



THE UNIVERSITY
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*Department of Civic Design and
Department of Public Health*

**Health Impact Assessment:
Measuring the Effect of Public Policy
on Variations in Health**

ANNEX 4

**Southport Private Rented Dwellings
Case Study**

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HEALTH IMPACT ASSESMENT CASE STUDY

The Private Rented Dwellings Project

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1. Introduction

1.1 Health impact assessment: background

There is overwhelming evidence that the major factors affecting our health and well being are social, economic and environmental (Acheson, 1998), reflecting a socio-environmental model of health. As these factors change, for better or worse, so our health is directly or indirectly affected. This has been recognised in recent Government policies and initiatives. For example,

- *'The New NHS – Modern, Dependable'* (1998) introduced the concept of Health Improvement Programmes (HimPs) to improve health and reduce inequalities. HImPs are to focus on the determinants of health as well as health services;
- *'Saving Lives: Our Healthier Nation'* (1999) reinforced the importance of 'tackling the causes of poor health' in the action to address the priorities of cancer, coronary heart disease/stroke, accidents and mental health; and
- *'Modernising Local Government – In Touch with the People'* (1998) is placing a statutory duty on local authorities to promote the economic, social and environmental well being of their areas and those who live, work or visit there. Local authorities must develop 'Community Plans' which are consistent with the HImP.

There are also strong links between regeneration strategies and health. Many of the issues associated with deprived local authority areas targeted for regeneration, e.g. high rates of unemployment, poor housing, crime, social exclusion, also contribute to the poor health status of these communities. Similarly, many of the consequences of poor health and well being, both mental and physical, e.g. low self esteem, high rates of limiting long term illness and permanent disability, can prohibit an area's successful and sustainable regeneration. Regeneration activity affecting these health determinants will, therefore, also impact on the health of the population, directly and indirectly.

The ability to be able to predetermine changes in health determinants stemming from the implementation of public policies, and therefore, health risk or opportunity, is clearly important in assessing how they might influence the health of a given population. Prospective health impact assessment (HIA) is an approach that predicts these changes; it involves 'the

estimation of the effects of a specified action on the health of a defined population' (Scott-Samuel, 1998) prior to the action taking place. It is a relatively new field, with the first formal example in the United Kingdom being conducted in 1994 on the proposed second runway at Manchester Airport (Will, Arden et al., 1994). Since then, HIA has been advocated at both Government and local levels. In particular, the *Independent Inquiry into Inequalities in Health* (Acheson, 1998), recommended that, as part of HIA, all policies likely to have a direct or indirect effect on health should consider their impact on health inequalities.

Over the last 3 years a number of local HIA projects have been undertaken across the UK; for example, the Liverpool Public Health Observatory has conducted a series of pilot projects including community safety and transport plans (Winters and Scott-Samuel, 1997; Fleeman, 1999). Some Health Action Zones (HAZs) – for example, Bury & Rochdale, Leeds and Merseyside have also included the HIA of specific projects within their implementation plans during 1999.

In addition, there have been significant developments regarding HIA in Europe with Article 152 of the Treaty of Amsterdam stating that,

“ A high level of human health protection shall be ensured in the definition and implementation of all community policies and activities.”

and the Council Resolution of June 1999 calling for the establishment of procedures to monitor the impact of community policies and activities on public health and health care. The World Health Organisation European Centre for Health Policy (WHO ECHP) contributed to these developments by producing a discussion paper on HIA as a tool for intersectoral health policy (Lehto & Ritsatakis, 1999). This was followed by the publication of the Gothenburg Consensus Paper which seeks to define HIA concepts and terms in order to facilitate understanding and implementation of HIA approaches.

Most recently in the United Kingdom, in 1998, the Department of Health has funded an investigation into HIA methodology and its application in reducing health inequalities. This report forms part of the findings from this HIA Research and Development Project.

1.2 The health impact assessment research and development project

In July 1998 a multidisciplinary team from the Departments of Civic Design and Public Health at the University of Liverpool secured funding from the Department of Health

Inequalities Research Initiative for a two year project on health impact assessment. The study is exploring the processes through which public policy impacts on inequalities in health and developing rapid appraisal methods for prospective HIA. It is doing this through a series of five case studies, most of which are urban regeneration projects funded through the Single Regeneration Budget and are prime examples of inter-agency collaboration. The focus of the selected regeneration programmes and projects fall into the following categories:

- modifying the physical environment, for example housing projects;
- facilitating community empowerment, for example community development projects; and
- enhancing employment opportunities, for example education and training projects.
- Reducing fear, anxiety and stress, for example, crime reduction initiatives

They provide an ideal opportunity to explore the links between health and its determinants, and to examine how inequalities in health, well being and quality of life can be tackled. The case studies include:

- ‘Stepping Out’ – a project aiming to empower young women to make informed decisions about their future, providing alternative choices to criminal and anti-social behaviour;
- ‘Parenting 2000’ - a parenting programme which aims not only to facilitate the development of parents as educators, but also to develop the skills of those parents re-entering the job market;
- ‘Private Rented Dwellings’ – (This case study) –a programme designed to improve the quality of privately rented dwellings occupied by vulnerable tenants, particularly accommodation converted for multiple occupation;
- ‘New Deal for Communities’ – a bid for a New Deal for Communities funding to regenerate a housing estate, focussing particularly on crime reduction, housing quality, employment and education;
- ‘Target Hardening’ – a project aiming to reduce the incidence of repeat burglaries to vulnerable properties by undertaking security improvements to these properties;

The findings from each case study have been compiled into separate reports. In addition, a working paper on HIA and its application to regeneration programmes has been produced as well as a final report on the project as a whole.

This report describes a rapid HIA case study of the Private Rented Dwellings project which is part of the Central Southport SRB programme. The primary objectives of the case study were:

- to test out methods which can be used for conducting rapid HIA/HIIAs in order to inform the process of developing HIA/HIIA methodologies; and
- to assess the value of rapid HIA/HIIA in terms of its usefulness in policy making, programme planning and project implementation.

The authors' view the development of the work as an iterative process and it is expected that as the research continues there will be cause to re-evaluate the efficacy and appropriateness of the methods described in this report.

1.3 Housing and health: background

The place where we live is perhaps one of the most important influences on our health and well being. We all need not just a roof over our heads but a home which is warm and dry, safe and free from infestation. This is one of the pre-requisites for health set out by the World Health Organisation (WHO, 1995).

Housing quality

There are now 1.5 million homes (7.5% of the total) which are considered unfit for human habitation, a state of affairs which has not changed since 1991 (Department of the Environment, Transport and the Regions, 1998). In addition there are many more homes which are poorly designed or equipped, putting their occupants at risk of accidental falls, fires and carbon monoxide poisoning.

Respiratory infections are associated with damp conditions and a lack of adequate heating is responsible for increased incidence of hypothermia, heart disease and stroke, particularly in older people. It is estimated that there are 8,000 additional deaths for each degree Celsius that the temperature falls below average and yet a survey in 1988 indicated that 25% of older people do not use their heating as much as they would like to on account of the cost (Savage, 1988; Best, 1995; Christopherson, 1997).

