking programmes in schools" were established by the health services in Ballyfermot, deriving their rationale from the HIA findings (22nd November, 2007).

The Senior Engineer in the Office of the Director of Traffic, DCC, stated that "cooperation between agencies was good….bringing organisations together leads to greater understanding" and so, greater opportunities for HIAs to be used and assimilated into the various decision making institutions that were involved, namely the local authority and health services (12th October, 2007).

Additional barriers were also suggested by interviewees. The community representative on the HIAs identified the "high falutin language" of some stakeholders in the process as a barrier. This person stated that this can lead to a "misunderstanding, an un-understanding of terms" around the table, and can place a knowledge 'wall' between the statutory experts and community representatives in the process. This would reduce the successful implementation of the HIA on the ground by the Local Action Group, with whom the community representative would have had an integral role.

The current Local Area Manager of the Council (28th November, 2007) stated that it seemed DCC was "passing the buck" of implementing the HIA to the community, "as it might be seen as the case, passing on responsibility. There's too much onus on volunteers, and it's not fair." This, as the interviewee went on to say, "was expecting too much of people (as) no resources are allocated to them" to implement the recommendations.

However, the reactivation of the Local Action Group, backed with the institutional support of DCC through the RAPID programme in Ballyfermot (RAPID Coordinator, 24th April, 2008), may provide the support the group requires.

KNOWLEDGE UTILISATION AND POLICY ANALYSIS (y)

Each interviewee was asked to what extent, as far as they knew, was the HIA used in policy. Responses were divided into 15 indices, and after further abstraction, were coded into 5 categories. The results from the interview data collection will be presented in this section.

HIA Recommendations

The chairperson of the HIA Steering Group stated that some recommendations were implemented, and admitted, some were not implemented (24th July, 2007). Kearns and Pursell (2007) conducted an evaluation of the Ballyfermot HIA and concluded that the recommendations that were not yet implemented were just not feasible or realistic. This is a lesson of learning for future HIAs; to ensure recommendations are feasible and deliverable.

However various local activities were implemented on the ground, which were rooted in the HIA and its recommendations for action. Examples of these were cited by some of the interviewees, for instance, the change of the sequencing of traffic lights near Tesco shopping centre (Chair of the HIA, 24th July, 2007); healthy eating and walking programmes were commenced as a result of the findings of the poor health status of the local community (community representative, 22nd November, 2007); an improvement of local mental health services was identified during data collection of the HIA, (*ibid*; Local Area Manager, 24th April, 2008; RAPID Coordinator, 24th April,

2008); and a project promoting physical exercise was started, as well as a Health Fair held in Tesco shopping centre. In addition, "Dublin Bus has taken (it) on board to make travel safer. Bus stops are now safer for the disabled and it's good to have a document like this" (Local Area Manager, 28th November, 2007).

Future of HIA

When asked about how the HIA was used in policy, some responses pertained to the future of the tool. A future of health impacts within the consideration of IIA was suggested by the Steering Group chairperson, stating that "work is (already) being done on IIA which will be interesting for the future. EIA is too narrow, it doesn't consider the social determinants of health," and so cannot fully integrate the health impacts of projects, programmes and policies.

The external expert stated that there were too high expectations of the HIA process, and the generalizability of the tool is questionable, according to this individual. This expert went to say the following:

> "HIA's objectives are to firstly provide evidence, secondly inform decision makers and thirdly empower communities, but tensions between those three. Involving the community is a load of rubbish because they can't be empowered in the timetable of HIA. Tensions between need for robust evidence, the policy timetable, and involving the community" (11th October, 2007).

There are ongoing issues regarding what is expected of HIAs and what HIAs are capable of providing. This tension, as illustrated above, is an issue that the HIA field of study and practice must address in order to ensure the sustainability of the tool into the future.

The member of the IPH stated that the Ballyfermot HIA was "paving the way for engagement of this kind, it was a good robust exercise and is good for the future of HIAs" (9th October, 2007).

Policy environment

A number of responses dealt with issues relating to the policy environment and how the HIA would influence it, both concurrently and into the future.

The chairperson stated that all city and county managers in the country received a copy of the HIA report in 2005. This act was one which aimed at raising awareness of the health impacts of traffic and transport, of raising awareness of the HIA tool, and in providing evidence to such high-level local authority officials. Feedback from such individuals was deemed as "positive" by this interviewee (24th July, 2007).

In relation to the policy environment and the use of HIAs, the danger of the tool being viewed as an "administrative burden" and used as a "tick the box exercise" was highlighted by the chairperson of the process (24th July, 2007). This manner of dealing with HIA in such a mundane way is already being conducted with regard to SEA and EIAs in Ireland; whether or not this is the road for HIA to travel down will be decided into the future.

Regarding the influence of the Ballyfermot HIA, the IPH member stated it would inform policy in an incremental manner, as "it may drip into policy, not an explosive contribution to policy but may inform it indirectly", and was good for the future (9th October, 2007). The senior engineer of the DCC also stated that it has informed city council policy indirectly (12th October, 2007).

The community representative stated that there was a clear lack of policy coordination between Dublin City Council and South County Dublin Council, as was seen by the lack of cross-information on traffic management and traffic lights sequencing. Ballyfermot is based on the border between the two authorities. This apparent lack of policy coordination, which was however rebuked by the current Local Area Manager when questioned on it (24th April, 2008), does not bode well for policy making processes at local government level which HIAs are aiming to influence and inform.

The chairperson of the HIA stated that the future of HIAs and especially in terms of the policy environment and influencing it, values and principles, and where people are coming from conceptually, is important and must be taken cognizance of when attempting to use such HIAs to influence policy (24th July, 2007). This individual also stated the importance of raising the awareness of this Ballyfermot HIA and of disseminating its findings, which happened by presenting at the 6th HIA International

Conference (Birmingham, 2005), presenting at the Healthy Cities Network in Belfast, and by sharing the experience at the comprehensive training days, as organised by the IPH.

Political advocacy

When asked whether or not the HIA had been used in policy, one interviewee stated that local elected councillors were made aware of it during a presentation by URBAN II at a Local Area Committee meeting, and this tool in turn made the elected representatives aware of the health implications of traffic and transport in the area (4th October, 2007). There is a potential for the HIA to be used in local electoral politics, as a political advocacy tool.

Sustainability of the HIA

The HIA chairperson stated that the Local Action Group had been, and would be once again, "very effective, facilitated previously by URBAN II and now to be facilitated by DCC, which is a positive move" (24th July, 2007). This activation of the LAG implies a sustainability of the HIA process, especially as the group will continue to implement the HIA recommendations and will formulate new suggestions for action.

Was the HIA well received?

Interviewees were asked whether or not they believed the HIA was well received or not, by their relevant institutions, and by the community. Two categories were devised, deriving from four indices from the interview data.

Negatives

A member of DCC was not positive about the process as is illustrated in the following:

> "I don't think people cared about it. It was interesting, went to conferences, I mean, you're looking at it, but no, too academic. There needs to be a first and have to start somewhere though. It's a method of learning for the HSE, then that's good, but it didn't benefit the people of Ballyfermot" (8th November, 2007).

This response indicates a poor opinion of the HIA process that this stakeholder was involved with, and does not provide a good impression of one's experience.
The current Local Area Manager stated that implementable recommendations were needed, in order to ensure the sustainability and credibility of the HIA process (28th November, 2007).

Positives

However, a number of positives were identified in the responses to this question.

The chairperson of the HIA group stated that there was good feedback from the community regarding the HIA, and all participants involved in the HIA data collection process attended the launch event in the city council (24th July, 2007).

The current Local Area Manager stated that the HIA report did highlight many problems, that it was not just a document, and was implementable in parts (28th November 2007 and 24th April, 2008).

Further Information

Interviewees were asked if they would like to contribute additional information to the study.

Community political mobilisation

Community spirit and mobilisation was identified by a member of the URBAN II team as being vitally important in the Ballyfermot area, for the maximum use of the HIA process by the community and for the future of consultative policy tools in the area, as the following illustrates:

> "Community involvement is very important and (hopefully) the partnership keeps it going, hopefully sustained.
>
> In Ballyfermot only 25 per cent of people vote and that spills over to involvement in the policy process. Political activity and motivation is very important in a community, and if a community if used to meeting agencies then they're able to get across their points of view, but not too much of that in

> Ballyfermot. They're a good group when they're brought together, but not when they're on their own, without an agency" (4th October 2007)

Dissemination

The dissemination of the Ballyfermot HIA was a priority for some stakeholders on the group, in order to highlight HIA as a feasible tool and the degree of work done with it in the Ballyfermot area, as indicated by the chair of the group (24th July, 2007), the IPH member (9th October, 2007) and a member of the URBAN II team (4th October, 2007).

5.4. HIA of Travellers' Accommodation Programme in County Donegal (2005-2008)

Part I: Descriptive

The Donegal Traveller's Project (DTP) commissioned a retrospective comprehensive HIA. The DTP is a community development project that represents the interests of Irish Travellers in County Donegal. The project was funded by the Health Service Executive (HSE). Given the poor quality of Traveller accommodation, in County Donegal in this instance, conducting a HIA on local authority accommodation was viewed as an opportunity to introduce a stronger health dimension into the county's policy (Doyle, 2006). This is the first comprehensive HIA conducted in the Republic of Ireland on Traveller accommodation.

Rationale and Background

The Housing (Traveller Accommodation) Act was ratified in July 1998. This piece of legislation requires that local authorities, in consultation with the Travellers and Traveller representative organisations, formulate and adopt five-year accommodation programmes. Such programmes are intended to ensure appropriate provision of accommodation to the Travelling communities, and to ensure the implementation of the measures of the programme (Silke, 2005). All local authorities had enacted such programmes from March 2000. As part of the 1998 legislation, the National Traveller Accommodation Consultative Committee was set up. This requires that all local authorities establish Traveller consultative committees. In accordance with this legislation, each council sets up a Local Traveller Accommodation Consultative Committee (LTACC) in order to enable consultation between the housing authorities and Travellers. This committee may advise only; it does not have decision-making powers. The rationale underlying these committees is to guarantee greater communication between the Travelling community and the housing services of the local councils in relation to the delivery of accommodation. In addition, the 1998 legislation increased the powers assigned to local councils to move unauthorised temporary sites, in situ in public spaces (section 32 of the Act). This was amended, adding even greater weight to such a measure and the Gardai Siochana's powers were increased in this matter (section 24 of the Housing (Miscellaneous Provisions) Act, 2002). They are entitled to arrest, without warrant, any person found offending this

order. This means that it is now "a criminal rather than a civil matter" (Silke, 2005:277).

An analysis was carried out in 2005 of the workability and the genuine consultation that arises from the LTACC in Counties Donegal, Galway and Longford. The study was commissioned by the Donegal Travellers Project. Both councillors and Traveller representatives, involved in that study, did not believe productive and adequate consultation came from the LTACC. Councillors identified the culture of the institution (local authority) as having a pervading influence in the way Council officials operated and dealt with Travellers and Traveller policy issues. The plans and Traveller Accommodation Programmes are "usually driven by professionals within the council who did not have a holistic view of the situation that councillors and community representatives have" (O Riain, 2005:12). The negative attitude towards nomadism is felt to influence the operations and policies at local authority level. A recommendation from the 2005 report stated the necessity for "a greater inter-agency dimension, bringing people with decision-making powers, together to address the issues" (O Riain, 2005: 13). This may help foster a "spirit of camaraderie." Other recommendations include the need for independent chairs on committees dealing with Traveller accommodation, as mediators between Council and Traveller viewpoints, and the need for acknowledgement of perceptions of Traveller's ways of life (*ibid*). These issues were taken on board in this HIA case; an independent chair was appointed and the DTP advocated the Travelling way of life as unique to the county council officials during the process.

The 1990s was a time period of modernisation in local government in Ireland. The seminal white paper 'Better Local Government: A Programme for Change' (Department of the Environment, 1996). This document put forward a number of reforms, which centered on principles of enhancing local democracy, increasing efficiency and serving the customer better (Keogan, 2003; Quinlivan and Collins, 2005). Strategic Policy Committees (SPCs) were established in each local authority. Each SPC performs focuses its work on a particular sectoral domain, for instance, housing. The needs of the Traveller community in each local council would be dealt with in such committees. In addition to this, in 2004 the Minister for the Environment, Heritage and Local Government introduced 42 service indicators, to assess the

performance at each local authority level. One of these indicators relates specifically to Traveller accommodation (Silke, 2005).

Poor health status is synonymous with this population group, having an average life expectancy a decade less than settled people (Murray, 1997; Department of Health and Children, 2002). According to the Census 2002 (the first national census that included a section on membership of the Travelling community) there are 23,681 Travellers in the country. This makes up 0.6 per cent of the general population (Central Statistics Office (CSO), 2002). Whilst there is some debate as to how accurate a census on a nomadic population can be (Silke, 2005), it still provides some pertinent information regarding life expectancy and demographic patterns of the sub-population group. Notably, Travellers on average live shorter lives, with older Travellers accounting for 3.3 per cent of the population (ie. aged 65 years and over), in comparison with 11.1 per cent of the general population. The group have a greater proportion of younger people, with 42.2 per cent aged 14 years or younger; this figure is 21.1 per cent of the general population (CSO, 2002; Donegal Travellers Project, 2005).

Other health status and epidemiological statistics infer that this community experiences a higher infant mortality rate, higher early-school leaver's rate and lower literacy levels when compared with the average of the Irish population (Pavee Point, 2007). The travelling community endure high levels of unemployment, low educational achievement and poor health status (Doyle, 2006). Housing is a greater determinant on health than any other factor, including lifestyle behaviours (Rahkonena *et al*. 1997; Thomson *et al.* 2002). An All-Ireland Traveller Health Status and Needs Assessment will be conducted in the country in the near future, and the HIA technique has been identified as one which can work to reduce health inequalities (Harkin, 2007). The second Donegal County Council accommodation programme (2005 to 2008), which was completed in 2004 and adopted in 2005, was deemed an opportunity for an HIA to be carried out. It was envisaged that the findings from the impact assessment process would be incorporated into the council's programme and policy plans, both concurrently and prospectively (Donegal Travellers Project, 2006).

The impetus for conducting this HIA came from the Donegal Travellers Project (DTP), who then garnered support from the HSE, and finally with Donegal County Council. The coordinator in the DTP stated that she was the convenor of the HIA and saw it run from beginning to the end (13th December, 2007). It was hoped that the HIA would reiterate and advocate to the Council the links between health and housing, and the need for improved Traveller accommodation policy. The Health and Social Policy Officer (HSE) also stated that the rationale behind conducting the HIA came from the community, as the Travellers were "saying that links weren't being made between housing and health (at Council level, during policy formulation), and that's why we did the HIA" (11th December, 2007). The Director of Service of the Council, involved in the HIA and interviewed in this research, was also supportive of the process, as illustrated in the following:

> "I mean it's an obvious fact that if travellers are sitting on a green field with temporary toilet facilities and all the rest, that they're not suitably accommodated and it's bound to happen that their health is impacted upon" (14th December, 2007).

In this case, as opposed to the Ballyfermot case, the statutory bodies were not the main instigators of the HIA but were intended as the main users of the HIA in policy. This then has important considerations in terms of the user/ owner dynamic in the use of HIA knowledge.

Objectives of the HIA

The HIA on Traveller Accommodation in Donegal was to facilitate the adoption of health knowledge into local council policy. A retrospective HIA was carried, the timing of which would not allow findings and recommendations to be incorporated into the 5 year plan. However, it was expected that the HIA would be included into the development of specific detailed protocols in order to deliver the scheme on the ground. In addition to this, a national mid-term review of all Traveller accommodation would be carried out in the future, which may utilise the HIA findings (Doyle, 2006).

The objectives of the HIA are as follows:

- To assess the potential health impacts of the implementation of the Traveller Accommodation Policy (TAP) on the health of the Traveller population.

- To produce evidence-based recommendations to implement the TAP in a way that would improve the health of the Traveller population in Donegal.

(Doyle, 2006)

Two unspecified yet expected outcomes from this HIA were firstly to facilitate the cross-sectoral collaboration on the issue of traveller health and accommodation, and secondly to inform all stakeholders of the health impacts of accommodation on the community.

Stakeholder Involvement

For this HIA there was interest from the HSE Western Area, county council officials and Traveller organisations. These include the main groups that were expected to work together on the key issues of health and accommodation. From a policy-making perspective, the county council officials were expected to drive the process and adopt its findings from within the local authority, as the HIA was conducted on a specific piece of local government policy (traveller accommodation programme (TAP)). An Advisory Group was established in early 2005 to oversee the implementation of the HIA. Representatives on this Group were drawn from Donegal County Council, the Health Service Executive, Donegal Traveller's Project (DTP), the County Development Board, and the community and voluntary sector. One health researcher was hired by the Council in December 2004 to carry out the research.

Donegal Travellers Project (DTP)

The DTP was initially established as a women's development project for a group of Traveller women in 1996, and then changed its focus to issues relating to the Travelling community in the environs of County Donegal in 1997. The Project offices are based in Letterkenny town centre. The information booklet regarding the Project and its work emphasises the work of the group as entailing "many highs and lows and

through the challenges faced what has emerged is a vibrant Traveller organisation committed to human rights" (DTP, 2005:1). The following gives the mission statement and description of the DTP:

> "The DTP is a partnership of both Travellers and settled people committed to improving the quality of life for Travellers in county Donegal and in the wider North West region. We aim to promote the social, political and cultural rights of Travellers as an ethnic group in Irish society and the regeneration of Traveller culture" (*ibid*).

The DTP runs a number of different projects and programmes within its remit, which aim to tackle "social exclusion and levels of disadvantage experienced by Travellers" (*ibid*).[28] The Primary Health Care (PHC) Project was the unit within the DTP that initiated and led the HIA process. This PHC Project currently employs a full-time coordinator, seven Traveller community health workers, and a public health nurse (HSE) visits the offices regularly to meet with the PHC team. It is the aim of this Project to work on a "broad range of initiatives which recognise that racism, discrimination, accommodation and poor education must be addressed if the health status of Travellers is to be improved" (DTP, 2005:4). This Project operates in partnership with the HSE, in coordinating action on the ground with Traveller families, and in tackling health inequalities through service provision.

There were six DTP (PHC team) individuals who were on the advisory group of the HIA; three of whom took part in a focus group for the purpose of data collection, including the full-time coordinator and two Travellers community health workers.

The coordinator of the PHC Project described her role as initiating the HIA, as the "convenor of the HIA project here in Donegal, so along with others in the group I would have been involved from the earliest stage right through to meeting with the county council, to discussing the idea, to deciding the policy document that we'd carry the HIA out on" (13th December, 2007). The community health workers

[28] Projects include the following: Community Development Project; Primary Health Care Project; Donegal Travellers Childcare Initiative; South Donegal Travellers Project; Building Ethnic Peace Project; Youth Project and After-Schools Initiative; Anti-Racism Training Unit; Adult Education; TravArt (Celebrating Traveller Culture through Art)

described their roles being "the researchers on the HIA" and "doing research out on the ground" in the Traveller community (*ibid*).

Donegal County Council (DCC)

DCC is the local government authority for County Donegal, which includes the six electoral areas of Donegal, Glenties, Inishowen, Letterkenny, Milford and Stranorlar. There are 29 county councillors sitting in the Council. They are elected by the system of proportional representation, occupying the council over a five year term. In line with all local authorities in the country, DCC provides services in land use planning and development, social housing, roads and transport, pollution control, general public maintenance, library services, and local community and enterprise projects.

The housing services section of the Council deal with requirements of the local populace in dealing with accommodation requests. It is the aim of the housing services to:

> "enable every household to have available an affordable dwelling of good quality, suited to its needs, in a good environment and, as far as possible, at a tenure of its choice. There are a range of specific measures and schemes available for Local Authorities, to provide a response to housing needs" (Donegal County Council, 2004a).

The Director of Service, who is also the Assistant County Manager, represented the local authority on the HIA. This individual was therefore at a high level of power and influence in policy making terms. The Director was interviewed as part of this research. In addition to this individual there was a social worker for Travellers on the advisory group. However, this latter individual was not working in the Council at the time of data collection.

The Director of Service described his role on the HIA advisory group as "representing the county council, and the town councils as well because the town council are housing authorities as well, as I was representing that broad view" (14th December, 2007).

Health Services Executive (HSE)[29]

The HSE supports the Donegal Travellers Project through the North West Traveller Health Unit (Donegal Travellers Project, 2007), and in particular the work of the Primary Health Care Project. The Social Inclusion team of the HSE Western Area is the relevant unit that operates in partnership with the DTP. The work ethos of the HSE staff would draw from the rationale of working from the recent Travellers Health Strategy (2002). This policy document endorses the principles of ensuring that health services are planned and delivered with the community, for the community, as far as is practicable (Department of Health and Children, 2001a). This is the first policy strategy dealing specifically with the community's health issues. It indicates a shift in thinking in policy matters relating to Travellers, who have been consistently marginalised, both in society and in national and local policy formulation processes (Hayes, 2007).

On the HIA advisory group there were three individuals representing the views of the HSE organisation. Two out of the three were interviewed (one of whom is the public health nurse in the DTP); the third person was no longer working in the HSE at the time of data collection.

The public health nurse described her role as representing the HSE organisation but stated that "I would have more contact than any other HSE people would have with the (Traveller) group, so I had a different perspective than anyone else" (11th December, 2007).

The Health and Social Policy Officer of the HSE described her role on the HIA as someone bringing knowledge of the HIA tool to the process, as illustrated in the following:

> "Well I suppose I was seen as someone who had done the training, and in talks with the Donegal traveller's project it (HIA) would have been seen as something good" (11th December, 2007).

[29] HSE West: Limerick, Tipperary North, Clare, Galway, Mayo, Sligo, Roscommon, Leitrim, Donegal
HSE South: Kerry, Cork, Waterford, Wexford, Carlow, Kilkenny, Tipperary South
HSE Dublin North East: Dublin North, Louth, Meath, Cavan, Monaghan
HSE Dublin Mid Leinster: Dublin South, Wicklow

Donegal County Development Board and the Donegal Local Development Company

Both of these organisations play a key part in the enterprise and community life of County Donegal. The Donegal Local Development Company, known in the locality as the DLDC, delivers twelve EU and Irish government funded programmes that are centred on local development and community enterprise matters (DLDC, 2007).

County Development Boards[30] were established in 2000 in every county and city in Ireland. This move indicated a "recognition of the need to integrate and co-ordinate the various elements of development and of service delivery at local level" (Donegal County Council, 2004b). The Donegal County Development Board (CDB) has 42 members, drawing from local government, and various statutory bodies in the vicinity. This body commissioned a screening exercise for HIA on a Local Area Plan in County Donegal, November 2004.

One representative from each of these organisations had a place on the advisory group. However, at the time of data collection, neither was available to discuss the HIA process as part of this research, as one had left their position and the other was not available to take part in the research. However, discussions with other members of the group indicate that both played a minimal role in this HIA.

Expert HIA Practitioner/ Researcher

An independent HIA researcher was hired to lead on the methodological procedures of this process, and to compile the relevant data for the HIA, drawing from both qualitative and quantitative sources. This individual worked with the Institute of Public Health in previous years and had a wide range of experience in conducting and researching HIAs, both in Ireland and in the UK.

[30] A key task of the CDBs in the first two years of existence was to prepare and over see the implementation of a new County Strategy for Economic, Social and Cultural Development (2002). This strategy will provide a common goal and vision for development in the county over a ten year period. (DCC, 2004b)

He describes his role as the HIA researcher, and the following illustrates this in more detail:

> "I conducted the HIA, I was the main researcher and the HIA was a communal process, I did the research, I did the interviews, analysis, and presented the findings. I was the only paid researcher who came in from the outside" (24th March, 2008).

Community Workers Cooperative

Donegal Community Workers Cooperative (CWC) was formed in 1994 and currently holds 81 members. The aim of the network is to implement social change by conducting policy analysis of local and national strategies, in order to ascertain where and how social action can be taken for the wellbeing of the socio-economic good of the locality (CWC, 2007).

An independent chairperson was brought into the process at later stages in the HIA, in order to facilitate the tension and disagreement that had developed between the DTP and county council officials. This is in line with recommendations in previous research for consultative committees working on Traveller issues (O'Riain, 2005). This individual also had familial links with the Council, which was cited as 'an added bonus' by members of the advisory group, as ascertained by both sides of the issue (Travellers on the one hand, statutory bodies, in particular the local authority, on the other) during the phase of interviews. This person was deemed more acceptable because of this by all members of the advisory group.

The representative from the CWC, who played her part as the chairperson of the HIA, describes her role as providing the necessary impartiality required for the HIA. Tensions between the council and the DTP were polarised to such an extent that the process had reached a stalemate, as clearly illustrated in the following:

> "I wasn't in on the project from the start, came in about half way, the reason being that the DTP and the Council weren't able to reach agreement, an impasse was reached and I was brought in. And the CWC would be seen as a suitable body, we've a good ten years work in community development approaches and would be seen as good for the job I suppose. They needed someone who would be seen as independent and impartial. It seemed as if the DTP and the HSE were on one side and the council on the other. The council felt they were dealing with old ground and the travellers were bringing in issues that had nothing to do with the HIA also" (23rd January, 2008).

Methodology

The Merseyside Guidelines were adhered to in the completion of this HIA (Scott-Samuel *et al*., 1998). This was a collaborative project, whereby the HIA researcher worked closely with the Donegal Traveller's Project Community Health Workers. This group guaranteed a 'gateway' into the population group. Table 15 outlines the mix of research methods used in this HIA.

A quantitative survey was formulated with the literacy and educational needs of Travellers kept in mind. The Community Health Workers (members of the Traveller community) received training and proceeded to conduct the fieldwork in the summer of 2005. There was a 64 per cent response rate. This data was correlated with the interviews held with residents of halting sites and with evidence from the literature review, to result in the main findings of the HIA.

Table 15: Methodologies used in the Traveller Accommodation HIA (Doyle, 2006)

Qualitative methods	**Quantitative Methods**
Interviews with residents of temporary sites and site visits (conducted April 2005)	Survey conducted of 64 households, gathering data on the health of 64 adults and 129 children (summer 2005)
	Literature review of evidence relating to the impacts of accommodation and housing on health

HIA Outcomes

A number of findings arose from this HIA on Traveller accommodation. Some of the most important findings are indicated below:

- Most people view improved accommodation conditions as key to improved health.
- Poor living conditions are the main reasons for differences in health between groups of Travellers.
- Health problems are more common among children living in homes with problems with cold and damp.
- Poor living conditions are concentrated in current temporary site accommodations.
- Stress levels are high amongst all groups in this research; Stress is mainly due to living conditions with site residents.

The health impacts of accommodation policy, as researched in this study, can be categorised in two ways; physical health (as indicated above) and mental health (stress levels and the anxiety associated with societal exclusion).

A Health Impact Analysis was carried out, in order to map the commitments made in the Accommodation Programme against the positive and negative health impacts of this HIA. Although the statements of action in the Programme are positive overall, there is much political rhetoric on the issue. The proponents of the project believe that it is by carrying on the cross-sectoral collaboration, which was intrinsic in the HIA process, into the adoption of recommendations by decision-makers that was vital (Doyle, 2006). Recommendations for the HIA were developed over the duration of 3 workshops, carried out in late 2005/early 2006.[31] Although recommendations have been agreed upon, the implementation and adoption of them in decision-making circles remains the challenge. Given the politically-controversial nature of the topic of Travellers and accommodation, the assimilation of evidence into decision-making within the Council and HSE, is testing. The continuation of multi-sectoral working and partnership on this issue of Traveller health and accommodation is key for the

[31] The HIA report was published in late 2007 and this researcher received a copy at that stage.

findings of the HIA to be incorporated and 'heard' within the policy formulation processes.

A key finding that emerged from the HIA process was that including health and community/ voluntary representatives on the Local Traveller Accommodation Consultative Committee (LTACC) was a worthy idea.

A number of positives and negatives of the HIA process were identified by the researcher leading the process, as indicated in table 16.

Table 16: Lessons Learnt from Doing the Traveller Accommodation HIA (Doyle, 2006).

Positives	**Negatives**
Evidence-based and robust piece of work emerged from the HIA	Gathering partners and stakeholders to work in partnership a major difficulty
The HIA process initiated communication and dialogue where none had existed previously	Getting partners to incorporate the recommendations and findings will be even more difficult
The HIA may have helped widen the participation in accommodation policy of voluntary, health and community representatives	There is a lack of political interest in stakeholders wanting to join the HIA
The HIA demonstrates the abilities and competencies of Travellers in conducting research in their own community	Recommendations may be agreed but implementation may not be so smooth
	HIA is just aspect in an overall effort and need to find a sustainable solution to Traveller's accommodation issues

Policy Process for the Traveller Accommodation HIA

The fundamental goal of this HIA was to evaluate the potential impacts on health of the Traveller Accommodation Programme, and to formulate recommendations for the implementation of the Programme by using the findings from the impact assessment

process. It is aimed that findings would be used as part of the national Traveller Health study to be carried out in the near future, and by the HSE and Donegal County Council when formulating policies and services for the Traveller community.

Appendix 8 provides a review of the key documents in the area of Traveller Accommodation in County Donegal.

Part II: Analysis

As with the other cases, the framework approach to analysing interview data will be used for this study (Ritchie and Lewis, 2003). In this Donegal case study, 10 people were included for semi-structured expert interviews, and three for exploratory interviews, as can be seen in appendices 4 and 5. Appendix 12 presents the process of data analysis, which traces the degree of abstraction and data refinement, beginning with the raw data through to the establishment of indices, categories and finally, classifications.

Contextual Information: The Development of HIA in County Donegal

Although 10 people were included for expert interviews, 8 of these were members of the advisory group for the HIA on the Traveller Accommodation Programme. Two individuals that were interviewed were members of the project team for 'Screening for Health Impact Assessment in the Local Area Planning Process in Donegal County Council' (Donegal County Development Board, 2004). This particular HIA screening exercise[32] was commissioned by the Donegal County Development Board. This planning HIA screening took place before the Traveller accommodation one.

Throughout the duration of the field trip to Donegal (time spent between the towns of Letterkenny and Lifford) it became clear to this researcher the extent of mutual learning and knowledge across the various statutory, voluntary and community bodies in Donegal. All individuals that were included in data collection, and also those who were conversed with during the time in Donegal, knew one another. It is a

[32] This process involved a screening exercise only of the Local Area Plan. Upon conclusion of this screening, a full comprehensive HIA was not deemed necessary by the Project Team.

concentrated community of knowledge in policy making circles; there is an undeniable sense of parochialism and a 'locality' mentality. This was reiterated during the interviews, and the chairperson of the HIA stated that "all politics in Donegal is local" (23rd January, 2008). The consequence of this for the development of HIA in this rural case, which may be absent from the urban centres, is that there was much cross-learning from one HIA (planning screening, 2004) to another (Traveller accommodation, 2006). Therefore, I found it helpful for the research, in establishing the full context for the HIA on Traveller accommodation in policy making in Donegal, to interview individuals who were members of the Planning HIA screening. These individuals were from a planning background (Donegal County Council) and a community background (Border Action (Peace III and Interreg IV programmes; also member of the County Development Board).

The following illustrates this point being made, as derived from an interview with the individual from Border Action:

> "Because, being a member of the County Development Board, and also of the sub-structures, I would have been keen to see how the approach (HIA) would be used, and then adopted, in a number of other areas. So, this was a real test-case. I wasn't involved in the traveller (accommodation HIA) project, I just couldn't commit in terms of time, but I was very much involved in the process of the planning one" (12th December, 2007).

The interview data from these two individuals is not used in the analysis below (as analysis includes interviews with those only included in the HIA steering/ advisory groups), except in parts when explicitly to triangulate certain findings.

Three exploratory interviews were also carried out for this research; a senior planner in the Central Planning Unit of Donegal County Council (4th December, 2007), elected representative, Donegal County Council (12th December, 2007), and a senior health promotion officer, HSE Western Area (12th December, 2007). These interviews informed this case study by providing necessary background information, and by contributing certain perspectives of the HSE and local authority institutions.

INSTITUTIONAL THEORY (x1 and x2)

Hypotheses: HIA utilisation is possible with institutionalisation

Sub-hypothesis (variable indicators)

The normative dimension alludes to the norms within institutions that can go some way to explain the behaviour of actors in the institutions and organisations. The influence of the institution, and its norms, has been cited in previous HIA policy research, as a further explanatory theory to explicate of the influence upon the use of HIAs in policy (Banken, 2001; 2003; Bekker *et al*. 2005; Kemm, 2005; Bekker, 2007; Morgan, 2008).

A number of questions were asked during the interview phase of data collection, in order to establish the degree of influence the norms of institutions had over the use of the HIA report, and the knowledge that came from that and it's preceding process. The topic guide, containing the standard interview questions, is in appendix 2.

Are Institutions Ready? The Timing of HIA as a Policy Support Tool

The timing of HIA as a policy support tool was asked during the expert interviews, in order to establish the perspective of those on the HIA advisory group, which included both decision makers of statutory bodies and the community perspective.

One interviewee stated that yes, the time is right to use knowledge and evidence that comes from HIAs. This individual was a senior county council official, being the Director of Services (head of the housing section) and Assistant County Manager in Donegal County Council. This individual was adamant that the time had come to use HIAs, stating that "yes, absolutely, yes," they should be used, because when "they're (Travellers are) not suitably accommodated and it's bound to happen that their health is impacted upon" (14th December, 2007).

Four interviewees stated that 'maybe' the time was right to use HIAs. These individuals include the two members of the HSE, the HIA chairperson from the CWC and the HIA researcher. These individuals were uncertain as to the timing of HIAs;

unsure as to whether their time had come to be used for policy. One HSE member stated that the time may not be right for all, alluding to the fact that certain stakeholders, and the institutions they come from, may not be ready. This individual had no qualms in saying that, in her opinion, Donegal County Council was not ready to use HIAs at the present time, as illustrated in the following:

> "I think the time isn't right for everybody. I would yeah very clearly, the council were a problem, especially housing, I'd have no problem saying that….I think the time is right, it's just that there's people in the council, in housing, that are the problem" (11th December, 2007).

The independent chairperson, who came from the Community Workers Cooperative (CWC) stated that perhaps the time was right, but it depended on the political will from the council; "the question is the will in the local authority" (23rd January, 2007).

Another member of the HSE (11th December, 2007) stated that she felt she did not have enough knowledge of HIAs to say whether or not the time was right, and so, was uncertain.

The HIA researcher, who has worked for a number of years on HIA research practice, questioned to the use and timing of HIAs in general. In relation to this particular impact assessment, he was unsure as to whether it was appropriate to use it on the issues of Traveller accommodation; "I'm not sure regarding the Traveller one, there were so many other issues involved which were preventing the HIA to work" (24th March, 2007).

Further to whether or not the timing was right for HIAs, the interviewees then expanded on their responses to this question. The answers to this question were analysed, firstly by indexing them, and then by categorising these indices. Different categories were derived from the data. An expansion of whether or not the time would ever be right for HIAs to be used ensued with some interviewees. In addition, the role of institutional factors (constraints) was also discussed in response to this question. The nature of HIAs and impact assessments in general was highlighted in response to whether or not the time for HIA had come. Finally, the subject area of the HIA,

Traveller accommodation, was highly controversial and this impacted on the planning, process and outcome of the HIA in Donegal.

Some interviewees reflected in more detail as to whether or not the time had come to use HIAs for the purpose they were elicited; in policy making and to inform decision makers. The Director of Services (and therefore head of housing) in Donegal County Council was very adamant that HIAs would, could and should be used in policy making in the local authority. Other interviewees were more sceptical, doubting that the time would ever be right, and more specifically, would ever be right in traveller accommodation, as stated in the Donegal Traveller Project focus group by the coordinator

> "It may be that the time is right in certain areas, but I don't think that the time is right in traveller accommodation…….. Generally and overall in traveller work there's a very bad record of implementation of policy in relation to traveller accommodation at a national level, so in a way we were taking on a big challenge from the very start and we knew that" (13th December, 2007).

It was clear in the discussions with all interviewees that the timing and process of the HIA was inextricably linked to the nature of Traveller accommodation work. The overarching tensions that accompany the field in political and policy discourses, both locally and nationally, result in a troubled atmosphere.

Deriving from the latter point of traveller accommodation practice and policy, it was clear from the interviews that this area of work impacted on the successful process and implementation of the HIA. This impact assessment framework was used by the convenors of the process, the DTP, explicitly as a tool to enhance cooperation between the County Council and the group. This relationship was fraught with tension and HIA was adopted as a tool to break down such tensions, as illustrated in the following:

> "(We) sit on the local consultative committee on traveller accommodation (LCCTA), and we did feel at that time that the two organisations, the county council and the traveller organisations, had become very entrenched in 2 different positions, and we did think that HIA, because it's about collaboration, partnership, and all those nice soft buzz words, that maybe this was a new way of working around traveller accommodation and we went into it with good faith" (13th December, 2007).

The HIA researcher in the process said during the interview that he had been "careful not to raise unrealistic expectations" of the HIA in the Travelling community, as there had already been a record of lack of policy implementation in the area of work (24th March, 2008). He went to explain how it was "such a fraught area" and the tool, as far as he was concerned, would not be "over-sold to Travellers and (a member of the HSE) was careful to say it's a potentially useful process" (*ibid*).

Another point that was raised during the responses to the question of HIA timing was the nature of evidence. As far as the interviewees were concerned, the evidence that came from the HIA "speaks for itself but people aren't moved by it" (11th December, 2007). In fact, because the area of Traveller work is such a fraught one, "evidence doesn't come into it" (24th March, 2008). In summation, it is somewhat irrelevant what the evidence alludes to; the subject area of Traveller accommodation is soaked in values, attitudes, prejudices and fears. The lens through which evidence on Traveller accommodation is viewed by the policy makers is pre-laden in value judgements.

The institutional perspective, and the timing of HIA to fit into institutional norms, and hence processes and standards, was raised in response to this question during the interviews.

The role of Donegal County Council, in particular its role as the housing authority, was highlighted by interviewees. It was stated that "the role of the housing authority was crucial" to the carrying out of the HIA and the subsequent use of knowledge from the impact assessment process (11th December, 2007). Others went on to state that the "Council were a problem; especially (the) housing (section)" (December, 2007). It was undeniable throughout this round of interviews the denigration all individuals had (except for Council officials) for the County Council individuals, and towards the institution. It was the opinion of a member of the DTP that "alot of people regarded the HIA as a threat, from the organisation's perspective… alot of stones were unturned with the HIA" and it was believed that individuals from the statutory agencies (HSE and Donegal County Council) felt threatened by the evidence arising

from the process, which was inextricably linking poor health with poor accommodation standards (13th December, 2007).

