Correspondence

Health impact assessment of Merseyside Integrated Transport Strategy

Sirs,

We read the paper on the health impact assessment of the Merseyside Integrated Transport Strategy (MerITS) with interest.1 We have recently completed similar work on the City of Edinburgh Council’s Local Transport Strategy2 and were struck with some similarities between the Merseyside work and our own. Both projects were opportune in that they seized on the current enthusiasm of partners about the impact of transport on health. In both Merseyside and Edinburgh there was a desire to enhance the health potential of a transportation policy that was being actively developed.

Our work assessed the impact of three scenarios for transport policy based upon different levels of available funding. We chose to explore explicitly the impacts of the policy on different population groups within Edinburgh. We identified the main areas of health impacts as: accidents, community severance, access to services, pollution and physical activity. We prepared matrices looking at how different population groups would bear each of these impacts to compare impacts on affluent and disadvantaged populations. This showed clearly, as has been reported elsewhere, that more disadvantaged groups bore the brunt of the impact of car-dominated transport policies and emphasized that transport policy has great potential to reduce inequalities in opportunity and health.

Freeman and Scott-Samuel’s paper does not mention the difficulty in obtaining adequate public participation in an assessment involving such a wide area as a city or region. Obtaining representation from all the communities involved in as major a policy as this is problematic. We also relied on key informants with knowledge of health or of local transport issues. We did not obtain direct participation from members of all the population groups that were considered in our assessment. Given the broad scale of the policy and the large numbers of people affected, our resources did not allow representation of all the different interests and perspectives. We do recognize that people affected by proposed policies have a unique perspective of the impact these policies will have on their lives and should be involved in the assessment. Further thought needs to be given to the best methods for meaningful involvement of such diverse populations in health impact assessment.

Finally, we wish to stress the need to consider the local context when conducting a health impact assessment. Local factors will be crucially important in determining the importance of different impacts and the potential to adjust the policy to maximize health gain. Edinburgh’s economic drivers are in the tourism and financial sectors. This differs from most British cities and therefore we would not propose simply transferring recommendations to other cities without a similar health impact assessment process being conducted.

References

Yours faithfully,

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Health impact assessment

Sirs,

We read with interest the prospective health impact assessment (HIA) of Fleeman and Scott-Samuel, identifying key health impacts of the Merseyside Integrated Transport Strategy (MerITS).3 We welcome the emphasis on health on the transport agenda for Merseyside, and the action plan to adjust MerITS to address the health impacts identified. However, it is with this action plan in mind that we write to suggest some refinements to the methods piloted by Fleeman and Scott-Samuel.

Since that paper was accepted, the City of Edinburgh Council has published an HIA of its own transport strategy.2 Although we realize that the MerITS assessment was prospective in nature, piloting methods, we believe that some refinements might be made to the pilot by incorporating some features of the Edinburgh HIA. In particular, we have identified two key areas for refinement of the MerITS assessment that are included in the Edinburgh HIA.

First, we feel that if time and resources had allowed, the strength of the results of this HIA would be improved by seeking wider public participation and consultation in the identification of the health impacts of MerITS. This might allow representa-
tion of a broader range of interests and perspectives, rather than relying on key informant groups.

Second, we believe more emphasis should be put on the health inequalities relating to transport policy, following the Government’s emphasis on reducing inequalities in health. The construction of a population profile as part of the preparatory methods would help to focus on the different health needs of population sub-groups. This would allow identification of the health impacts likely to be borne by the various sub-groups of the Merseyside population. For instance, Edinburgh’s HIA looked at young families, adolescents, elderly people, and working people and unemployed people, living in affluent and deprived areas of Edinburgh. Other examples might include ethnicity, and household amenities, characteristics and tenure.

We feel that these measures might be incorporated in future HIAs of public policy in a particular area, leading to richer results that are more sensitive to the needs of, and impacts on, the various population sub-groups within that area. Let’s put the ‘public’ back into public policy.

References
3 Secretary of State for Health. Saving lives; our healthier nation. London: The Stationery Office, 1999

The health of students

Sirs,

Stewart-Brown et al. illustrate neatly a number of methodological problems of survey studies. The use of historical controls is fraught with problems. The main two are secular trends and equivalence of methods. Their Figure 2 illustrates both the long-term increase in prevalence of long-standing illness, disability or infirmity and the differences in prevalence between different types of survey. Although there were differences in the formulation of a few questions in the SF-36 in the 1997 local population survey, this does not make comparison between the students and the 1991–1992 local population surveys more appropriate. Those involved with survey design, whether repeated cross-sectional surveys or follow-up of a cohort, have a dilemma. Improving a question because of evidence of previous poor wording or changed circumstances must be weighed against loss in continuity when studying time-trends.

I am not surprised that many students are worried by their studies and finances. Only one-fifth of the students were aged >25 but this was presumably not the case in the local surveys. Is it possible to analyse the local population surveys by age groups 18–24 and 25–34 or to obtain an age-matched sample from within the local population survey? Worries and health problems vary with age, so the comparison surveys may be misleading in this way.

Most of the discussion in the paper by Stewart-Brown et al. is taken up with the issue of low response rates. However, as 49 per cent of their samples replied, their results show robustly a minimum prevalence of problems (of half the values stated in the results) that is still higher than desirable. Perhaps the most appropriate public health response is to campaign for the reinstatement of student grants. This would also help to reduce inequalities in access to higher education, particularly for longer courses, such as medicine.

Reference

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Reply

Sirs,

Dr Mindell makes some important points in her letter, one of which is that the sample of students who responded to our survey had an age distribution that was different from that of the comparison group. She is quite right that this important potential confounding variable needs to be taken into account in interpreting our results. However, before publishing we ran a series of regression analyses on the combined datasets comparing the SF-36 scores, long-standing illness prevalence, and the frequency of worries between students and people who were not students, adjusted for age and sex and social class. After this adjustment most differences were unchanged and some increased slightly. This suggested to us that our results were not