Amongst families on low incomes, overcrowded housing compounds the problems they already experience and makes them more vulnerable to respiratory infections, stress and accidental injury.

Housing tenure

Housing tenure appears also to be related to inequalities in health. All men and women of working age living in owner occupied accommodation have lower death rates than those in privately rented accommodation and those in local authority housing have the highest rates of all (Goldblatt, 1990). This may be a function of other variables for which tenure is an indicator although it is interesting to note that people from social classes IV and V who own their own homes have lower mortality rates than those from social classes I and II who live in rented accommodation (Office of Population Censuses and Surveys).

Indoor air quality

It has been estimated that most people living in this country spend 90% of their time indoors and 70% of that time in their own homes (Donaldson and Donaldson, 1993).

Indoor air quality can be compromised by pollutants from a number of sources. These include emissions from the ground, of radon for example, emissions from construction materials and from the use of chemicals such as paint strippers and glue. Cigarette smoke is also an important source of indoor air pollution. On its own it can be a cause of respiratory disease and lung cancer in passive smokers and people who themselves smoke; where there is an underlying radiation risk it enhances this risk by ten times.

Respiratory infections are also common, particularly among children, where houses are damp and have mould growth. If ventilation is inadequate there may be even more serious consequences of poor quality housing. Lethal concentrations of carbon monoxide in homes are responsible for around 100 deaths per year from as a result of gas or solid fuel fires which have been incorrectly installed or which have a defective air supply.

Pests and vermin

Infestation by insects such as flies, cockroaches and Pharaoh's ants pose a threat to the indoor environment, spreading pathogenic organisms, bacteria and viruses and contaminating food. There are no reliable estimates of how many homes are infested, at any one time, although, there is anecdotal evidence that infestation is more common in run down, poorly maintained homes. This is also true of rats and mice, which carry similar dangers. Infestation

by birds, such as sparrows and pigeons in urban areas, can also pose a threat to environmental health, not only in terms of physical disease, but also, through noise nuisance.

2. Résumé of the Private Rented Dwellings Project

2.1 Southport and the Central Southport Partnership

In comparison with many other areas of Merseyside, Southport is relatively affluent and this is borne out by the overall score the borough of Sefton (within which it is located) of 19.41 on the Index of Local Deprivation which places it as the 54th most deprived local authority in England. Elsewhere on Merseyside, Liverpool scored 40.07 and was the most deprived local authority in England; Knowsley (33.69) was 9th, Wirral (21.25) was 44th and St. Helens (20.98) 45th. Sefton also recorded a low standardised mortality ratio (SMR) (all causes = 94, LL89, UL98; England and Wales = 100). This picture, however, masks the fact that Southport is a seaside town in decline, with an ageing population and pockets of severe deprivation, particularly in the central area.

In response to this the Central Southport Partnership was established in 1997 to submit a bid for Single Regeneration Budget funding under Round 3 and was awarded £8.2 million in June 1997. Following this the Central Southport Partnership Board was formally established to oversee and direct the work.

The partnership has four strategic objectives:

- *Housing*

To improve living conditions and management of housing in the central area, particularly in the private rented sector, and provide greater choice and diversity, especially for special needs groups.

- *Economic development*

To encourage sustainable economic growth by improving the economic performance of local businesses, particularly tourism, and to support new business development.

- *Employment and Training*

To improve access to training and employment, to increase skill levels of local people, particularly young people, and to enhance the employment prospects of those at a disadvantage, particularly those with disabilities.

- *Community and Facilities*

To build up the capacity of the local community to contribute to local regeneration and to enhance the quality of life by improving cultural and sports facilities in the Central Area.

Each of these strategic areas is being developed by a sub-group of the Partnership Board and within each area there are a number of related projects. These are listed in full in Appendix 2.1.

2.2 Private rented dwellings

Introduction

Tourism, on which the economy of Southport is heavily dependent, has been in decline for the last decade. As a direct result of this, a relatively large proportion of the town's housing stock is substandard and occupied by residents experiencing levels of deprivation on a par with those seen in some of the country's most disadvantaged inner city areas.

As revenues from tourism have dwindled, many owners of guest houses and hotels, unable to continue running them profitably or to find a buyer for them, have subdivided and converted their properties for multiple occupation. In many cases, however, they have been unable to maintain them to an adequate standard. It is estimated that there are over 2,000 units in houses in multiple occupation (HMOs), accommodating perhaps as many as 5,000 people in Southport. Many of these residents are on low incomes and may also be economically and socially disadvantaged in other ways. In addition, their living accommodation may pose a significant threat to their health. This is exemplified by the fact that, in an average year, 25% of fatalities from property fires in Merseyside are in Southport, an area with just under 6.3% of the County's population.

Aims

The Private Rented Dwellings Project is involved in making risk assessments of HMOs and providing partial grants for housing improvements. This is a new and innovative approach which, where possible, uses carrots rather than sticks. The project works with landlords to assess and improve housing quality rather than simply putting pressure on them to make improvements which would almost certainly have resulted in many tenants becoming homeless.

Administration

The Private Rented Dwellings Project is based within the Environmental Health Department of Sefton Metropolitan Borough Council (the local authority), where it is the responsibility of an environmental health officer, whilst the overall direction is steered by the Central Southport Partnership sub-group on housing.

The project has been allocated £257,000 of the SRB monies and this must be matched with private finance. The funding covers the cost of three additional temporary members of staff – an administrator and two housing surveyors.

Policy context and history

The Housing Act (1995) stipulates that local authorities have a statutory duty to address the issue of substandard housing in their areas and allows them four possible courses of action where properties have been assessed and deemed unfit for habitation:

- renovation;
- closure;
- demolition; or
- deferred action.

Closure and demolition are usually related.

There has been increasing pressure from the government in recent years for local authorities to inspect HMOs in particular and to push for action to improve them. In recognition of this, some five years ago the project manager's predecessor proposed an HMO improvement programme which would, for example, convert hostel accommodation into bedsits or bedsits into self-contained flats.