It was noted during the interviews that there were "alot of organisations and alot of people involved" in the HIA, and the "relationship between Donegal County Council, the DTP, and the HSE" was crucial in the HIA process and in the implementation of the recommendations (11th December, 2007). It was difficult however, the find the "middle ground" (DTP, 13th December, 2007), where change can come about for Traveller accommodation. The HIA was used as an advocacy tool to help change the discourses and policy directions in this area of work.

It was considered a good document but as one member of the DTP noted, "they (the County Council) just thought they'd buy into it, get us to go along but it's getting it implemented, that's a hard one" (13th December, 2007). Clearly, the perspective of non-Council officials in this case study was that the local authority acted as a barrier to the full implementation of the HIA recommendations and process.

Finally, in response to whether or not the time has come for HIAs to be used in policy, one respondent believed that the impact assessment field is crowded already and there may not be room for HIAs to find space within the policy making processes, as illustrated in the following by the HIA researcher:

> "I worked ….on HIAs for a number of years and the problem with HIA, is that the IA field is so crowded and I think HIA's voice is difficult to be heard and there's a certain amount of fatigue in general, it can act as a barrier to evidence being used" (24th March, 2008).

Normative Dimension: Do Institutions Shape Behaviour?

The use of institutional theory in this study is to establish the extent of the influence certain institutions have on the use of HIAs and the knowledge that came from them which was intended to inform policy.

Those interviewed in this case were stakeholders in the HIA process, and were on the Advisory Group as representatives of their relevant bodies, be it from a local authority (Donegal County Council), health service (HSE) or the community perspective (Donegal Travellers Project, community representative). The responses to this section

were grouped into categories after an indexing process took place. Firstly, at an institutional-level, HIA process- and policy process-levels, a number of constraining factors upon behaviour were found. Secondly, the nature of traveller policy and the impact this has upon the use of HIAs in policy was elicited from the data. Thirdly, ideas and values played a constraining role in this case study, in the use of HIAs.

Institutions and Organisations: Macro-Level of Analysis

An issue came up in this case study that has arisen in other instances, as is evidenced in the HIA literature. An issue of the owner/ user dynamic was clearly evident in this HIA on traveller accommodation. The main driver (owner) of the HIA was not also the main user of the HIA in policy. This is to say, the DTP were the convenors and instigators of the HIA, and they were conducted the research. However, it was Donegal County Council that was envisioned to use the HIA knowledge and evidence once the process had been completed. Therefore, in this instance, there was no symbiotic relationship between owner and user of the HIA, and this may have been a factor in its successful implementation of process and recommendations.

One interviewee alluded to this point, as indicated in the following:

> "It is more difficult when it wasn't in one organisation; it was a voluntary organisation and two statutory organisations. And also maybe that it was one organisation carrying out the research but the recommendations related more to another organisation, that was a difficult situation as well" (11th December, 2007).

The institution (Donegal County Council) that was envisioned to use the HIA was perceived as "a big barrier anyway before it started. They considered this an attack on their policy, for them to implement they'd have to have big changes in their policy" (DTP, 13th December, 2007). The feeling around the local authority was undeniably negative, as evidenced from all interviewees (except the council officials) during data collection. Institutional constraints from the perspective of this interviewee from the DTP depended on which agency the HIA would impact most on; this was a confounding factor in the successful process and use of the HIA in policy.

A member of the DTP, the full time coordinator, stated that it seemed from their agency's perspective that some individuals on the Advisory Group were constrained

by their institutions; "people saying 'oh there are constraints,' because of the institution they come from'" (13th December, 2007).

It was felt also by the same individual that there was a negation of responsibility on the part of some stakeholders in the HIA process, as illustrated in the following:

> "So therefore health is not only the responsibility of the HSE but also of the local authority. And then people fell back into being defensive, and fell back into saying 'oh no no no that's the job of the HSE,' and people took up positions again and became defensive and that undermined the whole notion of collaboration again in HIA, which is a central piece if the whole thing is going to work" (*ibid*).

One interviewee, the Director of Services in Donegal County Council, stated that this HIA was the first one completed on Traveller accommodation in Ireland, and no other local authority had been involved in one as of yet elsewhere. He was proud that it had been carried out, as the HIA being conducted at all was an achievement in his opinion, despite the on-going usefulness of the document and process.

The chairperson of the HIA highlighted the fact that there were staffing issues constraining the process of the HIA, and the way that people worked and behaved, as illustrated in the following:

> "Staff issues especially the embargo on recruitment has a big role to play, there is many dedicated staff but they're understaffed. All local authorities have this embargo and if they're asked to do more work, I mean, unless people are prepared to do within their own work programme but that's difficult too" (23rd January, 2008).

It is clear that those interviewed for this case study were more than aware of the institutional constraints upon individual behaviour and action. In addition to this overarching influence upon behaviour regarding the HIA and the subsequent use of it, there were also influences at HIA and policy process levels.

HIA Process: Micro-Level of Analysis

At the level of the conducting of the HIA process, amalgamation of evidence and recommendations, and subsequent assumed use for informed policy, there were misunderstandings at play.

Most notably, among certain stakeholders on the Advisory Group, there was a lack of understanding of what the HIA would be about, as illustrated in the following by the full time coordinator of the DTP:

> "I think alot of people thought it would about the health services and how health is delivered, and that it would be the responsibility of the HSE……..And because HIA is quite new, I don't think that everybody coming to the table on the steering group knew that. And I don't think they realised that the accommodation policy, which sits in the local authority, which is under the dept. of the environment, impacts on the health of the travellers" (13th December, 2007).

The HIA tool, as indicated in the above quotation, is indeed quite new and therefore required explanation to all those envisioned to be part of the process, before it commenced.

Policy Process: Micro-Level of Analysis

From the perspective of the policy process and the use of the HIA in it, a number of factors impacting upon this utilisation were highlighted in the interview data.

The senior County official, the Director of Services, was quite assured that the HIA would be used; "we'll be informed by the HIA, we will be, we have to be, we're part of that so we will be. I mean we didn't have that before so we'll have it now" (14th December, 2007). This use of the HIA was discussed in the context of the next four-year Traveller Accommodation Plan; plans for which commence in 2009.

The HIA researcher stated that there are definitely institutional constraints upon the use of HIAs "because there's so many (constraints) on Traveller policy and the room for manoeuvre for decision makers is limited because of the hostility towards Travellers" (24th March, 2008). The limitations upon decision makers in the formulation of policy were highlighted by this researcher.

The chairperson of the HIA pointed out that the local authority, which was envisioned as the main user of the HIA, both in the on-going formulation of Traveller accommodation policy, and in the delivery of services to the group, "haven't enough (people) working from a community perspective, which is a problem" (23rd January, 2008). The different approach of working which the HIA entailed, (collaboration with the community; a bottom-up community development approach) is not one endorsed at local authority level in its daily workings, and so would have proven difficult for it's employees on the HIA to adapt to the different mode of practice.

Finally, a point was raised regarding the need for political and managerial commitment to the HIA process; "if you don't have buy-in to the idea of the HIA, there is a risk that it is just a paper exercise or a research exercise, and that the follow through that you expect won't materialise" (11th December, 2007). This point highlights the need for the espousal of all stakeholders in the process, and support from their relevant institutions is also necessary.

In particular, Traveller policy.....

It was evident during the gathering of data for this case, that the area of Traveller policy, especially regarding accommodation policy, was highly contentious. This controversial nature of the policy area, where animosity and resentment breed fiercely, acted as a barrier to the use of the HIA conducted on the Traveller Accommodation Policy.

The HIA researcher highlighted this point, stating that it was a difficult HIA to conduct research for, as the mere fact that the policy area the impact assessment was relating to was rife with constraints by virtue of the Traveller policy area; "constraints because there's so many on traveller policy" (24th March, 2008).

In addition, the full time coordinator of the DTP stated that the local authority, in coming to the table, in the belief that the area is under a "protective notion that it's their area of policy," and not of a primary concern of other institutions or agencies (13th December, 2007).

Ideas as Constraints

The HIA researcher also noted in his interview that subjective values and ideas surrounding the topic area of Traveller policy was a greater influence upon the use and conduct of the HIA, as opposed to the objective recognition of the evidence proved as useful and worthy; "(We) did a health survey of travellers as part of the HIA and it's the 1st piece of hard evidence to use to influence the decision makers. There's polar opposite ideas on traveller issues, incredible amount of tension and hostility" (24th March, 2008).

Political Dimension: Does Politics Matter?

Elliott and Francis (2005) found in their research into the Welsh HIA experience that the influence of the political environment and agenda, and the different interests around the HIA 'table' was considered an important dimension to consider when looking at the influences upon HIA usage in policy. This was also found is other HIA research (Davenport *et al.* 2006; Bekker, 2007, Wismar *et al*. 2007). The new institutionalist strand of political science theory also contends that the political dimension is an important one to take into consideration, when investigating the influences upon individual and collective behaviour and action (Immergut, 1992; Peters, 1999).

This study investigated the influence of such a political dimension, by asking the interviewees to what extent were politics at play between the varying interests in the conduct of the HIA.

The responses to this question have been categorised into five groups. The political dimension at a micro-level (individuals) and macro-level (institutions) was identified, the perception of politics, politics and polarised attitudes and positions regarding the area of Traveller work, and the issue of HIA requiring statutory recognition.

<u>Individuals: The Gatekeepers to the Institutions (withholding the keys?)</u>

In response to the question of politics during the conduct of the HIA and in the steering committee, many interviewees focused attention upon the different interests involved in the HIA, on the Advisory Group. It was clear that at an individual level,

many interviewees felt that other stakeholders introduced an element of tension and misunderstanding, as evidenced by their behaviour and actions.

A member of the HSE involved in the process stated that the workings of the HIA were too complicated on the committee; "if an ordinary person like me doesn't understand what's going on, there's something wrong" (11th December, 2007). This statement was further qualified by the same individual, by stating that there were definite problems on the advisory group, because of what people were saying, not saying, and saying with double meanings and intentions; points of view were not being stated upfront. This will be further illustrated in a following paragraph.
With regards to the Advisory Group, a number of interviewees pointed out some prohibitive behaviours that were noted by some members of the HIA; there were "delaying tactics at the meetings" (DTP full time coordinator, 13th December, 2007); "people not showing up for meetings," (*ibid*); "just things that weren't being said (upfront), you know, if people could have said 'no' or 'there's difficulty in progressing with that' but when people don't say things like that there's a difficulty" (11th December, 2007); "alot of politics, alot of back benching" (DTP health worker, 13th December, 2007).

Due to the varying degrees of commitment and agreement on the Advisory Committee, an independent chairperson was introduced to the HIA half way through its completion. The reasoning behind this act was to introduce an impartial person, who was deemed acceptable by both polarised sides on the HIA (the Traveller organisation on the one hand, the statutory bodies on the other, in particular the County Council), into the process. At the time that this individual was introduced, a stalemate had been reached on the Advisory Group; such was the disagreement and discord between the different stakeholders. As one member of the HSE pointed out, the Group "had to take on an independent chairperson, whose husband is high up in the Council, which I think helped!" This individual went on to explain how the chairperson was considered a good choice, and conflict resolution techniques were at the fore in the process, in order to ensure greater harmony and concord in the HIA (11th December, 2007).

However the following passage indicates, how, although as much as possible was done in order to introduce greater ease amongst the stakeholders in the process, the evidence and findings of the HIA were still not taken on board by the local authority, from this individual's perspective:

> "So we saw her (chairperson) as an acceptable choice, and we also had a meeting where everyone was allowed to speak their views. and we also wanted the representative groups on board, so we had the council, the HSE, DTP, and also some community based groups that didn't have a big stake in it but were there, and we were conscious that people didn't feel ganged up on, or pressured, so we did put alot of thought into it but nothing really changed the , well I think some things have been implemented, I mean alot of things were changed at the meetings, alot of mechanisms we used for that, but when you're going to change things or ask the, to be changed, and they are, wouldn't you think you'd use those changes then?"

The Director of Services in Donegal County Council, when asked about the politics on the HIA Advisory Group, stated that with a "cross section of different organisations, hopefully all with the same intent, but com(ing) from a totally different perspective" (14th December, 2007). He explained how, in his opinion, it was inevitable that people would come to the process with different perspectives. However, there was little indication in this interview of the tension, strife, disquiet and disagreement amongst all stakeholders, in particular in disagreement with County officials, which other interviewees discussed in response to this question.

Institutions: The Gate and the Building

In discussing the degree and nature of politics and conflicting interests in this HIA, some interviewees focused on the County Council and the HSE. The full time coordinator of the DTP stated that senior people from the local authority primarily, and from the health services also, was needed so that any recommendations agreed during the HIA could be taken back to the relevant institution to be adopted and used:

> "We did have alot of meetings to get buy-in from people, and Hughie's touched on the idea of us wanting senior representation around the table so that the people sitting with us had the ability to carry out the recommendations, and had the authority to say 'our agency will be A, B and C.' which would mean, without authority, at recommendation stage action and decision would be put back and back and back" (13th December, 2007).

It was felt that the Council were "playing lip service" and that they had "no intention that any real decisions would come out" (HIA researcher, 24th March, 2008). This negativity towards the Council was reverberated, although in varying degrees, throughout all interviews, except those involving Council officials. However, this resistance in cooperation may have been related to the institutional constraints facing the individuals that any personal animosity on the HIA. The chairperson stated that, while acknowledging and recognising the sometimes defensiveness of the Council officials, such officials are accountable to the elected representatives of Donegal County Council, and their actions and statements in the HIA were reflective of this. The chairperson pointed out that "all politics is local in Donegal" and "there's alot of resistance around traveller accommodation, and restrictions on budgets at the moment would impact on the area of traveller work" which impacted on the HIA process.

Stakeholders in the process were overall deemed as helpful from the HSE institution by the chairperson. However, this individual qualified this statement by stating that "alot of good people came to it (the HIA), they were well meaning, especially the HSE who were driving the agenda. Individuals in the HSE, maybe, it mightn't reflect the ethos of the organisation, it might just be that the individuals we dealt with were particularly good" (23rd January, 2008).

A member of the HSE stated that staffing issues and procedures at an institutional level within the local authority became an issue; "problems arose, like the turnover of staff and gaps in the staffing was an issue for this HIA" (11th December, 2007). This problem was also highlighted by the chairperson of the HIA (23rd January, 2008).

<u>The Perception of Politics</u>

It is beyond doubt that in this HIA case, politics and tensions was endemic from beginning to end, and played a role in the process of the HIA, the formulation of recommendations, and the subsequent use of the HIA in policy.

Interviewees reiterated this in their discussions, stating that there were "alot of politics…with a small p and big P….I couldn't see the path forwards in the HIA in the Advisory Group because of the politics there" (11th December, 2007). Due to the tension between the stakeholders, and the history of conflict between the voluntary

and statutory interests, the HIA was actually used as a tool to break down such negative history and resentments; the HIA was used to cut through the politics. This point was highlighted by the HIA researcher:

> "Used the HIA to cut through the politics, it was the hope that if they discussed health it would break down barriers and depoliticise the issues on Traveller accommodation needs" (24th March, 2008).

Controversies, Adversaries and Resentments: Let it go...? Working on Traveller Accommodation

As indicated already in the previous section, there was a legacy of conflict in the area of work in Traveller accommodation in County Donegal, between the DTP and the local authority in particular. This "history of confrontation…..was in the room and in the process" (HIA researcher, 24th March, 2008) and the "baggage from previous encounters" (11th December, 2007) acted as a barrier to the workings of the HIA. Although it was hoped the HIA would prevent this "baggage" from becoming a problem, this aspect interfered to a large extent the way that the HIA was perceived by the Council, and the way that it was presented by the DTP. The former body viewed the HIA with scepticism, viewing it as a mechanism that the Traveller representative body would use to attack the policy of the Council. The latter body went into the process with the intention of presenting the facts and evidence of the HIA, which would prove that the accommodation policy of the local authority was providing sub-standard services, which led to poor health of Travellers. Undeniably, the two groups, at polar opposite sides of the policy spectrum, were bound to clash. The fact that it was within the space of the HIA was irrelevant, as the subject area of Traveller accommodation was controversial.

On the Advisory Group there was a certain amount of "controversy over the wording of terms," in particular the use of 'anti-racism' (DTP coordinator, 13th December, 2007). The context of this issue was in relation to anti-racism training that the DTP provides on an on-going basis to statutory bodies. The DTP questioned whether it may be provided during this HIA process. During this interview, it was pointed out that for a number of years such training has been provided to the HSE, without any defensive reaction or controversy. However, when the issue was brought up with the

local authority officials around the table, there was uproar, as they felt they were being called racist and anti-Traveller. This example illustrates the fraught tension that was embedded in the process, and the quick-fire reactions from the Council with regard to issue around Traveller practice and policy.

The Director of Services stated, when asked about the political dimension in this HIA, acknowledged that some people came to the process "with prejudice and fear, some with attitudes that don't value the ethnic value of Travellers. There are always those things at play when there's a cross section of people" (14th December, 2007).

HIA: Must become Mandatory, not remain Voluntary

A member of the HSE, in response to the question on the political dimension, stated that until HIAs are statutory, there will always be a problem with them and conflicting interests will continue to interfere in the process. She acknowledged that with statutory recognition for HIA, would come about a certain standardisation and it would not matter what the subject area of the HIA was, or who the stakeholders were in the impact assessment:

> "But until there's a plan for HIA, until the government sets about on an inter agency level to put it in place and put officials to do it, it's difficult. I mean in Northern Ireland, with Investing for Health, they have inter-agency plans and a better framework than here" (11th December, 2007).

VALUE JUDGEMENTS (IMPACT ASSESSMENT THEORY) (x3)

Hypothesis: HIA utilisation depends on the value judgements of the policy actors

An important issue is the question of the role that values, beliefs and assumptions play in the policy process. The role of these values has been the topic of research in impact assessment literature, and is being used as an explanatory variable in this study; to assess the influence of value judgement in the use of HIAs. As no matter how rational the policy process may appear to be, it is ingrained with value systems and beliefs (Carley, 1980; Krnv and Thissen, 2000; Weston, 2002; Bekker *et al.* 2004).

The following categories were elucidated from the interview data. Four categories were devised from the data, that group together the varying ideas and opinions of the

interviewees in the role that values play, and the influence they may have in the policy process. The values attributed to Travellers made up the bulk of responses to this question. The role of value judgements was highlighted in the interviews. The impact of miscommunication of values and assumptions during the HIA was noted during the interviews. The lack of understanding of the holistic concept of health that is at the core of the HIA technique, also indicated some conflicting values held by stakeholders in the process, which in turn would result in a conflict of the main values that HIAs hold true.

Values and Travellers

Values, attitudes and beliefs around the Traveller community arose during the data collection phase for this case study. The values placed upon the community by all stakeholders in the process, from the statutory and voluntary representative groups, played a key role in the HIA process and in the use of HIA knowledge thereafter.

The biggest stumbling block is the lack of recognition of the community in statute; "there is no statutory acknowledgement of the travelling community as an ethnic community" in either local or national policy, and this is a cause for controversy at any meetings between the voluntary group (DTP) and state agencies (the County Council, which is the local housing authority, and the HSE, providing health services) (Interview, coordinator, DTP, 13th December, 2007). It was "like an elephant in the room, whether Travellers are an ethnic minority or not" (*ibid*) There's immediately a "clash of belief systems around Traveller definition," which affects any collaborative working between the agencies as both points of view are polarised and entrenched (*ibid*). This issue was bound to affect the process and use of the HIA, and it did.

The coordinator in the DTP succinctly paints the picture of what reconition of the Traveller community would mean in the delivery of services, as the following illustrates:

> "If you're recognising people's ethnicity you're recognising people's right, if you're recognising people's right, you're recognising the right to nomadism, then you're into a policy arena where you have to provide for nomadism, and then you have to provide transient sites. It's not just the ideological base of

> what we believe and what the local authorities believe, it's an ideology of how you deliver services on the ground" (DTP, 13th December, 2007).

There was alot of tension at meetings, and there were very revealing comments being made, for instance

> "Planners might say something, or even public health workers, would vocalise those attitudes, saying things like "well what do you expect from them" or "it's their own fault for doing that", "they bring it on themselves," things like that" (HIA researcher, 24th March, 2008).

It was clear that the prejudices and fears that mainstream society has towards the Travelling community were present in the interaction between the statutory bodies and the representative community agency. In meetings, stakeholders were talking down to the Travellers, "criticising them…the process did show up that values made a huge difference" (11th December, 2007). Finding a "common space was very very difficult" (ibid) in meetings, yet there was a strained "politics of politeness" as both the Traveller voluntary agency and the statutory bodies were keen to attempt to work the HIA process as best as possible (DTP coordinator, 13th December, 2007).

The DTP recognised that they were a "politically based organisation, we have very clear values and beliefs in terms of what we want to achieve as an organisation, and for us we have our baggage too," as would the statutory authorities (DTP coordinator, 13th December, 2007). However, entrenched views on the HIA Advisory Group led to an impenetrable impasse, as there are "people who see housing as the best option (for Travellers) and that's it" (11th December, 2007). An immovable stalemate on clashing attitudes and values illustrated clearly what a "difficult area of work Traveller accommodation is, as every person comes from a different perspective and I suppose people don't know what it's like to be a Traveller" (Director of Services, County Council, 14th December, 2007).

Value Judgements

The interviewees were keenly aware of the role that values played in this HIA, most notably in relation to the subject of the HIA, as opposed to the impact assessment technique and process itself, however. An individual from the HSE did point out that "the process did show that values did make a difference" (11th December, 2007). The

HIA researcher also stated that there were "alot of underlying value judgements, although the value judgements were not around the HIA but attributable to Travellers and the impression was that the attitude of the settled community was very prevalent in the minds of the policy makers" (24th March, 2008). Clearly the subject area of Traveller accommodation, and the context of the policy area, took precedence in the HIA, over the actual impact assessment process itself!

Social Determinants of Health

It was noted by the researcher that there was a "reluctance to engage with the concept of social determinants of health" by some of the statutory stakeholders. This lack of common ground and common understanding of some of the fundamental issues and values at the core of HIA became problematic during the HIA meetings, as this difference of opinion and understanding arose, as the following indicates:

> "There are values around perceptions of what they think health is, decision makers think it's a medical issue, not a social issue; (the Director of Services) wouldn't accept my qualifications as a researcher because I wasn't a medical doctor! There's a lack of understanding of the social model of health. There was a reluctance to engage with the concept of social determinants of health. It was had to get across that the solution needed to be social not medical" (HIA researcher, 24th March, 2008).

A more holistic conceptualisation of health, however, is not wholly accepted or known on the part of non-health sector individuals throughout Ireland, and perhaps in time the determinants of health theory can become more acceptable and understandable.

Miscommunication

A major issue that can be traced through all the interviews, is the role that 'miscommunication' played in the HIA process, both on the Advisory Group and outside the meeting rooms. An individual from the HSE noted that, stating that "people coming from different perspectives were not the problem, but it's that it's not communicated….. But if we don't communicate that then it's difficult to find a way forward, going around in circles" (11th December, 2007). It certainly seems that, from an objective viewpoint, better communication of values, opinions and positions,

would have resulted in a more open, transparent and productive process for the HIA to operate.

It is also important to note that HIA is a novel approach and may not be fully understood, which may have added to the lack of communication/ miscommunication issue, as an official from the Council noted:

> "I don't think it's been fully understood ….. We're in there, with the HSE and the people who run the working group are in the HSE as well so we carry it forward from that perspective. The DTG certainly would be driving it, driving us to meet the recommendations. On a wider field, it's something we have to develop yet" (14th December, 2007).

ENABLERS AND BARRIERS: A CHECK-LIST

The respondents in this study were asked about enabling and hindering factors towards to the use of HIAs in the decision making process. The Donegal case study was the second one investigated in the data collection of this study. The check list (below) was formulated by Dr. Catherine Hayes. It was presented at the three day comprehensive Health Impact Assessment Training which this researcher attended, as run and organised by the Irish Institute of Public Health (September 2006, Grand Canal Court Hotel, Malahide, Co. Dublin)

For the purpose of this research, it was deemed appropriate to use this check-list, formulated in Ireland, for the case study research. This is so as to establish the level of agreement on the contextual conditions for use of HIAs in policy and to construct any additional suggestions that may come from the interviewees. Another comparable study of such enablers and barriers was conducted in the UK (Davenport *et al.* 2006) and provides an interesting instance for comparison in the results section.

<u>Enablers and Barriers to the policy process in having decision makers involved (Ballyfermot) (September 2006)</u>

1. Involved in planning and conduct of HIA
2. Input from outside decision-making process
3. Clear organisational commitment
4. Subject non-controversial
5. Realistic recommendations

Bad points of decision makers and policy process

1. Lack of awareness of health by other sectors
2. Lack of knowledge of policy-making environment

During data collection, all 8 interviewees were asked as to their level of agreement with the abovementioned enablers and barriers. As can be viewed in appendix 11, all respondents agree with the first two enablers. Regarding organisational commitment, however, two agreed that it was present (and therefore an enabler) in the Donegal HIA case (a member of the HSE and the senior official in the County Council). Apart from these two individuals, the members of the DTG, a member of the HSE, the HIA researcher and the independent chairperson from CWC disagreed that there was organisational commitment in the HIA on Traveller accommodation. In qualifying their standpoints, the chairperson stated that individuals from the Council sent other colleagues to meetings and did not attend some themselves. However, the chairperson iterated that "but you're dealing with very senior people in the council also and actions were at the most senior level" (23rd January, 2008). The HIA researcher stated that "they wanted to be seen, the decision makers, but doubtful that they had commitment to change anything in any real way" in response to this item on the check list (24th March, 2008).

The same member of the HSE and the chairperson agreed that the subject of this HIA was non-controversial, and was therefore an enabler in the process. The other 6 interviewees disagreed with this statement. No respondents qualified their itemising in this instance with additional statements.

Regarding realistic recommendation, 4 agreed that there were realistic recommendations arising from the HIA, and therefore they acted as an enabler to the HIA being used in the policy process. 4 interviewees disagreed with this assertion. The two members of the HSE, the senior official of the Council and the HIA researcher agreed that realistic recommendations arose from the HIA. However, one member of the HSE stated that there were practicable suggestions but organisational commitment was lacking, which hindered their use and adoption in the policy process (11th December, 2007). The official from the Council agreed with the statement, but stated also that they would take time to be used and adopted.

The three members of the DTG and the chairperson disagreed that realistic recommendations came from the HIA process, therefore stating that this was not an enabling factor in the use of the HIA in the policy process. The coordinator in the DTP said that the recommendations would have been realistic is the subject of the HIA was non-controversial; the area of Traveller accommodation being a hindering factor in the use of the HIA in policy making. The chairperson reiterated this point about the area of Traveller accommodation, and stated that it took a great deal of time and energy to agree on specific recommendations, as the following illustrates:

> "Too many travellers and so traveller issues dominated the meetings, so how we resolved it to sign off on recommendations was to meet in the CWC offices, a neutral venue, and we'd 2 from the council, 2 from the HSE and 2 from the DTP and that's how we signed off. There had to be give and take on them" (23rd January, 2008).

No interviewee contributed any factors that they believed would aid or enable the use of the HIA in the policy process. Indeed, the researcher on the project stated that "because of the difficulty with this HIA I can't think of anything that would have been helpful and enabling for the process" (24th March, 2008).

In response to the barriers in the use of the HIA in policy making, two individuals agreed that a lack of awareness of health by other sectors was a barrier to the use of the HIA in policy. These individuals included the senior official of the County Council, and the HIA researcher. The others disagreed with this statement, and the chairperson went further to say that all stakeholders had a good knowledge of health, suggesting that "maybe there's a country versus city bias, in Ballyfermot maybe there's not as much meetings between the different sectors but in Donegal we meet each other alot" (23rd January, 2008).

Four respondents agreed that a lack of the policy making environment was a barrier to the use and adoption of the HIA in policy (including the two members of the HSE, the senior official of the Council, and the HIA researcher), and four disagreed (three members of the DTG and the chairperson). Those who disagreed were all from a voluntary or community sector; three of the four who agreed came from statutory institutions.

Regarding the suggestion of additional barriers to the check list, the coordinator of the DTG suggested a lack of understanding of HIA as a barrier; the senior Council official stated that people's prejudices were a barrier to the use and adoption of the HIA; the chairperson stated that people on the HIA sitting on the fence was another barrier; and the HIA researcher stated that the fact that HIAs are presented to decision makers as an "all singing, all dancing methodology" acted as a barrier to the process (24th March, 2008).

KNOWLEDGE UTILISATION AND POLICY ANALYSIS (y)

Each interviewee was asked to what extent, as far as they knew, was the HIA used in policy and how useful was the HIA. Responses were divided into 20 indices, and after further abstraction, were coded into 6 categories. The degree of utilisation of the Donegal HIA will be assessed in the next chapter when a cross-case comparison is conducted. The results from the interview data collection is presented in this section.

HIA Recommendations

In response to this question, the overall consensus was that "some of them were taken on board, some not" (11th December 2007). The recommendations were deemed as realistic "but some people didn't think so," referring to the local County Council in this instance (11th December, 2007). Agreeing on the recommendations took a greater length of time than the entire data collection period for the HIA, such was the stalemate, lack of agreement and entrenchment of positions on the Advisory Group (DTP, 13th December, 2007). There was much negativity and disappointment with this HIA, as "we did alot of work, and it was diluted by the Council" in the formulation and adoption of recommendations (11th December, 2007).

From the perspective of Donegal County Council, the HIA was deemed as useful but would have to be considered within the "bigger picture" of Traveller work and what the Council can and cannot achieve (Director of Services, 14th December, 2007). In the recommendations, it was noted by this individual that there were a number issues that were done, being done, or too early to be carried out, as illustrated in the following:

> "I think while I was sitting at the table I was aware were we actually doing something or was there a 'to do' or 'done' or still too early. To that extent some things are moving anyway. There are many good recommendations in the report, there are needs and the travellers themselves subscribe to that, and because of that, then I'm assuming we're doing something right. so, yeah, I think so yeah."

There were a number of spin-offs, intangible benefits, which arose from the HIA. For instance, the community health workers of the DTP were now up-skilled in interviewing skills and could participate in the upcoming national Traveller health status study. Findings from the HIA on children's health were used as part of a workshop in September 2005, highlighting the impact of housing on health. The HIA was used in many respects as an individual from the HSE noted; "we used the findings of the HIA, and that wouldn't have happened at all, or it wouldn't have happened as fast if the findings of the HIA weren't there, so there were spin-offs from it, exactly" (11th December, 2007).

Institutions

In response to the question on the HIA recommendations, some interviewees state that institutional rules, processes and standards acted as a barrier to the use of the HIA, and "maybe would be better to use when statutory" (11th December, 2007). In addition, to this point, the need for political and managerial buy-in and commitment to the idea of HIA is a necessary ingredient if the HIA is to be used for the purpose it was elicited. Indeed, as one interviewee pointed out, recommendations would be used is there was strong organisational and institutional commitment to the HIA. If this is missing, then the recommendations and what they entail are meaningless (DTP coordinator, 13th December, 2007).

Policy process

In relation to the policy process, and the use of the HIA to inform policy, a number of issues arose regarding the utilisation of the recommendations.

One interviewee believed that there was a lack of understanding of the tool by policy makers, even by the end of the process, which inhibited the use of the HIA; " I don't think there's a full appreciation of it, even from policy makers, I don't think there's an understanding what it's all about" (11th December, 2007).

The researcher noted that the HIA may not be "immediately useful for policy, maybe it's a brick in the wall towards something more substantial, it started as a process and may show results down the road" (24th March, 2008). The HIA may have an indirect impact that may require further examination over a longer term period.

This researcher also pointed out that there was an "overwhelming negativity attributed to the area by the decision makers, there was a real 'not in my back yard' mentality coming from them. There's a vicious cycle of hostility and it came from the Travellers too" (*ibid*). The attitudes of those making policy affect the way in which such evidence is viewed and used in policy.

Collaboration and Partnership

Due to the nature of HIAs, partnership and cross-sectoral working was integral to the success of the project. In relation to this case specifically, some interviewees focused on the issue of collaboration, partnership and inter-agency consultation, in both positive and negative light.

The Director of Services in Donegal County Council stated that there was alot of "good collaboration and yet on the ground alot of difficulties too" (14th December, 2007). With regard to difficulties he was referring to difficulties with working with the Travelling community on issues of security and in working with the Gardai on such issues. Such difficulties were not directly related to the HIA but played a part in enhancing tension at the meetings, and went some way to explain such tensions. As has been stated already in this section, this Traveller accommodation HIA was set within a myriad of problems and issues of working on accommodation and with the community. However, good collaboration did come out of the HIA. Indeed, it is miraculous the extent of agreement around the final recommendations that came from the HIA, because of the degree of friction and discord during the process.

The local consultative committee (LTACC) has used the HIA in its work, and also refers to it as a method of good practice in fostering collaboration and inter-sectoral working on Traveller issues (HIA chairperson of the CWC, 23rd January, 2008).

However, it is undeniable that "participation with stakeholders was difficult" and the degree of hostility coming from the statutory and voluntary agencies on certain matters relating to Traveller policies and accommodation (HIA researcher, 24th March, 2008). Although the HIA does require collaboration and partnership, in certain contexts it can be difficult. This HIA on Traveller accommodation policy is one such context.

Political Will

Regarding the recommendations, some interviewees did point to the fact that political and managerial "will isn't there to implement them, and the steering group isn't there to push it" (DTP coordinator, 13th December, 2007). The commitment to implement and use the HIA recommendations needs to be in place. Otherwise, the HIA will gather dust on the shelves of various institutions, never used. One interviewee pointed out that it "all depends on an individual's will and their power to act" (*ibid*). The will and drive to act must come from key senior individuals in relevant tiers of power in relevant institutions. Without such key people, the utilisation of the HIA, and the implementation of the recommendations, is uncertain, as is clear from this case study. The chairperson of the HIA stated that the process and the outcome recommendations and findings were useful but without commitment, they could fall by the wayside, never to be used or referred to again.

HIA process

The process of the HIA was considered a "very interesting process," as stated by one individual and as communicated by many others who were interviewed (11th December, 2007).

However there was "alot of negative feeling around the HIA," both during its conduct and in the aftermath (11th December, 2007). One individual compared it to a relationship break up. In the following analogy, the feeling of wasted time, energy and resources, and disappointment and frustration as is expressed by one individuals, who was deeply involved in the HIA from beginning to end:

> "It's like when you break up with someone, you're in a relationship for 5 years and you break up, and you think, 5 good years of my life is gone! Maybe in

> time all seeds bear fruit, and you realise that experience really taught me alot, but right now it's still a bit raw. I mean if you've someone in another agency that you can work with that's great, you can work together, it's all based on individuals, but I mean that's not right, that's not a very equal way of doing things, so in other words, if you want to do something and another person in another agency will do it too, especially if they're high up, you'll get loads done, but you're doing a HIA where there's already difficult communication, and there's somebody who won't shift, I'm not sure it's then a good tool to use, unless there's a government directive saying to do that, but someone might say I'm not going to do this, nobody told me to do this, this isn't in my spec" (*ibid*).

This passage also highlights the importance of key individuals in key positions of power, with an attitude of commitment and motivation for the HIA. Such individuals also referred to as 'policy entrepreneurs' in the literature are identified as necessary ingredients in the conduct of HIAs, and just as importantly, in the use of them once they are completed.

The chairperson of the HIA outlined how the HIA document was launched by Minister for Health and Children at the time, Mary Harney. A big event was planned for the HIA; it was a highly politicised event in order to garner support and attention towards the HIA on the Traveller Accommodation Programme. The extent to which this event garnered such support is questionable, as stated by the chairperson, but was a well organised event and did illustrate the importance the stakeholders in the process attributed to the process and outcome document.

Was the HIA well received?

Interviewees were asked whether or not they believed the HIA was well received or not, by their relevant institutions, and by the community. Three categories were derived from the data in response to this question.

<u>Highly Politicised Launch Event</u>

The chairperson explained how the launch event of the HIA report was taken over by local councillors in Donegal. She felt it was a mistake having someone as high profile

as Mary Harney, as "she was taken off by Councillors to places and there was no publicity for the launch in the press" (23rd January, 2008). The chairperson stated that it illustrated once again how "all politics is local," as the elected representatives came into the launch event and to a certain extent, took it over.

Traveller Area of Work is a Barrier

The researcher on the HIA pointed out that while the process was well received, "there was too much other stuff going on. The HIA was almost irrelevant in the topic area; not hostile to the HIA but the area was full of hostility" (24th March, 2008).

HIA will not prompt Radical Change but…..

The researcher in the project stated that while the HIA may not prompt any radical change in policy, "it can give an angle or suggest an improvement in health. It (HIA) is reasonably non-controversial and it may be too ambitious to instigate radical policy making" (*ibid*). This policy-aiding tool is designed to inform policy, and as will be discussed in the cross-case analysis section, the manner in which it has done this may be both indirectly or directly.

Further Information

Interviewees were asked if they would like to contribute additional information to the study. In this part of the interviews, respondents had a chance to bring up any issues they felt they had not the chance to do so earlier on in the process.

Senior Level Commitment is Crucial

The coordinator in the DTP reiterated at the end of the interview session that HIAs, in her opinion, would not work if there was not senior level buy-in to the process from the very beginning (23rd January, 2008). From her perspective, as an employee in a community development agency, an HIA would not work without this essential ingredient.

Need HIA to become Statutory

The senior Council official stated that HIAs need to become statutory into the future if they are to succeed and become institutionalised. He was confident that they would be legislated for in the future.

Conflict Resolution: Independent Chairperson

An independent chairperson was brought into the HIA, as an impasse had been reached and little agreement or trust existed between the stakeholder sin the process. Views were particularly entrenched between the Travellers and representatives, and the statutory employees. The chairperson said that she was "parachuted in because they couldn't reach agreement," in order to act as a neutral stakeholder in the process (23rd January, 2008).

Research Skills for the Community Health Workers

A member of the HSE stated that the research skills learned by the Traveller community health workers during the HIA could be used and transferred into the data collection phase for the upcoming all-Ireland health status study (11th December, 2007), which was identified as an intangible benefit of the process.

Lack of Understanding of the Concepts of Health

The coordinator of the DTP stated that the non-health sector statutory stakeholders involved in the HIA had little or no understanding of the W.H.O. goals; "no-one seems to understand these (health) concepts" (13th December, 2007). This point was reiterated by the researcher on the project, who found this lack of understanding of a holistic concept of health, which incorporated the social determinants, as a hindrance in the process (24th March, 2008).

