Correspondence

Health impact assessment in relation to other forms of impact assessment

Sirs,

I read with interest the paper by Mindell and Joffe on health impact assessment in relation to other forms of impact assessment, seeking throughout comments on the links with sustainable development/sustainability appraisal. I reached the final paragraph on integrated assessment, still to find no mention.

The authors make appropriate points about local authorities being empowered to promote the economic, social and environmental well-being of their population; about health status depending primarily on factors outside the health services; and about lessening the burden on officials by consolidating the number of impact assessments. The authors go on to comment that there is still a common fallacy that health is the responsibility of only the health services. For all of these reasons, much work has been undertaken over the last 2 or 3 years to forge links with the wider government agenda, at regional and local levels, for health improvement and for reducing health inequalities.

The Government requires a Regional Sustainable Development Framework (RSDF) be produced for every English region, setting out the sustainable development context for all other regional strategies. In Yorkshire and the Humber, sustainable development is a cross-cutting theme of all regional strategies. The RSDF has 15 aims (see Figure), each with defined objectives, all of which relate to the wider determinants of health (economic, social and environmental), and hence is an integrated framework for ensuring that sustainable development is at the heart of decision-making. The RSDF contains a Sustainability Appraisal tool for screening policies, plans and projects that has now been modified by a multi-disciplinary team of public health specialists, academics, and government office and Regional Development Agency officers from a variety of backgrounds, better to serve as a screening phase tool for health impact assessment (i.e. an integrated assessment tool).

This tool has been used to assess the Regional Economic Strategy and major projects submitted for Regional Development Agency funding, as well as Regional Planning Guidance, and shortly will be used to appraise the Regional Housing Strategy. Having completed the ‘health impact’ modifications to the RSDF (currently out for consultation in the region) in North and North East Lincolnshire with officers from the two local authorities (sustainable development) and the two Local Strategic Partnerships, the tool has now been officially accepted for use locally to screen all major policies, plans and projects –

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1 Good quality employment opportunities available to all
2 Conditions that allow business success, economic growth and investment
3 Education and training opportunities that build the skills and capacity of the population
4 Conditions and services that engender good health
5 Safety and security for people and property
6 Vibrant communities that participate in decision-making
7 Culture, leisure and recreation opportunities available to all
8 Local needs met locally
9 A transport network that maximizes access whilst minimizing detrimental impacts
10 A quality built environment and efficient land use patterns that make good use of derelict sites, minimize travel and promote balanced development
11 Quality housing available to everyone
12 A biodiverse and attractive natural environment
13 Minimal pollution levels
14 Minimal greenhouse gas emissions and a managed response to the effects of climate change
15 Prudent and efficient use of energy and natural resources, and minimal production of waste

Cross-cutting themes include:
- Social inclusion and equity across all sectors
- A partnership and participative approach
- Geographical adaptation to the needs of rural and urban communities
- Creativity, innovation and the appropriate use of technology

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Figure Regional Sustainable Development Framework aims.

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Hepatitis B vaccine uptake among injecting drug users

Sirs,

We read with interest the paper by McGregor et al. and support the conclusions they reached, particularly with regard to the effectiveness of hepatitis B vaccination being targeted at high-risk groups. Because of the mode of spread of blood-borne viruses such as hepatitis B, contact tracing may raise complex interpersonal issues and the need for counselling and informed consent to allow further investigation to take place. Relatively few health care workers possess the training and experience required to carry this out, and misunderstandings may occur as to whose role this is. Family practitioners have a key role in that they know the patient and their social circumstances, but may not have the time available for extended consultation and often see this as a public health role.

In the autumn of 2001 the County Durham and Tees Valley Public Health Network carried out a survey of public health departments in all health authorities in England, Wales and Northern Ireland, while these still existed, to establish what proportion of them were informed of, and then followed up, cases of hepatitis B virus (HBV) infection and their relevant contacts. The principal aim was to ascertain the extent to which this latter vulnerable group was likely to be protected by the current recommended management for contacts of cases or carriers of HBV infection.

A response rate of 87.2 per cent was obtained, the results indicating that almost all (93/95 (97.9 per cent)) consultants in communicable disease control (CsCDC) were informed of cases of HBV infection following identification of viral markers by their local microbiology laboratory. This was fortunate, as formal notification by a medical practitioner varied very much between districts. Only four (4.2 per cent) CsCDC were always notified, 53 (55.8 per cent) were notified sometimes, 32 (33.7 per cent) rarely and five (5.3 per cent) never. The Table indicates the variety of health workers involved in the follow-up of known cases of HBV infection and their contacts.

If selective immunization is to be successful at controlling HBV infection within our population, it must be effectively carried out in all risk groups, including contacts of cases. CsCDC are in a position to co-ordinate this through liaison with other health care agencies within a geographical area, yet this did not take place for cases and contacts of cases in 24 (25.3 per cent) and 26 (27.4 per cent) of the districts surveyed, respectively. It must also be remembered that the majority of cases informed to CsCDC will have had laboratory identification of HBV markers and will therefore be a minority of all cases of HBV infection.

The results of our survey indicated an inconsistency in the information provided and action undertaken in dealing with cases of acute HBV infection and their contacts. Perhaps the time has come for the Department of Health Advisory Committee on Hepatitis to develop formal standards for the completeness and timeliness of laboratory investigation of suspected cases, the speed of conveying results to attending physicians and CsCDC, and the subsequent speed at which those physicians, liaising with CsCDC, are expected to ascertain and vaccinate relevant contacts. An alternative, as suggested by McGregor et al., would be the introduction of universal hepatitis B vacc-