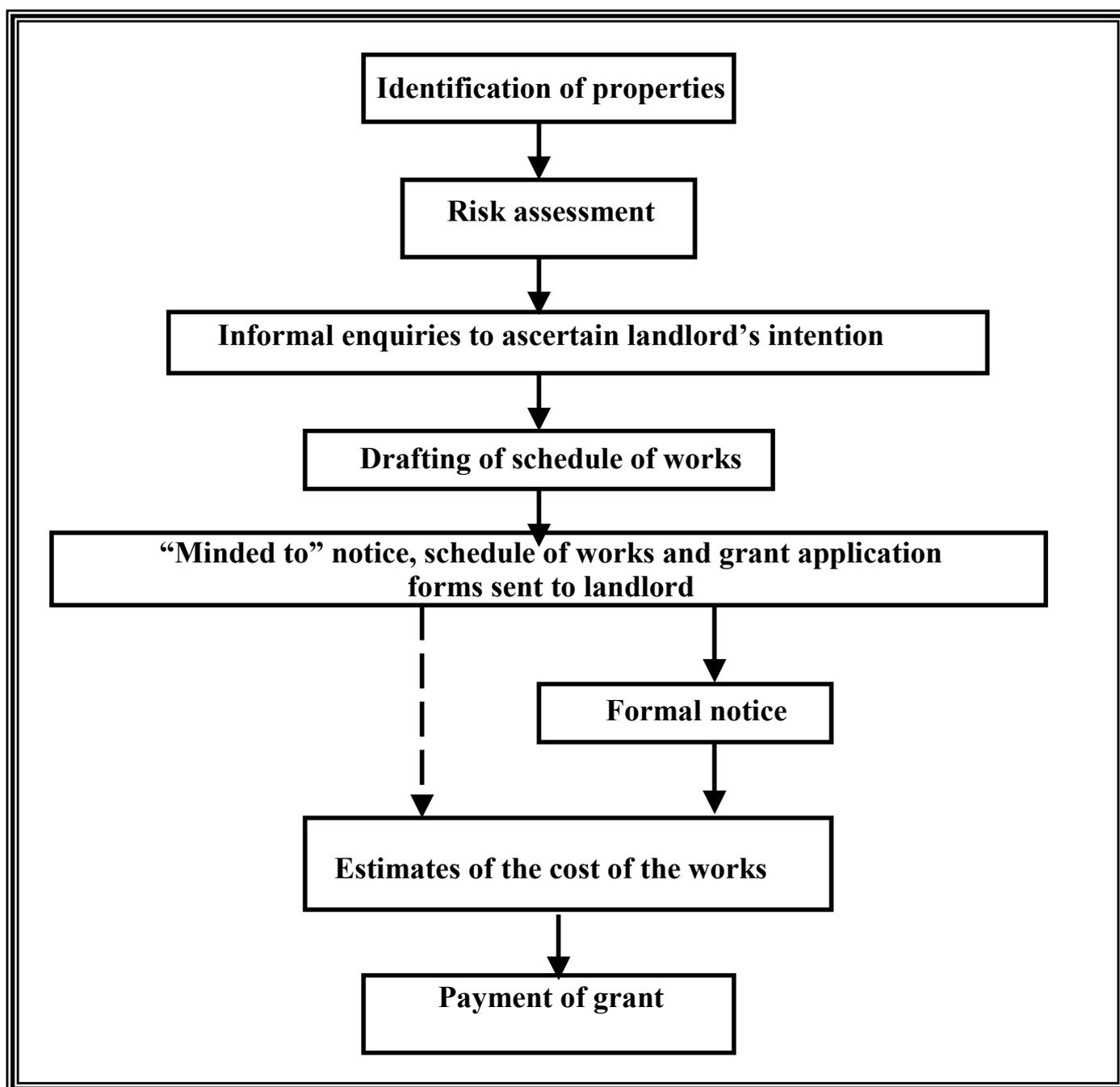
The Housing Department apportioned a slice of the Housing Improvement money to the Environmental Health Department for this work but its effects were limited. This was partly because of the prohibitive cost and time implications - at that time, 570 HMOs were known of and it would have taken approximately 20 years to cover them all - and partly because of the detrimental effect improvement of HMOs may have had on the availability of low cost housing for disadvantaged groups.

The SRB bid provided an opportunity to revisit this work and to develop it further in a way which would take equity issues into account.

The improvement process

The improvement process is summarised in Figure 2.1 and each of the main stages is described below.

Figure 2.1 The Housing Improvement Process



(1) *Identification of properties*

Properties are identified through

- Complaints from
 - tenants
 - neighbours
 - other teams, e.g. noise pollution

Complaints are responded to within 5 working days.

- Landlords

100 landlords were invited to a meeting where the scheme was explained to them. 50 attended and there were 36 requests for information and further details. These and subsequent enquiries go onto a waiting list (c. 3 months).

If landlords are co-operative, they may be offered grants; if not, and their properties are found to be unfit, the legislation can be used as a stick to enforce them to make improvements.

Grants fall into four categories. In summary,

- a) HMOs which are occupied and risk assessed may receive 20-80% of the costs of approved works.
- b) HMOs which are occupied and are to be converted to self contained units may receive a flat rate of 20% of the cost of improvement, to a maximum of £10,000.
- c) Vacant HMOs which are risk assessed – as for (a).
- d) Vacant HMOs which are to be converted to self contained units – as for (b).

Approved works must be in keeping with the fitness requirements set out in the Housing Act 1985 and the rulings and procedures which are used in the project are those which operated previously under the mandatory grants system.¹

(2) *Risk assessment*

Risk assessment inspections are made against the fitness standards for structure (Section 189) and people (Section 352) using a standard format.

The criteria for risk assessment are relatively limited, housing fitness being the most important criterion against which the assessment is made and the only one on which the decision to allocate a grant is based. Redecoration costs are not covered, although, some private finance may be levered in for other improvements. For example, carpets may be fitted and units redecorated following the improvements or, whilst scaffolding is up for repairs to the guttering, the building may be rendered at the same time.

No need has yet arisen to prioritise between properties but if it were necessary, the properties in the worst condition would receive the highest priority.

If a property is scored with 100+ points it becomes liable for a financial notice. If a property scores on some parts of the standards but is not unfit a 190 notice becomes payable. These do not legally require notice or action on a notice but none have been ignored so far.

(3) *What is the landlord's intention?*

Informal enquires are made to ascertain what the landlord intends to do about the property.

(4) *Schedule of works*

A schedule of works needed to bring the property up to fitness standards is drawn up. This is then sent to the landlords with grant application forms and a "minded to" notice (covering Sections 352 and 189). They are asked whether they intend to take action and advised that if they do not a formal notice will be served.

(5) *Formal notice*

If a response is not received within one month formal notices (again covering Sections 352 and 189) are sent to the landlord with a schedule of works and grant application forms.

They are usually asked to start the required works within one month and to complete them within three months of the date of the notice. The LA can prosecute them for a breach of the notice.

¹ The mandatory grants system became discretionary under the Conservative government.

Tenants are informed that a works notice has been served on the landlord and that works are about to be undertaken.

(6) *Estimates of the cost of works*

The landlord is required to submit two fully priced estimates which are compared with three national and local rates. The lowest rate is the approved cost on which the percentage of the grant is based. Sefton's comparative costs are generous in order to help avoid cost cutting and 'cowboy' builders.

(7) *Payment of grant*

The grant is paid in two instalments:

- an interim payment; and
- a payment after the final inspection.

Progress to date

Approximately 1,200 HMOs are known about at the time of writing (August 2000) and it is estimated that there are over 2,000 in total. In Year 1 of the project (1997/98) the target was to improve 20 units and 35 were in fact improved. The target for subsequent years is 120 per year.

Links to other developments

Accreditation scheme

A landlord accreditation scheme is currently being developed. This is related to the fact that, under the SRB project, priority is given to the worst properties, which usually have the worst landlords, and this is seen as unfair. A small pot of financial grant aid is, therefore, being set aside for better maintained properties which (usually) belong to the better landlords.