The following chapter outlines the health system and local government system in Northern Ireland. This institutional context will provide necessary background information for the presentation of the two case studies conducted in Northern Ireland; the HIA of the Draft Air Quality Action Plan for Belfast (2006) and the HIA of a Northern Ireland Housing Executive (NIHE) proposal to redevelop Dove Gardens Estate (2005).

CHAPTER 6
CASE STUDIES IN NORTHERN IRELAND

Chapter Outline

The aim of this chapter is to detail the case studies in this research from Northern Ireland. An overview of the health system is presented as well as an overview of the structure and history of this tier of government in order to provide the contextual background for this study.

A descriptive presentation of the two case studies that were investigated in Northern Ireland will be provided in this chapter. Such cases will be presented in terms of their rationale, background, and objectives, methodology, stakeholder involvement and HIA outcomes. A description of the policy process, which the HIA knowledge is to be assimilated into, will be provided. An analysis of the expert interviews will be carried out in sections 6.3. and 6.4., as well as the application of the research framework to the empirical data.

6.1. Health System in Northern Ireland

6.1.1. Historical Overview

The Northern Irish health system emerged from the same gene pool as that of the Irish Republic (chapter 5). Prior to partition of the island in 1920, the health and social welfare services were provided by the voluntary and community sector, including religious orders, in conjunction with the state (Clarke *et al*. 2001). Although the division of the island into two jurisdictions in 1920 resulted in a separation of health administrations, both north and south Ireland had already begun to diverge on matters of health and social welfare before that date (Barrington, 1987; Fuller, 2004). The dogmatism of the medical profession and Catholic Church in the Republic, and the reduced level of state involvement in health care provision, resulted in a health system which has only in recent decades come back into the fold of state governance.

Similar to mainland Britain, Northern Ireland's provision of health and social care became a collectivist mix of "state organisation and social regulation" from the 1880s onwards, until the establishment of the Beveridge universal health system (Clarke *et al*., 2001: 32). The British administration's laissez-faire philosophy was replaced by a

proactive, partnership approach to health and social welfare provision, whereby the state was henceforward the driving force in policy and provision. This policy change accumulated in the establishment of the British welfare regime from 1944 to 1948. The newly formed National Health Service (NHS) in 1948 was to become the framework within which health and welfare services would be provided and coordinated on behalf of the state. The model of care provision in Northern Ireland was a triadic mix of structures for acute care (hospitals), general practice and public health (Jordan *et al*. 2006). This structure was in place from 1948 until a change in the organisation of health services occurred in 1974. In that year, Northern Ireland was divided into four health and social services boards (eastern, western, southern and northern). A defining feature of Northern Ireland's health system is the integration of health and social services in the policy-formulation, implementation and provision stages of health care (*ibid*). These four boards had the responsibility for provision of services within their assigned boundaries, while the Department of Health, Social Services and Public Safety (DHSSPS) is the leading central government ministry in Northern Ireland to lead the direction of regional health policy and practice.

6.1.2. Health Policy and Reform

A restructuring of public administration was declared by the Secretary of State in Northern Ireland in 2005. The most pertinent reasons for reform of public administration are the need for efficient use of resources and responsiveness in the care services. Public expenditure in Northern Ireland is 29 per cent higher per person than the average figure across the UK, while revenue raised in Northern Ireland is smaller than any other region in the country (DHSSPS, 2006a). Each of the central government ministries must produce a public service agreement (PSA), which must outline the actions to be taken in the implementation of the public sector reform. The Northern Irish Health Minister promotes a strive towards change in the public services, in terms of improving efficiencies in the system. These concerns are set within the 'Priorities for Action' (PFA) framework, which underlines the reform programme.

The Health and Personal Social Services (HPSS) are encouraged, as are all public sectors, to display efficient use of resources, as outlined in continuous reviews of annual budgets and services costings. The HPSS has put together its reaction to the

PFA, with the establishment of health and wellbeing investment plans (HWIPs), primary care investment plans (PCIPs) and trust delivery plans (TDPs) (DHSSPS, 2006b). These strategic frameworks are aimed to implement the priorities for change in the HPSS public sector, in a coordinated manner based upon a partnership and joined-up governance approach. The HWIPs are produced by the Health and Social Service (HSS) boards, which aim to provide services for the geographical area; implement actions for the 'Investing for Health' (2002) strategy; and deliver on the public sector reform priorities.

All public sectors, including the local government and educational authorities, undergo radical change in their organisational make-up (Jordan *et al*., 2006). In relation to the health and social care system, the number of bodies providing and managing the system will be dramatically reduced (DHSSPS, 2007b). The system is disjointed due to the plethora of bodies administering care, and the centralisation and amalgamation of bodies is hoped to reduce this fragmentation. The reduction in bodies is the key feature of reform of public administration in Northern Ireland (Knox and Carmichael, 2005). It is the aim of this reform programme to improve efficiency and effectiveness within the public sector in Northern Ireland (Secretary of State Speech., 2006). Over the coming years, the number of public bodies that administer care in relation to health will be reduced from 47 to 18 (Jordan *et al*., 2006).

Numerous policy documents and strategies have been released in recent years, signposting the path to reform and modernisation in Northern Ireland's health and social care structures. Over recent years, major policy statements have been launched to signify the commitment to change and system reform in Northern Ireland. The key areas of acute hospital care ('Developing Better Services'), quality of care ('Best Practice, Best Care') and public health ('Investing for Health') have been targeted for action in the programme for change in Northern Ireland (Jordan *et al*. 2006). In line with the modernisation programme in the health system, a regional strategy 'A Healthier Future' was published in 2005. This policy document outlines a twenty year framework for the development of a health and social care service in Northern Ireland (DHSSPS, 2005a). 'A Healthier Future' outlines a framework for more integrated partnership within the services, and indicates a strategy vision for more responsive services for the consumer. This strategy is aimed to establish the vision for the health

and social services over the next two decades. During the formulation of the document, extensive consultation was carried out with the general public. This was to ensure that the long-term strategy would be tailored to the needs of the service users.[33] There is strong emphasis on public health initiatives, coordinating the implementation of the strategy over the next twenty years, and the improvement of multi-disciplinary team-working, quality of care, and responsiveness to care in the communities (tertiary care) rather than in acute hospitals. System modernisation in the health and social care services must take place in conjunction with the reform agenda across the UK (Jordan *et al*. 2006). The strategy published in 2005 is aimed to facilitate reform within the health and social care systems, as well as ensure adequate daily-running of the system takes place on the ground.

In 2005 Professor Appleby carried an extensive review of the funding provisions of the health and social care services in Northern Ireland. This review is part of the drive for value-for-money (VFM) and efficient use of resources within the services, as within the New Public Management (NPM) paradigm of contemporary governance. Findings from this report are considered within the context of the Review pf Public Administration (RPA) taking place across the UK. Professor Appleby (2005:13) concluded the following:

> "It is clear that a significant underlying reason for current problems with the Northern Ireland health and social care sector relates to the use of resources rather than the amount of resources available. There is considerable scope for improvement in the provision of services conditional on appropriate incentive structures being in place that focus on improving health outcomes, while recognizing that more efficient delivery means more resources available for service improvements."

The health boards must bid for funding allocation with planned guidelines for revenue utilisation and specific health outcomes. Health expenditure in Northern Ireland goes in large proportion towards the acute hospital programme and for care for the elderly (DHSSPS, 2005b).

[33] The five strategic themes of the strategy are as follows: 1) Investing for health and wellbeing; 2) Involving people; 3) Teams which deliver; 4) Responsive and integrated services; 5)Improving quality

6.1.3. Health Impact Assessment in Northern Ireland: Grounded in Policy Statement

The policy document, 'Investing for Health' (2002) is Northern Ireland's strategy to promote public health and wellbeing. It was launched in response to the previous Executive's commitment to population health and life expectancy improvements.[34] In order to achieve the aims and goals of the strategy, 'Investing for Health' (2002:172) outlines the rationale for Health Impact Assessment (HIA):

> "The success of much of the proposed agenda for action will depend on the impacts of all Department's policies and programmes. HIAs of non-health policies are increasingly seen as a key tool to facilitate cross-sectoral action, and to promote health and reduce inequalities."

The DHSSPS is the leading agency in promoting the use of the policy-aiding tool, whilst coordinating action in the area with the all-island Institute of Public Health and Department of Health and Children in the Republic. The promotion of HIA in Northern Ireland will occur in an incremental manner, in order to address "issues of coordination, capacity building, tool development and quality assurance" (*ibid*). The DHSSPS will coordinate action with other government ministries in order to support the institutionalisation of the tool. Mapping of policy formulation cycles and health policies in non-health sectors is one of the goals of the leading health Department in the strive for institutionalisation. The integration of HIA with an all-encompassing Integrated Impact Assessment (IIA) tool is an identified option for the way forward for HIA, as well within the Strategic Environmental Assessment, which was implemented in 2004.

[34] The domains for action on health status improvement include the following:1) Physical and functional health and wellbeing; 2) Tackling poverty and social education; 3) Mental health and emotional wellbeing; 4) The living and working environment; 5) The wider environment; 6)Accidental deaths and injuries;7) Making healthier choices (Jordan, 2006:32/33).

6.1.4. How healthy are the Irish? Health Status and Demographic Profile in Northern Ireland

The population in Northern Ireland, as estimated from the most recent Census report (2001), is 1.6 million people. This figure, taken with the population of the Republic, indicates that the island's population is 5.8 million (Northern Ireland Statistics and Research Agency (NISRA), 2002). Within the context of the demography of the UK, Northern Ireland constitutes 2 .87 per cent of the country's overall population. Over the past number of years the population has been increasing (*ibid*). It is set to increase steadily over the next 20 years, with a predicted population of 1.825 million in 2024 (DHSSPS, 2005a). Presentation of the demographic profile of Northern Ireland would not be comprehensive without due consideration of the religious affiliation.

Based upon the Census 2001 figures, the following make-up exists in the region:

Protestant: 53.13 per cent
Catholic: 43.7 per cent
Other: 0.39 per cent
None: 2.72 per cent

(NISRA, 2002)

There is a significant change in the number of people affiliating with the Catholic religion, as 41.5 per cent claimed to be of that faith in 1991 Census reportage (Melaugh and McKenna, 2007).

Northern Ireland has the youngest age structure with the UK. The average number of individuals under the age of 16 years throughout the country is 20 per cent, whereas the figure is 24 per cent in Northern Ireland (NISRA, 2002). Those over 65 years (pensionable age) across the UK constitute 18 per cent, while Northern Ireland has a lower figure of 16 per cent (*ibid*).

<u>Morbidity Rates: Disease Patterns</u>

According to the Health and Social Wellbeing Survey 2005/2006, (DHSSPS, 2007a), 63 per cent of people rate their general health as 'good.' However, there are important health status trends within the demographic profile which are integral to the future planning and service provision within the Northern Irish health system. As is a

common trend throughout the developed world, the population of Northern Ireland exerts characteristic trends; people will live longer and are more likely to die from non-communicable diseases ('the epidemiological transition'), directly related with lifestyle behaviours (DHSSPS, 2005a). Similar to the health status in the Republic, coronary heart disease, cancer and respiratory diseases are the main killers in Northern Ireland for both sexes. These diseases account for 65 per cent of all deaths, many of them preventable (DHSSPS, 2002a). Heart disease and stroke are the main causes of death and disease in Northern Ireland, and are the result of unhealthy lifestyle behaviours. These disease account for 40 per cent of deaths (*ibid*). The mortality rates for heart disease is twice as high with those in the lowest paid occupations, indicating the detrimental impact of health inequalities in Northern Ireland, as in the Republic (Department of Health and Children, 2001). The suicide rate in Northern Ireland is one of the lowest in the EU (DHSSPS, 2002a), although this figure is increasing, especially in the younger population segment (under 25 years).

Mortality Rates: Life Expectancy Patterns

According to NISRA (2005a), the life expectancy at birth for males between 2002 and 2004 is 75.9 years, while it is 80.6 years for women (NISRA, 2005). Birth rates in Northern Ireland for the year 2003 were 12.8 births per 1,000 population (*ibid*), while that figure for the same year in the Republic is 15.5 (CSO, 2007). Compared with statistics across the UK, life expectancy in Northern Ireland is below the country's average by 0.5 years for males, and 0.3 years for females (DHSSPS, 2004). As is a common trend throughout the developed world, the population of Northern Ireland exerts characteristic trends; people will live longer and are more likely to die from non-communicable diseases ('the epidemiological transition'), directly related with lifestyle behaviours (DHSSPS, 2005a).

6.2. Local Government System in Northern Ireland

This section will provide an account of the system of local government in Northern Ireland. Appendix 7 provides an historical account of the system. The establishment of the six-county northern administrative state will be described, as will also the development of local government to the present day.

The Current System of Local Government

As with the system in the Republic was illustrated, the following section will demonstrate the fundamental structure of local government today, in terms of form (composition), functions, financial arrangement, and the reform and modernisation agenda.

Form

Local government in Northern Ireland is made of up a single-tier of councils, as a result of the Local Government (Northern Ireland) Act (1972) and the recommendations within the Macrory Report (1970). The latter had stated that a new structure for local government in Northern Ireland was required because the two-tier structure was "an impediment to economic progress," among other concerns (Birrell and Hayes, 1999:17). There are now twenty-six district councils in Northern Ireland.

Functions

Although the 1972 act changed the structure of local government, in order to modernise the system, the division of functions allocated to the authorities was less than those allocated in the local government systems across the UK. The Local Government (Transfer of Functions) (Northern Ireland) (1973) act prescribed the functions, which can be divided into direct role, consultative role, and representative role (Birrell and Hayes, 1999). The passing of the Northern Ireland Constitution Act (1973)[35] also delineated the division of functions in local government.

Direct role: The district councils in Northern Ireland are responsible for their own geographical location and the provision on services to the resident citizens (*ibid*). 60 per cent of local government expenditure is spent on waste management, leisure and community services, street cleaning, recreation amenities and parks and open spaces. Some other important functions are regulatory in nature, and pertain to building control and environmental health functions. The regulatory role of councils has also been classified as part of the executive role of local authorities (Knox, 2003).

[35] Under the auspices of the Sunningdale Agreement, the legislation in 1973 abolished the Parliament of Northern Ireland, and the post of Governor (in place since 1921), and replaced the institutions with a devolved administration, made up of the Northern Ireland Assembly which would choose its own executive.

Consultative role:

Responsibilities in this regard relate to the authorities reflecting the opinions of their community. The district councils must be consulted on issues of regional importance to a particular council at any time (Knox, 2003). The most developed consultative function is with the Northern Ireland Housing Executive, which was established in 1971 (Birrell and Hayes, 1999). The district councils have the opportunity within this function to consult with central government departments on matters relating planning, development, roads and water services.

Representative role:

As part of this role, local councillors sit on area boards, in order to ensure public representatives serve the needs of their communities on public agency boards, in the provision of state services (Knox, 2003).

Finance

Spending by district councils accounts for less than 5 per cent of all public expenditure in Northern Ireland (*ibid*; Northern Ireland Executive, 2001), although this figure is rising. Local councils have three main sources of funding; district rate, the general grant and specific government grants (Knox, 2003). Northern Ireland is the only region in Ireland and Britain that administers the old system of property rates or taxes in financing local government (McKay, 1991). Services provided by local government are financed by the property tax system or rates. Both local and central government fix rates. Local councils set the district rate each year, and the tax base is made up of the "rentable value of property (residential and business) or its net annual value" (Knox, 2003:463).

For the period 2007 to 2008, the total estimated expenditure of district councils is £584.2 million, and this should be derived from rates income, general grant resources, transitional relief and other grants/ miscellaneous (Department of Environment Northern Ireland, 2007a).

Politicisation of local government

To say that local government in Northern Ireland is a highly politicised system is a gross understatement. For various time periods since the foundation of the state in

1920, Northern Ireland's local government has provided its citizens with ongoing and much-needed democratic representation (Knox, 2003), and laid the foundation for the densely instituted community sector currently in place in the region (Tonge, 2005). Indeed, in 2001 Knox (2001) found that there were 5,500 voluntary and community groups in Northern Ireland at that time, which is eleven times greater than was in place in 1975. The local governing form of representation is only recently being accompanied by a functioning Northern Assembly, led by First Minister Rev. Ian Paisley and Deputy First Minister Martin McGuinness.

There are currently 26 district councils, operated by 582 councillors. Since the 1972 legislation, the system has developed into a relatively stable party political arena. The extent to which small parties and independents occupy seats at local level has decreased in favour of a stable system. Indeed, after decades of numerous small parties and independents, by 1993 the five main parties occupied the political spectrum. These parties made up 88 per cent of the total preference vote (Birrell and Hayes, 1999:93). This trend of a stable party political scene in local government continues to the present day.

The most recent local elections took place in 2005, on the same day as the Westminster elections in London. The election demonstrated gains for the Democratic Unionist Party (DUP) and Sinn Fein, at the expense of other main parties. However, the Alliance Party returned an unchanged representation (Whyte, 2005). Independents made up just 4 per cent of the overall vote, which was the same figure in 1997. The 1997 elections witnessed a significant rise in support for Sinn Fein. Turnout for that election was 55.1 per cent, which increased in the 2001 local elections (68.7 per cent) but a reduction occurred in 2005 (63 per cent) (Electoral Commission, 2005). In the 2001 elections, the most notable party advances were the DUP and Sinn Fein, with the latter party winning more votes (but not seats) than the nationalist labour party, the Socialist and Democratic Labour Party (SDLP) (Whyte, 2001). Overall, analysis of the recent local elections, and a comparison with recent national assembly elections (2007; 2003), it is clear to note that the main parties are gaining more support from the electorate as opposed to support for smaller groups. The rise in support for parties representing the constitutional arm of loyalists and republicans is significant, resulting

in reduced support for the moderate unionist and nationalist parties (Birrell and Hayes, 1999; Carmichael, 2002; Whyte, 2005; Electoral Commission, 2005).

Reform

The viewpoint exists that Northern Ireland suffers from saturated governance and representation (Birrell and Hayes, 1999; Knox, 2003; Knox and Carmichael, 2005). There are 101 Assembly members and 582 local councillors, representing a population of cerca 1.6 million people (Northern Ireland Statistics and Research Agency, 2002). John (1993) points out that a reduction in the number of councils, in a bid to modernise the system in preparation for a transfer of more powers, would benefit the system overall. The recent appointment of a Local Government Boundaries Commissioner, Mr. Dick Mackenzie, whose task is to make recommendations to the Department of Environment as to the boundaries and names of the councils, and the wards within each council, indicates the progression of the reform agenda (Department of Environment, 2008a). Power-sharing has been a feature of local government politics over the past number of decades, and would facilitate the amalgamation of councils into larger authorities (Birrell and Hayes, 1999).

Presently, the Department of Environment (2007b), which has responsibility for local government under the Belfast Agreement 1998, is formulating a strategy in response to the Review of Public Administration (RPA). The reform programme in Northern Ireland is to ensure that local government is at the heart of community life and service delivery (Wilford *et al*. 2007). In order to achieve this, a reduction in the number of councils, from 26 to 7 by 2009, will take place (Department of Environment, 2007b). In 2006, a Local Government Reform Taskforce was established to ensure the process is well informed and is implemented smoothly. It is part of the central government's plan to transfer powers to local government once the larger councils have been established. A new function of community planning will be performed by councils, to ensure joined-up governance between central and local tiers. The legislative framework for the establishment of the new councils is via two acts; the Local Government (Structures) (Northern Ireland) Order and the Local Government (Transfer of Functions) (Northern Ireland) Order. Drafts of these Orders are to be published for consultation in 2007. District councils have, during the imposition of

direct rule in Northern Ireland, been the only foci of local representation and democracy. The people of Northern Ireland have associated political stability with the local government system, as it, unlike the mechanisms for central government devolved administrations, has never been abolished in favour of direct rule. The future of the local government system must balance the need for efficiency in the delivery of services, and the importance of the system in the daily lives of the Northern Irish (Blair, 1998; Birrell and Hayes, 1999; Knox, 2003).

The following sections (6.3. and 6.4.) will detail the two case studies that were investigated for this study in Northern Ireland; HIAs conducted in Belfast and Derry.

6.3. HIA of the Draft Air Quality Action Plan for Belfast (2005)

Part I: Descriptive

Belfast City Council elected for a HIA to be conducted on the draft Air Quality Action Plan in 2005 (Belfast City Council, 2006). Belfast Healthy Cities, which has pioneered the use of HIA on both a local and national basis,[36] supported the Council and led the steering group when carrying out this comprehensive prospective HIA (Devlin, 2006; Smith, 2006). Rapid appraisal and community workshops were conducted in the designated Air Quality Management Areas in Belfast city (Institute of Public Health, 2007). The Air Quality Action Plan and the HIA report were launched at the same event in May 2006 in Belfast City Council.

Rationale and Background of the HIA

Belfast City Council has a responsibility to develop an action plan to improve the air quality of the city. The Council opted for the use of HIA, alongside the drafting of the plan,[37] as it was an approach which provided "an opportunity for stakeholders to make suggestions that will minimise any negative aspects and also improve the way in which plans are implemented" (Belfast City Council, 2006c:81). The National Air Quality Strategy, which was first published in 1997 and a subsequent nationwide UK strategy proceeded in 2000, indicates what is expected from local authorities in order to improve air quality in their areas. The overarching premise of this strategy is that clean air is essential for the health of the population.

In 2004 the Council conducted a review of air quality in the city, measuring eight health-based pollutants. The result was that four Air Quality Management Areas (AQMAs) were formed. These areas are ones which are expected to exceed the pollutant target levels for nitrogen dioxide and particulate matter (PM10), as laid out

[36] Belfast Healthy Cities HIA experience (2002-2006): Community Health Impact Assessments (Ballybeen, Enter Site proposal; Ards, Water Reform) (2003/2004); HIA on the Lower Shankill Housing Strategy (2006); Eastern Health and Social Services Board (EHSSB), Investing for Health (IfH)- Funding for Health Development Officer with HIA remit until March 2008; Department of Social Development (DSD) Land Use Masterplans (recently submitted); HIA on Government proposals to reform liquor licensing laws (2006); HIA Connswater Greenway (2007) (Belfast Healthy Cities, 2007).

[37] This HIA case is categorised as a prospective one since the draft plan was already quite far advanced in its formulation stage, and would not be categorised as a concurrent HIA process. Lavin and Metcalfe (2007) also propose this assertion.

in the National Air Quality Strategy. The areas are located along busy arterial routes (Ison, 2006).

The rationale for the completion of this HIA was to ensure that successful and achievable solutions to air quality problems were proposed by the local authority. It was discovered that during the implementation of air quality action plans in local authorities in England (in accordance with the National Strategy), numerous proposals, as set forth in the action plans, had negative knock-on effects on an adjacent area and community. The HIA process is a structured framework for the consideration of all possible intended and unintended consequences of policy (Kemm and Parry, 2004), and would be beneficial for the formulation of the Belfast draft air quality action plan. The HIA was envisaged to mitigate the problems of unintended knock-on effects as experienced in parts of England. The Council's environmental health manager has stated also that "as statutory agencies we have an ethical and social duty to ensure the measures that are proposed are tested to some degree with the population on which they will have an effect" (Toland, 2006:3). It was the goal of the HIA to ensure the health gains in the action plan would be maximised, and negative impacts would be minimised, as far as practicable.

It was discovered during the interview with the Council's Environmental Health Manager that the idea of conducting a HIA came from attending an air quality conference in England. This individual was moved by evidence presented on the linkages between physical environment and health and wellbeing, and came to believe that carrying out an HIA would improve the air quality action plan, as the following illustrates:

> "I always try to get across to England to get to air quality conferences, they're ahead of us in legislation and best practice, and I heard a guy talk about how they changed the air quality by changing the road structure, and it was a simple change but had a huge impact on the community, they changed from two way traffic to one way, and then the children's area was impacted on. At the time there was some literature on HIA and Belfast Healthy Cities was going on at the time, and then I heard Erica Ison was doing a workshop so I asked could I sit in, so I looked at that and it seemed like a very good way to look at air quality, usually you only think of the technical dimension behind air quality but you don't really think of the social or community end of things. That's how I ended up getting into things with BHC through their connections and we then did the HIA" (20th February, 2008).

Objectives of the HIA

Specific objectives were not outlined the report of the HIA (Ison, 2006). However, consultation workshops that were held with relevant stakeholders were centred on the main themes of the draft air quality report, as are indicated in the following:

1. Initiatives to promote walking and cycling in Belfast
2. Initiatives to promote increased use of transport in Belfast
3. Initiatives to promote improved vehicle fleet management
4. Initiatives to encourage the uptake of greener energy options by large organisations
5. Implementation of policies that will contribute to reducing air pollution
6. Highway and road improvements that will contribute to reducing air pollution
7. Marketing and education initiatives to raise awareness among the public

(Ison, 2006:11).

During the four workshops that were held in the summer of 2005, different stakeholders were consulted on varying aspects of the abovementioned themes seven themes, as will be outlined in the 'methodology' section below.

Stakeholder Involvement

Stakeholders involved in the HIA were drawn from the public, private, voluntary and community sectors. Residents from two of the AQMAs (the M1/ Westlink and the Ormeau Road communities), were involved in the HIA consultation workshops. Workshops were also held at two schools which are in, or close to, two of the AQMAs (Strandtown Primary School and St. Malachy's Primary School).

Although a HIA expert consultant from the University of Oxford was hired to lead the process, a Steering Group was established to oversee the management and completion of the HIA. There were 35 members in this group.[38] A Management Team was also

[38] Members of the Steering Group were drawn from the following organisations: the East Belfast Partnership Board; Translink; Belfast City Council; Greater Shankill Partnership Board; South Belfast Partnership Board; Newtownabbey Borough Council; South and East Belfast Trust; East Health and Social Services Board; Northern Group Systems; Planning Service HQ; Institute of Public Health; Chamber of Commerce and Trade; Roads Service; Environment and Heritage Service; West Belfast

set up, which was a guiding force above the Steering Group; this group consisted of six members (four of whom were interviewed), drawn from Belfast City Council, Belfast Healthy Cities, and the Department of Public Health and Nursing.

Belfast City Council

The Environmental Health section of the Council, under the auspices of the Environmental Protection domain, was the driver of the HIA process from within that local authority. Three members sat on the management team; two of whom are still in the section and were interviewed for this research. The leading individual from within Belfast City Council (BCC) is Environmental Health Manager in the Council and was in this position at the time of the HIA. She described her role as "deciding on it, initiating it, starting it, as it was my budget and resources (within the BCC)" (20th February, 2008). This individual was integral to the process, as without her high-level position of power and influence within the Council, and her drive to commence the HIA, it would not have started. This individual was vital to the HIA. In addition, another member of the Environmental Health section of the Council was involved in the HIA, on the management team. This individual, along with another colleague, managed the HIA project. She described her role as "helping in the organising of the meetings for the HIA, and in keeping everyone on board" (22nd April, 2008).

Belfast Healthy Cities

Established in 1988, Belfast Healthy Cities is the oldest partnership in the city. It plays a major role in promoting health partnerships and projects and is one of the first organisations to carry out HIAs in Belfast. It is one of the leading cities within the WHO European healthy Cities Network which has 76 members across the continent. In Ireland, Galway and Belfast have Healthy City status; Dublin is an applicant. The organisation views its role as one to promote health on the political and social agenda, and included in this is an awareness and endorsement of the healthy urban planning approach. Belfast Healthy Cities plays a key role in promoting HIA as an important tool to ensure healthier urban planning in the formation of urban design and local area plans and city Masterplans (Belfast Healthy Cities, 2007a; 2007b). HIA is one of the

Partnership Board; DHSSPS; Northern Ireland Chamber of Commerce; North Belfast Community Support Group; Sustrans Northern Ireland; NIHE; Confederation of British Industry; Department of Social Development; Energy Savings Trust; Freight Transport Association

identified themes in the current phase of the Healthy Cities Network (2003 to 2008; phase IV) as was outlined in the 'Belfast Declaration for Healthy Cities: The Power of Local Action' (International Healthy Cities Conference, 2003; Devlin, 2007). The other themes include healthy ageing and healthy urban planning.

Two members from this organisation were included in data collection for this case study. One member was the chairperson of the HIA management team, who is also the director of Belfast Healthy Cities (BHC). When asked to describe her role on it, she stated that "it was one of the first HIAs we did, I chaired the steering group and management team also, that was because I suppose of our experience and knowledge of HIAs and doing them, very few in the public sector had that experience" (19th February, 2008).

The Health Development Manager of BHC was also included for interviewing in this research. This individual was not a member of the management team or steering group but played an important role in the facilitation of the process and training and informing individuals of HIAs, and how they work in practice.

Expert HIA Practitioner

The role of the HIA practitioner is one which is commonplace on such projects. There generally tends to be an experienced and dedicated practitioner and researcher who will conduct and lead the HIA.

Unfortunately for the purpose of this research, this individual was not available for an interview. However, this researcher met with her at the 8th International HIA conference and is in possession of a presentation given at a HIA seminar for Galway Healthy Cities in June 2007 (Ison, 2007b).

Department of Public Health and Nursing within the Eastern Health and Social Services Board (EHSSB)

This individual came onto the management team later than the others. The rationale underlying the inclusion of a dedicated public health specialist was to ensure matters relating to population health and the determinants of health were the sole focus and concern of one team member. This was to guarantee the primary of the process

continued to be one of health and wellbeing. This individual described her role on the management team as to "represent the public health perspective….was involved in deciding what pieces of work were required to be done, responsibility in conducting community health profiles and was one of the facilitators at the workshops" (25th February, 2008). This individual came onto the management team later than the other members. The decision to include a representative from a public health background in team was explained by the Environmental Health Manager of the Council, who stated that "we decided to get a health expert in it …so it was a case of learning by doing at the beginning" (20th February, 2008).

Department of Regional Development, Roads Service

The Regional Transportation Strategy (RTS) for Northern Ireland, 2002 to 2012, was endorsed by the Northern Assembly in 2002. It identifies the transportation agenda and funding allocation priorities until 2012. The DRD Roads Services contributions to the Action Plan are based on the Belfast Metropolitan Transport Plan (BMTP) which completes in 2015. It ensures the strategic vision of the RTS is operationalised on the ground.

An individual from the Roads Service was interviewed for this research, who was also a member of the Steering Group, describing his role as "representing roads service, representing transport needs" (19th February, 2008).

Community Groups

Community consultation workshops with residents of two of the AQMAs (M1/ Westlink and the Ormeau Road communities), with two schools (Strandtown Primary School and Saint Malachy's Primary School) and with individuals of the community, private and public sectors, were carried out. As in previous HIA research, which included this HIA case as part of the European evaluation of HIA effectiveness (Lavin and Metcalfe 2007), community representatives were not accessible in the time frame of data collection for this case. Contact details for such individuals were not found by the HIA stakeholders that were accessed for such information, and the individual who had been involved in the HIA in Saint Malachy's school, has since left the school. Although this is the case, discussions with the head mistress of this school informed

this researcher that health promoting campaigns and clean air programmes, involving have tree-planting areas on school grounds, were inspired by the HIA.

Institute of Public Health (IPH)

The Institute of Public Health is an all-island agency, which is based in Dublin and Belfast. It aims to address the island's public health needs by conducting research and informing governing departments of health requirements for the population. One of the key areas of work of the IPH is to promote awareness of HIA, to provide training of the technique and to conduct research into the health impacts of non-health sector domains (for instance, health impacts of the built environment, IPH, 2006). The Steering Group had one member of the IPH on it, who described her role as one of an "information capacity", adding that " the Institute is tasked by the Department of Health to do work on HIAs, so it would have been in that capacity also" (20th February, 2008).

Methodology

Little information exists as to the exact HIA methodology used in this case. However, it is known that a literature review was conducted regarding other HIAs conducted on similar proposals elsewhere and data of the local area was used to establish a profile of the community. Workshops were held, during which time people were called upon to "judge the effects of the draft Air Quality Action Plan on the health and wellbeing of people living and working in Belfast" (Ison, 2006:13). One workshop was held for members of the public, private, voluntary and community sectors; workshops were held in two resident areas and in two local primary schools (*ibid*).

HIA Outcomes

Suggestions (not specifically termed as recommendations, as is the protocol of Ison) were established, as a result of the stakeholder workshops. Suggestions were framed within the context of either reducing potential negative effects or enhancing potential positive effects of various initiatives in the plan. These initiatives come under the seven themed areas. Suggestions were made by all stakeholders in relation to each of these seven areas. The Air Quality Action Plan, which was published in 2006, utilised evidence in each of the themed areas in the final report (Belfast City Council, 2006).

Policy Process for the Draft Air Quality Action Plan for Belfast

The main institution using the evidence and knowledge from the HIA was Belfast City Council. This organisation was both the initiator of the process and will use the HIA for Council policy. However, this local authority does not have any operational function over transport policy. In reality, this means that although the Council can coordinate action on air quality, it has no statutory power to enforce the measures.

There is a direct relationship between the HIA on the draft plan (conducted in 205; reported in 2006), and the outcome final plan (2006). Less information is available as to the utilisation of evidence by other key statutory, voluntary or community bodies (Belfast City Council, 2006). This was explored during the conduct of expert interviews with members of the Management Team (5) and Steering group (2), and others (3).

Appendix 8 provides a review of the key documents in the area of air quality in Belfast City.

Part II: Analysis

As with the other cases, the framework approach to analysing interview data will be used for this study (Ritchie and Lewis, 2003). In this Belfast case study, seven people were included for semi-structured expert interviews, and one for an exploratory interview, as can be seen in appendices 4 and 5. Appendix 14 presents the process of data analysis, which traces the degree of abstraction and data refinement, beginning with the raw data through to the establishment of indices, categories and finally, classifications.

An exploratory interview was carried out with a representative of the Policy Innovation Unit in the Office of First Minister and Deputy First Minister (OFMDFM), in Castle buildings, Stormont, Belfast. This individual is charged with researching and presenting the Integrated Impact Assessment tool, (and also as the Policy Toolkit which provides guidance on the IIA) of which health impacts, and the HIA approach, inform the concept of integrating all impacts assessment frameworks at central government level (O'Mullane, 2008).

INSTITUTIONAL THEORY (x1 and x2)

Hypotheses: HIA utilisation is possible with institutionalisation

HIA is a policy support tool that aims to inform policy decisions by making explicit the health impacts of each policy document or proposal, and strives to maximise the benefits and minimise the negative aspects of HIA (Scott- Samuel, 1998; Barnes and Scott-Samuel, 2002). It aims to inform the decision makers of such potential impacts of a policy, project or programme.

Sub-hypothesis (variable indicators)

The normative dimension alludes to the norms within institutions that can go some way to explain the behaviour of actors in the institutions and organisations. The influence of the institution, and its norms, has been cited in previous HIA policy research, as a further explanatory theory to explicate of the influence upon the use of HIAs in policy (Banken, 2001; 2003; Bekker *et al*. 2005; Kemm, 2005; Bekker, 2007; Morgan, 2008).

A number of questions were asked during the interview phase of data collection, in order to establish the degree of influence the norms of institutions had over the use of the HIA report, and the knowledge that came from that and it's preceding process. The topic guide, containing the standard interview questions, is in appendix 2.

Are Institutions Ready? The Timing of HIA as a Policy Support Tool

The timing of HIA as a policy support tool was asked during the expert interviews, in order to establish the perspective of those on the HIA steering group, which included decision makers and representatives of statutory bodies.

Except for two respondents, all those who were interviewed stated that yes, the time was right and had come for HIAs to be used in policy making.

Two respondents were more cautious in their appraisal of the HIA tool, stating that maybe the time had come to use HIAs in policy making. One of these individuals was

from the Roads Service, and had a more reserved opinion of the HIA conducted on the action plan. He believed that the fact the HIA and action plan were conducted concurrently was unhelpful for the air quality plan; "There's an issue about how it influence the action plan, they were done together and there's a problem with timing….they were done in parallel and like ticking boxes" (19th February, 2008). An individual from Belfast City Council who was involved in the HIA also was more cautious in evaluating the timeliness and appropriateness of the tool.

Five of those interviewed stated that yes; the time had come to use HIAs in public policy, from their experience with the Belfast City Air Quality Plan (2006). The representative on the management team from the Department of Public Health and Nursing stated that it is a "workable tool and we should be using it," and there is a need to raise its profile by using it also (25th February, 2008). The chairperson of the HIA, who is also director of Belfast City Councils and with responsibility for the development of HIAs within the Healthy Cities network, stated that the time had come but there were a number of issues that needed to be dealt with and recognised in order to maximise the use of HIAs for public policy.

The Health Development Manager of BHC agreed that the time was right to use evidence from HIA but believed that political and administrative reform could hinder the process (19th February, 2008).

On balance the Environmental Health Manager of the Council believed the time was right for the use of HIAs in policy, qualifying her statement with "was there ever a right time? It was never going to be an easy task so we just decided to get on with it and see what happens. BHC felt was a right time and way to get it in back door to influence strategic agendas" (20th February, 2008).

The representative of the IPH on the Steering Committee concurred that the time had come to use HIAs, as "there's a need for evidence in policy, especially looking at health in all polices. Evidence shows to date if you don't have evidence then nothing is going to change" (20th February, 2008).

Further to whether or not the timing was right for HIAs, the interviewees went on to expand on their responses to this question. The answers to this question were analysed, firstly by indexing them, and then by categorising these indices. Different categories were derived from the data. Seven categories arose from the interview, namely the institutional factors at play enabling and hindering the use of HIAs. The policy process was elicited as a factor in the timeliness of the tool, and the evidence that will inform the process. The public administration reform programme ongoing in Northern Ireland was found to impact the use and acceptance of HIAs. The nature of community engagement, the Integrated Impact Assessment (IIA), and the nature of HIA, the meaning of health (conceptualisation of health) and the lack of statutory recognition surfaced also as factors affecting the timeliness and suitability of HIA as a policy-aiding tool in the current day phenomenon of policy making.

Firstly, a number of issues relating to the impact of institutional forces upon the use and acceptance of HIA arose during the interviews. the director of BHC stated that there was commitment from the Northern Ireland Housing Executive (NIHE) and Belfast City Council to mainstream HIA for all projects, programmes and policies (19th February, 2008). There are also ongoing constructive discussions between BHC and the OFMDFM regarding the formal establishment of IIA, which would incorporate the consideration of health impacts with statutory recognition in the long run (*ibid*).

