Health Impact Assesment: Hints and Cautions from Critical Epidemiology

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"HEALTH IMPACT ASSESMENT: HINTS AND CAUTIONS FROM CRITICAL EPIDEMIOLOGY"

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A vigorous health paradigm reform movement arose in Latin America in the seventies. It recovered the intellectual inheritance, as well as the wisdom, of progressive thinkers and social reformers in the last three centuries.

For historical and cultural reasons which we will not discuss here, the theoretical and practical results of that movement, the valuable experience contained in many of our books, remain almost unknown to First World scholars. We must find ways to overcome this mutually limiting academic gap in order to strengthen sound, equitable and mutually respectful scientific links between your work and our work: each situated in an opposite corner of globalization; both demanding a renewed alliance towards a humane and healthy World.

It is impossible for me, under the format of this conference, to convey the possibilities for health impact assessment of Latin American Critical Epidemiology, sometimes referred to under the tautological designation of "social epidemiology", but I will try to sum up in the next few minutes some reflections based on them.

1. The organizing committee is pointing in the right direction, when recognizing the importance of a broader scope and the present influence of "environmental health assessment"; signaling the enlightening relation of this goal with human rights and social inequality; but from our point of view, it is unfeasible to articulate those important elements to a positivistic scheme of thought. In other words, we advance by expanding our scope, but we gain little if all that expansion is worked upon under the same umbrella of positivistic reasoning.

2. The whole conceptual and methodological building of positivistic health analysis is based on the disintegration of health as a *study object*, health as a *concept*, and health as a *field for intervention*, in other words it relies on the object/subject separation and the assumption of practice as a phenomena external to knowledge. We cannot explain in these few minutes the contributions of different Latin American scientists in overcoming this problem, but we can bring up some arguments, stated in our most recent book, which could be important for HIA.

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[1] Health impact assessment: multidisciplinary perspectives on the promise & pitfalls of measuring effects of policy & politics on public health. Toteston Medical Education Center, Harvard Medical School, august, 2002

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3. Conventional health analysis applies a reductionist scheme that: a) disintegrates the object in factors or causes; b) uses the risk paradigm to analyze their supposedly "external" associations; and c) derives from that atomized view of reality a functionalist approach to health action, focused on isolated factors.

4. If we want to surpass positivistic reasoning in HIA and assume a holistic paradigm to tackle the problem of health's complexity, we must analyze health as a dynamic and complex unity.

We fully agree that the one fundamental line of work is the understanding of social determinants of health, basically related to "society´s past and present economic, political and legal systems…as well as external political relationships to other countries", but achieving such a scientific objective is not a matter of changing the names of conventional study variables with newer ones: such as "human rights", "equity" or "justice". Positivistic ontology views health determination only as a set of causal factors which can be reified as independent variables; from that standpoint, health assessment would be reduced to the monitoring of empirical associations, in the form of constant multifactorial conjunctions. The elements of *movement, connection* and *hierarchy* are absent, providing a static scheme.

Scientifically speaking, we must assess health inter-connectedly as an *object*, as a *concept* and as a *field* of action. In all three dimensions it is a process explained both by generative or determining conditions and by empirical outcomes; those conditions and outcomes are neither mainly an individual problem, nor a medical care problem; nor a policy dependent problem; they depend on an complex and multidimensional process of social determination, deeply rooted in the quality of different modes of life of specific population groups; a part of which is the access to human rights satisfaction. So those rights are not carried out by decree, nor are they reinforced essentially by norms and codes, even if they appear as theoretically good. The social economic system in totality, and its corresponding political and cultural power structure, and not only the market nor isolated institutional policies, distribute the quotas of well-being to the different groups, according to their possible ways of life and in agreement with their quota of power. A triple structure of power exists -socio-economic, ethnic, and gender- which molds working conditions; the quality and enjoyment of consumption goods; the capacity to create and to reproduce cultural values and identity; the capacity for empowerment and to organize actions in benefit of a group; and, finally, the quality of our ecological relationships.

We have been able to demonstrate that the *epidemiological profile* of a group is defined in the movements of the contradictions between the protective and destructive processes that operate in those characteristic ways of life and that, at the same time, puts possible limits upon the *individual lifestyles* of people. Life and health depend on these movements between the processes that protect us and those that deteriorate us, and the development of all of these depend on the capacity of enjoyment of human rights which relies, certainly, upon the level of equity or inequity that characterizes the structure of power in which life is unfolding. A social system that institutes the proliferation and deepening of inequity and that increasingly deteriorates human rights

within those ways of life, will thus institutionalize mechanisms for the deterioration of health; these systematically affect the physiological patterns, norms of genetic reaction, morbidity and mortality patterns of that population's organisms, and produce signs of over-aging. In contrary circumstances, when they open up possibilities for the enjoyment of an equity that allows for the satisfaction of rights, such as those in which personal and family supports and the physiological defenses and possibilities are potentialized, then the quality of physiological and genetic life increases, we witness the appearance of patterns of mental and physical health, as well as improved survival indexes.

5. It is crucial to differentiate between the notion of inequality and the notion of inequity. In the field of public health it seems to be that in recent years the category of *inequity* has become one of those cardinal problems that stirs up different forces. Since, to impel the construction of a different world, it is not enough to describe the deep social inequalities and those of health, but rather it is indispensable to put up for discovery the roots of those inequalities. *Inequity* is an analytic category that takes account of the essence of the problem, while *inequality* denotes the empirical evidence that becomes statistically observable.[3] Inequity is the lack of equity that arises from power concentration; it is a product if asymmetrical relations between social classes, ethnic or gender groups; that is to say, it is an inherent characteristic in a society that impedes the common good, and institutes the impossibility of an allotment among humans that grants to each according to their need, and that allows each person to contribute fully according to her or his capacity; for this reason the study of inequity is a crucial point in the analysis of human rights. *Inequality*, on the other hand, is a typically observable and group-defined expression of inequity; it conveys a contrast -of a characteristic or measurement— produced by inequity.

6. When updating alternative methodology we must keep in mind that the ontological problem of redefining the *study object* is intermingled with the epistemological problem of redefining the *study subject*, so in this sense we are strongly emphasizing the need to incorporate intercultural and community-driven research.

7. Finally, in order to translate these ideas into practical terms we have developed a *critical process matrix* which enables as to cover the different domains and dimensions of social health determination. Our experience with community organizations and flower worker unions, developed in one of the most important cut flower production regions of the World, could be interesting to illustrate our theoretical and methodological framework and could be taken as a case example of integral and participative human and ecosystem health assessment.

I know that you in the North, and we in the South, work for life, and that we know that public health is a fundamental tool with which to defend it. Let’s develop an HIA system that corresponds to the real challenges which our people and human life are placing in front of us.

Boston - August 17th, 2002

[3] In fact the category "inequity" is an anglicism. The Spanish term " iniquity" corresponds more properly to injustice or inequality. The anglicism is adopted here because it is a widely-used term and is central in the contemporary debate under discussion.