In the future, social services departments and others will be able to make referrals to accredited landlords.

Tenant / landlord agreements

The government is about to introduce licensing of HMOs and LAs are being encouraged to start doing this now.

Rent deposits / bond guarantees

As another SRB measure, “Light for Life”, a charity, has the local franchise for “Smart Move”, a scheme licensed by Crisis and started two weeks ago as part of the accreditation scheme. “Light for Life” also plans to run a Housing Advisory Centre.

Housing strategy document

The borough has recently developed a housing strategy.

Kosovo refugees

The HMO standards are now being used by the social services department to assess housing for Kosovo refugees in Sefton.

3. Methodology

3.1 The case study

The case study was carried out as a rapid, concurrent HIA/HIIA using an adaptation of the model set out in the Merseyside Guidelines for HIA (Scott-Samuel, Birley and Ardern, 1998). The stages involved

- policy analysis;
- profiling of communities;
- identification of the health determinants affected;
- assessment of the evidence and identification of potential health impacts; and
- follow up - discussion of the findings with key stakeholders.

Policy analysis

At an early stage in the case study two meetings were held with the SRB project manager in order to gather information on the overall context of the project, the project itself and the processes and procedures involved in its implementation. The information gathered at this time formed the basis for the overall policy analysis and fed into the exploration of the health determinants potentially influenced by the project.

Community profile

A profile of the Central Southport SRB area was compiled using routinely available data. This profile forms the basis of the section outlining the current situation within the sections on positive and negative health impacts.

Identification of the health determinants affected, assessment of the evidence and identification of potential health impacts

Using the Merseyside Guidelines as a starting point, a simple framework was developed and used to identify and structure the potential health impacts of the project and the

categories of health determinants they are likely to affect (see Appendix 3.1). The categories of health determinants are shown, with examples, in Appendix 3.2.

The impacts were categorised as positive or negative, distinguishing where possible between potential impacts on the direct “beneficiaries” of the project (residents of the privately rented dwellings) and on other stakeholders such as the landlords or other residents of the area. An attempt was made to assess the measurability of the impact (whether it was qualitative, estimable or calculable), the level of risk of the impact (whether it was definite, probable or speculative) and the likelihood of the impact resulting in wider or narrower differentials in terms of health inequalities. In addition, data sources which could be used to quantify the impacts were identified where possible.

This assessment was based on expert public health knowledge with additional input from the SRB project manager. Where baseline data were available they were taken into account in assessing the likely scale of the impact and recorded so that they may be used by the project implementation team in the future for monitoring or projection purposes as appropriate.

Follow up - discussion of the findings with key stakeholders

Following the initial rapid HIA the preliminary findings were discussed with the SRB project manager and the chair of the SRB Partnership Board sub-group responsible for the development of the Private Rented Dwellings Project. Their comments were then incorporated into the relevant sections of the report.

4. Findings and analysis

4.1 Community profile

The Central Southport SRB covers 635.13 hectares (ha) of which 27.1% (172.33 ha) is built up area and 72.9% (462.80 ha) open spaces, a similar ratio to that seen in Merseyside as a whole. Within the built up areas, 83.7% of properties are residential but other data from the Merseyside Special Address file suggests that there are also many social meeting places such as church halls, pubs and nightclubs. Central Southport has two and a half times as many pubs and thirteen and a half times as many nightclubs per hectare as Merseyside as a whole.

Demography

The 1991 Census of Population shows that the resident population was 11,516 although it is estimated that the population swells to over 18,600 during the day, with an influx of visitors and people coming to work in the area. Anecdotal evidence suggests that these numbers are unlikely to have changed markedly in the years since the last Census. The population is, however, a relatively transient one with almost 18% having changed their address in the year prior to the Census - two and a half times the proportion seen in Merseyside as a whole.

Age structure

As shown in Table 4.I, the age structure of the population is markedly different from that in Merseyside as a whole, with relatively few children and large numbers of elderly people. Central Southport is home to just under 1% of Merseyside's total population but nearly 2% of its pensioners - 39% of the total population in central Southport - and almost 4% of the population aged 85 and over live there.

Table 4.1 Central Southport SRB: population by selected age group

Age group	Population		Location quotient ¹
	Number	Percentage	
10 - 15	341	3.0%	39
16 - 19	470	4.1%	75
20 - 24	898	7.8%	107
25 - 29	822	7.1%	94
Pensioners ²	4,501	39.0%	204
85 +	789	6.8%	465
TOTAL (all ages)	11,516	100%	(100)

1 A location quotient of 100 indicates that central Southport SRB and Merseyside have the same values (in this case percentage of total population). A quotient of less than 100 indicates that central Southport has a lower value (a smaller proportion of the population in the age group than that seen in Merseyside as a whole); a quotient of more than 100 indicates a higher value.

2 Males aged 65+ and females aged 60+

Source: derived from Census of Population 1991

Ethnicity

As in Merseyside as a whole, the population is predominantly white, with only 2% belonging to black and Asian minority ethnic groups.

Socio-economic characteristics

The Census provides a number of standard indicators of socio-economic status and these are summarised in Table 4.2. The overall picture is one of relative affluence coexisting directly alongside considerable socio-economic disadvantage. Almost 38% of residents are in social classes I and II and this figure appears to be rising, with a 12% increase between 1981 and 1991 in the number of households headed by a person in social class I or II. Whilst high by national standards, unemployment, at over 12% for the total population and over 21% for people aged 16 to 24, was rather lower than elsewhere in Merseyside. Perhaps reflecting the overall age structure of the population, there are few lone parent families and even fewer families with children where there is no wage earner, but a high proportion of households - over 13% of the total - consist solely of people who are economically dependent. The "Super Profile Lifestyle" ratings, which combine a number of socio-economic variables from the

Census to give an overall picture of an area, suggest that central Southport is characterised, in particular, by exceptionally large numbers of older people on low incomes.

Table 4.2 Central Southport SRB: selected socio-economic indicators

Socio-economic variable	Population / households		Location quotient ¹
	Number	Percentage	
Social classes I and II (population)	1,620	37.2%	147
Social classes IV and V (population)	890	20.4%	92
No qualifications (pop. aged 18+)	8,920	90.1%	100
Unemployed (population)	625	12.8%	81
Unemployed aged 16-24 (population)	217	21.1%	63
One parent, unemployed (h/h)	15	0.3%	51
Two parents, both unemployed (h/h)	10	0.2%	28
Dependants only (households)	739	13.6%	123
No car (households)	2,700	49.8%	110

¹ A location quotient of 100 indicates that central Southport SRB and Merseyside have the same values (in this case percentage of total population). A quotient of less than 100 indicates that central Southport has a lower value (a smaller proportion of the population in the age group than that seen in Merseyside as a whole); a quotient of more than 100 indicates a higher value.

Source: derived from Census of Population 1991

Housing

It is perhaps the housing data which best exemplify the level of disadvantage found in central Southport.