Leadership within the institutional organisations is a necessary ingredient for HIAs to be conducted smoothly, and of evidence to thereafter be used in public policy. This point was raised by the Health Development Manager of BHC, who believed that the time had come to use evidence from HIAs in policy, aslong as top-level leadership was in support of the concept, which was overall the case in the Belfast air quality HIA (19th February, 2008).

The Environmental Health Manager explained the institutional difficulties in formulating the air quality action plan. Getting the NIHE, Department of the Environment, Department of Health, Department of Regional Development and Roads Services on board was hugely difficult. The reality of the situation was that the air quality action plan is a statutory requirement for the Council but not for the bodies

required to participate, and even though it is not the priority of such key stakeholders for the deliver of the plan, it was "hugely frustrating, it took us nearly two years to get the plan together, especially roads services, and planning never came to table, and that was a huge partner not there before the HIA started" (*ibid*). Many of the key stakeholders were central government departments and were not accustomed to inter-relating their agendas with others; "central government departments work alone unlike local government, and it's very very difficult to influence their agendas" (*ibid*).

The chairperson of the HIA stated that there was difficulty in doing the HIA on the Air Quality Action Plan – it was resolved but there was a difference in opinion between two individuals on the credibility of evidence on air quality that was used by the HIA specialist and an air quality expert within City Council: the HIA researcher on the project used findings from the London Health Observatory to support the evidence within the HIA. However, although this instance demonstrated some reluctance of the upper echelons of knowledge and power to accept evidence which incorporates outside research and academic evidence, overall the Council accepted willingly the evidence that came from the HIA (19th February, 2008).

The Environmental Health Manager (19th February 2008) stated that there was a problem with cooperation and mutual sharing of information across institutional boundaries; "in broader terms people are very self-focused and don't inter-relate with other people's agendas." In addition, this individual stated that there was a major issue of some "huge partners not (being) there, even before we did the HIA." Two of these major partners were the planning services and roads service. The latter came to the table but the former group never did. Missing the planning services meant that a major stakeholder in the process was missing and was to the detriment of the HIA In achieving the maximal benefit from the process.

Secondly, the policy process arose as a factor impacting upon the use of HIAs. The representative from Roads Service believed that the issue was "the timing in the policy process," that the conducting of the HIA and draft action plan concurrently was problematic for the HIA (19th February 2008). A representative from the Environmental Health division in Belfast City Council, who worked on the project management of the HIA, believed that the fact that this was the first HIA being

conducted was a problem for the tool making an impression on policy makers and the policy process (22nd April 2008).

The representative from the IPH stated that "evidence was needed for policy," which was why HIA's time had come as there was increasingly more evidence needed for informed policy making (20th February 2008). The chairperson of the HIA also believed that evidence coming from the process was important, as well as health's place on policy maker's agendas (19th February, 2008).

Thirdly, the issue of public administration reform arose as a major factor in the timeliness of HIAs, and the manner in which the tool can succeed in the current institutional climate of public administrative reform. The reinstitution of central power in Stormont (Health Development Manager, BHC, 19th February) and the political and administrative changes have influence the use of HIAs. The chairperson of the HIA, also Director of BHC felt the opportunity for the institutionalisation of HIAs during this time of change was not seized (19th February 2008). The Environmental Health Manager in the Council stated that circa 2005 and 2006 there was tension across all statutory bodies regarding what the Reform of Public Administration (RPA) would bring, and this was a big influence in the level of engagement of statutory bodies in the HIA; "In theory a good tool for collaboration but the timing, RPA was a big influence, was started to be muted, the roads service were nervous that they'd come under local government and the planning service" (*ibid*). This individual believes, that because of the RPA at the moment, there is much more uncertainty and it would be more difficult to conduct the HIA (*ibid*). Overall, it was a case of 'now or never' regarding the conduct of this HIA on the draft air quality action plan in the institutional climate at the time.

Fourthly, the "the proposers didn't have a problem with what came from the community groups, and that fed into the action plan, they took that on board alright, they were positive and would say it did influence the action plan" (19th February, 2008). A positive aspect of HIAs in relation to the evidence derived from the process, is that the communities involved in the process are, at the end, in possession of

evidence that they can use at a later date and in other proposals or in lobbying policy makers on other issues. [39]

Fifthly, according to the chairperson of the HIA, there is a case to be made for the development of an Integrated Impact Assessment (IIA), which would incorporate the main tenets of all IAs inhabiting the policy process at the moment (19th February 2008). Constructive discussions between BHC and the OFMDFM are ongoing regarding the formal establishment of IIA, which would incorporate health impacts with statutory recognition.

The sixth category that arose from the interviews was the nature of HIA, and the manner in which the tool was formed to ensure its time had come for use in policy. It became clear during the interviews, which was not apparent from reading the documentary evidence alone, that one of the primary reasons behind conducting the HIA was to broker cooperation between the stakeholders in the action plan. It was carried out in order to try "to influence them, influencing them with another new tactic……and I thought, why not give it a go and let these gentlemen, mostly gentlemen, have a think about the wider determinants of health and what the implications of road structures might be" (*ibid*).

The seventh category that came from the interviews in response to the timing of HIAs was the conceptualisation of health, and how it impacted on the progress of the approach. The chairperson of the HIA and Director of BHC stated that there were difficulties during the conduct of the project with the various non-health sector stakeholders around the meaning of health. She also explained there were difficulties with those from a public health background also, as their understanding of health was from a biomedical health perspective (19th February 2008). The Environmental Health Manager felt that doing the HIA was a good way to inform statutory professionals of the wider determinants of health (20th February 2008).

[39] This was the situation with other cases and was pointed out → Ballyfermot and spill over effects and keeping the evidence; Donegal and traveller accommodation; Derry and social housing, have evidence linking health and housing and education and employment and can use it again at a later date.

The final category was the lack of statutory recognition, which in turned hindered the development of HIAs in Northern Ireland, as explained by the Health Development Manager of BHC (19th February, 2008). Although it was clear in many respects that the timing was appropriate for the use of HIAs in policy, there were a number of factors influencing this utilisation.

Normative Dimension: Do Institutions Shape Behaviour?

The use of institutional theory in this study is to establish the extent of the influence that certain institutions have on the use of HIAs and the knowledge that came from them, which was intended to inform policy.

Those interviewed in this case were stakeholders in the HIA process. They were on the Management Team as representatives of their relevant bodies, be it from statutory institutions (Belfast City Council, Belfast Healthy Cities) and the public health services perspective (Department of Public Health and Nursing, EHSSB). The Steering Group was made up of an eclectic range of statutory bodies, all having an interest professionally in the air action plan. Representatives from the Roads Services and the IPH were involved in interviews for this study. The responses to this section were grouped into categories after an indexing process took place. Firstly, at an institutional-level, HIA process- and policy process-levels, a number of constraining factors upon behaviour were elicited. Secondly, gathering local evidence and the way it is collected was deemed a constraint for the HIA approach. Thirdly, community human resources played a constraining role in this case study, as there was little community infrastructure around the issue of physical development in the four AQMAs.

<u>Institutions and Organisations: Macro-Level of Analysis</u>

A number of constraints were identified by the interviewees in response to this question, pertaining to the institutional barriers upon the use of HIA evidence. According to the Environmental Health Manager, the "constraints would be planning and roads service, they're very independent, part of central government so no real accountability, no one to answer to if they don't play ball" (20th February 2008). The other representative from this section in City Council also had a negative viewpoint of the planning services, saying that they were invited to the process but there "wasn't

any real commitment, presumably they had more important things to do" (22nd April, 2008). Whilst a number of key stakeholders were missing from the process, or not engaged fully, some of the players that were involved were not accustomed to sharing information or perspectives across institutional boundaries, as the chairperson of that HIA illustrates:

> "Barrier about partnership working and a lack of willingness to have information in case they don't look good. I'm not sure they're all there for health improvement, if it's on their agendas. Partnership working is good at the surface but maybe not underneath, they're all there for their own individual reasons" (19th February 2008).

The issue of a lack of power at city council level arose as a constraint on the use of HIA in policy. The Environmental Health Manager (20th February 2008) stated that there were a number of institutional barriers at play, namely "strategic planning barriers, there's legislative planning, and there's financial programming barriers." After the experience of the air quality HIA, her opinion was that conducting HIAs on smaller projects would be easier, but at strategic level, the ability to influence other institutions and their policy agendas was difficult, bordering on impossible. Power was limited in the council, as it was with the Department of Regional Development (DRD) and planning services, but there was little cooperation or pooling of resources across these institutions (*ibid*). There is greater accountability and transparency at the local government level, according to the Environmental Health Manager, which is not present in central government agencies which work alone and to their own agenda; "needed to change the agendas of other organisations but that does not work" (*ibid*). The clearly subservient role that the council appeared to fulfil when compared with the central government agencies was a hindrance to the HIA and its maximum usage in policy and to inform policy makers. However, the representative from Roads Service stated in a matter-of-fact manner that since the Council were leading and using the HIA, there should be no constraints at all (19th February, 2008).

<u>HIA Process: Micro-Level of Analysis</u>

In response to institutional constraints, the nature of the HIA process and some problems that came from operating within and around it, arose. The meaning and conceptualisation of health, which is at central to HIA, came up as a difficulty again

for the chairperson of the HIA (19th February 2008). The lack of HIA awareness (Environmental Health representative, 22nd April 2008) and the lack of capacity-training in HIA were cited as barrier to the use and acceptance of HIAs and the evidence that came from the process (Health Development manager, BHC, 19th February 2008). The fact that the HIA was a new concept was a constraining factor within the institutional context, and is not compulsory, was a barrier. It was "a totally new animal to us, we'd never done it before" (Roads Service representative, 19th February 2008). In addition, the public health representative on the management team stated that people involved in the conduct of the HIA were overloaded with work; people did not envisage how time-consuming the process would be, which was cited as a constraint on the process and outcome of the tool (25th February 2008).

Policy Process: Micro-Level of Analysis

Within the policy process, institutional constraints were identified regarding the use and acceptance of the HIA. There were constraints "because of the timing of the action plan," as, according to the Public Health representative, the fact that the action plan and the HIA were conducted concurrently there was major time pressure to complete the HIA and action plan within a limiting time frame (25th April 2008). The Public Health Development Manager of the IPH stated that the "policy process is not static, there is no guarantee the HIA will be used" (20th February, 2008). The uncertain and quick-moving nature of the policy process is a constraining factor upon the use of HIAs and the findings of the process.

Evidence

The way that evidence is collected in the local area to provide the evidence base for the HIA, which would in turn hope to influence and inform the policy process, was regarded as constraining. Different bodies collected evidence differently, and were not keen or willing to share information across institutional boundaries (chairperson of the HIA, 19th February 2008). The lack of evidence for policy was constraining, which was identified, in turn, as the main rationale behind conducting the HIA- to fill the evidence gap (IPH representative, 20th February 2008).

Community Resources

It was identified by the Health Development Manager of BHC (19th February 2008) that there "was little community infrastructure but once we informed them then they were able to get involved and were interested in it." It was a constraint on the process that there was not already in existence a strong community spirit, which could work with and on the HIA.

Political Dimension: Does Politics Matter?

Elliott and Francis (2005) found in their research into the Welsh HIA experience that the influence of the political environment and agenda, and the different interests around the HIA 'table' was considered an important dimension to consider when looking at the influences upon HIA usage in policy. This was also found is other HIA research (Davenport *et al.* 2006; Bekker, 2007, Wismar *et al*. 2007). The new institutionalist strand of political science theory also contends that the political dimension is an important one to take into consideration, when investigating the influences upon individual and collective behaviour and action (Immergut, 1992; Peters, 1999).

This study investigated the influence of such a political dimension, by asking the interviewees to what extent were politics at play between the varying interests in the conduct of the HIA.

The responses to this question have been categorised into three groups. The political dimension at a micro-level (individuals) and macro-level (institutions) was identified. The use of HIA as an advocacy tool was identified, and the expectations of the process arose also from the interview responses to this question.

Individuals: The Gatekeepers to the Institutions

With regards to politics at play, both in the conduct and aftermath of the HIA, some of the interviewee responses related to the fact that perhaps some individuals on the steering group were not fully committed to the idea of the HIA, and were defending their institutional line while involved in the process. This latter point was more obvious on the Steering Group, as those on the Management Team were more united and collaborative than the former group; "everyone was backing their organisations

and were defending their own areas. For instance, DRD were not going to say anything that would result in them had to dramatically change their policy or plans" (Environmental Health representative, City Council, 22nd April 2008). This point was reiterated by the Environmental Health Manager, who stated that while "there was softening, people came to the table with organisations perspective too" (20th February 2008). Indeed, how ever tense or implicitly political the interactions were between the key stakeholders, a "key outcome is building professional relationships with people, especially good people" (*ibid*). This is to say, that the Environmental Health Manager found that there were some key bright innovative-thinkers across the organisations that were involved in the HIA, and meeting and collaborating with such policy entrepreneurs was an important outcome from the process. On the other side, there were individuals who were unreceptive to the HIA, to the findings and the essence of collaborative working; "one department who came along and were very 'closed book' about it all and had made up their mind beforehand, but then after some group meetings and after doing up the suggestions he was very much in support of the HIA, so that's a 'win'" (IPH representative, 20th February 2008).

Institutions: The Gate and the Building

The representative from the Public Health Department on the Management Team stated that from her perspective there were very little politics at play during the conduct of the HIA, "politics with a small p, as it was a multi sectoral and multi disciplinary process" with many stakeholders involved (25th February 2008). Other interviewees were more convinced that there were institutional politics at play, across the institutional gene pools involved; "there were alot of politics but not very overt. I wouldn't understand the politics between the DRD, roads service, health department" (HIA chairperson, 19th February 2008). There were tensions identified between various stakeholders, namely between planning services and roads services, as implied by their lack of commitment (Environmental Health Manager, 20th February 2008).

This individual stated that the following:

> "I wouldn't say politics just institutional barriers. Maybe RPA (reform programme) had a bit to do with it, (roads services) wouldn't be seen to be led by local government, and the "only show in town comment" was clear…. "Our show is the only show!" (*ibid*)

On the other side, there were tensions between central government departments and the local authority, as stated by the representative from Roads Service (central government agency); "there's always tensions in terms of departments like roads service , seen as directorial, and then local councils, and it seems to me that local councils always want more power" (19th February 2008).

The NIHE was deemed as an exceptional body, which was "really a forward thinking agency; it's unlike other departments such as the Department of the Environment or planning, where it's just like pulling teeth" (chairperson, 19th February 2008).

The Health Development Manager of BHC reiterated this statement also, by stating the following:

> "The housing exec is the only one really driving it (HIA) on but that's the nature of the organisation always up for change change, they're sharp, on the ball, up to date, working at a local level with very difficult communities. And they see HIA as a very positive tool which helps too" (19th February 2008).

It was clear from informal conversations with other individuals that the NIHE has an excellent reputation as an innovative organisation. Where the institutional make-up in this HIA in concerned, the NIHE is ahead of all others in terms of innovation and flexibility, and is willing to allow others enter the metaphorical institutional gate and building with more openness and willingness than other institutions.

The chairperson of the HIA stated that it was interesting for her to observe that there was "no internal politics around HIAs in the health services yet," as in general, there is much tension between various health service sectors with regard to new tools and approaches (19th February 2008).

HIA: An Advocacy Tool?

The representative from Roads Service explained how he believed the HIA may have been a tool for the City Council to endorse their view on the issue of transport and roads, as the local authority is keen to reduce the number of roads built, which contradicts the policy of the Roads Service. The following illustrates the view that the HIA tool was perceived to be a tool advocating one particular viewpoint; that of the leaders and primary users of the HIA:

> "At one stage there were tensions between how we're regurgitating what's in our transport plan at the HIA and draft plan, for instance we want to put in certain roads and there's great tensions because the council doesn't want certain roads, would this HIA be seen as endorsing their view? There was alot of playing around with words" (19th February 2008).

The extent, to which HIA can be used for as an implicit political means to a political end, is an issue that was pertinently raised by this interviewee.

What do we expect from HIA?

The chairperson of the HIA raised the question of expectations of HIA, and that they need to be clarified when commencing a process. There are number of priorities that the HIA tool can work towards, such as "placing it on someone's agenda, engaging communities, engaging stakeholders" (19th February 2008). However, as raised by this individual, it is not a one-size-fits-all and what is expected from the process should be communicated and elucidated at the beginning of the process, which was not done in the HIA on the air quality draft action plan.

VALUE JUDGEMENTS (IMPACT ASSESSMENT THEORY) (x3)

Hypothesis: HIA utilisation depends on the value judgements of the policy actors

An important issue is the question of the role that values, beliefs and assumptions play in the policy process. The role of these values has been the topic of research in the impact assessment literature. It is being used as an explanatory variable in this study; to assess the influence of value judgements in the use of HIAs. As no matter how rational the policy process may appear to be, it is ingrained with value systems and beliefs (Carley, 1980; Krnv and Thissen, 2000; Weston, 2002; Bekker *et al*. 2004).

Five categories were elucidated from the interview data. The institutional and organisational values played a role in the use and perception of the HIA. Other categories that arose from the interview data relate to the impact of values in the policy process, values around health, values regarding the contributions to the HIA and the importance of the key enterprising and exceptional individuals in organisations in pushing the HIA agenda.

Institutional and organisational values

In response to this question, the interviewees were confident that values, and value judgements regarding the use of HIA evidence, played a role.

The representative from the Environmental Health unit in the city council agreed that values played an important role, as the following illustrates:

> "There were constraints in having so many organisations involved, so many agendas and budget pressures to consider and the HIA was looking at things in isolation but within each org it wasn't going to be acted through in isolation needs to be looked at within the entire org plan" (22nd April 2008).

The Environmental Health Manager explained how it was "difficult to make strategic changes with the big guys, values are not the same across institutions" (20th February 2008). It was difficult, according to this individual, to implement change and ensure the use of the HIA across the stakeholder institutions involved in the draft action plan, due to the varying value systems in each of the institutions. For instance, roads services and the planning services were reticent; to say the least, while the NIHE have organisational values which welcome such a tool as HIA, as the following illustrates:

> "Depends on who's leading the HIAs, depends in alot of ways on the individual but we have had some commitment at organisation level too. The housing executive is a very good organisation to lead it and there's been an agreement to implement HIA across the board and maybe they see the value, that might have to do with their ethos and culture and they've changed an awful lot in the 35 years, unlike the city council which is more difficulty, whereas the housing exec has always been willing to change" (chairperson and Director of BHC, 19th February 2008).

Indeed, the values of the city council are service-focused, although this orientation is changing but will take time, as the Environmental Health Manager stated in the following:

> The values of this council is very service focused service delivery focused and also the health aspect is very integral to that, improving the quality of life for future generations is a corporate mission and it's changed slightly in the last year we've moved towards value creation maps but I'll not bore you with them, but it's to improve health and quality health is so big as well as customer orientation" (20th February 2008).

Both the Environmental Health Manager and the chairperson of the HIA agreed those institutional values, and how institutions and the actors within them judge HIAs and evidence coming from them, is influenced by organisational culture and values, as the following explains:

> "It depends on the organisational culture and the organisation's value and that then follows on to how and why they'll engage with HIA. We haven't had a Celtic tiger and the council's priority is to have a prosperous city but they've little understanding that to have a wealthy city you need a healthy population and those in poorer areas need a certain standard of health" (chairperson, 19th February 2008).

The lack of statutory recognition of HIA also implies a value judgement from an institutional and central government policy level; without accordance of legislative footing of HIAs, the credibility of the tool will be doubted by statutory players involved in the city council's policy making environment, as explained by the Environmental Health Manager (20th February 2008).

Values in Policy Process

The representative from the health services on the management team explained that as far as she was concerned, "values played a positive role in the policy process," and especially in the promotion of the HIA on policy makers agendas (25th February 2008). According to the representative from Roads Services, "you can't separate personal and professional values" and this was the case in the perception of policy makers of the HIA tool and the evidence arising from the process (19th February 2008).

Valuing Health

The chairperson of the HIA believed that "the biggest challenge here is the economic versus health, wealth versus health" agenda (19th February 2008). In her opinion, and from her experience of leading the Healthy Cities agenda in Belfast for a number of years, the issue is still s fundamental as prioritising health with the economic priorities, at an institutional level.

The impression of the representative from the IPH was that, at an institutional level the local authority was indeed attempting to establish the appropriate means of incorporating the health and wellbeing agenda into policy; "Belfast City Council believes their role is to indirectly work towards the overall health of the population and they will look to all avenues to work at that, HIA being in that. They've a value to work towards overall health and well being" (20th February 2008).

Valuing contributions to the HIA

The contributions to the HIA from the community stakeholders were vital to the process. The contributions made by this group were valued by the statutory bodies, which were a most welcome aspect to the process as "people aren't usually asked about their opinions for policy" (*ibid*).

It depends on the person….

It was identified during the interviews that the influence of certain enthusiastic and innovative individuals can determine the successful implementation and utilisation of the HIA in policy. The chairperson believed that "it depends on who's the chief executive in the council, depends on the leader. Because that filters right down through to all staff" (19th February 2008). Apart from forward-thinking institutional leadership, certain individuals within organisations can make a difference, and their absence is also a hindrance to the process; "It's individual dependent, yeah we'd to formally ask them for individuals to come on board, and getting was difficult in the beginning" (Environmental Health Manager, 20th February 2008).

ENABLERS AND BARRIERS: A CHECK-LIST

The respondents in this study were asked about enabling and hindering factors towards to the utilisation of HIA knowledge in the decision making process. The Donegal case study was the second one investigated in the data collection of this study. The check list (below) was formulated by Dr. Catherine Hayes. It was presented at the 3-day comprehensive Health Impact Assessment Training which this researcher attended, as run and organised by the Irish Institute of Public Health (September 2006, Grand Canal Court Hotel, Malahide, Co. Dublin)

For the purpose of this research, it was deemed appropriate to use this check-list, formulated in Ireland, for the case study research. This is so as to establish the level of agreement on the contextual conditions for use of HIAs in policy and to construct any additional suggestions that may come from the interviewees. Another comparable study of such enablers and barriers was conducted in the UK (Davenport *et al.* 2006).

<u>Enablers and Barriers to the policy process in having decision makers involved (Ballyfermot) (September 2006)</u>

6. Involved in planning and conduct of HIA
7. Input from outside decision-making process
8. Clear organisational commitment
9. Subject non-controversial
10. Realistic recommendations

Bad points of decision makers and policy process

3. Lack of awareness of health by other sectors
4. Lack of knowledge of policy-making environment

During data collection, seven interviewees were asked as to their level of agreement with the abovementioned enablers and barriers.

As can be viewed in appendix 13, all respondents agree with the first two enablers. There was variation in agreement for the other categories. Regarding the fact that there was clear organisational commitment to the HIA, and this being an enabler to the process, the public health representative, Environmental Health Manager, IPH

representative and roads service representative agree that it existed in the air quality HIA. The chairperson of the process and the representative from the Environmental Health unit in BCC disagreed. The chairperson believed that the higher tiers of power within the council were in favour of the HIA but commitment dwindled within the lower tiers. The representative from the Environmental Health unit believed that organisational commitment varied in the steering group, not all stakeholders were as committed to the process as others.

Regarding the HIA having a non-controversial subject matter, the representative from the public health services was the only respondent to state that air quality was non-controversial and this was therefore an enabler in the process.

The other respondents believed that the subject matter was controversial; "it was controversial as an issue…the actions to reduce air quality was controversial" (chairperson, 19th February 2008); "transport and air quality, blaming air quality on transport is not a comfortable position, not easy, can't always stay around non-controversial concepts. And with the community it is controversial" (environmental health manager, 20th February 2008); "I'd disagree, can be quite controversial, pull between the people who want cycle lanes, and then people who drive taxis and everyone wants something for everyone. Transport is a controversial area" (Roads Service representative, 19th February 2008).

All respondents agreed that realistic recommendations came from the HIA, except for a representative in the Environmental Health Unit, who stated the following:

> "No, not realistic, because the recommendations involved the coordination between organisations and as a council we have not got the power to force anyone who was dragging their feet.
> If doing within an organisation where the whole organisation was committed and the power source at the top was committed to the idea and was allocating resources to it, then it would be better. Different organisations, with varying commitments and plans and budgets and pressures, means that it's more difficult to implement recommendations from the HIA" (22nd April 2008).

Regarding additional enablers in the process were provided by some of the interviewees. The public health representative pointed out that having a HIA expert leading the process was an enabler. The chairperson also agreed with this last

statement, and stated also that "the key enabler is leadership, either from the community geographical area or from the proposer" (19th February 2008). The Health Development Manager in BHC (19th February 2008) agreed also that an HIA expert was helpful to the process. The Environmental Health Manager (20th February 2008) stated that community involvement as an enabler to the process overall.

Regarding the barriers in the process, the public health representative and the two BHC individuals disagreed that the lack of awareness of health by all stakeholders was a barrier to the process. The two environmental health individuals and the roads services and IPH representatives agreed that the lack of awareness of health were barriers in the HIA process, and especially in advancing the findings and concept of HIA in the policy making process.

Regarding the lack of knowledge of the policy making environment, only one individual agreed that this was a barrier to the process of HIA, the representative from the Environmental Health Unit (22nd April 2008), from a community perspective. On the other hand, for instance, the representative from roads service stated that "everyone on board had decision making roles so that wasn't an issue" (19th February 2008).

Additional barrier to the process were provided by some respondents. The representative from the public health services stated that "health was not a priority for some members" (25th February 2008). The Environmental Health Manager (20th February 2008) explained that organisational limitations were a barrier to the process, as stated in the following:

> "We should have teased out the limitations that all the organisations had, instead of realising them down the road, people should have been up front from the start what they could and couldn't do."

The IPH representative stated that the fact the HIA was being done concurrently with the action plan was a barrier.

KNOWLEDGE UTILISATION AND POLICY ANALYSIS (y)

Each interviewee was asked to what extent, as far as they knew, was the HIA used in policy and how useful was the HIA. Responses were divided into 16 indices, and after further abstraction, were coded into 6 categories. The degree of utilisation of the Belfast HIA will be assessed in the next chapter when a cross-case comparison is conducted. The within-case results from the interview data collection is presented in this section.

Action Plan

According to the public health services representative on the management team, the HIA "was useful and changes were made to the action plan" (25th February 2008). This was reiterated by the Environmental Health Manager (19th February 2008), whose unit in the city council were drafting the air quality action plan which was using the HIA. The representative from the IPH also agreed that the suggestions from the HIA were taken on board into the action plan (20th February 2008). The action plan, although it does explicitly state the suggestions from the HIA were used, has been confirmed during the interviews with the stakeholders involved in the process.

However, the chairperson of the HIA believed it was a mistake not to form an implementation group to ensure and record that the suggestions from the HIA were fully implemented and taken on board:

> "I think one of the limitations on our part was that we didn't establish a implementation group in it, having invested so much energy in it, so it's a lesson for us. And we've raised it at the air quality forum to ensure it being used" (19th February 2008).

The representative from Roads Service believed that there was "a flaw in the timing, the HIA being in parallel with the action plan" (19th February 2008). From his perspective, if the HIA had been conducted prospectively, it would have had more impact.

Suggestions (HIA recommendations)

The Environmental Health Manager, who is the individual closest to the institutional machinery destined to use the HIA, and with the most knowledge of the process of HIA utilisation, admitted that while most suggestions from the HIA were incorporated, not all were fully implemented (20th February 2008). However, a difficulty that was acknowledged by this individual was that other organisations had responsibility to implement HIA suggestions and it is difficult to ensure they are taken on board, as there is no statutory obligation for the suggestions to be implemented.

Policy making process (incidental benefits)

The rationale of the HIA was to inform the air quality action plan. However, it has been used for other purposes in policy; a number of incidental benefits to the HIA have been realised.

It will be useful for developing a transport plan for the city council. The Environmental Health Manager (20th February 2008) explained that "the council is starting talks on developing a transport policy, even though we've no responsibility or powers in that area, we still need an opinion, a council line on the issue." It will also inform the council's submission for the planning services metropolitan area plan review, and more particularly will be used in the council concern over a fly-over, as illustrated in the following:

> "A suggestion for strategic road called the Bank Moore link, putting in a fly-over, linking south and east Belfast, might cause community severance and we articulated that by drawing from this HIA how communities are cut off, one half from another, because of such developments and what they think about it " (*ibid*).

The HIA, although it was designed and formulated primarily to feed into the air quality action plan, will also be used to inform other city council plans and policies, which was an unexpected side-effect of the process.

Institutional utilisation

The city council appears to have used the HIA evidence into its policy formulation processes more than other stakeholders have done. The chairperson of the HIA and

Director BHC stated that the reason for this may be due to the council having greater ownership over the HIA; "more ownership but the city council were different, they held project management not us, for me there's something about a factor of success of the HIA is ownership of the project" (19th February 2008). According to this individual, because the users of the HIA were also leading it, this was a factor in the successful institutionalisation of the HIA evidence.

The Environmental Health Manager (20th February 2008) stated that the HIA is used in the Environmental Health Unit of the city council, she is "not aware of others using them which is disappointing, air quality forum which looks at the action plan and Belfast Healthy Cities pulled us up on the HIA had we been driving and using it." Indeed BHC will be working with the city council "to see how we can use it more" (*ibid*).

HIA

In terms of the HIA findings and process being used, some responses to this question referred to the process of HIA itself, and how it results in workable outcomes. The representative from the Environmental Health unit stated that there were "interesting outcomes but a pity that the power is so factionalised, and so it's hard to get action taken. Even in England, the councils have an input into planning, transport and roads and so it's easier to get action done and more productive, but in Northern Ireland it's different and power is fragmented" (22nd April 2008). According to this individual, the process of HIA was good and practicable, but the context within which the tool is trying to infiltrate and influence, is fraught within political and administrative constraints.

The representative of the IPH stated that the HIA process on the draft air quality action plan was a "good example of getting stat players around the table to work on the HIA, there was a positive shift in the attitude towards the HIA and the benefits that can come from it" (20th February 2008). This was identified as a tangible outcome of the process, and one way in which the process itself was used.

Community

The IPH representative also stated that this HIA case "showed the use of engaging the community, who wouldn't be engaged in a normal process, and there were realistic recommendations which helped" (*ibid*). The fact that the community were engaged in the process, and are foreseen to use the evidence that comes from the HIA in future development and planning proposals, is deemed as a way that the HIA has been effectively used and has proven a useful tool.

Was the HIA well received?

Interviewees were asked whether or not they believed the HIA was well received or not, by their relevant institutions, and by the community. Three categories were derived from the data in response to this question.

Institutional-level

At an institutional level, it was identified, in response to this question, that the turnover of staff was a problem. Many of the individuals who were involved in the HIA on the management and steering groups have left or changed jobs, and this makes the implementation of suggestions difficult, as explained by the Environmental Health Manager:

> "All those individuals have changed now, there isn't anybody left , changed faces and names, because at least people were in the process, so when I go knocking on doors looking for action plan and HIA updates there'll be new faces and that's a difficulty" (20th February 2008).

The representative from the IPH stated that at an institutional level, since the city council was receiving the HIA, and had led on it, it was received without any problem; "Belfast City Council were receiving it and were on the groups, so it was, and included in the action plan, they were the leaders and accepters of it" (20th February 2008).

The chairperson of the HIA found that some of the statutory stakeholders, although they were reticent about coming involved in the HIA, "saw the light and saw the benefits of HIA" (19th February 2008). In this sense, some stakeholders' beliefs and

values were changing towards the acceptance of such a tool for informed public policy making.

The representative from the public health services stated that in demonstration of the HIA being well received, there was a big launch event for the air quality action plan and the HIA report.

Dissemination

According to the Health Development Manager in BHC (19th February 2008) the planning students at Queens University Belfast use the air quality action plan HIA as a case study in their module on Healthy Urban Planning and HIA. This is one avenue for dissemination of the case's process and findings; "we do some work with planning students in Queens and they find the air quality HIA as very beneficial to learn from it and easy to learn from the process"

The Environmental Health Manager stated that although her unit in the city council is using the document, for both air quality policies and others, the HIA is probably seen as a secondary document to the air quality report; " I think it's probably sat on shelves of other organisations, which is a pity" (20th February 2008).

Community-level

According to a representative in the Environmental Health unit, all stakeholders and their relevant institutions received the HIA well, but "the community groups, residents and schools, were most appreciative and open to what the HIA was trying to achieve, and to the idea of the HIA" (22nd April 2008). Communities have had their voice heard in the policy making process and will have a body of evidence that is theirs to use thereafter.

Further Information

Interviewees were asked if they would like to contribute additional information to the study. In this part of the interviews, respondents had a chance to bring up any issues that they felt they had not the chance to do so earlier on in the process. Two categories arose from the interviews for this section.

Local authority

The city council are the local authority with the responsibility for drafting the air quality plan, by including the relevant stakeholders and drawing up future recommendations for action. According to the representative from the roads service, "the council have the remit to look into air quality and so we were sucked in, they identified four areas and they see those areas that transport would play a big role in that, in resolving them" (19th February 2008).

However he believed that the HIA was the council's way of introducing more consultation and into the action plan, and that the action plan was better because the HIA introduced a health and community dimensions, "I suppose if in the future someone comes and says how did you make sure the action plan was forward thinking, fitted the bill in terms of health and consultation, well then yeah in that sense we've ticked the boxes with the HIA."

The representative of the IPH stated that there was a need for great communication between the steering and management groups in order to ensure implementation; "role for greater communication such members to ensure there's greater implementation of the HIA. The steering group and the management team were playing different roles, the former a more informative and informal role (20th February 2008).

HIA

The chairperson was anxious that some HIAs (excepting the air quality HIA) are not in fact HIA at all, and there is potential for confusion as to what HIA will deliver and the expectations of the process also; "there are some HIAs being conducted that I wouldn't call HIAs so are we conducting HIAs, or incorporating health into policies, into corporate practice and capacity building" (19th February 2008).

The representative of the roads service was critical of the HIA as he did not feel the HIA brought anything novel to the air quality action plan, but did see a role for it in the review of the action plan.

6.4. HIA of Northern Ireland Housing Executive Proposal to Redevelop Dove Gardens Estate (2005)

Part I: Descriptive

A comprehensive prospective HIA on a Northern Ireland Housing Executive (NIHE) proposal to redevelop an estate in the Brandywell electoral ward in Derry city was conducted in 2005 and 2006. This is the first prospective HIA on housing redevelopment in Ireland. The findings of the HIA have influenced the structural shape of the redevelopment. The agency that led the implementation of the HIA is CAWT (Cooperation and Working Together), a cross-border health and social care initiative. CAWT was established in 1992 when the health boards working along the geographical border between the Republic of Ireland and Northern Ireland signed the Ballyconnell Agreement[40]. This agreement signifies commitment on the part of these health boards to work together to improve the health and wellbeing of their populations (Glackin and Farrell, 2006). This housing HIA was part financed by the EU through INTERREG III 'A Programme for Ireland' (2000 to 2006), under measure 3.2 (health and wellbeing).

Rationale and Background

CAWT was approached by the West Area Planner from the Northern Ireland Housing Executive to consider conducting a HIA of a housing regeneration project planned for Derry. This was agreed upon by CAWT and the NIHE, and the Departments of Health in both the Republic and Northern Ireland were approached for support and permission to proceed.

Dove Gardens is a council housing estate on the periphery of the Bogside, is predominantly Catholic, and is less than one mile from Londonderry city centre. It is made up of 76 dwellings which were built in 1966. Deficiencies of the Dove Gardens estate were established by the NIHE Project Team in 2003, which was set up to develop proposals for redevelopment of the area.

[40] The Ballyconnell Agreement (Ireland) was signed in July 1992 between the North Eastern Health Board/North Western Health Board (south), and the Southern Health and Social Services Board and the Western Health and Social Services Board (north).

The following are some of the problems with the housing, which arose from the team's investigation:

- Communal access: via open public stairwells and deck
- No defensible space: there was little space between the residents' front door and the street. The front doors of the upper story maisonettes open directly onto the public deck.
- Poor clothes drying and waste disposal facilities: Bin chutes and clothes drying areas were communal, which created a health hazard. Drying areas were deemed insecure and unsafe at night.

(Glackin and Farrell, 2006:9)

Dove Gardens was originally built for small to medium sized families. However, household composition in 2004 showed that 80 per cent of households were made up of single occupants or small family units. The living space was unsuitable for the current population demographic profile.

There are a number of reasons why the HIA in the Dove Gardens estate was carried out. Primarily, the residential community exists in one of the most deprived of Northern Ireland (Northern Ireland Statistics and Research Agency, 2005b; Bonner, 20077) and would benefit from the HIA process. The estate was known locally as Beirut, due to its run-down appearance and reputation for crime and anti-social behaviour (Bonner, 2007). Just 1 per cent of the population go on to third level education (*ibid*), which illustrates the picture of social inequality experienced within the community. The housing proposal would be influenced at its design stage, so that the findings of the HIA would be considered in the planning of the regeneration scheme. The HIA would add to the evidence-base correlating health and housing, and would inform decision-makers of this wider issue. In addition, the HIA would improve cross-sectoral cooperation and provide "a structural framework for investigation and discussion of health impacts and the identification of more impacts compared to not doing one" (Glackin and Farrell, 2006:10).

Objectives of the HIA

The purpose of this HIA is to increase the awareness of health implications of the regeneration programme in the Dove Gardens estate. The Steering Group of the HIA developed objectives of the project, and are presented in the following:

- To influence the design for the regeneration of Dove Gardens.
- To improve the health and wellbeing of people living in Dove Gardens and surrounding areas.
- To promote community participation to enable local communities to contribute to, and influence, the decision-making processes as they impact on their community.
- To communicate the work of the Steering Group to all stakeholders in the regeneration project.

(Glackin and Farrell, 2006:12)

The objectives were decided upon at the scoping stage of the HIA, which is the second stage in the impact assessment process.[41]

Stakeholder Involvement

There were a number of stakeholders in the process. The organisations of CAWT, NIHE, and members of the Health Action Zone 'Investing for Health' teams comprised the leading statutory health bodies leading and directing the HIA. Local community residents, both Dove Gardens residents and from nearby neighbourhoods, were involved in the process. Members of the Local Assembly, Derry City Council and Local Strategic Partnerships were involved in the HIA also, comprising the representative and political element.[42]

The Health Services in Partnership: Cooperation and Working Together (CAWT)

CAWT operates on a partnership basis, by facilitating cross-border working on health social care issues, and has established European connections in relation to the cross

[41] Please refer to chapter 2 of the thesis for information regarding Health Impact Assessment and the stages of the process.

[42] Other stakeholders include the Derry Children's Commission, the Planning Service, Department of the Environment Roads Service, TRIAX Neighbourhood Renewal Taskforce, Dove House (community centre), health visitors/ other health professionals/ social care professionals, school principals, pharmacists, Gasyard Healthy Living Centre and the local Credit Union.

border agenda (CAWT, 2007). CAWT provides a forum which enables staff from the HSE, Northern Health Boards and Trusts to meet and work on cross-border health social issues. These groups within CAWT have developed many projects, and have successfully received European funding through INTERREG IIIA (Priority 3, Measure 2, Health and Well-Being) and PEACE III (Priority 5.2, Improving Cross-Border Cooperation: Public Sector Cooperation). The objectives of CAWT are as follows:

- To improve the health and social wee-being of the resident population.
- To identify opportunities for cooperation in the planning and provision of services.
- To assist border areas in overcoming the special development problems arising from their relative isolation in national economies and within the European Union as a whole.
- To involve other public sector bodies in joint initiatives where this would help fulfil common primary objectives.
- To exploit opportunities for joint working or sharing of resources where these would be of mutual advantage.

(*ibid*)

The structure of CAWT comprises of a Management Board which provides strategic direction and consists of the Chairpersons and Chief Executives of the Western Health and Social Services Board (WHSSB) and the South Health and Social Services Board (SHSSB), and representation from the border trusts in Northern Ireland. From the Irish Republic, the HSE is represented by two senior managers from the West and Dublin North East regions.

The cross border sub-groups are at the core of CAWT activity. There are 15 groups, operating in areas across the entire health and social care areas of work.

For the purpose of this research, the two members of CAWT that took part as chairperson and project manager in the HIA were interviewed for this research, both from the Southern Health and Social Services Board (SHSSB) in Northern Ireland. The chair of the HIA saw her role as "to oversee the methodology of the HIA" and the

write-up stages of the project (Interview, 4th March, 2008). The project manager was "the HIA practitioner…doing the HIA," running and organising the workshops and the operational aspects of the project (Interview, 21st March, 2008).

Northern Ireland Housing Executive (NIHE)

The NIHE operates as the legally competent regional housing authority, which, under existing legislation, the main responsibilities of the organisation are as follows:

- Regularly examine housing conditions and housing requirements
- Draw up wide ranging programmes to meet these needs
- Effect the closure, demolition and clearance of unfit houses
- Effect the improvement of the condition of the housing stock
- Encourage the provision of new houses
- Establish housing information and advisory services
- Consult with District Councils and the Northern Ireland Housing Council
- Manage its own housing stock in Northern Ireland.

(NIHE, 2008a)

In relation to the abovementioned objectives, the NIHE operated within its rights and duties to demolish and redesign more suitable accommodation in Dove Gardens estate in Derry.

It is the goal of the NIHE to

> "Provide everyone with the opportunity to access decent, affordable housing in safe and sustainable communities, deliver excellent housing services, develop strategies to influence the wider housing market and work with others to foster urban and rural renewal and contribute to improved health and social well-being" (NIHE, 2008b).

There exists a Board which is responsible for the general policy, management and direction of the NIHE. The chairperson (at the time of writing, Brian Rowntree) meets once a month with the other Board members to discuss matter pertaining to expenditure and policy planning. The Minister of Social Development of the Northern Ireland Assembly appoints seven members onto the Board, and the remaining three are appointed by the Northern Ireland Housing Council. There exists a provision that at least one member is female (NIHE, 2008c).

The Northern Ireland Housing Council was established by the Housing Executive Act (Northern Ireland) 1971. It is consulted by the NIHE and the Department of Social Development on issues pertaining to housing policy in Northern Ireland (*ibid*). The Housing Council consists of one representative of each of the 26 District Councils in the region.

A team of six Central Directors report to the Chief Executive of the NIHE, who then reports to the board on matters relating to the implementation of the Executive's policies and standards. These Directors are members of the Chief Executive's Management and Business Committees and decide on operational matters as well as deriving approval from the Chief on various issues of work. The following areas are within the Director's areas of activity:

1. Director of Corporate Services / Deputy Chief Executive
2. Director of Design and Property Services
3. Director of Finance
4. Director of Housing and Regeneration
5. Director of Personnel and Management Services
6. Head of Information and Secretariat

(*ibid*).

Due to the controversial nature of social housing in Northern Ireland, which was subject to charges of discrimination in service-provision, changes had to be implemented to ensure greater fairness by the 1970's (Birrell and Hayes, 1999; McSheffrey, 2000; Tonge, 2005). Indeed, the Macrory Report (1970), which had been developed throughout the 1960s, faced new challenges and provisions by the time it was legislated. In relation to housing matters, the contentious issue of housing was to be removed from local government to the more 'technocratic' Northern Ireland Housing Executive which was to allocate housing according to need, in an unbiased and objective manner as possible (Wilford, *et al*., 2007). The NIHE has an excellent good track record in ensuring housing provision is based upon need, and so has developed a well-respected reputation and perception among the general public. It continued to receive high levels of public investment into its housing stock during the Thatcher governing regime throughout the 1980s (*ibid*). Today the NIHE continues to

uphold its reputation as a fair, equitable and innovative public body. The interviews conducted for this case study strongly reiterated this message.

For the purpose of this research, the West Area Planner (who is also a partnership member of the IFH) and the Housing Officer involved in the Dove Gardens HIA were interviewed for this research. The Area Planner saw his role as instigating the HIA, and a "strategic role, an overseeing one but not very operational" (Interview, 25th February, 2008). This individual viewed his role to look at "how could they (the HIA steering group) influence the organisation (NIHE) in terms of time scale and delivery (*ibid*). The Housing Officer viewed the conduct of the HIA as "a labour of love" (Interview, 25th February, 2008). This individual has been the Housing Officer for the Bogside and Brandywell electoral area for a number of years and has established good links between the NIHE and the community. This history and trust that existed between this individual and the community was a positive resource for the HIA process.

'Investing for Health' (IFH) (2002)

Northern Ireland's health strategy, 'Investing for Health' (2002), sets out the Northern Executive's vision for population health improvement and for the reduction of health inequalities (Barr and Burke, 2006). 'Investing for Health' (IFH) is founded on partnership working between the central Government Departments, statutory, private sector, community and voluntary organisations.

The Western Investing for Health Partnership (WIFH) works in the geographical area of the Western Health and Social Service Board (WHSSB). It promotes and operationalises the vision of the regional health strategy. The WIFH Partnership is funded by through the Department of Health, Social Services and Public Safety, Northern Ireland. WIFH consists of 28 organisations, drawing representatives from the community, statutory and voluntary sectors that work within the health and social care spectrum in the Western Board area.

In accordance with objective 4 of the IFH Strategy[43], Health Impact Assessments are supported and promoted by the Western IFH Partnership (*ibid*). Two major HIAs have been encouraged and supported by the WIFH; the Dove Gardens urban regeneration and the HIA on the West Tyrone Area Plan. The HIA mechanism is being used appropriately in these two sectoral domains of housing and planning, in order to ensure everyone has "the opportunity to live and work in a healthy environment and to live in a decent affordable home" (*ibid*: 11).

One member of the WIFH was interviewed for this research, viewing his role as representing the IFH organisation. The second member, who is also the IFH manager, presented his research on the Dove Gardens HIA experience at the HIA Forum (April 2007), organised by the Institute of Public Health (Bonner, 2007). This IFH manager attended this event and also pursued discussions at the eighth International HIA Conference held in Dublin (October 2007).

Derry City Council

Derry City Council is composed of 30 elected members, elected every four years and serving 5 District Council Electoral wards (Cityside; Northland; Rural; Shantallow; Waterside) (Derry City Council, 2006).[44] The Department of the Environment (DoE) is the statutory authority with responsibility over planning and development in Northern Ireland (Birrell and Hayes, 1999). However, a Planning Officer of the Planning Division of the DoE attends Council meetings and answers questions put forward by local Councillors; there exists formal consultative structures between the two authorities. In relation to the Dove Gardens HIA, the Planning Division (Strand Road, Derry) were invited to participate, as were planning officials within the Council. Neither groups sent any representatives to take part, although they were invited.

[43] IFH Strategy Objectives: 1) To reduce poverty in families and children; 2) To enable all people and young people in particular to develop their skills and attitudes that will give them the capacity to reach their full potential and make healthier choices; 3) To promote mental health and emotional wellbeing at individual and community level; 4) To offer everyone the opportunity to live and work in a healthy environment and to live in a decent affordable home; 5) To improve our neighbourhoods and wider environment; 6) To reduce accidental deaths and injuries in the home, workplace and collisions on the road; 7) To enable people to make healthier choices.

[44] As of May 2005, the Council is composed of 14 SLDP members; 10 Sinn Fein; 5 Democratic Unionist Party (DUP); 1 Ulster Unionist Party.

North and West Housing Association

In Northern Ireland, housing policy and delivery is going through a period of change. Currently, whilst the provision of social housing remains in the hands of the NIHE, the building programme of new houses and accommodation is completed. This building is presently taken over by Housing Associations. There currently are 39 such associations, and the policy target to meet housing need is for 1,500 to 2,500 units for social housing, in accordance with waiting lists (exploratory interview with Mr. Paddy Gray, University of Ulster, Derry, 24th February 2008). This changing nature of housing results in the need for close cooperation and working between the NIHE and housing associations.

The member of the North and West Housing Association (NWH) who was involved in the HIA was interviewed for this research. He viewed the role of NWH as just one of many stakeholders, and not the most relevant (Interview, 1st May, 2008).

Bogside and Brandywell Health Forum and Community Representation

The Brandywell and Bogside Health Forum (BBHF) was established in 1999 in order to assess the well being and health of the community. It was set up initially as a working group. As a result of its work and the allocation of funding from the New Opportunities Fund (currently the Big Lottery Fund), the BBFH was granted assistance to establish a Healthy Living Centre initiative in the community (Lindsay, 2006). The Forum was locally born and developed "as a response to the worsening situation in respect of ill health and health inequalities," which is commonly found in areas of social and economic deprivation (Doherty, 2006:17). Other community groups in the area operate alongside the Forum, working on health and social issues raised by the community (Lamberton, 2005; Doherty, 2007).

The BBHF works with a range of statutory, community and voluntary bodies in order to work in the following areas of activity:

- Plan health improvement projects and programmes
- Provide access to primary care within our premises
- Raise the health improvement profile throughout the community

(*ibid*)

The BBFH has been in full operation since 2001. Its work spans over various areas, such as health promotion in the local primary schools, drug awareness programmes, older people's Monday Club, and the HIA on Dove Gardens is cited as a large part of the Forum's work.

The manager of the BBHF was interviewed for this research. He viewed the input of the agency as important to the process, and viewed the HIA as a "God-send for us because we anticipated alot of fights and arguments over that development (the Dove Gardens rebuild) with the various statutory powers, agencies, because that's how things like this have been done in the past…and all the players involved would be encouraged to come to the table at the one time to future-proof the project and the programme (Interview, 22nd February, 2008). He saw the role of the BBHF as representing the community, and more specifically, the residents. This was the view taken by the community worker, who is based in the community centre, the Gasyard Centre, and who works closely with the BBHF (also based in the Gasyard). He, "as a community worker, saw the potential (in doing the HIA), (as) there are health and educational outcomes and my interest was in the community and residents" (Interview, 25th February, 2008).

A community representative of Dove Gardens, who participated in the HIA, was interviewed for this research. She viewed her role in the process as "representing the former residents of Dove Gardens…representing the residents in the HIA" (Interview, 25th February, 2008).

Methodology

The five-stage process of HIA was followed for this HIA. Screening guidelines, as developed by the Institute of Public Health were used, and the scoping checklist as developed by Ms. Erica Ison was utilised.

Both qualitative and quantitative methodologies were used in this HIA. A literature review was conducted of the evidence-base of housing and living conditions on human health. Four appraisal workshops were carried out in total. The purpose of these workshops was to marry what the residents said in the workshop setting about factors pertaining to the health impacts of the regeneration project, with evidence

from the literature (Glackin, 2006). A health profile was collated of the community, using local expertise, and information from the Northern Ireland Statistical and Research Agency (NISRA). It was the responsibility of the Steering Group to develop recommendations and to evaluate the impact of the HIA on the decision-making process (Glackin and Farrell, 2006).

HIA Outcomes

It is the overarching goal of a HIA to influence the decision-making processes relating to a specific policy, project or programme (WHO, 1999). In the case of the Dove Gardens prospective HIA, a positive outcome arising from the project was the amendment of the housing proposal in order "to enhance the positive aspects and reduce or eliminate the negative impacts of redevelopment" (Glackin, *et al*., 2006). Currently, the former dwellings of the estate have been demolished and the area is flattened, awaiting the rebuilding of homes. This is set to commence in autumn 2008.

A number of recommendations were developed which were to inform the decision-makers of the manner in which the regeneration scheme needed to be amended, in order to maximise the positive benefits and reduce the negative aspects. The results of the appraisal process were 37 coded health impacts, from which 35 recommendations were produced. All of the recommendations are linked with one or more impact statements from the workshops. Below indicates the areas within which recommendations were developed.

For each sub-category within these recommendation areas, lead agencies were identified which would be responsible for implementing the recommendations:

The recommendations pertain to:

- Environment
- Homes and Housing
- Built Environment
- Sense of Community
- Service Provision
- Health Awareness
- Creating Local Jobs and Skills
- Partnerships

(Glackin and Farrell, 2006a:24)

Incidental or unexpected outcomes also arose from the HIA. The Steering Group identified a number of such outcomes and recommended that future HIAs should take into account such outcomes, and elicit a way of measuring such outcomes which are not identified at the scoping stage when set objectives are formally established.
As a result of the HIA process, a Dove Gardens resident group was established; there was an increase in stakeholder knowledge of their role in influencing health determinants; a working relationship between statutory, community and voluntary groups were established, which did not exist before; engaging local residents in the process has helped contribute to building sustainable community infrastructure; and the profile of HIA has been raised as a feasible tool to use in planning and community development. There is a possibility that the NIHE will mainstream the use of HIA to all redevelopments and regeneration projects in Northern Ireland (*ibid*).

Policy Process for the Dove Gardens HIA

The Steering Group had representation from the key and primary decision-makers (the Northern Ireland Housing Executive and the North West Housing Association), which was vital to the development and dissemination of realistic recommendations that could be acted upon.

In order to monitor and evaluate the HIA, an Implementation Group was set up in order to "oversee and influence the implementation of the recommendations of the HIA" (Glackin and Farrell, 2006:30). This group comprised mainly of members of the Steering Group, which disbanded once the Implementation group was established. The latter group will work closely with decision-makers to plan and organise for the delivery of the recommendations. To date all 35 recommendations have been included in the North West Housing Association design brief. It is the responsibility of the Implementation Group to ensure the recommendations are presented to all decision making agencies and fora.

One of the key benefits of this HIA was the involvement of decision-makers at all stages of the HIA, from start to finish. The involvement of such an integral group has been identified in the literature as an enabler to the success of a HIA (Davenport, *et al.*, 2006).

Appendix 8 provides a review of the key documents in the area of social housing regeneration in Derry city.

Part II: Analysis

As with the other cases, the framework approach to analysing interview data will be used for this study (Ritchie and Lewis, 2003). In this Derry case study, nine people were included for semi-structured expert interviews, and four for exploratory interviews, as can be seen in appendices 4 and 5. Appendix 16 presents the process of data analysis, which traces the degree of abstraction and data refinement, beginning with the raw data through to the establishment of indices, categories and finally, classifications.

Four exploratory interviews were also carried out for this research; the district planner of the NIHE (22nd February, 2008); a community worker, Women's Group based on Dove House (in estate near Dove Gardens) (22nd February, 2008); a senior academic and expert of the University of Ulster, in the area of social housing in Northern Ireland (24th February, 2008); and two programme coordinators working in the Bogside and Brandywell Health Forum (22nd February, 2008). These interviews

informed this case study by providing necessary background information, and by contributing certain perspectives of the HSE and local authority institutions.

INSTITUTIONAL THEORY (x1 and x2)

Hypotheses: HIA utilisation is possible with institutionalisation

Sub-hypothesis (variable indicators)

The normative dimension alludes to the norms within institutions that can go some way to explain the behaviour of actors in the institutions and organisations. The influence of the institution, and its norms, has been cited in previous HIA policy research, as a further explanatory theory to explicate of the influence upon the use of HIAs in policy (Banken, 2001; 2003; Bekker, *et al*. 2005; Kemm, 2005; Bekker, 2007; Morgan, 2008).

A number of questions were asked during the interview phase of data collection, in order to establish the degree of influence the norms of institutions had over the use of the HIA report, and the knowledge that came from that and it's preceding process. The topic guide, containing the standard interview questions, is in appendix 2.

Are Institutions Ready? The Timing of HIA as a Policy Support Tool

The timing of HIA as a policy support tool was asked during the expert interviews, in order to establish the perspective of those on the HIA steering group, which included both decision makers of statutory bodies and those coming from a community perspective.

Except for two respondents, all those who were interviewed stated that yes, the time was right and had come for HIAs to be used in policy making.

The two individuals who were interviewed from the NIHE organisation were more reticent about the timing of HIA utilisation. The housing officer said that although the HIA was "a labour of love," it would be after the monitoring and evaluation of the process after a number of years (after the residents have been re-housed in the new

development) that the timing and appropriateness of the HIA could be assessed (Interview, 25th February, 2008). From the same organisation, the area planner stated that "it's too early for us yet to make that kind of assessment" (Interview, 25th February, 2008). As far as these two stakeholders are concerned, they will "wait and see the results" of the health and wellbeing of the residents in the regeneration project (*ibid*). Their attitude is more cautious in support of HIA, which may represent the organisational viewpoint. The community worker from the Gasyard Centre was also cautious, stating that he would still "reserve judgement until people are back in the new houses," even though he was adamant that the causal pathways between housing, health, education and employment that arose from the HIA findings are evidence that it should be used within policy with due timeliness and ease (Interview, 25th February, 2008).

The other interviewees stated that when HIAs are done correctly and in a rigorous manner they can be used in policy (CAWT chairperson of the HIA, 4th March 2008). The community worker from the Gasyard stated in responses to whether or not the time has come for policy makers to use HIAs, "yes, very beneficial, very clear lessons to be learnt, very clear causal links between health, education, employment and housing" (Interview, 25th February, 2008). The individual from the Western Investing for Health (WIFH) team was in agreement with HIA timeliness, arguing that the policy direction of the central government in Belfast was "forcing us to look at policy making and to make evidence based decisions" (Interview, 22nd February, 2008). The Manager of the Bogside and Brandywell Health Forum (BBHF) agreed that the time had come for HIAs to be used in policy making, as working in a multi-sectoral manner was the norm in policy making and service delivery, from the community perspective (Interview, 22nd February, 2008), which the HIA approach advocated. The community and resident representative on the HIA agreed that the time had for its utilisation in policy, as it enhanced the regeneration process and ensured the "residents are there, giving their opinion" (Interview, 25th February, 2008). The project manager of the HIA, an individual from CAWT, believed that the time was right in the Dove Gardens case specifically, as there were high level decision makers involved in the HIA, which made the process easier from a policy and evidence utilisation perspective (Interview, 21st March, 2008). The individual from the housing association agreed that the time had come for HIA to be used in policy, as it promoted

community participation and joined-up working, which "we're all supposed to do but never do so much in reality, but did with the HIA" (Interview, 20th May, 2008).

None of those interviewed in this research believed that the time had not come in public policy making processes to use the knowledge and evidence that comes from HIAs.

Further to whether or not the timing was right for HIAs, the interviewees went on to expand on their responses to this question. The answers to this question were analysed, firstly by indexing them, and then by categorising these indices. Different categories were derived from the data. Six categories arose from the interview, namely the institutional factors at play enabling the use of HIAs and the nature of HIA in being a feasible policy-aiding tool. The policy process was elicited as a factor in the timeliness of the tool. Stakeholder participation, the plethora of impact assessments in the field of policy making, and the subject of urban regeneration surfaced also as factors affecting the timeliness and suitability of HIA as a policy-aiding tool in the current day phenomenon of policy making.

According to those interviewed in this case study, the timeliness of HIAs in policy making circles today was encroached in a contextual setting of workability. The tool's development is aided by the re-establishment of the Northern Ireland Assembly in Belfast (2007), and this administration's emphasis on evidence-based policy making (Interview, WIFH individual, 22nd February, 2008). Indeed, the Assembly's manifesto on informed policy making has been in place since the publication of the document "A Practical Guide to Policy-Making in Northern Ireland" by the Office of First Minister and Deputy First Minister (OFMDFM) in 2003. The WIFH team has written a request to the central government departments at Stormont, calling for HIAs to be made statutory instruments in all policy making and planning for services in Northern Ireland. HIAs are also a timely tool to be used within the institutional context of joined-up working and in advocating a multi-agency approach (Interview, housing association, 20th May, 2008).

The nature of HIA as a practical tool for informing decision makers, and as an approach to evidence based policy making, was viewed as a factor in its

appropriateness and timeliness by the interviewees. It was identified as a tool that is "still very much a developing approach itself," illustrated by the fact that this was the first HIA carried out on social housing on the island of Ireland (Interview, housing association, 20th May, 2008). However, even in its embryonic state and although judgement of it would be reserved until recant commenced and health outcomes of residents would be measured thereafter, the HIA produced findings on health impacts that provided lessons to be learnt on the nature of health impacts of policies and projects on the local community (Interview, community worker, 25th February, 2008). The manager of the BBFH stated that it was a tool to prevent conflict between the different sector interests "before you get to the conflict" (Interview, 22nd February, 2008). Its timeliness was dependent on factors by some of the interviewees, namely that the recommendations should be constructive outputs from the process (NIHE area planner, 25th February, 2008); the HIA should be robust in its research methodology and design (CAWT chairperson, 4th March, 2008) and should use appropriate local evidence wherever possible (WIFH member, 22nd February, 2008).

In order that the tool remains timely and appropriate for use, the CAWT chairperson, although in agreement that the time had come to use HIAs in policy, she was adamant that they should be produced with the aim of use, and not to be left to gather dust on the shelves of various institutions and bodies (Interview, 4th March, 2008). In addition to this point on the policy process category, the fact that there were forward thinking decision makers on the HIA, who were also working at a high-level tier in their relevant organisations, was a big enabler in the utilisation of the HIA findings and outcomes (CAWT project manager, 21st March, 2008), as is illustrated in the following:

> "We were very lucky in this project that the housing executive we the decision makers on this project. They're very innovative and are well known throughout Europe for being forward thinking, they're known for it. They saw it and so did we as a golden opportunity to do a HIA on such a project like this. The district manager in the NIHE was pushing and actually came to me, so we had the major high level decision makers involved."

A category of participation of stakeholders in the process also arose from the interview data, in the assessment of HIA as a timely tool. Ensuring all stakeholders

have ownership of the HIA was raised by the chairperson of the HIA, in order to ensure the HIA would be an appropriate and credible tool (4th March, 2008). It was viewed by those interviewed as a vehicle for community consultation and as one that needs to be sustainable into the future and not just for the duration of the HIA process, as the community worker explained (25th February, 2008). The manager of the BBFH, in response to the question of HIA timeliness, stated that it was a realistic tool, as "I think we've gone beyond the point of the government agencies, private sector and communities working in isolation" (22nd February, 2008). It was also viewed as an approach to facilitate "trust and partnership with the various players" (*ibid*). The area planner of the NIHE was in support of community consultation and actively encouraged it in this HIA, and in other developments, but acknowledged that the community may not be influenced by "outside opportunities" or new and different way of designing housing, as is illustrated in the following:

> "One of the problems I envisaged a couple of years ago when we sat down to do the consultation with the community, you're going into a community whose perceptions were their community and they hadn't been influenced by outside opportunities, I mean take energy efficiency, what do they know or understand about energy efficiency in their home and how can they influence or suggest change" (25th February, 2008).

Another issue raised in the interviews, was that of the plethora of impact assessments that are already institutionalised in the policy making world. Although HIA was deemed as a timely tool by the team member of the WIFH (22nd February, 2008), it was also acknowledged that the various IAs already being used, and with a statutory footing, HIA is viewed as a burden by the planning officials in particular.

From the interview material the category relating to the subject of urban regeneration arose. The relativity of HIA to regeneration, and its usefulness in such development, was emphasised by the interviewees. The community representative stated that it "should be involved in every build, every development, every regeneration, (it) definitely needs to be part of the process" (25th February, 2008). The HIA adds value to the development, as the housing officer of the NIHE stated (25th February, 2008). Indeed, the tool was considered so worthwhile for urban regeneration that the community worker stated he was "sympathetic to the rationale behind HIA and now having gone through one it would be madness not to consider it, Limerick, for

instance, similar problems, and an example of community regeneration" (25th February, 2008). The redevelopment of Dove Gardens was a project that would be a premier example of a "gold star" standard of urban regeneration, as the individual from the housing association explained, and the HIA added value to an already worthwhile development (20th May, 2008).

Normative Dimension: Do Institutions Shape Behaviour?

The use of institutional theory in this study is to establish the extent of the influence certain institutions have on the use of HIAs and the knowledge that came from them, which was intended to inform policy.

Those interviewed in this case were stakeholders in the HIA process, and were on the Steering Group as representatives of their relevant bodies, be it from statutory institutions (NIHE and North/ West Housing Association), health services perspective (WIFH and SHSSB/ CAWT) or the community perspective (Gasyard Community Centre, the BBFH, and the resident representative). The responses to this section were grouped into categories after an indexing process took place. Firstly, at an institutional-level, HIA process- and policy process-levels, a number of constraining factors upon behaviour were elicited. Where the policy process level is concerned in this case study, it is policy formulation at the planning service level that is the constraining and problematic issue. Secondly, gathering local evidence and information for the HIA was a constraint in the conduct and thereafter use of the HIA. Thirdly, beliefs and values played a constraining role in this case study, in the use of the HIA and in the conduct of the process.

<u>Institutions and Organisations: Macro-Level of Analysis</u>

In this case study, specific institutional bodies were openly named as acting as constraints to the process and subsequent use of the HIA findings in policy.

The housing association, planning services and roads services were identified by an individual from the NIHE as constraints, their mindset being a constraining factor in the process and use of the HIA in policy. These institutional organisations were identified as lacking some commitment to the idea of HIA (25th February, 2008). The missing of such key stakeholders, and the lack of engagement of these players, was

perceived as a constraint on the advance of the HIA use in policy (BBFH manager, 22nd February, 2008). The lack of open and transparent sharing between the planning services and the NIHE was deemed as an institutional constraint on the maximum use of the HIA, and the absence of the planners from the process, particularly at the earliest stage of the HIA, was considered a negative factor in this HIA case study (NIHE, area planner, 25th February, 2008). Indeed, into the present time tension continues between the community and statutory sectors, as illustrated in the following:

> "Some organisations, still, can retreat back into their silos very quickly when they're expected to contribute and make the project better. We've just to keep reminding people that this is a worthwhile project and worth going the extra mile, to make sure the problems are ameliorated" (BBHF manager, 22nd February, 2008).

On a related but separate issue regarding institutional constraints, and their impact on the HIA utilisation, the NIHE area planner stated that it is vital to the HIA that the correct tier of decision makers are accessed at a high-level tier in their relative institutional setting, as one of the most important issues for us was, engaging with the correct partners, really it wasn't even engagement, and it was identification. Who are the partners that need to be engaged in this" (25th February, 2008). This individual stated that if the HIA was being conducted again, this engagement and identification of partners with a high degree of influence in their institutions would be a priority, as he felt those around the table did not have the breadth of knowledge and influence to maximise the use of the HIA in their relevant institutions. On the issue of engagement of individuals with a high degree of influence was also raised by the HIA project manager, but in a more positive light. He stated that during the conduct of the HIA, the lower level staff working on the rebuild (referring mainly to manual workers and builders) were not interested in the HIA; "builders are just not concerned with community health and well being. There were constraints in the local management structures but the high level managers (from the NIHE) were on board and that's what matters" (21st March, 2008).

Regarding institutional constraints, the NIHE area planner referred to the issue of time commitment that the various players on the steering group had to make to the HIA.

He cited the huge amount of time that the HIA required from all the members around the table. However, he justified the decision of the steering group to advance with a comprehensive HIA process on the regeneration, and not a desk-top one, which would have required less time and resources from individuals, as the full HIA would involve the community stakeholders. This point of view is illustrated in the following:

> "I prefer the community approach, and especially with this scheme we've had the community representatives still involved, but actually I find it's more important to have the community rather than only representatives, better to have the residents. Okay, the community reps will be more articulate but the residents is critical to the project" (25th February, 2008).

HIA Process: Micro-Level of Analysis

At the level of the HIA, in terms of the conduct and process of it, a number of constraints were identified regarding the tool. Firstly, one interviewee cited the fact that this HIA was the first conducted in the city was a constraining factor, (BBFH manager, 22nd February, 2008). Since it had never been conducted before, there was a certain amount of misunderstanding and wariness of the concept. This was reiterated by the community resident, who stated that "because it was a new thing for the NIHE and the North West housing association which is going to be in charge of the new housing, they didn't kinda know what role the HIA should have" (25th February, 2008).

Secondly, the community resident on the HIA had a positive perspective of the process, and when asked about institutional constraints regarding this case, she referred to the fact "(the HIA) might have pushed things to get things that we may not have got without it, they mightn't have give as much if we hadn't this on board. For definite the HIA helped push some issues onto the table" (*ibid*).

Thirdly, the BBHF manager said during the interview that a "lack of knowledge and awareness of the HIA acted as barriers" (22nd February, 2008). Indeed, the novelty of the tool was considered a hindrance, as perceived from personal experience with the HIA tool.

Policy Process: Micro-Level of Analysis:

Where are all the planners?

With regard to the policy process, some interviews referred to the planning process as a constraint in the use of HIA evidence to the maximum effect. At the end of the HIA, when the planning services were consulted, "a long protracted process with planners" ensued and would have been alleviated if they had been present at earlier stages of the HIA (community worker, 25th February, 2008). The fact Derry City Council and the planning services were missing from the table, was a huge constraining factor in the successful conduct of the HIA and the appropriate use of its findings in policy thereafter (housing association member, 20th May, 2008).

Values and Beliefs

Value judgements and beliefs pertaining to the HIA concept were identified as institutional constraints during this phase of interviews. One phrase was quoted and paraphrased by most of the interviewees during data collection, which they all believed illustrated, succinctly the mindset of one of the key institutions that were involved in the regeneration and rebuilding process for Dove Gardens. The chief architect was quoted as saying "I build houses, I don't design communities." The BBHF manager, in analysing this quote said "but residents have to live there, so he has to think beyond the drawing board" (22nd February, 2008). For the purpose of this research the architect was unable to be included for interviewing. Therefore, the statements and perceptions of those interviewed must be balanced against this proposition, and indeed the NIHE housing officer was adamant that by the conclusion of the HIA process, this individual had changed his belief around the need for community engagement in such regeneration projects, especially when the residents are displaced for a period of time before moving back into the new housing (25th February, 2008).

A second issue arisen by those interviewed for this research was the need for an "improved understanding of others' perspectives" during the process of the HIA, with the values of the community perspective (CAWT chairperson, 4th March, 2008). This was addressed with the multi-agency dimension of the HIA process, however.

A third issue that was brought up during the interviews was the barrier that knowledge and language played during the HIA process, and the need to overcome this obstacle, as identified by the NIHE area planner. The following illustrates this point, and also highlights this individual's acknowledgement of the need for officials in the NIHE to communicate and connect in the more accessible manner with the people who are in receipt of the services they plan:

> "I remember being in the post-HIA stage and we were looking at the delivery of the scheme, when I chaired that first meeting I wanted those people involved, this would be an open and transparent meeting I said and that's been a useful learning curve for our own staff. To listen to a voice and to be challenged, and to have to use a language that's understood by others, to a level for understanding because we can all get into our own lingo" (25th February, 2008).

Where's the Evidence?

A member of the WIFH team stated that a constraining factor upon the utilisation of HIAs is getting local evidence, community profiles and research on the locality, to feed into the HIA, which would then be envisaged for use in policy (22nd February, 2008). This was deemed as an institutional constraint as the lack of research on the locality was deemed a barrier in ensuring appropriate services were planned into the future.

Political Dimension: Does Politics Matter?

Elliott and Francis (2005) found in their research into the Welsh HIA experience that the influence of the political environment and agenda, and the different interests around the HIA 'table' was considered an important dimension to consider when looking at the influences upon HIA usage in policy. This was also found is other HIA research (Davenport, *et al.* 2006; Bekker, 2007, Wismar, *et al*. 2007). The new institutionalist strand of political science theory also contends that the political dimension is an important one to take into consideration, when investigating the influences upon individual and collective behaviour and action (Immergut, 1992; Peters, 1999).

This study investigated the influence of such a political dimension, by asking the interviewees to what extent were politics at play between the varying interests in the conduct of the HIA.

The responses to this question have been categorised into three groups. The political dimension at a micro-level (individuals) and macro-level (institutions) was identified, and the use of the HIA tool to depoliticise the regeneration process was also depicted from the interviews.

Individuals: The Gatekeepers to the Institutions

With regards to politics at play, both in the conduct and aftermath of the HIA, some of the interview responses related to the fact that perhaps some individuals on the steering group were not the most appropriate individuals, meaning that some individuals did not have the breadth of knowledge or the high degree of decision making influence required for the process. Indeed, the area planner stated that he would have "been more selective with the people on the steering group" (25th February, 2008), and the BBHF manager stated that the HIA was targeted at the "wrong people in organisations, the Council didn't engage very well and that's probably because we targeted the HIA at the wrong people and they didn't see the benefit of it" (22nd February, 2008).

On the other hand, there were key stakeholders who were not part of the HIA, and their involvement would have enabled the process to run smoother, as the area planner of the NIHE illustrates in the following:

> "And what we were doing meeting after meeting with the HIA to come up with different outcomes, that's where we could have delivered through the different organisations and that's where we could have had a better product. Not that we haven't a good product, I think we have, but if roads service had come and had given a long term strategic view of where the fly-over would sit, and our first recommendation deals with the fly over. I think it would have been constructive if the planning service had been there and could tell us the long term plan vision and given some sort of time frame" (25th February, 2008).

If some of the key stakeholders had engaged in the process, such as the planning services, many of the issues towards the end of the HIA could have been ameliorated, as the following describes:

> "They didn't engage in a way that would have solved some of the problems the project had at the latter stages of the design phase. And we had arguments with them. They didn't see why they should engage, even in the latter phase of the design; they didn't see why the HIA took place at all. They just saw their role as planning and to make sure the town operated as a cohesive unit" (22nd February, 2008).

One interviewee interpreted the 'politics' to refer to political parties and their role in the HIA. This individual stated that the political parties were invited to consult in the HIA but none came, which was no great loss according to the housing officer of the NIHE, as "the community were very capable of representing themselves" (25th February, 2008).

Institutions: The Gate and the Building

In terms of the political dimension of the institutional influence upon HIA utilisation, some interviewees identified tensions and politics between various institutions and organisations, such as between the NIHE and North/ West Housing Association. The area planner in the NIHE stated that "as the process went through there's a level of politics between ourselves and the housing association but you could have lifted that out, that hadn't anything to do with the HIA" (25th February, 2008). However, the tensions between the organisations impacted on the transfer of knowledge and information across institutional boundaries, and hindered the cohesive nature of housing design and planning that should have characterised the HIA. In addition to inter-institutional tensions, there were also tensions identified between different sectors, namely statutory and community, as highlighted by the HIA project manager, who stated that there were "definitely politics at play, big p and small p" between the NIHE and the community residents who initially wary at becoming involved with the housing executive, due to antagonistic relations in previous times between the community and various statutory bodies (21st March, 2008).

A member of the WIFH team stated that there was politics at play between different sectors and some members on the steering committee. This interviewee illustrated that there were tensions between the planners and everyone else involved in the HIA (22nd February, 2008).

This tension and apprehension that was interpreted from the planning services was correlated to the political culture within the organisation, as the NNHF manager describes in the following:

> "They didn't see why they should engage, even in the latter phase of the design; they didn't see why the HIA took place at all. They just saw their role as planning and to make sure the town operated as a cohesive unit. It took the pressure from all those around the table to let them know to take part in a far more user friendly and constructive way. But that's down to the political culture that exists still within the planning service" (22nd February, 2008).

It is clear from this round of interviews that certain institutional structures were regarded as barriers to the development of the HIA on the Dove Gardens estate, and the planning and roads services were two major players who refused to take part in the HIA. Their absence was interpreted by the Steering Committee as a protest and demonstrated a lack of support for the HIA concept.

<u>HIA: Diluting politics?</u>

A theme that emerged from the interview data, in response to the political dimension with the HIA, related to the dilution of politics. The tool was deemed appropriate in depoliticising the process. The CAWT chairperson iterates this point, stating that "this was a new innovative way of working, so politics was counter balanced. During the scoping stage it's explicit about what will and won't be done, who will do it and won't, and it's explicit on the agenda" (4th March, 2008). The resident representative stated that each of the stakeholders came to the HIA in good faith and with a shared interest in the regeneration of Dove Gardens, and so there were no politics at play from her perspective (25th February, 2008). The politics was diffused due to the stakeholders' common goal of a successful regeneration and rebuild process.

VALUE JUDGEMENTS (IMPACT ASSESSMENT THEORY) (x3)

Hypothesis: HIA utilisation depends on the value judgements of the policy actors

An important issue is the question of the role that values, beliefs and assumptions play in the policy process. The role of these values has been the topic of research in the impact assessment literature. It is being used as an explanatory variable in this study; to assess the influence of value judgements in the use of HIAs. As no matter how rational the policy process may appear to be, it is ingrained with value systems and beliefs (Carley, 1980; Krnv and Thissen, 2000; Weston, 2002; Bekker, *et al.* 2004).

Three categories were elucidated from the interview data. Firstly, the institutional and organisational values played a role in the use and perception of the HIA. Secondly, the issue of the valuing of contributions to the HIA arose. Thirdly, the need for balance between different types of evidence was raised, and the need to value all types.

Institutional and organisational values

The CAWT chairperson stated very simply in her response to the question, that values are everywhere and are undoubtedly present in the context of the HIA. The member of the WIFH team stated that it was important on the steering committee to have a balance between professional values and communities values and interests, in order to ensure a balanced agenda (22nd February, 2008). It was also important to ensure none of the institutions felt under attack, and so a balance within the statutory pool of people was also important (*ibid*). In addition, the manager of the BBHF believed that organisation culture, and the values that exude from such bodies, plays both a positive and negative role, as the following illustrates:

> "I've no doubt that the organisational culture and the values from the organisations played both a positive and a negative role in the process. If you look at some of the statutory organisations they've always been at logger heads with communities, that's how they've existed, they've grown up separately and distinctly from the communities, some communities in Derry, and the HIA was seen as having to engage with communities. And that's seen as a threat. They're wary and sometimes hostile to it. We had to use a bit of guidance to around the hostility, we don't mind fighting but nowadays if you can find a way around fighting it's better" (22nd February, 2008).