Type of housing

In 1991 there were 5,926 properties in the area, of which 83.7% were residential. As shown in Table 4.3, a high proportion of these are purpose built and converted flats. 2% of all purpose built flats and over 8% of converted flats in Merseyside are located in central Southport as are almost 13% of its 'bedsits'.

Table 4.3 Central Southport SRB: housing type

Housing type	Number	Percentage	Location quotient ¹
Detached houses	365	6.5	70
Semi-detached houses	1,059	18.9	53
Terraced houses	395	7.0	18
Purpose-built flats	1,580	28.2	204
Converted flats	1,956	34.9	846
Bedsits	32	0.6	1,317
Residential properties (total)	4,958		
Households (total)	5,426		

¹ A location quotient of 100 indicates that central Southport SRB and Merseyside have the same values (in this case percentage of total population). A quotient of less than 100 indicates that central Southport has a lower value (a smaller proportion of the population in the age group than that seen in Merseyside as a whole); a quotient of more than 100 indicates a higher value.

Source: derived from Census of Population 1991

Tenancy

Table 4.4 shows the number of households in central Southport by tenancy. Almost 60% of households live in owner-occupied properties, a proportion similar to that seen in Merseyside as a whole. In the rented sector, however, the picture is rather different to that elsewhere with a very low level of local authority housing provision (less than 1% of the total). The privately rented sector is, as a consequence, quite large, with almost 22% of households living in privately rented furnished properties and over 14% in unfurnished units. Almost 9% of Merseyside's privately rented furnished properties are located in the central Southport SRB area and almost three times the proportion of households here live in privately rented unfurnished properties as do in other parts of Merseyside.

Many of these households - over 15% of the total - live in accommodation which is not self-contained and this figure represents over 13% of all such households in Merseyside as a whole. In addition, a large number of people - over 2,000, 18.1% of the total population - in

central Southport live in institutions. This is more than eleven times the proportion in Merseyside as a whole and it is almost certainly a reflection of the area's unusual age profile.

Table 4.4 Central Southport SRB: tenancy

Tenancy	Households		Location quotient ¹
	Number	Percentage	
Owner-occupied	3,119	57.5%	91
LA rented	44	0.8%	3
Privately rented – furnished	1,183	21.8%	890
Privately rented – unfurnished	769	14.2%	273
Other	309	5.7%	88
TOTAL	5,424	100%	(100)

¹ A location quotient of 100 indicates that central Southport SRB and Merseyside have the same values (in this case percentage of total population). A quotient of less than 100 indicates that central Southport has a lower value (a smaller proportion of the population in the age group than that seen in Merseyside as a whole); a quotient of more than 100 indicates a higher value.

Source: derived from Census of Population 1991

Housing quality

In some households, overcrowding is a problem, with almost 3% having more than 1.5 persons per room - half as many again as in the whole of Merseyside. Large numbers of households - almost 10% of the total - are also disadvantaged by lacking private access to a bath or WC and residents in central Southport, compared with Merseyside as a whole, are almost seven times as likely to be living in such conditions. Over 6% of households are multiply deprived in terms of housing, being overcrowded, lacking private access to basic amenities and having no central heating.

Table 4.5 Central Southport SRB: indicators of housing quality and socio-economic deprivation

Indicator	Households		Location quotient ¹
	Number	Percentage	
Overcrowding (> 1.5 persons per room)	147	2.7%	142
Lacking private use of WC or bath	523	9.6%	695
Multiple deprivation ²	334	6.2%	760
TOTAL (all households)			

1 A location quotient of 100 indicates that central Southport SRB and Merseyside have the same values (in this case percentage of total population). A quotient of less than 100 indicates that central Southport has a lower value (a smaller proportion of the population in the age group than that seen in Merseyside as a whole); a quotient of more than 100 indicates a higher value.

2 Overcrowding, lack of private amenities and no central heating

Source: derived from Census of Population 1991

Crime

Fear of crime disproportionately affects women and elderly people despite that fact that it is young men who are most likely to be its victims as well as its perpetrators. Given its age structure, it would, therefore, seem likely that residents of central Southport suffer more from the fear of crime than from crime itself. The crime figures shown in Table 4.6 indicate that rates of reported crime and disorder of all types, with the exception of juvenile disturbance, are higher in central Southport than in Merseyside as a whole although it is not clear whether this is because the rate of crime is actually higher or whether there is more awareness of crime and a greater willingness to report it to the police.

Table 4.6 Central Southport SRB: Calls to the police, 1998

Subject of call	Calls		Location quotient ¹
	Number	Percentage	
Property (all crimes)	6,592	19.1	235
Assault	568	1.6	301
Sexual offence	46	0.1	124
Burglary	574	1.7	100
Dispute	620	1.8	145
Serious disorder	11	0.0	224
Minor disorder	3,265	9.5	164
Robbery	80	0.2	169
Juvenile disturbance	689	2.0	78

¹ A location quotient of 100 indicates that central Southport SRB and Merseyside have the same values (in this case percentage of total population). A quotient of less than 100 indicates that central Southport has a lower value (a smaller proportion of the population in the age group than that seen in Merseyside as a whole); a quotient of more than 100 indicates a higher value.

Source: University of Liverpool, Environmental Criminology Research Unit ECRU

4.2 Potential positive and negative health impacts

Biological factors

Current situation

The evidence relating to the age structure and ethnic make up of the population living in privately rented dwellings in Southport is largely anecdotal but it seems likely that it is a young, relatively transient population of people who have their family origins in the area. It is also likely that disadvantaged groups are disproportionately represented in terms of income, educational attainment, employment and, in particular, mental health.

Potential health impacts

The Private Rented Dwellings Project is unlikely to affect the current pattern as it cannot influence the health determinants themselves, although, it is possible that their distribution might undergo some small changes within the private rented dwellings population and in the area as a whole. The local authority's landlord accreditation scheme, whereby

privately rented properties which meet the HMO housing fitness and safety standards can be registered, means that the social services department and other agencies may refer tenants to the newly renovated properties as they become vacant. Potential accommodation for refugees is currently being assessed using the housing fitness standards and there is, therefore, a possibility that more privately rented dwellings (as opposed to local authority accommodation) will be used for housing refugees in the future. If this were to happen it might radically change the age and gender structure of the population as well as the ethnic mix of the area as a whole.

Additionally, if the quality of private rented accommodation is improved it may attract a wider range of tenants other than those referred from elsewhere, again with implications for the overall structure of the population although it is unclear whether this might have implications in terms of health impacts.

Table 4.7 Potential health impacts on biological factors

Health determinant	Predicted health impacts		Indicators / data sources	Risk of impact
	Positive	Negative		
Age	Possible changes to the demographic make up of the population resulting in changes in health status indicators for the “new” population.	Possible changes to the demographic make up of the population resulting in changes in health status indicators for the “new” population.	Changes in the demographic structure of whole area could be calculated using routinely available data sources (e.g. Census data). Additional data on tenancies are not currently available.	S
Gender				
Ethnicity				
Disability	Amelioration of problems through the provision of aids and adaptations			S

Risk of impact: d = definite; p = probable; s = speculative

Personal or family circumstances and lifestyle

Current situation

Although some Census data on family structure exists for the wider population there are no data relating specifically to the residents of privately rented dwellings. Anecdotal evidence, however, suggests that the majority of the tenants are on low incomes, with high unemployment rates and a low level of educational attainment. They are likely to be single people living alone or young families.