How institutions view health inequalities was raised during the interview phase of data collection also, and "these inequalities in the area were profound and entrenched" (21st March, 2008). The reduction of health inequalities is one of the founding pillars of the HIA concept, and agreement and an understanding of the concept and health inequalities and the determinants of health is important for the successful process and outcome of HIAs.

Valuing contributions to the HIA

In terms of value judgements playing a role on the HIA, there were issues raised related to the improved values within the community regarding confidence and belief in its ability to articulate its views. The housing officer of the NIHE articulates this viewpoint succinctly in the following:

> "Dialogue and community is marginalised, without this the tool was good to facilitate, HIA gave them greater input and they were allowed to increase voice and increase confidence and they were angry that they were being asked about having before the designs was drawn up, involved children, families, involved values of the community and confidence; belief and self belief values. They would have a tree, garden, drive way, can have choice to buy car. Some things money can't buy and self-worth came from this" (25th February, 2008).

The resident representative on the HIA stated that the role of values and value judgements related solely to the values attributed to the community, and their input into the process. The HIA "was about trying to make the best for the community for the people through the HIA…heightening the positive and lessening the negatives, which would be of value to the people that's what that was for, and I suppose with having residents on they were listening. They want what we wanted" (25th February, 2008).

Valuing the evidence balance

The project manager stated the there was a "need for balance between research and community evidence, there's values about how both are viewed" (21st March, 2008), which impacts on how evidence and information is perceived, collected and analysed within the context of a HIA. The evidence on health impacts then goes on to be used, it is hoped, within the institutions that decide on policy, and their value judgements on

different types of evidence also plays an important role in the assimilation of types of knowledge and evidence in policy making.

ENABLERS AND BARRIERS: A CHECK-LIST

Three respondents did not take part in completing this check-list, because they either had to leave the interview early (community worker) or did not feel adequately informed to complete the check-list (WIFH member and housing association member).

The respondents in this study were asked about enabling and hindering factors towards to the utilisation of HIA knowledge in the decision making process. The Donegal case study was the second one investigated in the data collection of this study. The check list (below) was formulated by Dr. Catherine Hayes. It was presented at the three-day comprehensive Health Impact Assessment Training which this researcher attended, as run and organised by the Irish Institute of Public Health (September 2006, Grand Canal Court Hotel, Malahide, Co. Dublin)

For the purpose of this research, it was deemed appropriate to use this check-list, formulated in Ireland, for the case study research. This is so as to establish the level of agreement on the contextual conditions for use of HIAs in policy and to construct any additional suggestions that may come from the interviewees. Another comparable study of such enablers and barriers was conducted in the UK (Davenport, *et al.* 2006) and provides an interesting instance for comparison in the results section.

<u>Enablers and Barriers to the policy process in having decision makers involved (Ballyfermot) (September 2006)</u>

11. Involved in planning and conduct of HIA
12. Input from outside decision-making process
13. Clear organisational commitment
14. Subject non-controversial
15. Realistic recommendations

Bad points of decision makers and policy process

5. Lack of awareness of health by other sectors

6. Lack of knowledge of policy-making environment

During data collection, 6 interviewees were asked as to their level of agreement with the abovementioned enablers and barriers. As can be viewed in appendix 15, all respondents agree with the first two enablers.

Regarding organisational commitment, 4 agreed that is was present in the Derry HIA; 2 did not agree with the proposition. However, within the segment that agreed commitment was present, there were some contingent factors associated with their answers. The HIA project manager stated that commitment came into the process gradually; some stakeholders became willing, slowly: "after a while there was commitment, at the start, not from everyone, specifically the builders" (21st March, 2008). The BBHF manager stated that "at the beginning what organisations would do and not do, and what resources and consistency and continuity would be offered, unclear…… but generally not bad" (22nd February, 2008).

The two respondents who disagreed that clear organisational commitment was present were both from the NIHE. One of the interviewees from this organisation stated that "not all stakeholders had this (commitment), but they couldn't refuse being involved, were dragged into process……..alot of resistance around consultation process" (25th February, 2008).

All respondents, when asked if the Dove Gardens HIA had a non-controversial subject at its core and in their assertion whether it was an enabler or not, five disagreed with the proposition that it was non-controversial. The resident representative agreed with the proposition that housing was non-controversial, stating that "I don't see it as being any real obstacle if no-one hasn't anything to hide then they shouldn't have a fear of the HIA being part of the process" (22nd February, 2008).

In response to whether or not there were realistic recommendations in the HIA, and if this was in turn an enabler in the process, five agreed. The project manager explained that it "was really important, we kept them brief and workable, 20% were very easy like write a letter to the council about some matter, and then others were more difficult and time consuming" (21st March, 2008).

However, the area planner stated he believed more workable recommendations could have come from the HIA, qualifying his statement by saying "I think we could have gone a wee bit further but we're all fledglings. I don't know how this would compare to what anyone else has done, the steering group were happy and Dermot pulled it all together, while I signed up to it I'd like to have seen something different. Maybe I'm looking for something with more management words in it, more constructive, maybe it's too simplistic for me and I'm looking for structured measurable outputs" (25th February, 2008).

With regard to any additional enablers proposed by the interviewees, the chairperson stated that "sound evidence base is needed and is best," which came from this project, and if it is to be used in policy, robust evidence is vital (4th March, 2008). The BBFH manager explained that the Brandywell and Bogside area had a very "robust community sector, (it) has the best community network in the city, those of us in the community sector have invested alot of resources in building up their capacity. If you took this in a community which didn't have such a robust community sector you might have difficulties" (22nd February, 2008). In the case of the Dove Gardens HIA, a strong and capable community was deemed an enabler to the completion and implementation of the process. The project manager of the HIA stated that the community being well informed and amenable to concepts of the social determinants of health, "making the link between health and the broader determinants," was an enabler in getting the community involved into the idea initially of conducting an HIA (21st March, 2008).

In response to the barriers in the use of the HIA in policy making, all individuals disagreed that a lack of awareness of health by other sectors was a barrier to the use of the HIA in policy. The overall sentiment in disagreement with this proposed barrier was summed up in the assertion made by the project manager, who stated that "that's always a barrier but people here were quickly caught on" (21st March, 2008).

Regarding a lack of awareness of the policy making environment, two individuals agreed that this was a barrier in the HIA for a number of stakeholders around the table, which in turns impacts on the quality of the process.

The resident representative stated the following:

> "It was (a barrier) for me at stages, people coming in talking in technical terms and at times it went over my head and I'd to ask 'ok what does that mean' and you've to say 'look break it down into English because I don't know those terms.' I had to, I was there to represent my neighbours and they'd be asking me what's going on, I didn't want to say I don't have a clue, so I'd to ask to break down into layman's terms…using language as a barrier? They can do, they can do it to blind people, yeah, they think that they come out with all this blah blah blah, that they're saying then what they need to be saying and no-one's going to question them, because maybe they haven't been questioned before, but the HIA gave the opportunity to question, I believe" (25th February, 2008).

The housing officer in the NIHE also agreed that a lack of awareness was a barrier in the process of the HIA, which impacts on its utilisation in policy making.

Regarding the lack of awareness as being a barrier, the project manager, in qualifying his disagreement with the assertion that a lack of awareness of policy making was not a barrier, stated that this issue was prevented from arising, as "in the scoping stage we looked at what the points of influence for tapping into in the policy level, and we established what we would and would not do, so at this stage we dealt with alot of issues to do with this" (21st March, 2008).

Additional barriers were identified by the interviewees. The BBHF manager added that the fact that this HIA " a prototype and cutting new ground and going for organisations who didn't see their role and people in the organisations who didn't now what their role was (in an HIA)" (22nd February, 2008), was a barrier.

The project manager of the HIA added that people not thinking beyond their professional boundaries was a barrier within the HIA process. While conducting the data collection, workshops were organised in order to inform certain groups with an interest in the Dove Gardens estate of the HIA, its purpose, process and proposed outcomes for policy. One of these workshops was delivered to the workers and

political representatives in the area, and "the group were so hard to deal with. They just found it so hard to think outside their silos, they were the hardest group to move on with the broader determinants of health, for the teacher they just do teaching and the pharmacist only gives out anti-depressants they don't see the need to know outside their boxes" (21st Match, 2008). This mindset displayed by some members of the broader community was cited as barrier for the development of the HIA in the area, and the perception of it as a policy-aiding tool.

KNOWLEDGE UTILISATION AND POLICY ANALYSIS (y)

Each interviewee was asked to what extent, as far as they knew, was the HIA used in policy and how useful was the HIA. Responses were divided into 11 indices, and after further abstraction, were coded into 6 categories. The degree of utilisation of the Derry HIA will be assessed in the next chapter when a cross-case comparison is conducted. The within-case results from the interview data collection is presented in this section.

Policy Making Process

In terms of HIA utilisation, and the degree to which it was used in policy and in other ways, the interviewees in this case study perceived that it was used within the policy making processes. An enabling factor was identified by the team member of the WIFH, who stated that with regard to the use of the HIA, "timing is important, getting into the policy process early enough" is deemed the most successful way of evidence and knowledge being used (22nd February, 2008). Also, another enabling factor was the involvement of high-level decision makers in the HIA, which was the case with this Dove Gardens project (Project manager, 21st March, 2008). The recommendations were used at policy level, "especially health and policy level, which were addressed at policy level by the NIHE and taken on by the health services" (BBHF manager, 22nd February, 2008). Indeed, the same individual stated that "everyone talks about consulting communities but few methods or approaches actually do it properly, and the HIA gives a good basis for that, engagement, and for trying out new ideas. I think it's a good basis for policy development" (*ibid*).

The chairperson of the HIA stated that it is "useful in getting health on the agenda of policy makers, it's a must. HIA is one way of getting health on the agenda of policy makers from outside the health sector" (4th March, 2008). As illustrated here, HIA is identified as an appropriate tool in bringing health awareness to policies, projects and programmes to the attention of policy makers.

Institutional utilisation

In terms of the institutionalisation of HIA, there is work being done at the strategic level of the NIHE to mainstream the tool, so that it would be conducted on all urban regeneration projects, and for all developments in the coming years, as was stated I n the interviews with the project manager of the HIA (21st March, 2008) and the NIHE area planner (25th February, 2008).

Planning services

In every interview, without exception, the planning services were mentioned. The lack of involvement of this stakeholder in an urban regeneration project was a serious failing in the process and framework of action of the HIA. The chairperson stated that "if planners were involved, it's better. Planners think in terms of exists and entrances of the building, not in terms of what goes on inside" (4th March, 2008). The BBHF manager reiterated the sentiment of this statement, explaining that "I don't think it (HIA) has impacted on the planning service, which is a major issue…At city level I'd say it hasn't impacted at all" (22nd February, 2008). These are two statements made in response to this question regarding the utilisation of the HIA upon completion. However, throughout the entire round of interviews, the identification of the absence of the planning services and the manner in which this was a barrier in the full use of the HIA was relayed by all interviewees. This indicates the importance the planning services role was regarded, and the important value placed on their input into the process of health impact assessments.

HIA

In terms of the further use of the HIA on the Dove Gardens estate, the area planner (25th February, 2008) and the housing officer (25th February, 2008) of the NIHE both stated that monitoring and evaluation of the process was required, in order to establish the health gain and health outcomes that the community experience three years after

they have moved back into the new housing. This focus upon health gain as an appraisal indicator for the effectiveness of HIA is difficult to measure, as has been outlined in the research rationale of the European study on HIA effectiveness in decision making processes across the continent, completed by Wismar, *et al.* 2007. However, this was an important facet to the outcome measurement for the NIHE, as the greater the increase in community gain post-redevelopment, the greater the credibility the organisation will attribute to HIA.

The NIHE area planner also stated that until the tool in mainstreamed the tool would continue to be used on an ad-hoc basis, and not in a systematic manner. However, there were numerous impacts that the HIA had upon the rebuild, which "is all specifically a consequence of the HIA" (25th February, 2008).

An example of this was in relation to educational space in the bedrooms of the new housing. The residents recommended that there be space for study desks in each of the bedrooms, so that children "would not compete with the television when doing their homework" (Chairperson, 4th March, 2008; NIHE area planner, 25th February, 2008). The new development now has study space for children, which is hoped to impact on those who attend third level education in the long run, as just 1 per cent of the population attend third level education at the moment (Bonner, 2007).

Work practices

The chairperson of the process was adamant that many intangible benefits and outcomes arose from the HIA, namely the influence the HIA will have on people in their work practice (4th March, 2008).

Recommendations

According to the resident representative, who is also a member of the Local Implementation Group (which came into existence after the HIA finished to carry out the recommendations of the process) and a member of the Dove Gardens Design Team, "alot of the recommendations have been used" (25th February, 2008).

Was the HIA well received?

Interviewees were asked whether or not they believed the HIA was well received or not, by their relevant institutions, and by the community. Six categories were derived from the data in response to this question.

Community

The resident representative on the steering group, when asked was the HIA well received, stated that it "probably was not, because the HIA was there to benefit us, the residents, it wasn't there to benefit the builders, it wasn't there to benefit the housing executive or bodies like that, it seemed to be there to give the residents of this area a voice so it was definitely beneficial to have it" (25th February, 2008). In this instance, the resident representative believed that the HIA being well received by the statutory bodies was not a primary concern.

The HIA allowed an opportunity for the "community to shape their own community" (NIHE area planner, 25th February, 2008). The fact that the regeneration project involved community consultation was a major asset for the proposal going to the planning services, as in accordance with PPS8, regarding community the gain, the proposal has already consulted with the community and this 'ticks' an important box for the planning guidelines in Northern Ireland.

The housing officer was adamant that the HIA was very well received by the community, as it was the "first time ever asked their (community) opinions and hopefully as a result of the HIA their quality of life has been enhanced" (25th February, 2008).

Policy

The manager of the BBFH (22nd February, 2008) stated that the HIA was very well received at the policy level locally, it being "an opportunity to do things better."

Institutional and Organisational level

According to the NIHE area planner, the organisation "now know we have a quality product" in the Dove Gardens regeneration project (25th February, 2008). The HIA ensured that in as far as practicable, the re-design of the social housing estate has been formulated to enhance the quality of life of its future inhabitants, and to minimise the foreseen negative implications of the project.

Intangible benefits

A number of intangible benefits arose from this HIA project. This point came up during the interviews, and was also identified incidental benefits in the Dove Gardens HIA report (2006), as a number of outcomes arose from the process that were not accounted for in the objectives and outcomes in the strictest sense, but were outcomes that were caused by the process of HIA.

The NIHE area planner talked about this concept of intangible benefits of the process, and the following illustrates one example of such an outcome. In essence, this individual explains how, because of the process and framework of HIA, the design was improved and enhanced:

> "It's the balance between top down and bottom up. Because the concept has been difficult to get to where we are now… but to digress as I like to do, I was standing on the front door with the then manager of then Gasyard (community centre), he said do you want that green area in front of the Gasyard? (Pointing to map) I said aye yeah, the Gasyard trust don't allow children for insurance purposes onto the area, it's fenced off, I said, we need to use that green area so we can integrate it into our plan and there's a planning policy 8 which says you must have green space as part of any concept or any design solution. That then became our open space which then meant there was more room for housing in the original plan, all the open space is catered for in here (the formally owned Gasyard space). And because of that simple conversation we have this, and that wouldn't have happened if we hadn't a HIA. And now we have an outcome here of 63 houses , our original design had 54, though I think if we had our green space we'd have had only thirty something so we've doubled the amount because of the HIA.
>
> Not alone can we now house everyone who left the area, we now have housing for more people, and we've a surplus, a net gain. If we'd gone with the design prior to the HIA we'd only have housed 30 of the 54 people who want to come back. Much more land use efficiency" (25th February, 2008)

This extract from the interview with the area planner of the NIHE indicates the degree of benefit that the HIA provided to the project.

Subject area

The manager of the BBHF stated in response to this question that the subject area of the HIA was a contentious topic, as housing in Derry is historically a controversial topic. The following illustrates this point being made:

> "Housing as an issue is very contentious in the city of Derry, historically, from the point of view of civil rights and politics and so on. What's happened in the past is that housing has been landed on people, whether it's the provision of high rise flats or housing, which, after a number of years have proven inadequate. Housing in Derry is an issue that goes to the heart of problems that went on here. And the people in the local community, by engaging in large numbers, were to ensure that wouldn't happen again. They weren't going to be spoken down to, nor have people's ideas and plans about their own future imposed upon them. So I think it worked very very well from that point of view" (22nd February, 2008).

This individual, when asked whether the HIA was well received or not, noted the controversial nature of housing in Derry, and the manner in which housing policy had changed towards one of increasing consensus and decreased elitism in the area of policy formulation. HIA, as noted by this individual, was an important tool to continue along the path of negotiated agreement and community consultation.

Stakeholder Commitment

The area planner noted that "the fact that we've talked so much about HIA and about how prestigious this scheme is, that we've got more buy-in for it. This is a first time ever for this type of project" (25th February, 2008). This increased stakeholder commitment to the project, because of the HIA, has added credibility and value to the project, which, from an institutional stand point, is a major asset when submitting the proposal to the planning services, as noted by the area planner.

Dissemination

The HIA project manager stated in response to this question, that he "gets so many invitation to talk about Dove Gardens, that's a sign too that it's been well received and is seen as a success" (21st March, 2008). There has been a vast amount of dissemination of knowledge regarding this HIA project, throughout Ireland and the UK. This was viewed by this individual as an indicator of good reception by the HIA community of this urban regeneration project.

Further Information

Interviewees were asked if they would like to contribute additional information to the study. In this part of the interviews, respondents had a chance to bring up any issues that they felt they had not the chance to do so earlier on in the process.

Organisational commitment

The commitment to the Dove Gardens HIA was necessary to the success of the project, but was not present by some of the identified key stakeholders. The manager of the BBFH stated that it is important to recognise that the HIA is not "stand alone, it needs to fully engage all organisations in all sectors" (22nd February, 2008). Some sectors, namely the statutory bodies (planning services and roads services) were not fully engaged. This point on the lack of involvement of the key stakeholders was emphasised by the representative from the housing association.

Indeed, reticence on the part of the housing association was also identified. However, the individual interviewed from that organisation stated that it was a workable tool but needed to be mainstreamed if to become fully incorporated into all designs and development projects (20th May, 2008).

Giving Communities a Voice

The resident representative stated that the HIA was a "beneficial tool and should be used for all regeneration and refurbishment projects, giving people who are living there or working there a say, it's always a good thing" (25th February, 2008).

Theory and Practice

The representative from the housing association stated that the HIA concept needed to continue as a workable tool, with realisable recommendations, as without practical

outputs it "could put alot of projects off, unrealisable objectives and recommendations and that's not good, not achievable recommendations, isn't good. The Council was also missing and that's a big problem and their input was needed, important to have them on board" (20th May, 2008).

The manager of the BBHF also reiterated this point, stating that "HIA is very good in theory, but how well it works in practice is what people should be talking about…must ensure connectivity and consistency, between the earlier stages of HIA and the final ones" (22nd February, 2008).

The following chapter provides the conclusions and recommendations of this research study.

CHAPTER 7
RECOMMENDATIONS AND CONCLUSIONS

Chapter Outline

The purpose of this chapter is to present the findings of research. In doing this, the degree of applicability of the research framework is provided and its relevance to the empirical data will be illustrated. Practical recommendations and theoretical conclusions will be provided in this section of the study.

This thesis started with questions regarding the use of HIAs for policy-making, asking were HIA reports being produced and left to [45]"gather dust on the shelves" of state authorities, glossy evidence-profiles unused in the policy process? Clearly some individuals in each of the cases were fearful that the HIAs were being produced but were having little impact on the formulation of policy. At the conclusion of this research, it is clear that the HIAs in this study were used in policy. There are influences impacting the use of HIA for policy and these influences can relate to the extent, or variation, of direct and indirect use in policy.

The indicators from the institutionalist, impact assessment, knowledge utilisation and policy analytical theories have been applied across the cases, as indicated in chapters 5 and 6. Regarding the use of the HIAs, both indirectly and directly, within the cases an analysis will be provided as reasons of variation across the different contexts. Enablers and barriers in the utilisation of HIAs are presented in order to inform the landscape of influences on HIA utilisation in policy and within the policy process.

HIAs *should* incorporate available evidence from processes and reports into policy concerns; HIAs *should* influence the policy process. An expectation of the HIA process has established this normative underpinning. This doctoral research is posited to examine whether this is the case or not, and can it be the case in the future. Therefore, a normative understanding underpins the research questions.

[45] This statement has been freely expressed by at least one interviewee in each case study, while discussing their experiences on the HIA steering groups: By a member of the URBAN II team (4th October, 2007) and Dublin City Council (28th November, 2007) from the Ballyfermot case; by the Donegal Traveller Project coordinator, (13th December, 2007) from the Donegal case; by the HIA chairperson (Interview, 4th March, 2008) of the Derry case; by the Environmental Health Manager of Belfast City Council (20th February 2008) of the Belfast case.

A European-wide evaluation of the effectiveness of HIA in policy formulation, funded by the European Union (EU) and WHO, was completed in 2007. This systematic review is long overdue, as no previous methodical appraisal of HIA effectiveness within policy processes has been carried out to date (Wismar, 2003; 2004; 2006; 2007). In terms of assessing the policy implications of HIA as a policy-aiding tool, this aforementioned research project has cited the influence of the institutional and political context upon the effectiveness of HIA as a decision making tool.

7.1. Recommendations for HIA in Practice

This section presents the findings from across the four cases regarding the practical recommendations for the development of this novel policy-aiding tool in Ireland.

7.1.1. The Role of Local Government

The tier of government that all the HIA cases operated in was at local government level. This tier of government is most appropriate for the maximum use of HIA evidence for policy formulation (Elliott and Francis, 2005; Davenport, *et al*. 2006; Ison, 2007b). The majority of HIAs conducted in Ireland are carried out at this level. Therefore, the role that local government plays, as a state player in local decision making, is an important consideration for the development of HIA into the future. Kearns and Pursell (2007) also concluded that the role of local government, in an Irish context, was an important one to understand in order for the use of HIAs in policy was be maximised. The Welsh policy document 'The Route to Health Improvement: An Organisational Package to Build Capacity for Local Authorities' (2004) is a good example of how local authorities may work towards integrated health considerations into their inter-sectoral policy development, and HIA is a workable tool for such integration and sectoral collaboration.

The Belfast case study illustrated that there is greater transparency and accountability at local government level which is lacking in the central government agencies in Northern Ireland. The lack of uniformity of policy agendas was a hindrance to the use of HIAs at local level in Northern Ireland. However many interviewees noted the unequal role that exists between central and local government, with the latter tier living a life of subservience to the

central government echelons. This was identified as a determining factor in the use and development of the HIA tool.

The current political and administrative reform movement ongoing, within the framework of the Review of Public Administration (RPA) has added a degree of uncertainty for the statutory stakeholders that are operating in the policy spheres. This impacted on the use of the HIAs, as the tool, and the knowledge it brought to the policy process, was overshadowed by the reform agenda among the key decision makers. This discourse, and uncertainty about the future implementation of the RPA, was evident in the Derry case also. However, Derry City Council played a ceremonial role at best in the HIA on Dove Gardens estate, whilst Belfast City Council was a key partner in the use and ownership of the HIA on the draft air quality action plan.

Local government was identified as an appropriate setting for health considerations to be incorporated into local policy making. The consultative and health dimension that HIA employed was deemed amenable for use at local authority level by those interviewed in the Northern Irish case studies.

In the Republic of Ireland the attitudes and institutional culture of the local authority played a role in sustaining societal prejudices against the Traveller community (O'Riain, 2005). The Donegal case highlighted the importance of political will in the local authority in advancing the path with a particular policy stance; in this case it was Traveller accommodation. The locality mentality that was noted during the interview stage of the Donegal case was evidenced by local electoral politics, with the highly politicised launch of the HIA amongst local councillors, which then resulted in a lack of political cognizance or action taken with the findings of the HIA. The important role that Donegal County Council played in ensuring the HIA evidence was used or not was obvious. It was clear that the perception of the non-Council interviewees was that the Council acted as a barrier in the full implementation of the Traveller Accommodation Policy, and in adopting new measures that would promote the health and wellbeing of accommodation centres. It was disappointing that the HIA did not achieve all it had set out to achieve in terms of accommodation policy and practice. However, the subject topic of this HIA (traveller accommodation) took over as the overriding factor. The HIA was subsumed in a policy discourse marred with prejudicial legacies, resentments and cross-institutional bitterness.

In the Ballyfermot case, the central role that Dublin City Council played, and the importance of having Council officials around the HIA, was of undeniable importance. Interviewees in this process stated that the cross-sectoral cooperation and learning that came from the HIA process was beneficial to the conduct of local government business and amenable to the consultative policy environment, which is characteristic of current day activities and values in consensual policy making. URBAN II team members reiterated this point and stated that local government reform and the process of community consultation was facilitated by the workability of the HIA. This was also concluded in the research carried out under the auspices of the European HIA effectiveness research (Lavin and Metcalfe, 2007).

The case studies clearly indicate the importance of the role that local government plays, as an enabler in the HIA process (Belfast; Dublin), as a barrier (Donegal) and as an indifferent player in the process (Derry). In the Dublin and Belfast HIAs, the local authority played important dual roles as both owner and user of the HIA, whereas Donegal County Council was not an owner of the HIA (Donegal Traveller Project were leading the process but were not the authority deemed to use the HIA) but was the expected user. Derry City Council played a ceremonial role. The absence of such a vital partner was realised further down the HIA road at the design stage of the regeneration project. In research conducted by Davenport *et al*. (2006) the decision makers having ownership of the HIA process was an enabler in the process, and this was clearly the case also in this study. The more ownership those making the policy decisions had over the HIA, the more likely the HIA would be used for policy.

7.1.2. The Planning Services: A Vital Partner

An unintended finding from this research which is an important consideration for all HIAs conducted in an Irish context is the vital role the planning services play in the conduct and implementation of HIAs. It was clear from each case study that the genuine involvement and commitment of planning officials to the HIA was a determining factor for the success in each case. This has been identified by HIA experts in the field (Higgins, *et al*. 2005; Barton, 2007; Birley and Birley, 2007; Cave, 2007). Planners are viewed as the 'gateway' to the processes of infrastructural and social development by HIA practitioners and academic experts (Cave, 2007; Mahoney, 2007). This point was highlighted in this research.

The importance of having the planning officials involved in all the cases was voluntarily stated by interviewees during the semi-structured interviewing phase. Those involved in the Ballyfermot case believed the input of planning authorities was integral for the strategic transport and traffic vision. Although the Donegal case indicated the polarised attitudes between senior planners and Council officials on the one hand, and the health services and Donegal Traveller Project on the other, the HIA on accommodation policy could not proceed without such officials in the process.

Whilst in the Republic of Ireland planning services are the function of local government, they are a separate entity in Northern Ireland. This distinction was evidently a greater barrier at the time of data collection, because of the administrative reform and structural uncertainty forthcoming due to the RPA. The obvious separation of local authority functions and planning services was clearly a barrier to institutional cooperation, for the purpose of the process of HIA.

The lack of involvement of the planning services in the Belfast air quality HIA was cited as a major barrier in the process. Their absence was considered a major limitation to the HIA, and also in the drafting of the action plan, as they would have provided strategic vision for the upcoming Metropolitan Area Plan and could have contributed an input in terms of the implementation of the HIA.

The lack of commitment to the urban regeneration HIA in Derry by the planning services was cited as a barrier to the HIA process; it was considered a negative factor in the case study. The planning services were involved at a later stage during the design phase but it would have benefited the process, and the planning services in the long-run, if they had been involved from the beginning. This was identified by many interviewees. This illustrates the importance that the planning services were attributed and the value placed on their input. However, planning services must be convinced of the benefits of the HIA, as there are numerous statutory impact assessments that take precedence over voluntary tools such as HIA, as pointed out by one senior planner in Donegal during an exploratory interview (Interview, 4th December 2007).

7.1.3. The Meaning of Health and the Role of the Health Services

Each of the cases indicated the importance of health conceptualisation and understanding of health inequalities and determinants of health. The social model of health is central to the HIA tool (Kemm and Parry, 2004). It was clear from this case study research that stakeholders in an HIA process must have a comprehension of such key underlying values of the policy-aiding mechanism.

The HIA was considered a suitable tool to inform non-health service statutory stakeholders of the determinants of health, as identified by the chairperson of the Belfast HIA. This has also been highlighted in previous research by Davenport *et al.* (2006) as an intangible benefit of the HIA process. The lack of understanding of social model of health concepts was deemed a barrier to the HIA process in the Donegal case, as pointed out by the Donegal Traveller Project coordinator. How institutions view health inequalities, and what value they place upon the concept, was deemed an important consideration in the Derry case. The reduction of health inequalities is the foundation rock of the HIA mechanism and its understanding is vital to the future development, understanding and success of the tool.

In the Ballyfermot case, numerous health promotion activities resulted from the HIA process, such as healthy eating campaigns at the local Tesco store and school health promotion programmes. This indicates a successful spill-over effect, an incidental benefit that the process had for the local health services.

The institutionalisation of HIA within the HSE in the Republic of Ireland was highlighted as a key area of action for the Health Intelligence and Quality Authority (HIQA), as identified by the senior HSE representative on this body in conjunction with the Institute of Public Health. The drive to embed HIAs within the bureaucratic machinery of the HSE poses a challenge for the future ahead, but it is necessary for the tool to become mainstreamed (Devlin, 2007; Wismar *et al.* 2007), institutionalised (Banken, 2003), and used on a systematic basis if it is to develop as a credible and feasible policy aiding tool (Kearns and Pursell, 2007). This drive for institutionalisation was highlighted by interviewees from the Western Investing for Health (WIFH) team in Northern Ireland. The tool may be institutionalised via the Integrated Impact Assessment (IIA) from a central government level initially, and mainstreamed at local level secondly.

The support for the HIA tool within the health services is vital for its future development. All interviewees from the health services who were involved in the HIA cases were fully supportive of the tool. However, an exploratory interview with a senior health promotion officer in the HSE Western Region of the Republic indicated how the dissatisfaction of one senior individual can impact on the conduct of HIAs at an institutional level; this individual was a self-confessed critic of HIAs being conducted (Interview, 12th December, 2007). Institutional leadership, high-level support, or non-support, plays an important role for the institutionalisation of HIAs within the health services.

7.1.4. Expect the Worst, Hope for the Best: The Role of Policy Makers

The involvement of key policy makers within the main institutional bodies that would use the HIA knowledge to formulate policy was integral to the process. However, the involvement of such individuals was not without difficulty or strain.

Partnership working between the various organisations and interests proved a frustrating battle in the Belfast case study, as although people came to the table, there was a lack of willingness to share information and an entrenchment of institutional attitudes was endemic across the statutory stakeholders.

The role of policy entrepreneurs was cited as an enabler in the case; an individual within an organisation who had the motivation, vision and decision making capacities to push the HIA agenda forward in their relevant institutional setting. This was highlighted in the Belfast HIA; who the leader of the Council is will have knock-on effects to lower level staff. Political leadership was deemed the determining factor in the success of the HIA by Belfast Healthy Cities interviewees. The meeting with innovative 'policy entrepreneurs' was cited as a bonus in this case study as well as in the Donegal, Dublin and Derry cases. Getting the appropriate individuals involved in the HIA, who are coming from an appropriate tier in their home institution with decision making capacities, was vital to the success of the Derry case. The need for senior level commitment and statutory recognition were identified as key factors for the integration of policy makers into the HIA process.

'Breaking Up is Hard to Do'

In the Donegal Case one interviewee from the HSE made an analogy in relation to working with individuals across institutional boundaries. It begins with hearty promise and intellectual romance but then dissipates into non-action and non-use of the HIA knowledge by policy-makers with shocking abruptness. Despite lip service and wordy promises the case was illustrative of the role of policy entrepreneurs or policy inhibitors. The Ballyfermot case illustrated the importance of policy maker's willingness to advance with HIA and the overall entrepreneurship at statutory level that was lacking in direct contrast with the Donegal case. The role that such key policy making individuals play has been highlighted in previous research (Elliott and Francis, 2005; Davenport, *et al*. 2006; Wismar *et al.* 2007) and was considered an important asset or hindrance in this study.

7.1.5. Engaging with the Community: The Role of Policy Receivers

"Then build people. Anyone can build buildings"
(Browne in McSheffrey, 2000: 111).

Previous HIA research has cited the importance of community input and community development approaches to the HIA processes (Mittelmark, *et al.* 2004; Cooke, 2007; Wismar, 2007). The HIA technique was cited by interviewees across the cases as enabling community mobilisation (Ballyfermot), fostering a bottom-up community development approach within the County Council (Donegal), tapping into fragmented community infrastructure and facilitating its growth (Belfast), and enabling community consultation on issues that were never before brought to the residential community (Derry). High falutin language and the use of technocratic jargon were cited as barriers for the full engagement of community representatives in the HIA at the beginning of the processes in both Ballyfermot and Derry but both community interviewees ensured that all stakeholders kept verbal communication at the level of lay man's terms. It was clear, despite the immovability of some statutory stakeholders in the Donegal case particularly, that 'communities shaping their own communities' and the empowerment that resulted from this ensured the sustainability of community involvement in the HIA issues when the official process had ended. This is evidenced in the Ballyfermot case where the Local Action Group (known locally as the Impact Group) will be restarted in September 2008 under the

direction of the RAPID programme; in Donegal the Travelling community health researchers will use their interviewing skills that were learned during the HIA for data collection of the Traveller national health surveys; in Belfast local primary schools are promoting clean air programmes and have tree-planting areas on site; and in Derry local residents having a role on the design and implementation team of the regeneration project. These are incidental benefits of the HIA that ensure sustainability of community involvement in local policy making.

Indeed as cited by a stakeholder in the Derry case HIA is an appropriate tool to encourage partnership-working across all stakeholders, which includes the community groups that will be affected by policy; the policy receivers. Cross-sectoral cooperation and mutual learning are important outcomes from the HIA processes in encouraging community empowerment and activity, as "theoretical planning expertise is of little significance in the absence of community resolution" (McSheffrey, 2000:109).

7.1.6. Integrated Impact Assessment (IIA): Paving the Route for Legislation?

Recommendations were made throughout this case study research for the development of an Integrated Impact Assessment (IIA). This IIA tool would amalgamate the main tenets of impact assessment frameworks that currently inhabit policy-making circles (environmental, health, social, poverty, regulatory), as many are analogous and have the capacity for being joined-up (Lyons, 2005). This was suggested by the Institute of Public Health representative in the Ballyfermot case and by the interviewees in the Derry and Belfast cases. The Office of First Minister and Deputy First Minister (OFMDFM) in the Northern Ireland Assembly is currently advancing the concept of IIA and lessons can be learnt from their work thus far, in facilitating the main tenets of the IAs and in ensuring cross-sectoral cooperation.

On a practical level, it may be via the IIA route that HIA can become legislated and mainstreamed in both Northern Ireland and the Republic of Ireland. The lack of mainstreaming has been identified as a barrier to the development of HIA in this research by interviewees in all the cases, as in other research (Elliott and Francis, 2005; Fry, 2006; Davenport *et al.* 2006). Discussions with planning officials throughout the cases, in particular with senior planners in Donegal, leads to the conclusion that for HIAs to become systemic and standardised

throughout policy making processes, and without adding to the workload of officials, an integration of health impacts and considerations may be the most pragmatic and realistic route. Some HIA purists fear this move (Scott-Samuel, 2006), as it would result in a dilution of the HIA focus. However, the integration of all impact assessment frameworks would ensure health impacts of policy are considered and it would be the most assessable route towards legislation of the tool.

7.1.7. The Use of HIA in Practice

Alex Scott-Samuel (1996) in a seminal paper entitled 'Health Impact Assessment: An Idea whose Time has come,' initiated academic and practitioner debate on the use of this policy-aiding mechanism, which can be used to foster healthy public policy (*ibid*, 2006; McBride, 2007, Bekker, 2007). In this case study research interviewees were asked if they believed the time had come for this novel HIA mechanism to be used in policy, in order to elicit cross-sectoral perspectives of this tool which has not been subject to much academic publication in a solely Irish context to date (Kearns and Pursell, 2007).

In the Donegal case study there existed the most reticence about the timing of HIA. Interviewees believed that although HIA was a workable tool to feed policy, the subject area of Traveller accommodation was inextricably linked to societal and institutional prejudice and misunderstanding. It would have been difficult for the HIA to cut through the politics of the area, which was one of the retrospectively misguided expected outcomes of the process, from the perspective of the Donegal Traveller Project.

The Ballyfermot case displayed warmer support for HIA, as evidenced amongst the key interviewees, believing the time was right to use HIAs in policy. However, endemic institutional constraints in the use of evidence by the local authority were cited as a barrier, as was noted by a Dublin City Council planning official.

In the Belfast and Derry cases, no interviewees stated that the time had not come to use knowledge that comes from the HIA process in policy, unlike in the Republic of Ireland cases. Instead of being sceptical of HIAs, interviewees in the Derry and Belfast cases adopted a 'wait-and-see' approach to the timing of the policy-aiding tool. Indeed, this attitude was reflective of the administrative reform environment as prompted by the RPA; many individuals within the

statutory bodies are ‘waiting-and-seeing’ if there will be structural change within their institutional homes.

The testing of the enablers and barriers check-list throughout the four case studies resulted in an amalgamation of overall agreement with the initial check-list, as devised by Dr. Catherine Hayes (appendix 14). This check-list facilitated the answering of one of the four research questions posed for this study (chapter 4, section 4.3), which is as follows:

What are the barriers and enablers to the use of HIAs?

Additional barriers and enablers were contributed by the interviewees which illustrates specific factors that were identified by the individuals who had experience the process of HIA in an Irish context.

Institutional leadership and political will were additional enablers identified in response to the check-list contributions by interviewees. This factor has been raised throughout all four cases, indicating the importance upper-level institutional leadership and support is for the advancement of HIA. This was also highlighted in research conducted by Davenport *et al.* (2006).

The involvement of the community sector in the process was identified also as an additional enabler for the conduct, implementation and acceptance of policy recommendations that came from the HIA. The existence of a robust community sector enables the smooth conduct of HIA.

Regarding additional barriers, interviewees indicated that the lack of institutional leadership and support for HIA could inhibit the process and the use of HIA for policy. A lack of understanding of HIA and of what decision makers required from the process was noted as barriers also, which was also raised in similar research conducted on barriers and enablers by Davenport *et al.* (2006). Institutional entrenchment of values and a lack of willingness to engage in cross-sectoral working was a barrier to the process. The HIA being conducted concurrently with the air quality action plan in the Belfast case study was cited as a barrier to the process, as it placed additional time pressure for the completion of the HIA.

Recommendations for the Integration of HIA at Local and National Level

The following includes practical recommendations for the development of HIA:

LOCAL LEVEL

There is capacity for coordination of resources and strategic vision across the local government and health service institutions. Horizontal ways of working in partnership would enhance the workability of HIA, as well as increasing the role for evidence-based policy-making. Local authority and health service strategic planning has the potential to guarantee greater coordination of resources and to reduce duplication of work.

- The local authority should be involved in the HIA from the beginning of process. This would maximise the use and ownership of the process and outcomes.
- The planning services should be consulted and involved at all stages of the HIA. This provides a more comprehensive picture for the impact assessment pathway and ensures greater integration of HIA into forward planning processes.
- The health services have a key role to play in leading, coordinating and mainstreaming HIAs in Ireland. In order to maximise the HIA process, a multidisciplinary network of representatives from statutory, voluntary, community bodies, and research institutions, with an interest in HIA should be formed. Such networks can be coordinated, although not exclusively, by the health services. A partnership approach to working is required for the maximum advancement of the HIA concept.

NATIONAL LEVEL

Institutional leadership and political will has been identified in this research as necessary enablers for the feasibility of HIA. Such higher-level advocacy for the practice and use of HIAs into the future is required. This would ensure longevity for the policy-aiding tool. This support is a necessary ingredient for HIA sustainability.

- The concept of the Integrated Impact Assessment (IIA) can be advocated as a feasible and cost-cutting tool in synchronising resources and basing policy on informed and comprehensive tools. The Department of Taoiseach and the Office of First Minister and Deputy First Minister (OFMDFM) both have an authorised and strategic role to play in this regard. The lessons learnt from the experience of the OFMDFM, in advancing the IIA, may be taken on board by the Department of Taoiseach in organising the future development of impact assessment techniques nationally.
- The Institute of Public Health has an excellent record in advancing the practice of HIA by providing training, capacity-building, and national forums to facilitate debate and learning of the tool. This role must continue to be recognised at a national level and can be involved into in the future development of local HIA networks across the island.
- The willingness to engage in cross-sectoral working, which is at the heart of HIA, must be encouraged from the higher echelons of management and leadership in state organisations.

7.2. Conclusions from the Research Framework: Answering the Research Questions

A theoretical framework, drawing from three schools of literature (chapters 2 and 3), was used in this study:

1. Institutional theory (incorporating HIA literature on the political dimension)
2. Policy analysis and knowledge utilisation
3. Impact assessment literature and the role of value-judgements

Each case study was analysed using the method of process-tracing in order to describe the hypothesised influences on HIA utilisation (independent variables) and the degree of use in policy (dependent variable).

The central research question, which is as follows, was the seedbed from which more specific theoretically-based questions were devised:

How and why do the overarching structures and underlying values influence the use of HIAs in policy?

The proceeding sections illustrate the suitability of the chosen theories and schools of literature in eliciting relevant data, in order to answer the research questions.

7.2.1. Institutional Theory

How do institutional structures influence Health Impact Assessment utilisation in policy?

New institutional theory was chosen to explain the influence of overarching structures that have the potential to shape individual behaviour and action, or non-action (Immergut, 1992; March and Olsen, 1984; 2005; Peters, 1999). The degree of convergence and divergence in the themes that arose from the interview data will be used to illustrate the practicability of this theory to explain the phenomena of influence on HIA use in policy making.

Normative Dimension

By employing a deductive and inductive approach to data analysis (Fenno, 1978), and ensuring that analytical induction was facilitated than raw empiricism (George and Bennett, 2004), contingent generalisations have been concluded from this case study research.

In response to the question of institutional constraints and these impacts upon individual behaviour and the way in which HIA utilisation may be affected, there was a mix of convergence and divergence of themes. The categories that came from the detection phase, after the indices of data arising from the interview transcripts was analysed, formed a thematic map of issues and findings. All cases converged on the categories of institutions as an influence upon behaviour at a macro-level, and the HIA process and the policy process as influences on the lower micro-level. This convergence indicates the degree of institutional influences, and the norms that such institutional structure exudes as influences, across the cases despite the difference in case study settings, topics and geopolitical locations.

The category of 'evidence' arose in the two Northern Irish cases, Belfast and Derry. Both cases highlighted the issue of accessing local evidence for policy-aiding mechanism such as HIA. A lack of local evidence and community profiles constrains the HIA process and the subsequent use of the knowledge that comes from this process for policy, as well as delaying the HIA as local evidence may have to be gathered as part of the impact assessment methodology.

In both the Derry and Donegal cases the influence of values, beliefs and ideas acted as institutional constraints. In the former case values and beliefs, the entrenched attitude of a senior architect in constrained statutory engagement in the HIA process, due to his own beliefs that he 'builds houses, but does not design communities.' In the Donegal case, ideas were deemed constraints as the subjective values and beliefs people held about the area of Traveller accommodation overtook the objective worthiness of the evidence that came from the HIA (Davenport, *et al.* 2006)

In divergence, categories came from the cases that were specific to each the individual HIA. In the Donegal case, the area of Traveller policy was itself a constraint and the institutional prejudices and attitudes acted as barriers to the willing engagement in the HIA. In the Derry case, the absence of the planning

services was highlighted as a key constraint on the activity of other stakeholders around the table, as this is a vital partner missing from the process. The lack of community resources and infrastructure in the Belfast HIA was identified as a constraint upon behaviour of the statutory stakeholders, and added time delays in engaging with the community sector for the HIA.

Political Dimension

Previous academic research, investigating the use of HIAs in policy-making, has established the influence of the political context upon HIA evidence utilisation (Bekker, 2004). The direct and indirect influence of the political environment, and actor's preferences in policy-making, are important considerations when investigating influences on HIA use (Elliott and Francis, 2005; Bekker *et al*., 2005; Putters, 2005).

The categories that came from case study findings displayed convergence and divergence on thematic agreements. All four cases acknowledged the influence of the individuals who were the micro-level gatekeepers to the institutions being investigated, and the influence of the institutions themselves as the 'gates and buildings.' This thematic agreement illustrates the feasibility of the political dimension and the acknowledgement of the influence of the political environment and actor's preference, and how the institution may affect and shape the behaviour of individuals.

Politics with a small 'p' was identified as an influence upon individual behaviour in the Donegal and Ballyfermot case studies, as has been identified in previous research (Bekker *et al.* 2004; Elliott and Francis, 2005). The HIA process was viewed as an advocacy tool in the Belfast and Donegal HIAs; as a tool which would be used to endorse particular standpoints, and therefore was not neutral or objective (Kemm and Parry, 2004). The area of Traveller work and policy, and the vested interests at play amongst all stakeholders, was highlighted as part of the political dimension. In the Derry case interviewees viewed the tool as a mechanism that would dilute the politics of urban regeneration amongst the statutory stakeholders, and within their institutional interests and structures.

A clash of opinions occurred on what evidence was deemed correct in the area of transport, traffic and air quality in the Ballyfermot case. The disagreement that

exists between expert and lay evidence was highlighted in this case (Lukes, 1998).

In the Belfast HIA the expectations of the HIA were not managed appropriately, priorities and expectations of the process should be established at the beginning of the exercise, so as to avoid unmet expectations and disappointment in the HIA tool. This point was concluded from the European evaluation of HIA effectiveness in policy (Wismar, *et al*. 2007).

The need for HIA legislative recognition and institutional embeddedness was highlighted in the Donegal case, as has been pointed out in previous research (Banken, 2001; 2003; Bekker, *et al.* 2004; Elliott and Francis, 2005; Fry, 2006; Davenport, *et al.* 2006; Wismar et al. 2007; Morgan, 2008).

7.2.2. Value Judgements and the Impact Assessment Paradigm

How do value judgements influence Health Impact Assessment utilisation in policy?

It is important to take account of the role that value judgements play in policy making. Such judgements relate to the perception of what a 'good' decision is over another groups', and the two may have diverging points of view. In order to avoid rationalising the policy process to any idealistic extreme, the role that values play in the consideration of HIAs in policy is an integral aspect of this research.

The WHO Gothenberg Consensus paper (1999), the most cited document in HIA literature, highlights the pertinence of values underlying the processes, institutions and actors that HIAs are attempting to influence. The WHO paper emphasises the need to consider the influence of values upon decision making processes and the need to take them into account when establishing the influence that HIAs can have upon such processes (ECPH, 1999).

Value judgements and the role values play in the use of HIAs for policy making, was identified in this case study research. Institutional and organisational values were highlighted in the Belfast and Derry cases, as the interviewees were adamant that value judgements played a role in the use, or non-use, of the HIA in policy, and indeed during the HIA process. What is considered good evidence for policy, and what is cast aside, was influenced by the institutional and

organisational value judgements. Institutional complexity, negative attitudes towards the process, and the need to persuade institutions and individuals (Majone, 1989) of the benefits of HIAs and the knowledge coming from the process, was raised in the Ballyfermot case study. Interviewees in the Ballyfermot case stated that HIAs need to be legislated for if they are to be mainstreamed and not conducted on an ad-hoc basis only, which has been identified in previous research (Wismar *et al.,* 2007)

Valuing the evidence balance between lay knowledge and expert knowledge was highlighted in the Derry case, which was also raised in the Belfast HIA in relation to the values placed upon the contributions to the HIA.

Values attributed to the conceptualisation of health, in a more holistic sense, impacted on the use of HIA knowledge, as the Donegal and Belfast cases indicated. The contributions and involvement of the community sector in the HIA (Ballyfermot) and the attitudes towards a particular community group, the Travellers (Donegal) illustrated the importance that value judgements play in all aspects of the HIA process, and not only in relation to the utilisation of knowledge for policy making.

Values implicit in the policy process and how the stakeholders, who are envisaged to use the HIA knowledge, was a determining factor in the Belfast HIA, as was the issue of policy entrepreneurs and the impact that innovative individuals across the various institutional boundaries had on the use of HIAs for policy.

A miscommunication of values and expectations in the Donegal case study illustrates the need for better clarity at the commencement of the HIA process, as previous research has highlighted (Wismar, *et al.* 2007).

Variable Indicators

<u>- Value judgements view HIA as an administrative technocratic burden</u>

The view that HIA is an administrative burden, and that this factor inhibits the use of HIA knowledge in policy, was raised during this research study. An interviewee in the Belfast case stated that he believed the exercise was just a check-list process, a burden for policy making. This was raised in the Ballyfermot case, which highlighted the point that the HIA was considered inhibitive for policy innovation and creation, and was identified by an interviewee as being too theoretical and not outcome focused. It was viewed as a

tool that was not operating in parallel with institutional structures of decision making, and could is in danger of being abandoned to gather dust on shelves. This point of the HIA being a cumbersome tool was raised in the Derry case also, as was the point of there being in existence a plethora of IAs already in the policy making environment. The fact that there are so many IAs in existence was identified as a barrier for use of HIAs by planning officials in particular, as was clear from the four case studies.

- Value judgements view HIA as a useful informative aide.

The value judgements as exhibited and displayed by the interviewees involved in this research focused upon the benefits of conducting the HIA, of the direct and indirect benefits of being involved in this collaborative exercise, as has been found in previous research (Davenport, *et al.* 2006; Bekker, 2007). There was an overwhelming support for the tool and if there were more institutional resources available for the conduct of HIAs (in terms of funding and staffing) and legislative recognition for the HIA, there would be a greater sense of garnered support for the policy-aiding tool, as illustrated by these four cases.

7.2.3. Policy Analysis and Utilisation Theories

Why is the degree of utilisation, both direct and indirect, varied in different contexts?

The influences (independent variables) upon HIA knowledge utilisation (dependent variable) are the effects that will be evaluated in this research. The hypothesised outcome, which in this case is the extent to which HIAs are used in policy processes, will be assessed in terms of the degree of knowledge utilisation, as indicated in the table below, as can be viewed also in chapter 1. Policy analysis and knowledge utilisation theories informed the construction of this variable and the direct and indirect utilisation indicators (chapter3).

Independent variable: Degree of utilisation	***Instrumental (direct)***	***Conceptual (indirect)***	***Persuasive (indirect)***
Ballyfermot			
Donegal			
Belfast			
Derry			

The work of Janowitz (1970) who recognised the potential for conceptual utilisation of knowledge over time, labelled as 'enlightenment.' The consideration of politics underlying the use of knowledge and the evaluation of policy rejects the rationalistic approach to evaluation, and recognises the degree of policy learning that can occur in the policy processes; direct use of knowledge is no longer the only form of utilisation that is recognised, given the political nature of using knowledge in policy (Patton, 1997; Sanderson, 2002).

Rossi *et al.* (2004:411) have moved this school of thought onwards with their conceptualisation also, with the following categorisation of utilisation of knowledge in policy, which is used in this research:

4. Instrumental utilisation: The documented and specific use of knowledge.
5. Conceptual utilisation: The use of knowledge "to influence thinking about issues in a general way."
6. Persuasive utilisation: The use of knowledge "to either support or refute political positions- in other words, to defend or attack the status quo."

A similar typology was also used in the European-wide evaluation of HIA effectiveness in policy making (Wismar *et al.* 2007: 19/20). Direct comparison and amalgamation of the degrees of utilisation can be incorporated into the Wismar *et al.* (2007) typology. Degrees of effectiveness (of use in policy) varied across the cases, between direct (instrumental), general (conceptual), opportunistic (persuasive), and no effectiveness.

This section of the chapter will examine each case for the three degrees of utilisation of HIA knowledge, taking account of the independent variables. Firstly the convergence of categories that were deducted from data analysis indicates contingent generalisations that can be made across the cases regarding utilisation.

It has been found that in the Ballyfermot, Derry and Belfast cases, the recommendations (suggestions in the Belfast case) were used **instrumentally (directly)** in policy formulation. The HIA in the Donegal case was not used instrumentally (directly), neither to inform present day policy, nor improve the Traveller Accommodation Policy (TAP) retrospectively. Whether or not the HIA will inform the future TAP remains to be seen, but is beyond the scope of this

research. The policy making process, and policy environment in the case of Ballyfermot, was informed directly by the findings of the HIA and the knowledge was used to inform policy. However, a full utilisation of all recommendations was not found in all cases, with greater instrumental utilisation evident in Belfast and Derry, to a lesser degree in Ballyfermot, and the Donegal case displaying the least instrumental utilisation of the HIA.

In all cases, the HIA process highlighted the degree to which the findings of the process would be used. The HIA indicated the level of factionalised power in the Belfast case which acts as an inhibitor to the use of knowledge in the long run; in the Ballyfermot case the future of the HIA is guaranteed is its sustainability, evident by the re-establishment of the Local Action Group. The HIA process in Derry highlighted the benefits of cross-sectoral collaboration and the policy learning and enlightenment that can come from such processes. A 'wait-and-see' attitude exists regarding the Dove Gardens regeneration project, and the extent to which the HIA has impacted on health gain into the future will be evaluated, in order to establish the linkages made between improved health status and the HIA recommendations. The HIA process in the Donegal case highlighted the need for political will and genuine statutory stakeholder commitment to the project.

In terms of **conceptual (indirect) utilisation**, whereby the HIA will be used in a general way to inform policy indirectly, all cases fit into this categorisation.

Interviewees in the Ballyfermot case indicated the manner in which the HIA would "drip into policy, not (be) an explosive contribution to policy but may inform it indirectly" (9th October, 2007). This point was reiterated by another interviewee in the case also (12th October, 2007). The HIA was identified as contributing findings on traffic and transport that the community could use into the future. The findings were also used to inform health promotion activities in the vicinity, which indicates the indirect utilisation of HIA knowledge.

Interviewees in the Donegal case also highlighted the fact that although the HIA may not be immediately used in policy, it may be a "brick in the wall towards something more substantial. It started as a process and may show results down the road (24th March, 2008). This was also raised by other interviewees in the case, but the overwhelming negativity and the hostile polarisation of attitudes towards Traveller accommodation between the stakeholders in this case acts

more as a barrier to the use of HIAs findings, rather than any implicit failing of the policy-aiding tool.

Interviewees in the Belfast case stated that in addition to the HIA informing the action plan concurrently, it also is being used in policy formulation within the Environmental Health section of Belfast City Council, and will be used to inform the planning review as led by the planning services, providing in particular the community perspective for the city's Masterplan.

Interviewees in the Derry case stated that in alongside the HIA being used instrumentally to inform the redesign and regeneration of the Dove Gardens estate, it is being used by the health services and the community health forum (BBHF) to provide adequately tailored local community health services.

In terms of **persuasive (indirect) utilisation**, whereby the HIA will be used to endorse a particular standpoint, two of the cases can be categorised in this grouping.

Interviewees in the Belfast HIA, in particular those on the management team, stated that the HIA was used as another means of facilitating collaboration and partnership between the statutory stakeholders. Entrenched attitudes, institutional dormancy and immovable institutional standpoints had brought the formulation of the draft air quality action plan almost to a standstill. It was at this point the HIA was introduced, to facilitate collaboration and to inform stakeholders of the wider determinants of health, which was not considered by the majority of non-health sector statutory stakeholders. In this case, the HIA was used as an advocacy tool, endorsing a particular direction and with underlying motives for improving collaborative mechanisms.

Interviewees in the Donegal HIA explained how the HIA was introduced as a mechanism that could "cut through politics" (13th December, 2007) and could facilitate better working relations between the County Council and the Donegal Traveller Project in particular. A history of conflict was characteristic of the subject area, and the HIA was expected to reduce these polarised attitudes, or at least keep them outside the HIA process.

Interviewees in the Derry also viewed the HIA tool as a means of diluting the politics of housing, as this subject is a historically controversial one, and the HIA mechanism was viewed as a means of neutralising any friction in the debate on the urban regeneration project. It was also a means of including the policy receivers in the process, who had been historically excluded from the processes in Derry, which had devastating effects, which are still in the communal memory of the area.

The following indicates the degree of applicability the utilisation typology has for this research. Belfast and Derry are the only two cases that fit into each of the three categories, whilst Ballyfermot is applied to instrumental and conceptual use, and Donegal applied to conceptual and persuasive use.

Instrumental: Ballyfermot, Belfast, Derry
Conceptual: Ballyfermot, Donegal, Belfast, Derry
Persuasive: Donegal, Belfast, Derry

Overall, the theories of knowledge utilisation and policy analysis have informed an appropriate and feasible utilisation measures for policy. There is variance in the applicability across the cases, which can be explained by the institutional and value judgements that impacted upon utilisation in this research.

7.3. Limitations of Research

Methodological and research limitations have been identified during the course of this study. The reality of case study research, which is contemporary and at times demanding an opportunistic and flexible approach to research, has resulted in some factors inhibiting the development of this study as envisioned from the beginning by this researcher. The following illustrates some of the most pertinent issues.

Inaccessible Stakeholders

Some individuals were unable to be accessed during the time frame of this study. In particular the community groups affected by the air quality plan in Belfast, the HIA researcher in the Belfast case, and planning officials in the Derry and Belfast cases. The community groups in Belfast were also not accessed for another study, the European-wide study of HIA effectiveness for policy (Wismar, *et al*. 2007), which indicates the difficulty in accessing these groups

despite numerous attempts. The HIA researcher in the Belfast case unfortunately was unavailable for a semi-structured interview for this study, although this individual was met with at the eighth international HIA research and the case was discussed there on an informal basis. The planning officials in Northern Ireland were extremely difficult to access despite numerous attempts and despite the assistance of other interviewees for this cause. These individuals missing from the discourse of research is a limitation of the study but is an accepted reality in the world of social science research (Dexter, 2006).

Case Study Research

The nature of case study research is one characterised by contemporary temporal settings (Yin, 2003; Bennett and Elman, 2006). This type of research requires flexibility and dynamism within the research framework, as reflection and contemplation of the study's questions must be expected to a certain extent. However the immovability of the central research questions in this thesis has allowed for any unexpected issues arising during the case study field trips and during the interview phases.

Health Impact Assessment: An Infant Child

The concept of HIA throughout Ireland is still in an infancy state and is much less developed than other more institutionalised impact assessment frameworks, such as Regulatory Impact Analysis, Poverty Impact Assessment in the Republic of Ireland, Equality Impact Assessments in Northern Ireland, and Environmental Impact Assessment and Strategic Environmental Assessments in both jurisdictions. The fact that HIA is less developed also means that it is less familiar to those involved in its process. Those involved in the HIAs in this study's cases were using HIA methodology for the first time. This research is an exploratory one which is filling a gap in the current literature. It progresses the research of HIA in Ireland. However the novelty of the area has also a down-side that must be acknowledged, as has been the situation in this study. This must be incorporated and used for the benefit of this research which has been incorporated as much as possible.

7.4. Proposals for Further Research

Carrying on the sentiment of the last section on the research limitations, it would be beneficial to this area of research if a quantitative study of HIA use in policy were to commence. Since there are more examples of HIA cases available in mainland UK, a study that involves a greater number of cases and individuals for analysis would be beneficial. This would also broaden the jurisdictional spectrum for research and enhance the learning on the contextual influences on HIA use.

Research that investigates the feasibility of the design of the HIA tool in particular and how would impact on its use in policy would be an area of possible future study in an Irish context, as it has been conducted in the Netherlands (Bekker, 2007) and would prove an excellent comparable study.

7.5. Overall Conclusion

When combining the theoretical and empirical findings of this research, the overall conclusion is that HIAs are used in policy development.

Practically, HIA use is influenced by the tier of government (local), the involvement of key partners (planning services), the conceptualisation health, the role of the policy-makers and the community receiving the policy product. The mainstreaming of the tool is important into the future. Its incorporation into an Integrated Impact Assessment (IIA) is one feasible route for it attaining a legislative footing.

It is clear that the extent of such use varies, and a linear and rational investigation of HIA use in policy that focused on direct instrumental utilisation would have proven superficial and lacking depth. By using the independent variables and investigating the relationship between the variables and the congruence of these theories and schools of literature with the findings, all cases displayed conceptual use of HIA for policy formulation. This indicates the conclusion that the tool does impact on policy development and can be used instrumentally in the future. The Ballyfermot, Belfast and Derry cases indicated instrumental use of the HIA. The fact that the Donegal case has not (within the temporal timeframe of this research) displayed use of the HIA for policy development may be more related to the topic area of Traveller accommodation being implicitly controversial than the infeasibility of the HIA tool. The Donegal, Belfast and Derry cases indicate

their use was of a persuasive nature. This would concur with previous research, whereby the HIA can lead to "a politicisation of knowledge rather than to the rationalisation of policy" (Bekker, 2007:194). This research has provided greater insight to the influences on HIA utilisation in policy, and more specifically, the extent of that utilisation. This study has indicated that the use of HIAs is influenced by its contextual conditions which could be foreseen prior to project commencement.

For the advancement of this policy-aiding tool, it must be recognised that no stakeholder may work alone on a HIA. What is required is a partnership approach to working and a pooling of resources, expertise, experience and interest. Without a top-down support for HIA, the tool and the evidence it provides, will be destined for dusty shelves. The time for HIA has come. It is up to those involved in the advancement and nurturing of the process to stand up to the challenge of furthering better informed and inclusive policy-making.

CHAPTER 8

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Appendix 1: Different Types of Impact Assessment

Environmental Impact Assessment

Without doubt, this is the most developed, recognised and institutionalized form of impact assessment. The term 'environmental impact assessment' (EIA) was coined in the seminal National Environmental Policy Act (NEPA) 1969 in the United States (Von Moltke, 1984). The rationale behind this legislation was to ensure that examination would take place of possible effects, which development plans may have on the surrounding environment (Lord Ashby, 1976). For the first time, developers were obliged to indicate how their projects and plans would not significantly harm the environment (Bradley, 1991; Grist, 2003). Developers had to provide Environmental Impact Statements (EIS) which would show the nature of the development, and illustrate the measures taken to reduce the possible impacts on the environment (Skehan, 1991). Nowadays in the United States, EIA is institutionalized in regulations and procedural activities of state and federal agencies. Perhaps more importantly, however, it is also ingrained in the mindset of local communities, government departments and authorities, elected officials, and construction and land-use development companies (*ibid*; Tromans and Fuller, 2003; Therivel and Morris, 2001). Since the development of EIA in the United States, it has undergone numerous international reviews (EC, 1993; Sadler, 1996; Lee, 1995; Barker and Wood, 1999), and has improved and advanced in terms of methodology and process since its inception three decades ago (Bond, 2004). Indeed, by the year 2000, 112 countries across the globe had EIA in place, although different variations of the process are in existence (Bond, 2000; 2004).

Environmental Impact Assessment: Definition

Numerous definitions exist of EIA, as it encompasses various strands of activity within its very nature. The International Association for Impact Assessment (1999, part 2) define it in the following:

> "The process of identifying, predicting, evaluating and mitigating the biophysical, social and other relevant effects of development proposals prior to major decisions being taken and commitments made."

EIA is the term used to define the "systematic examination of the likely impacts of development proposals on the environment prior to the initiation of any development works" (Grist, 2003:246). The conducting of EIAs does not necessarily mean that the development will proceed, but will ensure that unintended effects will be reduced or

not take place. In conjunction with EIA mitigating the risks of plans and projects (Scott Wilson, 1996), it is vital for the process to ensure information about impacts are interpreted and communicated appropriately, and presented suitably towards the audience such information is aimed towards (Munn, 1979). This audience is generally composed of policy makers (WHO-UNEP, 2004). The EIA process should provide decision makers with an estimation of the likely effects of policy actions, thus leading to more informed decisions. Consultation and stakeholder participation is central to the ethos of the EIA process, whereby the EIS report is one part (Petts, 1999). It is essential to note, however, that EIA operates in a political context (Weston, _; Dresner and Gilbert, 1999; Leknes, 2001). Therefore, it is not unusual for economic, social or political forces to take priority of place ahead of environmental concerns (Wood, 1995). However, the EIA process is designed to ensure that decision makers are enabled to make a more informed choice in policy selection (*ibid*), although this has sometimes been found not to be the case (Dresner and Gilbert, 1999).

Environmental Impact Assessment: Ireland's Experience

Environmental Impact Assessment is currently institutionalized in domestic law of EU member states, albeit implemented somewhat erratically and non-uniformly across the Union[46] (Tromans and Fuller, 2003). Certainly, EIA has generated a sizeable portion of case law pertaining to environmental protection throughout the EU to date (*ibid*). In Ireland, the first statutory obligation placed upon planning authorities, in order to ensure physical planning took place, was introduced by the Local Government (Planning and Development) Act, 1963. No longer would planning be a discretionary function of planning authorities (Grist, 2003). Between 1976 and 1999, eight planning acts were introduced into Irish law, which facilitated the evolution of the planning procedures and system that is in place today (*ibid*). Many of these acts were formulated in order to implement European Directives, as Ireland is obliged to incorporate community law into its existing legal procedures[47]. The European Directive on the assessment of impacts of developmental projects on the environment was introduced to Ireland by the European Communities (Environmental Impact Assessment)

[46] Various examples exist as to the different levels of implementation of EIA Directives across the Union. An example of such problems lies in the Commission V Ireland case (1999). In this instance, the European Commission argued that Ireland's interpretation of the size threshold for the types of EIA project negated the impact on the environmental area outside the geographical perimeters of the EIA boundaries. The Commission argued that projects may be allowed to continue while being in close proximity to environmentally sensitive areas, such as the Burren or an active blanket bog. The European Court found in favour of the Commission (Tromans and Fuller, 2003). (Case C-392/96 Commission V Ireland [1999] ECR I-5901)

[47] EIA legalisation and procedural formalities derive from EC Directives, notably Directive 85/337/EEC (as amended by Directive 97/11/EC).

Regulations, which were formulated under the 1972 European Communities Act (*ibid*). The Planning and Development Act, 2000, was an opportunity to consolidate the previous five sets of EIA procedures and regulations into primary legislation. The establishment of the Environmental Protection Agency (EPA) in 1995 is considered an important step towards ensuring private and public development projects undertake responsibility to mitigate the risks of long-term damage, within the EIA process and framework. It is an organisation that is integral in communicating EIA guidelines and procedures to the general public, planning authorities and private construction and development companies (EPA, 2006). Although the EU Directives have ensured that Ireland's planning and development legislation ensures EIA's are mandatory, thus giving the entire process credence and structure, it must be noted that some of the best impact assessments are voluntary (Fry, 2006).

The Irish EIA system implements the EU Directive, in relation to the EIA process, through understanding of its requirements into the land-use consent system and other development consent systems, which cover projects such as oil or gas pipe laying and roads construction (EPA, 2002).

Globally, the stages of the EIA process are universally similar, albeit variations of methodology and interpretation existing in some countries (Therivel and Morris, 2001). The procedural stages of the EIA start at the project design stage where it is decided whether an Environmental Impact Statement (EIS)[48] is required. This statement is embodied in a document, which emerges at the end of the EIA process (EPA, 2002; 2003). Screening of development projects is conducted by the relevant authorities, in order to determine whether an EIS is required or not. This initial stage in the EIA process is determined by EU regulations pertaining to environmental development projects. EU criteria states that projects over a certain size threshold are required to produce EIS reports. However, the competent authority may use its discretion in ordering the production of an EIS, even if it is below the threshold size (EPA, 2002). The second procedural stage of the EIA process, scoping, is then conducted. This involves identifying the issues to be dealt with in the process, and to simultaneously eliminate the irrelevant issues *(ibid*).

[48] An EIS is defined as " a statement of the effects, if any, which proposed development, if carried out, would have on the environment" (Statutory Instrument, No. 349 of 89, Article 3(1)) (EPA, 2002: 1).

The end-product of the EIA process, as contained in the EIS report, is required to describe the following:

- The proposed development
- The impacts of the proposed development
- The measures to mitigate adverse impacts
- A non-technical summary

(EPA, 2002:1).

The competent authority, having studied the EIS report, must make a decision regarding the proposed development project. The EIA is part of the decision-making process, and is conducted prior to consent being authorised. Therefore, it enables the competent authority to make an informed and appropriate decision, based on systematic and relevant analysis, as carried out within the EIA process (EPA, 2002; 2003a).

Critique

The reasoning behind EIA is accepted as essential for better informed policy making and in protection of the environment (Weston, 1997). However, it has been difficult to demonstrate the cost effectiveness of conducting an EIA (Tanvig and Nielson, 2002). Usually, case studies of previous EIA interventions are used to demonstrate the long-term usefulness of mitigating environmental risks, and the benefits of the EIA process ensuring a more transparent, inclusive and informed decision-making process (Bond, 2004). Although the quality and uniformity of EIA is improving, oftentimes it is only just adequate (Glasson, *et al*. 1999). Moreover, the degree to which information from EIA processes are used in policy making is unclear, as is to what extent members of the public have a role in such local or national project decisions (Therivel and Morris, 2001). In addition, although EIAs are obliged to consider the indirect and direct effects that projects or plans may have on 'human beings,' this seldom occurs (Canter, 1990; Sutcliffe, 1995; Mindell and Joffe, 2003). One survey conducted in the UK found that 28 per cent of EIAs analysed considered health impacts of project or plans satisfactorily (Birley *et al*. 1998). Research has been conducted into the feasibility of the satisfactory incorporation of health impacts consideration as part of the EIA (Ewan *et al*. 1993; Fehr, 1999b). However, generally a purely toxicological and illness-focused conceptualisation of health underlies the EIA view of impacts upon human beings. The emphasis is on mitigating harmful risks, as opposed to also considering opportunities whereby health could be promoted and benefits of plans could be increased (Regional Office for Europe WHO, 1979). However, a WHO (1986) conference did consider the

potential for incorporating mental health and wellbeing into the EIA process, albeit in an informal manner (Banken, 1999). Criticism has also been directed at the narrow focus of project-based EIAs, instead of a greater strategic vision for plans, regional planning guidelines and policies (Grist, 2003; Mindell *et al*. 2003). In addition, Dresner and Gilbert (1999) reviewed EIA by interviewing participants in the decision making processes in six European countries. Findings from this research indicated criticism of EIAs for their lack of independence from the project proposer (Mindell *et al*. 2003), failure to assess alternative options to the proposal satisfactorily, confusion of the process to non-expert individuals, and failure to consider social factors.

Strategic Environmental Assessment

Many criticisms of the EIA relate to its framework not facilitating earlier planning and engagement in the planning process, by which time it is often too late to incorporate changes or new evidence (Mindell and Joffe, 2003). Involvement of the EIA process is required at earlier (strategic) phases in the decision making process (Therivel, *et al*. 1992). The emphasis of Strategic Environmental Assessment (SEA) is more broadly focused than the EIA. While EIA applies to single projects at local level, the SEA applies to policies, plans and programmes. It is not as detailed as an EIA of a local project, instead taking account of broader regional and global issues (Mindell and Joffe, 2003; Byrne, 2006).

SEA was first recognised in Ireland in the government strategy document, 'Sustainable Development: A Strategy for Ireland' (1997). At this time Ireland was reliant upon innovation and leadership in the promotion of this policy tool from developments in the EU (Scott, 2006). Since then SEAs have been undertaken of numerous plans and programmes[49], although the tool is still evolving, and is not uniformly institutionalized across the country to date (*ibid*). The most recent EU Strategic Environmental Assessment Directive (2001/42/EC) was translated into Irish law in 2004. The objective of this Directive is to integrate environmental considerations into plans and programmes, in order to promote sustainable development and to protect the environment (Environmental Protection Agency, 2004; Byrne, 2006). Although SEA is not mandatory for the development of all Government policies, the Directive (2001)

[49] Examples of Strategic Environmental Assessments that have been undertaken include the following: Eco Audit of National Development Plan, 2000-2006; Eco-Audits of Operational Programmes under the National Development Plan, 2000-2006; Eco Audit of Common Agricultural Policy Rural Development Plan; Ballymun Regeneration Master Plan; Cork Area Strategic Plan; Cork County Development Plan; Dublin Docklands Master Plan (2003); Pilot Strategic Environmental Assessment of the Proposed Replacement Midlands Waste Management Plan, 2005-2010; Irish Offshore Oil and Gas Strategic Environmental Assessment 2005-Ongoing (Scott, 2006).

ensures strategic assessment of plans and programmes, which may include specific policies and objectives (O'Mahoney, 2006).

The procedural stages of the SEA are similar to that of the EIA process, as is illustrated by the following:

Stage 1: Screening of plans and programmes
Stage 2: Scoping of SEA
Stage 3: Identification, Prediction, Evaluation and Mitigation of Potential Impacts
Stage 4: Consultation, Revision and Post-Adoption Activities

(EPA, 2003b)

Critique

Although the SEA process and procedures ensure greater integration of environmental and sustainability issues into the preparation and formulation of plans and programmes, problems related to the tool require consideration. Much of the current SEA practice is not encouraging (Scott, 2006). In relation to regional planning, there is little planning from pre-assigned overarching objectives and fewer specific indicators for policies are in place, which would measure the extent to which the policy or the plan would protect the environment (Scott, 2006). In addition, planning and environmental authorities should provide more structured statements of underlying needs to be considered in the SEA, for instance, management of change and protection of environmental capital (*ibid*). Anecdotal evidence from those working in the field (Scott, 2006) indicates that the policy tool is considered more a bureaucratic hindrance than an aid for policy making. There appears to be little acceptance of the benefits of SEA, on the part of elected representative and administrative staff. However, during the 1990's the UK considered the policy tool as an administrative burden, but it is currently mainstream practice (*ibid*). It may take this length of time for SEA to become accepted and integrated into Irish environmental policy planning. Anecdotal evidence also suggests that SEA has been labelled as burdensome, an administrative headache and tarred with the same 'emotive environmental campaigning' brush that is associated with the EIA in Ireland (Fry, 2006; Scott, 2006).

Regulatory Impact Assessment/ Analysis

Regulatory Impact Analysis (RIA) is a policy instrument used to assess the likely impacts of a proposed new regulation or regulatory change (Department of the Taoiseach, 2005; Hahn, 1998). It aids the identification of possible side-effects or hidden effects of regulatory policy and activity, and quantifies the costs of compliance on the business or citizen (Department of the Taoiseach, 2005). RIA is not a substitute for decision making. Instead, the framework provides a guide to "improve the quality of political and administrative decision making, while also serving the important values of openness, public involvement, and accountability" (*ibid*: 12).

The European Commission, which takes its rationale for impact assessment from the Amsterdam Treaty (1998), utilises IA in order to improve the quality and coherence of the policy process. Although the Commission does not explicitly state what the focus of its impact assessments are, they are predominantly concerned with regulatory impacts of policies with regard to the economic, social and environmental dimensions (European Commission, 2002). The likely consequences of policies and actions upon the competitiveness for the European Union (EU) and its member states are assessed (*ibid*). It must be emphasised, however, that the Commission views impact assessment as providing an integral input into the policy process by informing decision makers of the consequences of possible policy choices. Impact assessment is not envisioned as a tool that will generate conclusions and recommendations (European Commission, 2002), but will instead inform the decision making process. Numerous impact assessments have been carried out in the Commission[50], and a policy document entitled 'Inter-Institutional Common Approach to Impact Assessment,' which was agreed upon in 2005, set out fundamental procedures for impact assessment to be integrated throughout the legislative process. Although the policy tool has been used frequently in the policy process (six impact assessments have been carried out in 2006), evaluation of the effectiveness of the tool has just commenced in the summer of 2006. Results from this evaluation will be available in early 2007 (Marcuzzo, 2006).

The procedural process of impact assessment as used in the EC starts with a Preliminary Assessment (screening), which serves as a filter to help identify the proposals that may require more in-depth assessment. If greater assessment is deemed

[50] Agricultural DG. 2006. Impact Assessment of Biofuels. SEC (2006) 142
Environment DG. 2006. Thematic Strategy on the Urban Environment. SEC (2006) 16
Employment DG. Competitiveness and Innovation Framework Programme. SEC (2005) 433

to be required, then an Extended Impact Assessment (scoping) will be carried out (EC, 2002). This involves examining all the possible alternative policy options available to the decision makers, conducting analysis of the possible impacts each option would have on the economy, society, environment and political arena, and consulting with relevant stakeholders and experts in the process. The impact assessment will be carried out according to principle of proportionate analysis (*ibid*), which means that the depth of analysis will proportionally depend on the significance of the likely impacts.