Potential health impacts

All the potential health impacts which have been identified relate specifically to the residents of the privately rented dwellings which are being improved. They are all speculative and most would rely on qualitative data or quantitative measures collected on an ad hoc survey basis if they were to be explored more fully, although some could probably be estimated by extrapolating data from existing national surveys. The potential health impacts are summarised in Table 4.8 below and described in more detail in the subsequent paragraphs.

The Private Rented Dwellings Project has some potential for impacting positively on the health of residents in terms of family structure and functioning through the provision of safer and more appropriately designed housing. In addition, where tenants are referred to private accommodation through the social services department or other agencies it is likely that some attempts will be made to match the available units to the housing needs of individuals and families. Conversely, the disturbance during the building works is likely to take its toll on mental health and well being and on family life and functioning in the short term.

Table 4.8 Potential health impacts on personal or family circumstances and lifestyle

Health determinant	Predicted health impacts		Indicators / data sources	Risk of impact
	Positive	Negative		
Income		Lower levels of disposable income as a result of higher rents, with knock on effects for diet and nutrition.	Would require specially designed surveys.	S
Education and training	Higher uptake of education and training opportunities as a result of improved self esteem and mental health and well being, leading to higher income levels and changes in health related behaviour and lifestyles.		Would require specially designed surveys unless data could be obtained from local educational establishments.	S
Family structure and functioning	Improved mental health and well being as a result of more appropriate housing design and needs based allocation for tenants referred by the local authority. Improved child development as a result of more appropriately designed and allocated housing.	Stress and anxiety caused by disruption during building works.	Would require specially designed surveys. Child health records.	Positive health impacts: S Negative health impacts: p
Self esteem	Improved mental health and well being as a result of better quality housing		Would require specially designed surveys.	s

Health determinant	Predicted health impacts		Indicators / data sources	Risk of impact
	Positive	Negative		
Income		Lower levels of disposable income as a result of higher rents, with knock on effects for diet and nutrition.	Would require specially designed surveys.	S
Risk taking behaviour	Lower rates of risk taking behaviour such as smoking and alcohol use as a result of improved mental health and well being		GP and other primary care records.	S
Recreation and leisure	Higher uptake rates as a result of improved self esteem	Lower uptake rates as a result of reduced income	Would require specially designed surveys.	S

Risk of impact: d = definite; p = probable; s = speculative

Positive health impacts in terms of improved self esteem might also be expected as a result of living in a safer - and possibly more pleasant - environment, with the potential for contributing towards changes in health related behaviour such as smoking, alcohol and other substance abuse, diet, recreation and leisure and the uptake of educational and training opportunities. There may, however, be negative health impacts - on income as a whole as well as on diet and leisure activities - as a result of a reduction in disposable income if rents are increased following the building works. This is unlikely as many of those living in privately rented accommodation are thought to be in receipt of housing benefit which is paid directly to the landlord. In addition, the improvement grants system is intended to cover the cost of building works to an extent which precludes the need to raise rents, although, there are no safeguards to ensure that this is the case.

Social environment

Current situation

Anecdotal evidence suggests that, whilst there are good social support networks for older people living in central Southport – characteristically those who have lived in the area for many years – young people, who are more transient, tend to be more vulnerable and

socially isolated. Despite the many opportunities for social interaction in the area, this group is not in a position, financially to take up these opportunities.

Potential health impacts

Work elsewhere suggests that by improving housing conditions, psychological health and well being can be greatly affected, at least in the short term, as can self reported health status and feelings of neighbourliness (Barnes, 2000).

Table 4.9 Potential health impacts on the social environment

Health determinant	Predicted health impacts		Indicators / data sources	Risk of impact
	Positive	Negative		
Social support networks	Potential improvements in mental health and well being as a result of improved living conditions	Disruption to social networks and community participation during the building works.	Would require specially designed surveys.	s
Community participation			Would require specially designed surveys or exploration of records kept (e.g. of attendance) by community groups.	s
Relationships with neighbours	Improved relationships with neighbours and concomitant improvements in mental health and well being as a result of better sound insulation		Would require specially designed surveys.	s

Risk of impact: d = definite; p = probable; s = speculative

Physical environment

Current situation

The private rented dwellings which are eligible for improvement under the scheme are, by definition, in an inadequate condition. They include housing units which are not self contained and which lack adequate bathroom and cooking facilities. Some of them are thought to be overcrowded and have no central heating.

In the wider environment, central Southport has relatively high levels of reported crime and fear of crime is thought to be a significant issue.

Potential health impacts

Table 4.10 below summarises the potential health impacts on the physical environment that might be expected to result from the Private Rented Dwellings Project.

Table 4.10 Potential health impacts on the physical environment

Health determinant	Predicted health impacts		Indicators / data sources	Risk of impact
	Positive	Negative		
Housing quality / living conditions	Reduction in respiratory diseases related to the eradication of damp and improved ventilation and heating		GP and hospital records.	
	Reduction in rates of asthma attacks related to the eradication of damp and improved ventilation and heating		GP and hospital records.	
	Improved mental health and well being related to sound insulation and general improvement in housing quality		GP and hospital records or specially designed surveys.	
	Reduction in accidental injuries in the home as a result of a safer home environment		GP and hospital records.	
	Reduction in crime and the fear of crime		Crime survey data and specially designed surveys.	
		Increased stress during building works or as a result of incomplete works	Would require specially designed surveys.	

		Reduction in availability of rented housing stock if HMOs are demolished.		
The wider environment	Improved mental health and well being as a result of improved exterior appearance of housing		Would require specially designed surveys.	
		Increased stress during building works	Would require specially designed surveys.	
		Increase in accidental injury during building works	GP and hospital records.	

Risk of impact: d = definite; p = probable; s = speculative

Improvements to housing quality might be expected to result in positive health effects in terms of several health status indicators. For example, a reduction in respiratory disease and rates of asthma attacks related to the eradication of damp and improved ventilation and heating. Similarly, better sound insulation and other general housing improvements might be expected to lead to improved mental health and well being whilst improved housing design could result in a reduction of accidental injuries in the home.

There may also be a reduction in crime as a result of improved security measures in the homes which are part of the scheme, resulting in less fear of crime amongst residents when they are inside their homes. A reduction in such stress and anxiety is likely to lead to improvements in mental health and well being.

On the minus side there is likely to be increased stress for tenants and other residents in the area whilst the building works are being carried out and, for tenants, afterwards if decoration is not included in the improvement programmes. As there are usually no plans to decant residents into other properties during this period it is also probable that there will be temporary health effects such as respiratory problems due to high dust levels. The building works may also carry with them the risk of accidents, for example, to children playing on the sites.

In the wider environment there are likely to be positive health impacts associated with a better external appearance of the properties which may have a wide impact – on tenants and other local residents alike – and may help to change non-residents’ perceptions of HMOs.

Public services

Current situation

Again there are no data for tenants of the HMOs being improved but health service uptake rates for the whole of the central Southport area are thought to be relatively low.

Potential health impacts

Table 4.11 below summarises the potential health impacts which might be expected to result from the Private Rented Dwellings Project.

Table 4.11 Potential health impacts on public services

Health determinant	Predicted health impacts		Indicators / data sources	Risk of impact
	Positive	Negative		
Uptake of health and social services	Health education and promotion as a result of higher service uptake. Treatment of ill health as a result of higher service uptake.	Lower quality of health services due to increased pressure resulting from higher demand.		
Integration between services	Improved service quality through better integration between housing, health and other social services.			

Risk of impact: d = definite; p = probable; s = speculative

Many of the tenants of privately rented dwellings are relatively transient. It is possible that if they see their homes, once improved, as permanent rather than temporary places to live they will be encouraged to make more use of the public services in the area. This might be expected to lead to their being exposed to more health educational and promotional material

and to higher rates of treatment of ill health. The downside of this might be increased pressure on local services.

For housing which is allocated by the local authority, the introduction of new policies to allocate housing according to need also gives the potential for better integration between services and referral to other agencies where appropriate.

Public policy

The Private Rented Dwellings Project has been shaped by both the national and local public policy climates. If it is successful in achieving its aims it could be used as a model for other areas or, finances permitting, be expanded within Southport, with the potential health impacts identified in previous sections for other tenants. With the application of a more detailed health impact assessment process and careful monitoring and evaluation the Project could contribute significantly to the evidence base, offering others about to embark on similar work useful pointers as to what does and what doesn't work.

4.3 Health inequalities and policy implications

The Private Rented Dwellings Project operates in an area of deprivation and targets its resources on some of the properties in those parts of the housing sector which are in the poorest condition and which are occupied by the most vulnerable groups of the population. As a result its health impacts are likely to have some effect on health inequalities between these residents and others living in the same area. However, the exact nature and size of these potential impacts is difficult to assess for a number of reasons:

1. The nature of the programme means that landlords have to come forward to apply for improvement grants under the project. It is likely, therefore, that these are the "better" landlords and, although grants are not made unless they are warranted, some of the landlords renting out the properties which are in the worst condition may not apply to become part of the scheme. This would have the effect of improving living conditions for some vulnerable people but not for others, thereby increasing inequalities between them.
2. There is also an issue related to the "property focus" of the scheme. The Private Rented Dwellings Project focuses on the need to bring properties up to an acceptable standard according to the housing fitness standards set out in the Housing Act of 1995. As a result, it targets properties not people and does not take into account the needs of the tenants when making the improvements to their homes. It does not, for example, include the provision of aids and adaptations for disabled people in its renovation and refurbishment process, neither does it include decoration, for example after plaster has been removed to

replace wiring systems. This means that there is potential for causing considerable disruption to tenants, with the associated ill effects of anxiety and stress, particularly where tenants may be left with a home which is technically safer but which is in a poorer state of decoration.

3. Furthermore there is no requirement for landlords to consult their tenants before carrying out the work although this issue is addressed to some extent by the fact that the local authority does contact them before the start of works. Where tenants are unable to make alternative living arrangements during the building works they may be at greater risk of accidents, respiratory disease and stress at this time.
4. There is also no provision within the Project to ensure that rents are not raised after the improvements have been made. For those tenants who are in receipt of housing benefit this may not be an issue but, if rents levels are raised after the improvements have been made, others may be forced to find alternative, cheaper accommodation which is likely to be in a poorer state of repair. This could change the demographic structure of the population, resulting in an apparent improvement in indicators of health status overall but a shifting of some of the most vulnerable groups into other areas.

If the Private Rented Dwellings Project is to be refocused towards health, there are a number of measures which might be taken:

1. The Project could be proactive in identifying those properties which are most in need of renovation, possibly through a wide ranging programme of property registration and inspection, so that more rigid criteria can be applied to ensure that it is the properties in the worst condition which are improved first.
2. It might also be possible to target not just those properties which are in poor condition but those tenants who have most need of housing improvements. This might also involve a change in housing allocation policies where privately rented dwellings are used by the housing department of the local authority, which would need to allocate properties on the basis of matching tenants needs with the type of property available.
3. The Project could also review the processes by which improvements are made to properties to address issues related to consultation with tenants, redecoration schemes, aids and adaptations and overall management of the improvement process. This could include exploring ways of minimising disruption during the building works or offering the option of a “decant” at this time.
4. Finally, mechanisms could be put in place to ensure that rents are kept at an affordable levels after the dwellings have been improved.

5. Evaluation of the HIA methods employed in this case study

Undertaking a rapid HIA for the Private Rented Dwellings Project has been useful in terms of identifying the issues which would need to be taken into account for a more in-depth study. It has, however, run into some difficulties in terms of identifying health impacts and has clearly demonstrated the considerable limitations of rapid HIA when applied to a project such as this. Some of these issues are outlined below.

Defining the population

It was not possible, in a rapid HIA, to define the population covered by the Private Rented Dwellings Project. Although routine demographic and other data is readily available to provide a denominator population for the whole area it was not possible to ascertain basic information such as how many people live in privately rented dwellings which are eligible for the Project or the characteristics of those people living in properties which are being improved. In the absence of a residents association or register of tenants this data could only be obtained by mounting purpose built surveys which were not within the remit of the rapid HIA process adopted for this case study. As a result, identifying the health and health inequalities impacts of the Project was based largely on speculation about the size and nature of the population and quantification was impossible.

Identifying health impacts

As noted above, most of the health and health inequalities impacts identified were speculative and qualitative because of the lack of evidence about the population affected. In addition, the lack of a comprehensive evidence base hampered the identification of health impacts. For example, although there is a body of evidence on the links between poor housing and conditions such as asthma or other respiratory disease, less is known about the ways in which poor housing affects psychological health and well being, social cohesion or community participation.

This is an issue which would apply to any HIA, whether it is rapid, in-depth or comprehensive. However, whilst a rapid HIA can only highlight the problem, more detailed studies would be able to contribute to the evidence base through survey work and might also allow time for more exploration of the published and “grey” literature.

Measuring health impacts

Although some extrapolations could be made, the lack of data on the population affected also has a knock-on effect in terms of the extent to which potential health impacts can be quantified. This may not be important in terms of the general principles of HIA, which include balancing quantitative and qualitative data, but it is often advantageous in the current climate, when negotiating for the recommendations of the HIA to be implemented, to provide some “hard facts” as well as quantitative assessments.

If the population could be identified, it would be possible to use some routine data sources, such as those kept in primary care, to obtain measure of, for example, health service uptake and reported incidence of disease. However, this is extremely resource-intensive and usually costly and a better way of obtaining data may have been to mount purpose built surveys of the population being addressed. This would have the advantage of being able to incorporate both quantitative and qualitative information.