In Ireland, emphasis in recent years has been upon improved regulation and enhancement of governance procedures (Lyons, 2005). The introduction of Regulatory Impact Analysis (RIA) is one other useful tool to ensure better governing procedures, in line with the Strategic Management Initiative (SMI) in Ireland. The Government White Paper, 'Regulating Better' (2004), sets out six principles integral to improving government regulatory activities, which include the following: necessity, effectiveness, proportionality, transparency, accountability and consistency. Based on such principles, and in recognising the need for better informed and more transparent decision making, the Government introduced Regulatory Impact Analysis (RIA) across all Government Departments and Offices (Department of the Taoiseach, 2005). To ensure that the RIA process does not become cumbersome, regulations are assessed firstly with a screening RIA, and those requiring more detailed evaluation will be subject to a full RIA. This two-stage approach is demonstrated by the diagram on page 428 and is similar to the impact assessment process as conducted by the EC. Screening requires describing the policy context for the proposed regulation, and identifying the costs and benefits of such a proposal (Department of the Taoiseach, 2005). Full RIA involves conducting impact analysis of each of the policy options, consulting with relevant stakeholders, and full examination of possible enforcement and compliance issues associated with the proposal.

Critique

Although examining the potential effects of new regulatory policies may have on the economy and society is beneficial for better informed decisions and a more transparent process (McGarity, 1991; OECD, 1997; Baldwin *et al*., 1999; Boyle, 2005; Department of the Taoiseach, 2005; Lyons, 2005), a number of concerns arose during the consultation relating to RIA on production of the draft report (Department of the Taoiseach, 2002). These issues were analysed in greater detail during evaluation of the RIA process by Richard Boyle in 2005. Concerns regarding RIA being resource intensive were raised; the negative effects on the timing and throughout of policies;

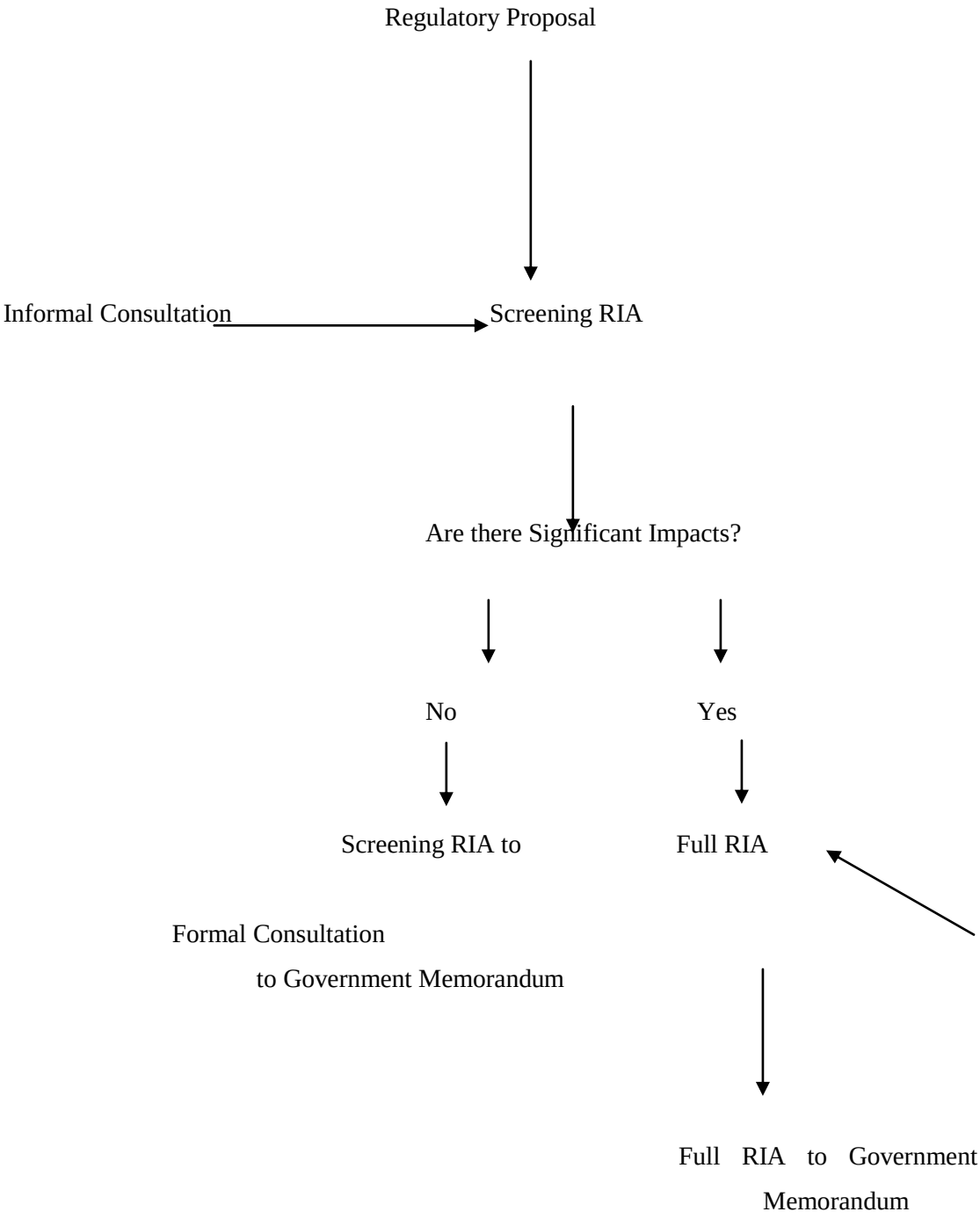
suggestions that cost/benefits analysis should not be mandatory; data availability issues; and social variables and impacts being difficult to quantify. During his review of pilot RIA's, Boyle (2005) concluded that, as resources intensive as the process appears to be, his overall conclusion indicated that in practice, the framework was more flexible than one may assume and leads to greater consideration of the regulatory impacts on the economy and society.

Boyle (2005:48) concluded the following:

> "RIAs can contribute to more effective policy making, reduce the risk of poor quality regulation, and may lead to savings of both the regulated and the regulators in some circumstances….The main point is that is RIA can lead to better quality regulation. This process is not automatic however. Limitations to the RIA process exist. But the focus should be on overcoming these limitations rather than saying RIA is unnecessary. The RIA process clearly has important benefits associated with it."

Long term evaluation of the RIA process is necessary and is feasible, as illustrated by the expenditure review initiative by the Department of Finance (2004). Boyle (2005) suggests that there may be a role in the future for the Comptroller and Auditor General to review to cost-effectiveness and cosy–efficiency of the process. However, Boyle warns against 'over evaluation' of the RIA process.

The Regulatory Impact Analysis Process in Ireland (Department of the Taoiseach, 2005:16).



Social Impact Assessment

Social Impact Assessment (SIA) evolved in North America during the 1970's and 1980's, mainly in relation to the assessment of major resource development projects, such as nuclear power stations (United States) and hydro-electric projects (Canada) (Glasson, 2001). This impact assessment mirrors EIA in both process and framework, as the purpose of both is to ascertain potential adverse impact in advance so as to mitigate these (Interorganisational Committee on Guidelines and Principles, 1994). In addition, interest grew surrounding the social impacts of projects which was spurred on by the National Environmental Protection Act (1969) in the US, and is demonstrated by the research conducted to date (Wolf, 1974; Carley, 1980; Lang and Armour, 1981; Carley and Bustelo, 1984; Becker *et al*., 2003; Morrison-Saunders and Arts, 2005). Some experts in the field view SIA as an integral component of EIA, which takes account of impacts of projects upon human beings. Others, however, view SIA as independent from other impact assessment frameworks (Glasson, 2001). Wolf (1974) defines this impact assessment as a framework facilitating the appraisal of societal circumstances as altered by the development of technology. Carley and Bustelo (1984) view SIA as providing for the analysis of somewhat intangible factors that other methods and techniques cannot measure. As with all impact assessment tools, SIA aims to analyse and monitor the intended and unintended social consequences of policies, programmes, plans and projects, and any social change which may result from such development (IAIA, 2003). SIA is best comprehended as an overarching framework which encompasses evaluation of the impacts on humans, and the ways in which people and communities interact "with their socio-cultural, economic and biophysical surroundings" (*ibid*: 2). The impact assessment tool operates in harmony with the more economic and technical tools used in policy making. It derives recognition from international declarations, most notably principle 1 of the Rio Declaration on Environment and Development, and principle 17 calls for impact assessment to be undertaken.

Poverty Impact Assessment

In Ireland, Poverty Impact Assessment (PIA), previously known as poverty proofing (Office for Social Inclusion, 2006a), is the process whereby government departments, local authorities and state agencies evaluate policies and programmes at the planning stage of the policy process. The emphasis of this impact assessment is upon poverty and inequalities reduction, ensuring that policies and programmes mitigate risks that can lead to poverty (Office for Social Inclusion, 2006b). The policy tool was introduced as part of government's commitment in the National Anti-Poverty Strategy (1998)

guaranteeing that policies would be appraised for significant impacts that may lead to groups at risk of poverty from entering such a state. It is cited as an essential policy proofing tool of legislative frameworks. The most recent strategy, the National Action Plan for Social Inclusion (NAPinclusion) (2007) reflects this priority for assessment of impacts. Calls have been made, via the national consultation process, for the extended use of such techniques, such as Health Impact Assessment, in identifying and focusing on specific aspects in the policy process (Office for Social Inclusion, 2006a).It has been concluded that the use of Health Impact Assessment across all policy sectors would greatly improve institutional mechanisms, for the better of population health and wellbeing (*ibid*).

The procedural stages of PIA mirror the two-stage approach of other impact assessment processes (Office for Social Inclusion, 2006b). Initial screening is conducted of policy and programme proposals. If it is deemed that the general nature of the proposal relates to poverty or inequality, and the relevance of the proposal relates to vulnerable groups, a full poverty impact assessment will be conducted (*ibid*).

Full scale PIA involves the following steps:

1. Consultation with relevant stakeholders
2. Define policy aims and target groups
3. Consider available data and research
4. Assess impacts and consider alternatives
5. Make decision and arrange monitoring
6. Publish results
7. Return summary sheet to Social Inclusion Liaison Officer

(Office of Social Inclusion, 2006:2)

Critique

There have been calls for an amalgamation of the policy proofing, or impact assessment, mechanisms in Irish policy making circles (Partnership 2000 Working Group, 2000; Programme for Prosperity and Fairness, 2000). Along with gender impact assessment, rural proofing (Department of Agriculture and Rural Development, 1999) and eco-auditing of policy proposals also takes place. However, after reviewing the poverty proofing process, the Economic and Social Research Council (ESRC) (2001) concluded that each issue, such as equality and poverty, require individual screening within the policy process due their distinctive nature. However, the ESRC has called for an integrated approach for policy impact assessment tools in order to ensure greater coordination of advisory functions and guiding procedures. In addition, the ESRC calls

for greater institutional, resource and training support to ensure impact assessments can be carried effectively. However, it does not recommend an amalgamation of poverty impact assessment with equality and rural proofing, or eco-auditing (ERSC, 2001).

F) Economic Assessments

Economic assessments, such as cost-benefit and cost-effectiveness analysis, multi-criteria analysis and scenario analysis, are forms of policy appraisal that are beneficial in evaluating in terms of inputs, process and outcomes (Mulreany, 2002; Shiell, *et al*. 2002; O'Reilly, 2006). Economic appraisal, also known as the cost-benefit approach, deals with issue such as technical efficiency, social efficiency, allocative efficiency and social welfare. It also allows examination between value judgements (Carley, 1980; O'Riordan and Hey, 1976) and technical judgements (McGuire, *et al*. 1988). In order to measure health or environmental outcomes, for instance, they must first be assessed so as to cost or place values upon such (European Commission, 1998; Filliger, *et al*., 1999; Appleby, 1999; Mindell and Joffe, 2003).

Critique

The benefits associated with economic appraisal techniques are widely accepted Carley, 1980; WHO-UNEP, 2004). It is difficult, however, to carry out such economic appraisals when such quantified data does not exist, or is difficult to quantify, such as health and wellbeing. Impact assessments, which are broader in scope and in assumptions, are required in this sense. Economic appraisals are useful techniques when they are integrated as part of impact assessment frameworks (Department of the Taoiseach, 2005). Indeed, both tools should work in harmony with one another, and become internalised and institutionalised in policy making (WHO-UNEP, 2004). As useful and essential economic appraisal techniques are in the policy making process, however, they do not constitute the full picture.

The impact assessment policy-aiding tool arose "as a reaction to the deficiencies of cost-benefit analysis, especially the problems of intangibles and the distribution of costs and benefits (or impacts) across various sectors of society" (Carley, 1980:54).

Appendix 2: Case Study Protocol and Topic Guide for Expert Interviews

Case Study Protocol

1. Overview of the case study project

Project objectives

➔ To find out the use of HIAs for policy; the perspectives of HIA of those who were involved in the steering groups; contextual information that is specific to the HIA case under investigation.

Case study issues

- HIA outcome report
- Policy document (if available) that the HIA is hoping to influence or was carried out on.
- Collect relevant documentation while on the field trips.

2. Field procedures

Presentation of credentials → email all interviewees with information about my project and myself, even if called on telephone initially.

Statutory bodies→ identify the state bodies being accessed and find out information on the relevant gatekeepers to the organisation.

Access to the case study 'sites'→ Once the gatekeepers are identified, make arrangements for meetings in the organisational buildings, and prepare for security checks and identification badges.

Procedural reminders→ always have college identification with me at all times; have the HIA outcome on my person during each interview for reference.

3. Case study questions

The specific questions that the researcher must keep in mind in collecting data

Keep in mind the research questions and the literature in the area that I've drawn the research framework, as indicated in the topic guide (below).

Research questions

How do institutional structures influence Health Impact Assessment utilisation in policy?

How do value judgements influence Health Impact Assessment utilisation in policy?

Why is the degree of utilisation, both direct and indirect, varied in different contexts?

What are the barriers and enablers to the use of HIAs?

4. Guide for case study report: Outline

Each case study report will be presented as follows:

Part I: Descriptive section- provides background information on each HIA rationale, background, stakeholders, methodology and the policy process.

Part II: Analysis section- provides the information as derived from the interview data and relevant documentation for answering the research question. This section is presented with headings pertaining to the theories and literature that was used to inform the research framework, so as to ensure direct application of the framework to the empirical findings.

Topic Guide for Expert Interviews:

TOPIC GUIDE QUESTIONS (*ITALICS*)

- *You were a member of the HIA Steering Committee. How would you describe your role on that?*

RESEARCH QUESTION- OBJECTIVES (as derived from the research framework)

INSTITUTIONAL THEORY (x)

- **To investigate why and how the institutional and political (contextual) influences affect the degree to which HIA evidence is utilised.**

Q: During the HIA process, and in the aftermath, did you think the time is right in our public policy making world to use the evidence that comes from HIA?

Q: Do you believe there were institutional constraints at play in the use of HIA evidence, from your perspective as an associate director of the IPH?

Q: On a general level, were politics at play, either on the Steering committee between the different interests or during the conduct of the HIA?

VALUE JUDGEMENTS (IMPACT ASSESSMENT THEORY) (x)

- **To examine why and how political discourses, via policy documents, textual communiqués (content), affect the degree to which HIA evidence is utilised.**

Q: In the political science literature there is alot of talk discussion of the role that values/ beliefs and dialogue play in the policy process. Do you think there are underlying values and discourses influencing the use of HIAs?

CONDITIONS CHECK-LIST (BARRIERS AND ENABLERS, HIA LITERATURE THEORY)

- **To identify barriers and enablers towards the utilisation of HIA evidence in the policy-making process.**

Good points of decision makers and policy process (Ballyfermot) (September 2006)

- Involved in planning and conduct of HIA
- Input from outside decision-making process
- Clear organisational commitment
- Subject non-controversial
- Realistic recommendations

Bad points of decision makers and policy process

- Lack of awareness of health by other sectors
- Lack of knowledge of policy-making environment

Q: Were there any other enabling/ hindering factors?

UTILISATION THEORY (EVALUATION RESEARCH) (Y) (information from this section can inform the dependent variable)

Q: As far as you're aware, have the recommendations been used in policy? Do you think the HIA was useful in policy-making? (DCC policy; national transport policy, community policy?)

Q: Was the HIA well received?

Q: Anything further to add? Anything you want to ask me?

Appendix 3: Procedure and Results for Inter-Rater Exercise

INTER-RATER RELIABILITY
Research Validity Measure

PROCEDURE:

For the purpose of this research, there were 74 indices (20% of total 364 indices) to be matched with 20 categories (15% of total 129 categories). This figure is in line with best research practice (Ritchie and Lewis, 2003). The indices are labelled as close to the language of the interviewees as possible, and the categories are labelled closer to the theories and schools of literature being used in the study; they are one step above the data in abstraction.

An average of 95% convergence was obtained during the inter-rating exercise. For qualitative research, where context impacts significantly on the analysis of data and its coding, this is a significantly high figure of convergence on coding. This exercise provided a quality assurance on the manner in which the data was analysed.

Section A provides the letter of instructions given to each inter-rater on commencing the exercise. I was available outside the room for any immediate questions.

Section B presents the categories and indices used in the exercise. I took a sample from each case, and from a section of the topic guide for each case study. These were selected randomly.

Section C makes available the results from this exercise.

A) INFORMATION LETTER WITH INSTRUCTIONS FOR THE INTER-RATERS

Thank you for agreeing to take part in an inter-coder exercise. The aim of this is to ensure greater validity in my system of categorisation of interview data, which I have abstracted for the purpose of my research.

This exercise should take approximately 20 minutes. On the left of the desk there are the categories that I have generated from the interview data, and on the right, there are direct quotations from the interviewees. Please read all categories and quotations once over, and then please group the quotations you feel are suitable with the categories.

Let me know if you have any queries.

Many thanks,

Monica O'Mullane
July 2008

B) INTERVIEW TRANSCRIPT CODING: CATEGORIES AND INDICES

Ballyfermot- Time is right?

Institutions
-HSE objective, institutionalisation
-local authorities
-different orgs and budgets
-institution needs to be persuaded
-Partnership difficult
-yes, constraints, but the DCC used money for initiatives

HIA processes
-HIA restrictive/inhibits policy innovation
-HIA process not understood
-danger of being too theoretical
-lack of awareness/increasing awareness

Policy process
-Viewed as burden by policy makers
-gather dust on shelves
-planning
-funding
-timing
-unrealistic recommendations as barrier
-mandatory basis already in health strategies
-HIA needs regulatory control and enforcement
-IIA, a place for health in that

Donegal- Institutional Constraints

Traveller policy
-So many (constraints) on trav policy
-protective notion that's it's their area of policy

Institutions and organisations
-more than one organisation involved, complex (ownership/ user dynamic)
-constraints of institution
-negation of responsibility
-one big agency was a big barrier anyway
-other housing authorities haven't done that (HIA) yet
-staff issue
-depends on which agency it impacts most on
-other housing authorities haven't done that (HIA) yet

HIA
-thought it would be about health services (misunderstanding) (came to process not fully understanding)

-HIA is quite new (misunderstanding)

Policy process
-we'll be informed by the HIA, we'll have to be
-room for manoeuvre for DMs is limited, hostility towards travs
-haven't enough working from community perspective which is a problem
-if don't have buy-in, there is a risk it is just a paper exercise

Ideas as constraints
-polar opposite ideas on trav issues (about values, not evidence)

Belfast- Does Politics Matter?

Individuals
-there was softening but people came to the table with orgs perspective
-key outcome is building professional relationship with people, good people (policy entrepreneurs)
-one player in process was very "closed book"
-workshops with council workers
-politics in steering group not in management team- people and their orgs views

Institutions
-institutional politics at play
-no internal politics around HIAs in health services yet
-politics with small p; multidisciplinary, multi sectoral
-NIHE a really forward thinking agency, unlike other departments like DoE and Planning
-roads services and planning
-wouldn't say politics but institutional barrier
-tensions between departments, local councils (local government versus central government)
-tensions on building new roads between councils and roads services

HIA: advocacy tool?
-Council viewed HIA as endorsing their view, playing with language and words (endorsing a viewpoint, like Donegal?)

Expectations of HIA
-must look at our expectations of HIAs too

Derry- The role of values and value judgements

Institutional and organisational values
-values everywhere
-don't want professional values coming out and pushing their agenda, need balance with community
-organisational culture and the values from orgs played both a positive and negative role
-institutions feeling attacked
-values in how organisations view health inequalities

Valuing contributions to the HIA
-involved values of the community and confidence, belief and self belief
-values, trying to make the best for the community for the people through the HIA, having residents on and being listened

Valuing the evidence balance
-need for balance between research evidence and communities evidence

Ballyfermot- Recommendations and usefulness

Recommendations
-recommendations have been implemented
-local things done (examples)
-recommendations not feasible

Future of HIA
-future in IIA
-too many expectations of HIA
-good for the future

Policy environment
-influenced policy
-administrative burden, tick the box exercise
-drip feed into policy/ incremental
-informed indirectly
-lack of DCC policy coordination
-values and principles important
-awareness raising

Political advocacy
-local electoral politics/ political advocacy

Sustainability of the HIA
-local action group

C) RESULTS

Inter-rater #1 (25/07/08)

Donegal- 'other housing authorities haven't done it yet' was put into Ideas as Constraints category

Ballyfermot- 'policy innovation' was put under Policy Process;
Dublin City Council index was put under HIA Processes

3 differences in coding

Inter-rater #2 (31/07/08)

Belfast- 'no internal politics around HIAs in health services yet' put under Expectations of HIA- health services (rater believed no internal politics equated with institutional theory)

Derry- Divergence between the category Institutional and Organisational Values and the index 'values and self belief'

Donegal- Ideas as Constraints: rater believed that this category should go to be a sub-category under Traveller Policy.

3 differences in coding

Inter-rater #3 (31/07/08)

Donegal- Ideas as Constraints, a category believed by the rater to more suitable for organisational culture.

Traveller Policy, 'polar opposite ideas' index should go in there

Derry- believed professional values should go into the Valuing the Evidence Balance category.

Belfast- believed 'key outcomes' belonged in Expectations of HIA. There was a difference of opinion on the meaning of the concept 'outcomes.'

4 differences in coding

Both inter-rater #2 and #3 warned against the use of the terms 'gatekeepers' and 'buildings' in the labelling of categories. They stated that the meaning of the terms must be explicit.

Ballyfermot Interview Code	Organisation Affiliation	Date
1	HSE	24th July 07
2	URBAN II	4th October 07
3	Local Resident of Ballyfermot and community representative on HIA	22nd November 07
4	Institute of Public Health	9th October 07
5	External HIA expert and advisor	11th October 07
6	Dublin City Council Official	12 October 07
7	Dublin City Council Official	8th November 07
8	Dublin City Council Official	28th November 07 and 25th April 08
9	URBAN II	24th April 08

Donegal Interview Code	Organisation affiliation	Date
1	Public Health Nurse, Donegal Travellers Project	11th December 07
2	HSE representative	11th December 07
3	Border Action(Peace III Programme and Interreg IV)	12th December 07
4 (Three participants)	Donegal Travellers Project (focus group)	13th December 07
5	Donegal County Council	14th December 07
6	Donegal County Council	14th December 07
7	Community Workers Cooperative (CWC)	23rd January 08
8	HIA Researcher	24th March 08

Belfast Interview Code	Organisation affiliation	Date
1	West Area Health and Social Services Board	25th February, Investing for Health offices, Derry
2	Belfast Healthy Cities	19th February, Lombard Street, Belfast (BHC office)
3	Belfast Healthy Cities	19th February, Lombard Street, Belfast (BHC office)
4	Belfast City Council	20th February Council office, Linenhall Street, Belfast city centre
5	Institute of Public Health, Ireland; Belfast office	20th February, Belfast city centre
6	Department of Regional Development, Roads Service	19th February, Hydebank offices, Belfast
7	Belfast City Council	22nd April

Derry Interview Code	Organisation Affiliation	Date (2008)
1	Health Services	4th March
2	NIHE	25th February
3	Bogside and Brandywell Health Initiative	25th February
4	Investing for Health	22nd February
5	Bogside and Brandywell Health Forum (BBHF)	22nd February
6	NIHE, West Area Planner	25th February
7	Resident and Community Representative	25th February
8	Health Services	21st March
9	North West Housing Association	1st May

Appendix 5: Exploratory Interviews

1. 5th-6th April 2006. 7th HIA International Conference. HIA expert and published author
2. HIA expert and published author (7th HIA Conference)
3. HIA expert and published author (7th HIA Conference)
4. 28th September 2006. Two Public Health Development Officers of the Irish Institute of Public Health, who oversee and organise capacity-building and development of Health Impact Assessment through Ireland.
5. 4th December 2007. Senior Planner, Central Planning Unit, Donegal County Council.
6. 12th County Councillor (elected representative), Donegal County Council.
7. 12th December 2007. Senior Health Promotion Officer, HSE West.
8. 21st February 2008. Senior Policy Official, Office of First Minister and Deputy First Minister (OFMDFM), Castle Buildings, Stormont, Belfast.
9. 22nd February 2008. Representative working in Dove Gardens Community Centre and Dove Gardens Women's Group.
10. 22nd February 2008. Oral Health Promotion Coordinator and Programme Planner of the Bogside and Brandywell Health Forum.
11. 22nd February 2008. District Manager of the Northern Ireland Housing Executive, Derry/ Londonderry region.
12. 24th February 2008. Northern Ireland housing policy expert at the University of Ulster, Derry/ Londonderry.
13. 24th April 2008. RAPID coordinator, Ballyfermot Area Office (Civic Centre).
14. 24th April 2008. City Councillor (elected representative) and former Lord Mayor, Dublin City Council.

Appendix 6: Field Notes

BALLYFERMOT NOTES

July; October/ November 2007 and April 2008 (day trips)

Questions I had to clarify while on the trip- Notes put together from discussions with members of Dublin City Council (DCC), the community resident, and an HSE official.

HIA recs that DCC would disseminate to the community on matters of traffic policy?

Hasn't happened to date except in an informal way maybe, it happens through the TAG (the advisory group) centrally and dissemination to the local area committees to the councillors, but when we've our website up and running which we don't have now, we'll put that information up then.

The fact that this area is bordering with south county Dublin, does that impact on the way policies are implemented? Especially regarding traffic management, traffic light sequencing etc?

Some coordination, but actually there needs to be a regional approach with traffic management, contacts between city council and south county council, e.g. bus lanes making sure they continue on, so there are contacts to make sure of joined up thinking.

HIA- a feasible tool for planners?

More planning is becoming more complicated, are action plans, local plans, integrated plans, there's more and more complexity, we're trying to get to a situation not to judge on an application on it own but look at the bigger picture and the broader frameworks of the plans locally. At the moment we're trying to draw up guidelines, for the in Ballyfermot for instance, guidelines not only for developers but also for the Planning Department, to be able to judge things and see does it fit into the overall plan of the area.

On a wider planning issue, on the one hand want density and accommodation as many people as people, stop urban sprawl, stop people having to live in Carlow, Cavan and so forth, we need better designed units in the city. Being honest nearly every living unit built from here on in in the city will be an apartment, and the city adopted approved residential standards for apartments in the future, better light, better designed areas, need to impact on health and lifestyle and don't just have a transient population. And not to have people move when they have kids but continue to live in apartment blocks. To emphasise -DCC trying to learn from the past, the apartments buit in the past, especially the size mix and general design were not great. Under the new guidelines for instance you have to have different mix of units, have natural light in kitchens, and that will have health implications as well- a better living environment.

Just by way of addition, as with any report you'll never find all recs are adopted and maybe they will be then over time, but the main point is it raises awareness. The traffic in Ballyfermot is very bad at the moment and maybe it's also to do with road works in the M50, so maybe people are using Ballyfermot to avoid the M50 and that can explain why it's chocabloc at the moment.

**** Ballyfermot community ****

Community are very well organised, they have very good vocal councillors, anyone can see a tremendous transformation over the past 10 years, Ballyfermot would have been one of the areas where houses were built first and the services were certainly lacking, but that has changed, there's been a catching up, it's sort of alot done more to do, it's very ably and well represented at city council level and Councillors want the best for Ballyfermot. Cherry Orchard is getting proportionately more resources than the main part of the area(Ballyfermot) Ballyfermot is doing better in terms that there is less social deprivation there than in Cherry Orchard , Saint Ultans is the first of its kind, it's a primary school, it has a pre school, primary school, and after school. It's the first of its kind in Ireland, follows a developmental approach of teaching, they have the facility to have educational needs met and help redress the social deprivation and lack of educational achievement which is especially bad in Cherry Orchard. Some parents just can't cope and they need the help. In Ballyfermot there's a very low transfer from secondary school to university, its way below the average, in Ballyfermot it's about 11% but in other parts of the city it's around 85%. It's to do with alot of factors, cultural, historical, money issues, whether you stay in school or college or go out and get a job.

In health impacts, there have been health fairs, healthy eating programmes, people become health trainers, and it's come from the HIA, and you sometimes don't know whether the things in the report were going to happen anyway but at least it's a reference point as well as raising awareness.

A support line was set up between ourselves and the Samaritans, for suicide prevention however,the Samaritans subsequently had a change of mind, they didn't want local branches of the Samaritans they wanted it to be centrally controlled instead. The service now operates from the Samaritans headquarters.

DONEGAL NOTES

Tuesday, (2)
Spent the morning in the library, then met the public health nurse in the Donegal Traveller's Project (DTP) offices. These offices are new to the group since July and are very spacious, with modern facilities. Ita Ward is the Public Health Nurse for Travellers and their families for the county of Donegal. She sat on the Advisory group of the HIA and although was new to her job at that time, she felt it was a process beneficial to herself and to the HIA, in bringing the perspective of the PHN.

After the interview I'd a tea with the public health nurse and a chat, and then she drove me to the county hospital where the HSE has a number of offices. The Social Inclusion Manager of the HSE, was based there and I'd a meeting with her. We discussed two HIAs she was involved in , the HIA on the Castlefinn LAP and the Traveller's Accommodation Programme HIA. Her disillusionment with the policy making process was undeniable.

Wednesday (3)
I spent the morning looking for local county councillors! With the help of the constituency offices on main street Letterkenny I visited a county councillor in his premise, and we chatted about the local government policy making environment. He had not heard of either of the two HIAs but was adamant that such documents and research was always good for informing the councillors and helping them do their jobs. The discussion centered on planning, and the tensions that exist continually between planners and councillors, although he cites a healthy and positive relationship with the planning department. He said that yes, it would be great to have HIAs on all LAPs, as the health and wellbeing of communities is important.

I met with an individual of Border Action, who was on the HIA of the LAP. I spent at least 1.5 hours in that office on the Pearse Road. He had an overall positive perception of HIA but was doubtful as to the organisational commitment of others in the process.

After the interview, I was invited to use the facilities of a spare office (with computer and telephone), and the staff gave me a phone number of a senior health promotion officer of the HSE Western Region, health promotion department. She specialises in youth issues, but is a senior figure and has expertise, experience and seniority in a number of areas. I spoke with her on the phone about any understanding she had of HIA. Overall, her perception is wholly negative of the HIA process, and she does not encourage anyone within the HSE to do the HIA training as provided by the IPH.

Thursday (3)
I met with members of the DTP, met with the primary care project coordinator and the peer researchers who conducted the data collection on the HIA. Others were to join but couldn't because of family commitments. The discussion was very enlightening as to the perception of those who are directly affected on a daily basis by the TAP. Their disillusionment of the lack of commitment of the

Council for the HIA was clear. However, they expressed positivity when questioned about the usefulness of HIA, as a general policy aiding tool. It seems that the controversial nature of the policy being conducted for a HIA (ie. Traveller accommodation) and the pre-existent tense relationship between the traveller's group and the planning department in DCC were barriers to the process feeding policy in a very tangible way.

Friday (2)
Spending time in the Council offices (Letterkenny Town Council and the central planning unit based in Lifford). Meeting with assistant county manager (also Director of Housing) and a planning official, who sat on the Local Area Plan (LAP) HIA group.

Have already had telephone interview with a senior planner of the central planning unit, who also sat on the HIA of the TAP.

Further phone interviews:
HIA researcher on the project (TAP)
Area Planner, Donegal County Council (LAP)
Public Health Officer (LAP)
Chairperson of the HIA (TAP)
Maybe some councillors…

Erica Ison presentation, HIA seminar Galway. 1st June 2007
Readiness not in Donegal.
Look at her presentation, good basis for analysis.

Maximising the influence of HIA
Introducing the methodology can be one of the most difficult tasks

- Identify the organisation's "readiness" to accept the innovation, and develop strategies to achieve "readiness"
- Identify the potential barriers to introduction, and develop strategies to address those barriers
- Identify champions to support you

BELFAST NOTES

Belfast Air Quality Action Plan HIA: Interviews List

19th Feb 2008

- Roads Services

  Met with this individual, he started the interview apologising for being cynical of HIA and of tools like it, in informing policy in a very real and tangible way. He reiterated this throughout the interview! He said he was profoundly affected in a positive way by a presentation on the health impacts of transport on health and this has impacted on how he approaches and views health issues now in policy development and direction. Very amenable to the idea of HIA, but wary of its workability.

20th Feb 2008

- Environmental Health Manager, Belfast City Council

  Very driven in pushing forward the agenda of HIA and in including health effects of air quality in policy. She was particularly keen to address the issue of the lack of coordination of work across policy sectors and central NI departments, and saw HIA as a mechanism which could ameliorate this problem. She initiated the HIA. She viewed some organisations, and pointed out the Roads Services, as being very narrow minded and entrenched in their own organisational culture and objectives.

  This person stated that the anomaly in the system of governance- that local authorities are charged with improving air quality but they do not have a role to play in it at a service/ operational level, was a huge factor. The role of Northern Irish local government and the impeding structural framework of that are important to note.

- Institute of Public Health Representative

  Was a steering group member, and is also the HIA rep for the IPH in the Belfast office. Very informative on the work of HIA in the North, and her role on the steering group was informative and participative.

21st Feb 2008

- Belfast Healthy Cities

  Both individuals are very proactive and driven in pushing the HIA agenda. One was the chair of the Belfast air quality HIA and the other heads up the HIA division in the BHC and much work is being done/ has been done in HIA in the North. They noted the Air quality one was one of the first they led and they were, in some ways, learning as doing. Very critical of the entrenchments of some in organisations, particularly roads services, planning dept (who were point blank just not involved) and some sections in BCC.

- Met with senior official, OFMDFM, Policy Innovation Unit. Policy tool kits, IIA, and the future of impact assessments and better informed policy making.

  A highly informative discussion on IIA, impact assessment background and context in northern Irish policy making from a central governing direction. A comparable interview should be arranged with someone in RIA in the Dept. of Taoiseach, Dublin

25th Feb 2008

- Dept Health and Nursing
  → Face to face interviews: 6
  → Telephone (to do) (4)
- HIA Practitioner
- St. Malachy's school (headmistress or vice)
- Environmental Health Officers (x2)

DERRY NOTES (the final layout of the Dove Gardens estate design is on the next page)

22nd Feb 2008

- Met the Manager of the BBHF (and 2 programme managers, health promotion in schools, community, mental health, physical exercise)

  The Manager has spent a long career in community development; he set up the BBHF, and was born and reared in the Bogside. Very familiar with community issues and played a large role in the HIA process, bringing the community perspective and ensuring an advocacy role on their behalf.

  ** The Manager is heading up (with the Investing for Health team) a community action strategy to tackle problem drinking behaviours. ToR were discussed at a meeting at the Gasyard today with a collection of interested partners. Touch base with him on this issue. **

  I spoke with two project managers informally who are involved in mental health promotion, schools, physical exercise. They both cited the Dove Gardens HIA as very worthwhile. One in particular gave an example of the type of success it brought- the involvement of the community in the design of the housing ensured that there isn't just one type of heating in the houses (as fuel poverty is a major concern with those in the area). Those in their 'ivory towers' were now better informed of how those who would subsequently inhabit the dwellings. One of the ladies stated also that the residents, because they had an input into the design of the houses, are looking forward to coming back, whereas before the HIA they were planning on leaving Dove Gardens and not returning even once the regeneration was completed.

- Senior Health Practitioner IFH-West

  This person wasn't involved directly in the Dove Gardens HIA, but was very informative in terms of the stance of the IFH, and current project work that the IFH are engaging in, particularly the West Tyrone Area Plan 2019 HIA. Very good example yet again of the influence and importance of planning in HIA success and development into the future.

- Dove House Community Trust & Bogside and Brandywell Women's Group
  Lady here leads on the Women's group, and is very proactive in the representative aspect of the Dove Gardens/ Bogside area. Alot of community based work being done to tackle the wide varying health issues of the area.

25th Feb 2008 – meetings

- (WHSSB, Belfast Air Quality but also can provide context of health services in the Western Region) 9.30 am
- (NIHE)
- (local community worker, BBHF
- resident and community rep for Dove Gardens, co-chair HIA Implementation Group & attends/ attends design meetings.
- Manager of the IFH West

Appendix 7: Process of Data Analysis

Ritchie and Lewis, 2003- Framework:

4) data management

-familiarisation
Analysis stage #1, putting answers of questions all together

- constructing index (give examples of indices in the thesis to illustrate the matrix and way of doing it)
Analysis stage #2, constructing the index, condensing the data but keeping the same wording as the interviewees

-applying the index
Excel document, analysis stage #3; applied the index that came from the second step, onto the data.

I found that some indices of some questions fit into others e.g. one respondents answers to question 2 fit into an index of another question also.

Therefore, the units of analysis would be greater than the number of respondents.

- setting up thematic charts
Excel documents, matrix formed with quotes of respondents included to illustrate the indices. The indices are taken as direct quotes. The labels are still grounded in the interviewee language. Still at this level of abstraction.

- **charting groups**
Did not have focus groups in this case so that's not relevant here.

Step 1 done

5) descriptive analysis

Detection (look at word doc on this)

(look at the phenomenon that have been labelled in the same way)

put the index matrix into the topic guide question, so put indices to question one under question one etc….. in order to elicit more abstract categories..

Step 2 done

- Categorisation (more abstract codes)
categories of codes done, coming from detection of phenomenon..

- Classification (groups of categories; highest level abstraction, comparative analysis)

Going to leave classification for explanatory analysis across the cases; can do single case analysis with the data I have in the categories

Using framework to produce descriptive accounts (charts, review categories)

6) explanatory analysis

- constructing summary and central charts