Consultation

In a rapid HIA there is usually very little time for consultation with “key stakeholders”. In this case, the meetings held with the Private Rented Dwellings project manager and the chair of the SRB Partnership sub-group were extremely helpful in terms of gathering background information on the Project, starting to make a qualitative assessment of its potential health impacts and highlighting the data issues involved. In retrospect, for this case study – or for a more detailed HIA - it would also have been helpful to meet landlords and tenants to give more depth to the picture obtained.

Timing

The case study was undertaken at a stage when the Private Rented Dwellings Project was already well underway and, therefore, represents a concurrent rapid HIA, which has highlighted some ways in which the Project could be modified in order to maximise its

positive health impacts and minimise the negative ones. The nature of the work – aiming to highlight methodological issues rather than to undertake a “real life” HIA – has meant that the scope for doing this has been limited, although, the findings of the work will be passed on to the SRB Partnership sub-group responsible for the Project.

Had the HIA been undertaken at an earlier stage, ideally before the Project started its implementation phase, there would have been more scope to influence the ways in which it was developed. For example, a prospective HIA could have been used to raise awareness of health related issues amongst those responsible for implementation and to bring together a range of “key stakeholders” in order to ensure that the Project does not operate in isolation. Steps could also have been taken to investigate further the potential health impacts which have been identified in the HIA and to eliminate some of the possible health risks such as those associated with the management of the building works and with housing allocation policies.

6. Conclusions and recommendations

This case study represents a rapid HIA of the Private Rented Dwellings Project, one of the initiatives being undertaken through the Central Southport SRB Partnership. It has followed an adapted version of the Merseyside Guidelines as a framework for identifying and assessing the potential health impacts of the Project.

The case study has provided some useful pointers as to when, where and at what level a rapid HIA is appropriate and to how a rapid HIA can be undertaken in order to have maximum benefit.

At what stage of the policy development process is rapid HIA appropriate?

From the evidence of this case study rapid HIA can be applied concurrently, although, it is probably more appropriate at an earlier stage in order to make the most of opportunities

- to shape policy and planning procedures and sharpen their focus on health issues;
- to engage the key stakeholders in the work; and
- to raise awareness of health related issues.

Where is rapid HIA appropriate?

Rapid HIA, by definition, cannot give a comprehensive and rigorously researched account of potential health impacts of any policy, programme or project. It is useful, however, not only as a tool for raising awareness of health issues but also to identify important health effects which were previously hidden and as a starting point for identifying where more detailed work may be needed. In doing this it is helped if

- there is a population likely to be affected which can be clearly defined and, preferably, counted; and
- where there is a “people focus”, with policies, programmes and projects which explicitly aim to improve the health of the defined population rather than those which are concerned with the regeneration of an area.

At what level is rapid HIA appropriate?

Rapid HIA can be applied at any level – to policies, programmes or projects – although the evidence from this case study would suggest that it may be more appropriate at a strategic (policy or programme) level than it is for more specific projects. For projects such as the Private Rented Dwellings Project, a quicker process of rapid appraisal is likely to yield similar results to those emerging from a rapid HIA and these could still be used as a springboard for identifying high priority areas for action as well as issues which might be addressed in a more detailed HIA.

How should it be done?

In a rapid HIA, the evidence from this case study suggests that resources might best be spent on consultation and discussion with key stakeholders and on making a qualitative assessment of the likely health impacts based on the existing knowledge and expertise of those involved. A detailed examination of quantitative data is probably less appropriate, except as background information, unless it is readily available and can be related specifically to the population being addressed by the policy, programme or project.

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Appendix 2.1

Central Southport SRB Partnership: Programme Areas and Projects

APPENDIX 2.1

CENTRAL SOUTHPORT PARTNERSHIP

Measure 1: Housing

Objective:

To improve living conditions and management of housing in the central area, particularly in the private rented sector, and provide greater choice and diversity, especially for special needs groups.

Projects:

1. Improving Private Rented Dwellings
2. Hostel for Alcoholics and Outreach Service
3. Specialist Housing for Defined Local Needs
4. New Accommodation in Vacant Upper Floors
5. Mullet-facetted Housing Advisory Service

Measure 2: Employment and training

Objective:

To encourage sustainable economic growth by improving the economic performance of local businesses, particularly tourism, and to support new business development.

Projects:

1. Hotel and Business Grants (2 projects)
2. Development of Telematics
3. Visitor Facilities at the Esplanade Park and Ride
4. Integrated Marketing Initiative
5. Management Initiative
6. Area-wide Security
7. East Bank Street / Scarisbrick Avenue

Measure 3: Employment and Training

Objective:

To improve access to training and employment, to increase skill levels of local people, particularly young people, and to enhance the employment prospects of those at a disadvantage, particularly those with disabilities.

Projects:

1. Opportunities Shop
2. Parents' Project
3. Young People's Project
4. Access to Employment and Enterprise

Measure 4: Community and Facilities*Objective:*

To build up the capacity of the local community to contribute to local regeneration and to enhance the quality of life by improving cultural and sports facilities in the Central Area.

Projects:

1. Community Development
2. Community Action Fund
3. Drug Prevention Initiative
4. Victims of Domestic Violence
5. Shopmobility Scheme
6. Community Facilities in Parks
7. Community Sports Facilities

Appendix 3.1

Framework for Rapid Health Impact Assessment

APPENDIX 3.1

CENTRAL SOUTHPORT SRB: PRIVATE RENTED DWELLINGS CASE STUDY

FRAMEWORK FOR RAPID HEALTH IMPACT ASSESSMENT *

Health determinants	Predicted health impacts		Indicators / data sources	Risk of impact	Comments
	Positive	Negative			

Predicted health impacts: Nature and, where possible, size of impact and how measurable the impact is.
Q = qualitative; E = estimable; C = calculable

Risk of impact: D = definite; P = probable; S = speculative

* Based on the Merseyside Guidelines (Scott-Samuel, Birley and Ardern, 1998)

Appendix 3.2

Examples of Health Determinants

APPENDIX 3.2

EXAMPLES OF HEALTH DETERMINANTS*

Biological factors

e.g. age, gender, ethnicity, other genetic factors

Personal or family circumstances and lifestyle

e.g. family structure and functioning
education, occupation, employment / unemployment, income
risk taking behaviour (smoking, alcohol use, other substance misuse)
diet, exercise, recreation and leisure

Social environment

e.g. culture, peer pressures, discrimination
social support (neighbours, social networks, isolation)
community, cultural and spiritual participation

Physical environment

e.g. air, water, waste disposal, energy
living (housing) conditions, working conditions
noise, public safety, civic design, land use, local environmental features
shops (location, quality and range)
communications (transport networks)

Public services

e.g. access to services
quality of services

Services might include health care, social services, housing, leisure, employment, social security; public transport, policing and other health relevant public services, non-statutory agencies and services.

Public policy

e.g. economic, social, environmental and health policy trends;
local and national priorities, policies, programmes and projects

* Based on work by Lalonde and Labonté

